

**T-MSIS Data Dictionary Appendices**

**December 04, 2020**

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# Preface

TMSIS is moving along the transition path of creating a comprehensive, integrated, and contextual Data Guide approach to supporting states and territories in their data submission quality improvement initiatives.

As part of this on-going process, the Data Dictionary Appendix approach will be undergoing significant changes over time to better meet these needs. This version 2.4.x release contains minimal changes from previous versions while this transformational work is being undertaken in parallel.

# Appendix A: Valid Values

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# NOTE

The content that previously has been included here in Data Dictionary Appendix A has been removed from this document and moved to a separate Excel-based file.

The purpose of this change was in response to feedback requesting to provide Valid Value Lists in a discrete data format which could be end-user manipulated, as well as to facilitate loading the data into a system. This is the first of many changes coming to the existing Data Dictionary Appendices approach as mentioned in the Preface section above.

# Appendix B: Home and Community-Based Services (HCBS) Taxonomy

The following table defines categories and services in the HCBS Taxonomy. It was approved by CMS in August 2012.

To acknowledge state variation, services and categories are defined based on the minimum definition necessary to establish mutually distinct categories and services. Some services are defined in part by characteristics that are NOT in that service. For example, the difference between companion services and personal care is that companion services do not include assistance with activities of daily living (ADLs) such as bathing, dressing, eating, and toileting.

Some of the services reflected below, including, but not limited to personal care, case management, home health aide, and physician services, may (and in some case, must) also be covered under the Medicaid State Plan. The definitions below only define these services for purposes of Section 1915(c) Waivers and the State Plan Home and Community-Based Services benefit authorized by Section 1915(i). States interested in reflecting services as “extended state plan” services must offer them in accordance with state plan service definitions. Consult with the CMS Division of Benefits and Coverage in those instances to ensure definition alignment.

The services and categories are arranged in order of consideration for placing a particular state service in the taxonomy. If one is not sure how to map a state’s service to the taxonomy, one should first consider Case Management, then Round-the-Clock Services, then Supported Employment, etc.

## HCBS Service Taxonomy Values:

| **Category** | **Sub-Category (where applicable)** | **Service** | **Common Names**  **(where applicable)** | **Definition** |
| --- | --- | --- | --- | --- |
| 01 – Case Management | N/A | N/A | N/A | The development of a comprehensive, written individualized support plan. In addition, case management often includes assisting people in gaining access to necessary services, assessment of a person's needs, ongoing monitoring of service provision and/or a person's health and welfare, assistance in accessing supports to transition from an institutional setting (but not the transition services themselves); and development of a 24-hour individual back-up plan with formal and informal supports |
| N/A | 01010 case management | N/A | care management supports coordination | Same definition as category 01. |
| 02 Round-the-Clock Services | N/A | N/A | N/A | Services by a provider that has round-the-clock responsibility for the health and welfare of residents, except during the time other services (e.g., day services) are furnished. If these services are provided in a 1915(c) waiver, the state must complete Appendix G-3 of the 1915(c) waiver application regarding medication management and administration. |
| N/A | 0201 group living | N/A | assisted living group home services | Round-the-clock services provided in a residence that is NOT a person’s home or apartment or a single family residence where one or more people with a disability live with a person or family who furnishes services |
| N/A | N/A | 02011 group living, residential habilitation | N/A | Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills by a provider with round-the-clock responsibility for the residents’ health and welfare in a residence that is NOT a person’s own home or apartment or a single family residence where one or more people with a disability live with a person or family who furnishes services. |
| N/A | N/A | 02012 group living, mental health services | N/A | Mental health services by a provider with round-the-clock responsibility for the residents’ health and welfare in a residence that is NOT a person’s own home or apartment or a single family residence where one or more people with a disability live with a person or family who furnishes services. |
| N/A | N/A | 02013 group living, other | N/A | Health and social services not identified elsewhere in subcategory 0201 by a provider with round-the-clock responsibility for the residents’ health and welfare in a residence that is NOT a person’s own home or apartment or a single family residence where one or more people with a disability live with a person or family who furnishes services. |
| N/A | 0202 shared living | N/A | adult foster care family living host homes | Round-the-clock services provided in a single family residence where one or more people with a disability live with a person or family who furnishes services. |
| N/A | N/A | 02021 shared living, residential habilitation | N/A | Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills provided in a single family residence where one or more people with a disability live with a person or family who furnishes services and has round-the-clock responsibility for the residents’ health and welfare. |
| N/A | N/A | 02022 shared living, mental health services | N/A | Mental health services provided in a single family residence where one or more people with a disability live with a person or family who furnishes services and has round-the-clock responsibility for the residents’ health and welfare. |
| N/A | N/A | 02023 shared living, other | N/A | Health and social services not identified elsewhere in subcategory 0202 provided in a single family residence where one or more people with a disability live with a person or family who furnishes services and has round-the-clock responsibility for the residents’ health and welfare. |
| N/A | 0203 in-home round-the-clock services | N/A | supported living | Round-the-clock services provided in a person's home or apartment where a provider has round-the-clock responsibility for the person's health and welfare. |
| N/A | N/A | 02031 in-home residential habilitation | N/A | Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills provided in a person's home or apartment where a provider has round-the-clock responsibility for the person's health and welfare. |
| N/A | N/A | 02032 in-home round-the-clock mental health services | N/A | Mental health services provided in a person's home or apartment where a provider has round-the-clock responsibility for the person's health and welfare. |
| N/A | N/A | 02033 in-home round-the-clock services, other | N/A | Health and social services not identified elsewhere in subcategory 0203 provided in a person's home or apartment where a provider has round-the-clock responsibility for the person's health and welfare. |
| 03 Supported Employment | N/A | N/A | N/A | Assistance to help a person obtain or maintain paid employment or self-employment. |
| N/A | 0301 job development | 03010 job development | N/A | Assistance to locate and obtain paid employment or self-employment. |
| N/A | 0302 ongoing supported employment | N/A | N/A | Assistance to maintain paid employment or self-employment. |
| N/A | N/A | 03021 ongoing supported employment, individual | N/A | Assistance to maintain self-employment or paid employment in an individual job placement (i.e., person is working with people without disabilities). |
| N/A | N/A | 03022 ongoing supported employment, group | N/A | Assistance to maintain paid employment in a group placement (i.e., person is working on a team of people with disabilities). |
| N/A | 0303 career planning | 03030 career planning | N/A | Focused, time-limited assistance to identify a career direction and develop a plan to achieve employment. |
| 04 Day Services | N/A | N/A | N/A | Services other than supported employment typically provided outside the person's home during the working day (i.e., Monday through Friday between 8 a.m. and 5 p.m.). These services provide a range of supports and are often, but not always, provided on a regularly scheduled basis at a site specifically established to provide day services. |
| N/A | N/A | 04010 prevocational services | N/A | Time-limited services to provide learning and work experiences, including volunteer work, to acquire general skills that help a person obtain paid employment in integrated community settings. |
| N/A | N/A | 04020 day habilitation | N/A | Regularly scheduled activities in settings separate from the participant’s residence, including assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills. This service includes community-based volunteer activities that include acquiring, retaining, and improving self-help, socialization, and adaptive skills. This service can include the supports offered in adult day health, adult day services (social model), and community integration if these supports are provided along with assistance in acquiring, retraining, and improving self-help, socialization, and/or adaptive skills. |
| N/A | N/A | 04030 education services | N/A | Services to help a person access post-secondary education. |
| N/A | N/A | 04040 day treatment/ partial hospitalization | N/A | Services necessary for the diagnosis or treatment of the person's mental illness provided in a fixed site facility during the working day. |
| N/A | N/A | 04050 adult day health | N/A | Skilled health services and other support services, NOT including habilitation (i.e., assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills), provided to adults in a fixed site facility during the working day. This service can include the supports offered in adult day services (social model) if these supports are provided along with skilled health services. |
| N/A | N/A | 04060 adult day services (social model) | N/A | Support services, NOT including skilled health services and not including habilitation (i.e., assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills), provided to adults in a fixed site facility during the working day. |
| N/A | N/A | 04070 community integration | escort | Assistance in participating in community activities, NOT including assistance with activities of daily living or assistance in acquiring, retraining, and improving self-help, socialization, and/or adaptive skills. This service can include supports furnished in the person’s residence related to community participation. |
| N/A | N/A | 04080 medical day care for children | N/A | Medical services beyond typical day care responsibilities provided during the working day for infants, toddlers, and pre-school age children. |
| 05 Nursing | N/A | N/A | N/A | Services within the scope of the state's nurse practices act provided by a licensed nurse. |
| N/A | N/A | 05010 private duty nursing | N/A | Licensed nursing services provided on a continuous or full-time basis (e.g., for more than 4 consecutive hours per day and for more than 60 days). This service can include the supports offered in health assessment, health monitoring, and medication assessment if the service also includes other services within the scope of the state’s nurse practices act. |
| N/A | N/A | 05020 skilled nursing | N/A | Licensed nursing services provided on a part-time or intermittent basis. This service can include the supports offered in health assessment, health monitoring, and medication assessment if the service also includes other services within the scope of the state’s nurse practices act. |
| 06 Home delivered meals | N/A | N/A | N/A | Prepared meals sent to a person's home, which may not comprise a full nutritional regimen. |
| N/A | N/A | 06010 home delivered meals | N/A | Same definition as category 06. |
| 07 Rent and Food Expenses for Live-In Caregiver | N/A | N/A | N/A | Payment for the additional costs of rent and food that can be attributed to an unrelated direct support worker living with the person. This service does not include payment for the direct support worker’s services, which may be covered as part of other services such as personal care. |
| N/A | N/A | 07010 rent and food expenses for live-in caregiver | N/A | Same definition as category 07. |
| 08 Home-Based Services | N/A | N/A | N/A | Services that support a person in his or her home or apartment, when the provider does not have round-the-clock responsibility for the person's health and welfare. These services can be provided in other community settings, but are primarily furnished in a person’s home or apartment. |
| N/A | N/A | 08010 home-based habilitation | supported living (provided on an hourly basis) | Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills provided in the person's home when the provider does NOT have round-the-clock responsibility for the person's health and welfare. This service can include the supports offered in community integration, home health aide, personal care, companion, and homemaker if these supports are provided along with assistance in acquiring, retraining, and improving self-help, socialization, and/or adaptive skills. |
| N/A | N/A | 08020 home health aide | N/A | Assistance with activities of daily living (ADLs) and/or health-related tasks provided in a person's home and possibly other community settings that are supervised by a registered nurse or licensed therapist and provided by a licensed home health agency. Home health aide may include assistance with instrumental activities of daily living (IADLs). Home health aide may include the supports offered in companion and homemaker if these supports are provided along with assistance with ADLs and/or health-related tasks. Home health aide does NOT include habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills). |
| N/A | N/A | 08030 personal care | attendant care personal assistance personal attendant services | Assistance with ADLs and/or health-related tasks provided in a person's home and possibly other community settings, NOT including both provision by a licensed home health agency and a requirement for supervision by a licensed nurse or therapist. Personal care may include assistance with IADLs. Personal care may include the supports offered in companion and homemaker if these supports are provided along with assistance with ADLs and/or health-related tasks. Personal care does NOT include habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills). |
| N/A | N/A | 08040 companion | adult companion night supervision | Supervision and/or social support provided in a person's home and possibly other community settings. Companion may also include performance of light housekeeping tasks (the supports offered in homemaker). Companion does NOT include assistance with ADLs or habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills). |
| N/A | N/A | 08050 homemaker | N/A | Performance of light housekeeping tasks provided in a person's home and possibly other community settings NOT including supervision and social support, assistance with ADLs, or habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills). |
| N/A | N/A | 08060 chore | N/A | Performance of heavy household chores provided in a person's home and possibly other community settings NOT including supervision and social support, assistance with ADLs, or habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills). |
| 09 Caregiver Support | N/A | N/A | N/A | Assistance to people who provide ongoing support to the person with a disability when assisting the support person is the primary purpose of the service. In most cases, the support person is unpaid. However, respite can be provided to relieve providers who furnish shared living. |
| N/A | 0901 respite | N/A | N/A | Short-term services provided because a support person is absent or needs relief when relieving the support person is the primary purpose of the service. |
| N/A | N/A | 09011 respite, out-of-home | N/A | Short-term services provided because a support person is absent or needs relief NOT provided in a person's home or apartment when relieving the support person is the primary purpose of the service. |
| N/A | N/A | 09012 respite, in-home | N/A | Short-term services provided because a support person is absent or needs relief provided in a person's home or apartment when relieving the support person is the primary purpose of the service. |
| N/A | 0902 caregiver counseling and/or training | 09020 caregiver counseling and/or training | N/A | Counseling, emotional support, and/or training provided to a family member or friend providing support when providing counseling or training to the support person is the primary purpose of the service. Examples of training topics include a) skills to provide specific treatment regimens or help the person improve function, b) information about the person's disability or conditions, and c) navigation of the service system. |
| 10 Other Mental Health and Behavioral Services | N/A | N/A | N/A | Services NOT identified in previous categories that support people in improving or maintaining mental or behavioral health. |
| N/A | N/A | 10010 mental health assessment | N/A | Assessment or evaluation of mental health status when the assessment is the primary purpose of the service. This service can include medication assessment if the assessment includes other mental health information. |
| N/A | N/A | 10020 assertive community treatment | N/A | A range of mental health supports characterized by assertive engagement of the person, availability 24 hours a day, and support by an interdisciplinary team. |
| N/A | N/A | 10030 crisis intervention | crisis support | Response to stabilize a person exhibiting behavior that puts the person at risk of hospitalization or institutionalization. |
| N/A | N/A | 10040 behavior support | behavior analysis behavior therapy | Services specifically to encourage positive behaviors and to decrease challenging behaviors, including a) assessment to identify antecedents to behaviors and b) development of a plan to improve behaviors. |
| N/A | N/A | 10050 peer specialist | peer support | Mental health support services provided by a trained and credentialed person with a mental illness. |
| N/A | N/A | 10060 counseling | N/A | Individual or group therapy to develop coping skills or improve mental health function. |
| N/A | N/A | 10070 psychosocial rehabilitation | N/A | Assistance to improve or restore function in ADLs, IADLs, and social or adaptive skills NOT identified in previous categories or services. |
| N/A | N/A | 10080 clinic services | N/A | Services for individuals with chronic mental illness furnished in a clinic or based in a clinic NOT identified in previous categories or services. |
| N/A | N/A | 10090 other mental health and behavioral services | N/A | Services NOT identified elsewhere in category 10 that support people in improving or maintaining mental or behavioral health. |
| 11 Other Health and Therapeutic Services | N/A | N/A | N/A | Services NOT identified in previous categories that support people in improving or maintaining health or functional capacity. |
| N/A | N/A | 11010 health monitoring | N/A | Ongoing monitoring of physical health status when monitoring is the primary purpose of the service. This service can include medication monitoring if other aspects of a person’s health also are monitored. |
| N/A | N/A | 11020 health assessment | N/A | Assessment or evaluation of physical health status when the assessment is the primary purpose of the service. This service can include medication assessment if the assessment includes other health information. |
| N/A | N/A | 11030 medication assessment and/or management | N/A | Assessment of medication administration and/or possible drug interactions—and/or oversight of ongoing medication administration—when the management of medications is the primary purpose of the service. |
| N/A | N/A | 11040 nutrition consultation | N/A | Assistance to a person to help him or her plan and implement changes to nutritional intake. |
| N/A | N/A | 11050 physician services | N/A | Services by a licensed physician. This service can include health assessment, medication assessment, and/or mental health assessment if other physician services are also provided. |
| N/A | N/A | 11060 prescription drugs | N/A | Prescription drugs. |
| N/A | N/A | 11070 dental services | N/A | Services by a licensed dentist. |
| N/A | N/A | 11080 occupational therapy | N/A | Services by a licensed occupational therapist. |
| N/A | N/A | 11090 physical therapy | N/A | Services by a licensed physical therapist. |
| N/A | N/A | 11100 speech, hearing, and language therapy | N/A | Services by a licensed speech, hearing, and language therapist. This service includes services by a speech pathologist or a qualified audiologist. |
| N/A | N/A | 11110 respiratory therapy | N/A | Services by a licensed respiratory therapist. |
| N/A | N/A | 11120 cognitive rehabilitative therapy | N/A | Assistance to manage or restore cognitive function. |
| N/A | N/A | 11130 other therapies | N/A | Therapeutic interventions to maintain or improve function NOT identified in previous categories or services. This service includes specialized interventions such as those using art, music, dance, or trained animals. |
| 12 Services Supporting Participant Direction | N/A | N/A | N/A | Services that assist a person and/or his or her representative in managing participant-directed services, as identified in the Participant Direction of Services section of the 1915(c) waiver or 1915(i) State Plan Amendment application. |
| N/A | N/A | 12010 financial management services in support of participant direction | N/A | Assistance to help a person and/or representative manage participant-directed services by a) performing financial tasks to facilitate the employment of staff; b) managing the disbursement of funds in a participant-directed budget; and/or c) performing fiscal accounting and making expenditure reports to the person, representative, and/or state authorities. |
| N/A | N/A | 12020 information and assistance in support of participant direction | N/A | Training the person and/or representative in directing or managing services. Topics include: a) the person's rights and responsibilities in participant direction; b) recruiting and hiring staff; c) managing staff and solving problems regarding services; and d) managing a participant-directed budget. |
| 13 Participant Training | N/A | N/A | N/A | Training provided to a participant when training the participant is the primary purpose of the service. Topics may include: a) specific treatment regimens, b) the person's disability or condition, and c) navigation of the service system. |
| N/A | N/A | 13010 participant training | N/A | The same definition as category 13. |
| 14 Equipment, Technology, and Modifications | N/A | N/A | N/A | Material goods to help a person improve or maintain function. |
| N/A | 1401 personal emergency response system (PERS) | 14010 personal emergency response system (PERS) | N/A | Devices that enable participants to signal a response center to secure help in an emergency. This service can include installation, maintenance, and monthly response center fees. |
| N/A | 1402 home and/or vehicle accessibility adaptations | 14020 home and/or vehicle accessibility adaptations | home and/or vehicle modifications | Physical changes to a private residence, automobile, or van, to accommodate the participant or improve his or her function. |
| N/A | 1403 equipment, technology, and supplies | N/A | N/A | The purchase or rent of items, devices, product systems, and/or disposable medical supplies. |
| N/A | N/A | 14031 equipment and technology | assistive technologyspecialized medical equipment | The purchase or rent of items, devices, or product systems to increase or maintain a person's functional status. This service can include designing, fitting, adapting, and maintaining equipment, as well as training or technical assistance to use equipment. |
| N/A | N/A | 14032 supplies | N/A | The purchase of disposable medical supplies, including nutritional supplements. |
| 15 Non-Medical Transportation | N/A | N/A | N/A | Transportation not provided as part of another service such as a round-the-clock service or a day service. This service may include: a) transportation to and from other HCBS services; b) transportation to community activities where HCBS services are not provided; and/or c) the purchase of public transit tokens or passes. |
| N/A | N/A | 15010 non-medical transportation | N/A | Same definition as category 15. |
| 16 Community Transition Services | N/A | N/A | N/A | Non-recurring set-up expenses for moving to a residence where the person is responsible for living expenses. |
| N/A | N/A | 16010 community transition services | N/A | Same definition as category 16. |
| 17 Other Services | N/A | N/A | N/A | Services NOT identified in previous categories. |
| N/A | N/A | 17010 goods and services | Individually directed goods and services | Services, equipment, or supplies in the person's support plan NOT otherwise provided in the Medicaid program. |
| N/A | N/A | 17020 interpreter | N/A | Services provided by an individual to support communication by someone who has limited English proficiency or verbal skills, such as a sign language interpreter or communicator. |
| N/A | N/A | 17030 housing consultation | N/A | Information and assistance to help a person identify and select housing. |
| N/A | N/A | 17990 other | N/A | Services NOT identified in previous categories and services. |

# 

# Appendix C: Comprehensive Eligibility Crosswalk

MAS/BOE - INDIVIDUALS COVERED UNDER SEPARATE CHILDREN’S HEALTH INSURANCE PROGRAMS (Separate-CHIP)

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Children covered under a Title XXI separate CHIP) | 42 CFR 457.310, §2110 (b) of the Act. |
| 2 | Legal immigrant children and pregnant women covered under a Title XXI separate CHIP | §2107(e)(1) of the Act, P.L. 111-3. |
| 3 | Children receiving dental-only coverage under a separate CHIP | §2102 and 2110 (b) of the Act, PL 111-3. |
| 4 | Targeted low-income pregnant women covered under a Title XXI separate CHIP | §2112 of the Act, PL 111-3. |
| 5 | Infants under age 1 born to targeted low-income pregnant women made eligible under a Title XXI separate CHIP | §2112 of the Act, PL 111-3. |
| 6 | Children who have been granted presumptive eligibility under a Title XXI separate CHIP | 42 CFR 457.355, §2105 of the Act. |
| 7 | Pregnant women who have been granted presumptive eligibility under a Title XXI separate CHIP | §2112 of the Act, PL 111-3. |
| 8 | Caretaker relatives and children covered under the authority of an 1115 waiver and a Title XXI separate CHIP | §2107(e) of the Act. |

**MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 OF THE ACT-AGED MSIS Coding (MAS-1, BOE-1)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Aged individuals receiving SSI, eligible spouses or persons receiving SSI pending a final determination of disposal of resources exceeding SSI dollar limits; and persons considered to be receiving SSI under §1619(b) of the Act. | 42 CFR 435.120, §1619(b) of the Act,  §1902(a)(10)(A)(I)(II) of the Act, PL 99-643, §2. |
| 2 | Aged individuals who meet more restrictive requirements than SSI and who are either receiving or not receiving SSI; or who qualify under §1619 of the Act. | 42 CFR 435.121, §1619(b)(3) of the Act, §1902(f) of the Act, PL 99-643, §7. |
| 3 | Aged individuals receiving mandatory State supplements. | 42 CFR 435.130. |
| 4 | Aged individuals who receive a State supplementary payment (but not SSI) based on need. | 42 CFR 435.230, §1902(a)(10)(A)(ii) of the Act. |

**MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 OF THE ACT - BLIND/DISABLED MSIS Coding (MAS-1, BOE-2)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Blind and/or disabled individuals receiving SSI, eligible spouses or persons receiving SSI pending a final determination of blindness, disability, and/or disposal of resources exceeding SSI dollar limits; and persons considered to be receiving SSI under §1619(b) of the Act. | 42 CFR 435.120, §1619(b) of the Act, §1902(a)(10)(A)(I)(II) of the Act, PL 99-643, §2. |
| 2 | Blind and/or disabled individuals who meet more restrictive requirements than SSI and who are either receiving or not receiving SSI; or who qualify under §1619. | 42 CFR 435.121, §1619(b)(3) of the Act, §1902(f) of the Act, PL 99-643, §7. |
| 3 | Blind and/or disabled individuals receiving mandatory State supplements. | 42 CFR 435.130. |
| 4 | Blind and/or disabled individuals who receive a State supplementary payment (but not SSI) based upon need. | 42 CFR 435.230, §1902(a)(10)(A)(ii) of the Act. |

**MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 OF THE ACT – CHILDREN MSIS Coding (MAS-1, BOE-4)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Low Income Families with Children qualified under §1931 of the Act. | 42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act, §1931 of the Act. |
| 2 | Children age 18 who are regularly attending a secondary school or the equivalent of vocational or technical training. | 42 CFR 435.110, §1902(a)(10)(A)(I)(I). |

**MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 OF THE ACT – ADULTS MSIS Coding (MAS-1, BOE-5)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Adults deemed essential for well-being of a recipient [see 45 CFR 233.20(a)(2)(vi)] qualified for Medicaid under §1931 of the Act. | 42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act, §1931 of the Act. |
| 2 | 1. Pregnant women who have no other eligible children. 2. Other adults in "adult only" units. | 42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act. |

**MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 -U CHILDREN MSIS Coding (MAS-1, BOE-6) - (OPTIONAL)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Unemployed Parent Program - Cash assistance benefits to low income individuals in two parent families where the principle wage earner is employed fewer than 100 hours a month. | 42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act, §1931 of the Act. |
| 2 | Children age 18 who are regularly attending a secondary school or the equivalent of vocational or technical training. | 42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act. |

**MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 - U ADULTS MSIS Coding (MAS-1, BOE-7) - (OPTIONAL)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Adults deemed essential for well-being of a recipient (see 45 CFR 233.20(a)(2)(vi)) qualified under §1931 of the Act (Low Income Families with Children). | 42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act, §1931 of the Act. |
| 2 | 1. Pregnant women who have no other eligible children. 2. Other Adults in "adult only" units. | 42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act. |

**MAS/BOE - MEDICALLY NEEDY – AGED MSIS Coding (MAS-2, BOE-1)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Aged individuals who would be ineligible if not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212, and the same rules apply to medically needy individuals. | 42 CFR 435.326. |
| 2 | Aged | 42 CFR 435.320, 42 CFR 435.330. |

**MAS/BOE - MEDICALLY NEEDY - BLIND/DISABLED MSIS Coding (MAS-2, BOE-2)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Blind and/or disabled individuals who would be ineligible if not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals. | 42 CFR 435.326. |
| 2 | Blind/Disabled | 42 CFR 435.322, 42 CFR 435.324, 42 CFR 435.330. |
| 3 | Blind and/or disabled individuals who meet all Medicaid requirements except current blindness and/or disability criteria, and have been continuously eligible since 12/73 under the State's requirements. | 42 CFR 435.340. |

**MAS/BOE - MEDICALLY NEEDY – CHILDREN MSIS Coding (MAS-2, BOE-4)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Individuals under age 18 who, but for income and resources, would be eligible. | §1902(a)(10)(C)(ii)(I) of the Act, PL 97-248, §137. |
| 2 | Infants under the age of 1 and who were born after 9/30/84 to and living in the household of medically needy women. | §1902(e)(4) of the Act, PL 98-369, §2362. |
| 3 | Other financially eligible individuals under age 18-21, as specified by the State. | 42 CFR 435.308. |
| 4 | Children who would be ineligible if not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals. | 42 CFR 435.326. |

**MAS/BOE - MEDICALLY NEEDY – ADULTS MSIS Coding (MAS-2, BOE-5)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Pregnant women. | 42 CFR 435.301. |
| 2 | Caretaker relatives who, but for income and resources, would be eligible. | 42 CFR 435.310. |
| 3 | Adults who would be ineligible if not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals. | 42 CFR 435.326. |

**MAS/BOE - POVERTY RELATED ELIGIBLES – AGED MSIS Coding (MAS-3, BOE-1)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Qualified Medicare Beneficiaries (QMBs) who are entitled to Medicare Part A, whose income does not exceed 100% of the Federal poverty level, and whose resources do not exceed twice the SSI standard. | §§1902(a)(10)(E)(I) and 1905(p)(1) of the Act, PL 100-203, §4118(p)(8), PL 100-360, §301(a) & (e), PL 100-485, §608(d)(14), PL 100-647, §8434. |
| 2 | Specified Low-Income Medicare Beneficiaries (SLMBs) who meet all of the eligibility requirements for QMB status, except for the income in excess of the QMB income limit, but not exceeding 120% of the Federal poverty level. | §4501(b) of OBRA 90, as amended in §1902(a)(10)(E) of the Act. |
| 3 | Qualifying individuals having higher income than allowed for QMBs or SLMBs. | §1902(a)(10)(E)(iv) of the Act. |
| 4 | Aged individual not described in S 1902(a)(10)(A)(1) of the Act, with income below the poverty level and resources within state limits, who are entitled to full Medicaid benefits. | §1902(a)(10)(A)(ii)(X), 1902(m)(1) of the Act, PL 99-509, §§9402 (a) and (b). |

**MAS/BOE - POVERTY RELATED ELIGIBLES - BLIND/DISABLED MSIS Coding (MAS-3, BOE-2)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Qualified Medicare Beneficiaries (QMBs) who are entitled to Medicare Part A, whose income does not exceed 100% of the Federal poverty level, and whose resources do not exceed twice the SSI standard. | §§1902(a)(10)(E)(I) and 1905(p)(1) of the Act, PL 100-203, §4118(p)(8), PL 100-360, §301(a) & (e), PL 100-485, §608(d)(14), PL 100-647, §8434. |
| 2 | Specified Low-Income Medicare Beneficiaries (SLMBs) who meet all of the eligibility requirements for QMB status, except for the income in excess of the QMB income limit, but not exceeding 120% of the Federal poverty level. | §4501(b) of OBRA 90 as amended in §1902(a)(10)(E)(I) of the Act. |
| 3 | Qualifying individuals having higher income than allowed for QMBs or SLMBs. | §1902(a)(10)(E)(iv) of the Act. |
| 4 | Qualified Disabled Working Individuals (QDWIs) who are entitled to Medicare Part A. | §§1902(a)(10)(E)(ii) and 1905(s) of the Act. |
| 5 | Disabled individuals not described in §1902(a)(10)(A)(1) of the Act, with income below the poverty level and resources within state limits, which are entitled to full Medicaid benefits. | §§1902(a)(10)(A)(ii)(X), 1902(m)(1) and (3) of the Act, P.L. 99-509, §§9402 (a) and (b). |

**MAS/BOE - POVERTY RELATED ELIGIBLES – CHILDREN MSIS Coding (MAS-3, BOE-4)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Infants and children up to age 6 with income at or below 133% of the Federal Poverty Level (FPL). | §§1902(a)(10)(A)(I)(IV) & (VI), 1902(l)(1)(A), (B), & (C) of the Act, PL 100-360, §302(a)(1), PL 100-485, §608(d)(15). |
| 2 | Children under age 19 (born after 9/30/83) whose income is at or below 100% of the Federal poverty level within the State's resource requirements. | §1902(a)(10)(A)(I) (VII) of the Act. |
| 3 | Infants under age 1 whose family income is below 185% of the poverty level and who are within any optional State resource requirements. | §§1902(a)(10)(A)(ii) (IX) and 1902(l)(1)(D) of the Act, PL 99-509, §§9401(a) & (b), PL 100-203, §4101. |
| 4 | Children made eligible under the more liberal income and resource requirements as authorized under §1902(r)(2) of the Act when used to disregard income on a poverty-level-related basis. | §1902(r)(2) of the Act. |
| 5 | Children made eligible by a Title XXI Medicaid expansion under the Child Health Insurance Program (CHIP) | P.L. 105-100. |

**MAS/BOE - POVERTY RELATED ELIGIBLES – ADULTS MSIS Coding (MAS-3, BOE-5)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Pregnant women with incomes at or below 133% of the Federal Poverty Level. | §1902(a)(10)(A)(I), (IV) and (VI); §1902(l)(1)(A), (B), & (C) of the Act, PL 100-360, §302(a)(1), PL 100-485, §608(d)(15). |
| 2 | Women who are eligible until 60 days after their pregnancy, and whose incomes are below 185% of the FPL and have resources within any optional State resource requirements. | §§1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(D) of the Act, PL 99-509, §§9401(a) & (b), PL 100-203, §4101. |
| 3 | Caretaker relatives and pregnant women made eligible under more liberal income and resource requirements of §1902(r)(2) of the Act when used to disregard income on a poverty-level related basis. | §1902(r)(2) of the Act. |
| 4 | Adults made eligible by a Title XXI Medicaid expansion under the Child Health Insurance Program (CHIP). | Title XXI of the Social Security Act. |

**MAS/BOE - POVERTY RELATED ELIGIBLES – ADULTS MSIS Coding (MAS-3, BOE-A)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Women under age 65 who are found to have breast or cervical cancer, or have precancerous conditions. | §1902(a)(10)(a)(ii)(XVIII), P.L. 106-354. |

**MAS/BOE - OTHER ELIGIBLES – AGED MSIS Coding (MAS-4, BOE-1)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Aged individuals who meet more restrictive requirements than SSI and who are either receiving or not receiving SSI; or who qualify under §1619 of the Act. | 42 CFR 435.121, §1619(b)(3) of the Act, §1902(f) of the Act, PL 99-643, §7. |
| 2 | Aged individuals who are ineligible for optional State supplements or SSI due to requirements that do not apply under title XIX. | 42 CFR 435.122. |
| 3 | Aged essential spouses considered continuously eligible since 12/73; and some spouses who share hospital or nursing facility rooms for 6 months or more. | 42 CFR 435.131. |
| 4 | Institutionalized aged individuals who have been continuously eligible since 12/73 as inpatients or residents of Title XIX facilities. | 42 CFR 435.132. |
| 5 | Aged individuals who would be SSI/SSP eligible except for the 8/72 increase in OASDI benefits. | 42 CFR 435.134. |
| 6 | Aged individuals who would be eligible for SSI but for title II cost-of-living adjustment(s). | 42 CFR 435.135. |
| 7 | Aged aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care. | PL 99-509, §9406. |
| 8 | Aged individuals who would be eligible for AFDC, SSI, or an optional State supplement if not in a medical institution. | 42.CFR 435.211, §1902(a)(10)(A)(ii) and §1905(a) of the Act. |
| 9 | Aged individuals who meet income and resource requirements for AFDC, SSI, or an optional State supplement. | 42 CFR 435.210, §1902(a)(10)(A)(ii) and §1905 of the Act. |
| 10 | Aged individuals who have become ineligible and who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract. | 42 CFR 435.212, §1902(e)(2), PL 99-272, §9517, PL 100-203, §4113(d). |
| 11 | Aged individuals who, solely because of coverage under a home and community based waiver, are not in a medical institution, but who would be eligible if they were. | 42 CFR 435.217, §1902(a)(10)(A)(ii), (VI); 50 PL 100-13. |
| 12 | Aged individuals who elect to receive hospice care who would be eligible if in a medical institution. | §1902(a)(10)(A)(ii), (VII) of the Act, PL 99-272, §9505. |
| 13 | Aged individuals in institutions who are eligible under a special income level specified in Supplement 1 to Attachment 2.6-A of the State's title XIX Plan. | 42 CFR 435.236, §1902(a)(10)(A)(ii) of the Act. |

**MAS/BOE - OTHER ELIGIBLES - BLIND/DISABLED MSIS Coding (MAS-4, BOE-2)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Blind and/or disabled individuals who meet more restrictive requirements than SSI, including both those receiving and not receiving SSI payments | 42 CFR 435.121, §1619(b)(3) of the Act, §1902(f) of the Act, PL 99-643, §7. |
| 2 | Blind and/or disabled individuals who are ineligible for optional State supplements or SSI due to requirements that do not apply under title XIX. | 42 CFR 435.122. |
| 3 | Blind and/or disabled essential spouses considered continuously eligible since 12/73; and some spouses who share hospital or nursing facility rooms for 6 months or more. | 42 CFR 435.131. |
| 4 | Institutionalized blind and/or disabled individuals who have been continuously eligible since 12/73 as inpatients or residents of Title XIX facilities. | 42 CFR 435.132. |
| 5 | Blind and/or disabled individuals who would be SSI/SSP, eligible except for the 8/72 increase in OASDI benefits. | 42 CFR 435.134. |
| 6 | Blind and/or disabled individuals who would be eligible for SSI but for title II cost-of-living adjustment(s). | 42 CFR 435.135, §503 PL 94-566. |
| 7 | Blind and/or disabled aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care. | PL 99-509, §9406. |
| 8 | Blind and/or disabled individuals who meet all Medicaid requirements except current blindness, or disability criteria, who have been continuously eligible since 12/73 under the State's 12/73 requirements. | 42 CFR 435.133. |
| 9 | Blind and/or disabled individuals, age 18 or older, who became blind or disabled before age 22 and who lost SSI or State supplementary payments eligibility because of an increase in their OASDI (childhood disability) benefits. | §1634(c) of the Act; PL 99-643, §6. |
| 10 | Blind and/or disabled individuals who would be eligible for AFDC, SSI, or an optional State supplement if not in a medical institution. | 42 CFR 435.211, §§1902(a)(10)(A)(ii) and 1905(a) of the Act. |
| 11 | Qualified severely impaired blind or disabled individuals under age 65, who, except for earnings, are eligible for SSI. | §§1902(a)(10)(A)(I)(II) and 1905(q) of the Act, PL 99-509, §9404 and §1619(b)(8) of the Act, PL 99-643, §7 |
| 12 | Blind and/or disabled individuals who meet income and resource requirements for AFDC, SSI, or an optional State supplement. | 42 CFR 435.210,  §§1902(a)(10)(A)(ii) and 1905 of the Act. |
| 13 | Working disabled individuals who buy-in to Medicaid | §1902(a)(10)(A)(ii)(XIII). |
| 14 | Blind and/or disabled individuals who have become ineligible who are enrolled in a qualified HMO or “§1903(m)(2)(G) entity" that has a risk contract. | 42 CFR 435.212, §1902(e)(2) of the Act; PL 99-272, §9517; PL 100-203, §4113(d). |
| 15 | Blind and/or disabled individuals who, solely because of coverage under a home and community based waiver, are not in a medical institution and who would be eligible if they were. | 42 CFR 435.217, §1902(a)(10)(A)(ii)(VI) of the Act, 50 PL 100-13. |
| 16 | Blind and/or disabled individuals who elect to receive hospice care, and who would be eligible if in a medical institution. | §1902(a)(10)(A)(ii)(VII), PL 99-272, §9505 |
| 17 | Blind and/or disabled individuals in institutions who are eligible under a special income level specified in Supplement 1 to Attachment 2.6-A of the State's title XIX Plan. | 42 CFR 435.231. §1902(a)(10)(A)(ii) of the Act. |
| 18 | Blind and/or disabled widows and widowers who have lost SSI/SSP benefits but are considered eligible for Medicaid until they become entitled to Medicare Part A. | §1634 of the Act, PL 101-508, §5103. |
| 19 | Certain Disabled children, 18 or under, who live at home, but who, if in a medical institution, would be eligible for SSI or a State supplemental payment. | 42 CFR 435.225; §1902(e)(3) of the Act. |
| 20 | Continuation of Medicaid eligibility for disabled children who lose SSI benefits because of changes in the definition of disability. | §1902(a)(10)(A)(ii) of the Act; P.L. 15-32, §491. |
| 21 | Disabled individuals with medically improved disabilities made eligible under the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999. | §1902(a)(10)(A)(ii)(XV) of the Act. |

**MAS/BOE - OTHER ELIGIBLES – CHILDREN MSIS Coding (MAS-4, BOE-4)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Children of families receiving up to 12 months of extended Medicaid benefits (for those eligible after 4/1/90). | §1925 of the Act, PL 100-485, §303. |
| 2 | "Qualified children" under age 19 born after 9/30/83 or at an earlier date at State option, who meet the State's AFDC income and resource requirements. | §§1902(a)(10)(A)(I)(III) and 1905(n) of the Act, PL 98-369, §2361, PL 99-272, §9511, PL 100-203, §4101. |
| 3 | Children of individuals who are ineligible for AFDC-related Medicaid because of requirements that do not apply under title XIX. | 42 CFR 435.113. |
| 4 | Children of individuals who would be eligible for Medicaid under §1931 of the Act (Low income families with children) except for the 7/1/72 (PL 92-325) OASDI increase and were entitled to OASDI and received cash assistance in 8/72. | 42 CFR 435.114. |
| 5 | Children whose mothers were eligible for Medicaid at the time of childbirth, and are deemed eligible for one year from birth as long as the mother remained eligible, or would have if pregnant, and the child remains in the same household as the mother. | 42 CFR 435.117, §1902(e)(4) of the Act, PL 98-369, §2362. |
| 6 | Children of aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care. | PL 99-509, §9406. |
| 7 | Children who meet income and resource requirements for AFDC, SSI, or an optional State supplement | 42 CFR 435.210, §1902(a)(10)(A)(ii) and §1905 of the Act. |
| 8 | Children who would be eligible for AFDC, SSI, or an optional State supplement if not in a medical institution. | 42 CFR 435.211, §1902(a)(10)(A)(ii) and §1905(a) of the Act. |
| 9 | Children who have become ineligible who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract. | 42 CFR 435.212, §1902(e)(2) of the Act, PL 99-272, §9517, PL 100-203, §4113(d). |
| 10 | Children of individuals who elect to receive hospice care, and who would be eligible if in a medical institution. | §1902(a)(10)(A)(ii)(VII), PL 99-272, §9505. |
| 11 | Children who would be eligible for AFDC if work-related child care costs were paid from earnings rather than received as a State service. | 42 CFR 435.220. |
| 12 | Children of individuals who would be eligible for AFDC if the State used the broadest allowable AFDC criteria. | 42 CFR 435.223, §§1902(a)(10)(A)(ii) and 1905(a) of the Act. |
| 13 | Children who solely because of coverage under a home and community based waiver, are not in a medical institution, but who would be eligible if they were. | 42 CFR 435.217, §1902(a)(10)(A)(ii)(VI) of the Act. |
| 14 | Children not described in §1902(a)(10)(A)(I) of the Act, "Ribikoff Kids", who meet AFDC income and resource requirements, and are under a State-established age (18-21). | §§1902(a)(10)(A)(ii) and 1905(a)(I) of the Act, PL 97-248, §137. |

**MAS/BOE - OTHER ELIGIBLES – ADULTS MSIS Coding (MAS-4, BOE-5)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Families receiving up to 12 months of extended Medicaid benefits (if eligible on or after 4/1/90). | §1925 of the Act, PL 100-485, §303. |
| 2 | Qualified pregnant women whose pregnancies have been medically verified and who meet the State's AFDC income and resource requirements. | §§1902(a)(10)(A)(I)(III) and 1905(n) of the Act, PL 98-369, §2361, PL 99-272, §9511, PL 100-203 §4101. |
| 3 | Adults who are ineligible for AFDC-related Medicaid because of requirements that do not apply under title XIX. | 42 CFR 435.113. |
| 4 | Adults who would be eligible for Medicaid under §1931 of the Act (Low income families with children) except for the 7/1/72 (PL 92-325) OASDI increase; and were entitled to OASDI and received cash assistance in 8/72. | 42 CFR 435.114. |
| 5 | Women who were eligible while pregnant, and are eligible for family planning and pregnancy related services until the end of the month in which the 60th day occurs after the pregnancy | §1902(e)(5) of the Act, PL 98-369, PL 100-203, §4101, PL 100-360, §302(e). |
| 6 | Adult aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care. | PL 99-509, §9406. |
| 7 | Adults who meet the income and resource requirements for AFDC, SSI, or an optional State Supplement. | 42 CFR 435.210, §§1902(a)(10)(A)(ii) and 1905 of the Act. |
| 8 | Adults who would be eligible for AFDC, SSI, or an optional State Supplement if not in a medical institution. | 42 CFR 435.211, §§1902(a)(10)(A)(ii) and 1905(a) of the Act. |
| 9 | Adults who have become ineligible who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract. | 42 CFR 435.212, §1902(e)(2)(A) of the Act, PL 99-272, §9517, PL 100-203, §4113(d). |
| 10 | Adults who solely because of coverage under a home and community based waiver, are not in a medical institution, but who would be eligible if they were. | 42 CFR 435.217, §1902(a)(10)(A)(ii)(VI) of the Act. |
| 11 | Adults who elect to receive hospice care, and who would be eligible if in a medical institution. | §1902(a)(10)(A)(ii), (VII); PL 99-272, §9505. |
| 12 | Adults who would be eligible for AFDC if work-related child care costs were paid from earnings rather than received as a State service. | 42 CFR 435.220. |
| 13 | Pregnant women who have been granted presumptive eligibility. | §§1902(a)(47) and 1920 of the Act, PL 99-509, §9407. |
| 14 | Adults who would be eligible for AFDC if the State used the broadest allowable AFDC criteria. | 42 CFR 435.223, §§1902(a)(10)(A)(ii) and 1905(a) of the Act. |

**MAS/BOE - OTHER ELIGIBLES - FOSTER CARE CHILDREN MSIS Coding (MAS-4, BOE-8)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATIONS** |
| --- | --- | --- |
| 1 | Children for whom the State makes adoption assistance or foster care maintenance payments under Title IV-E. | 42 CFR 435.145, §1902(a)(10)(A)(i)(I) of the Act. |
| 2 | Children with special needs covered by State foster care payments or under a State adoption assistance agreement which does not involve Title IV-E. | §1902(a)(10)(A)(ii) (VIII) of the Act, PL 99-272, §9529. |
| 3 | Children leave foster care due to age. | Foster Care Independence Act of 1999. |

**MAS/BOE - SECTION 1115 DEMONSTRATION MEDICAID EXPANSION MSIS Coding (MAS-5, BOE-1)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATION** |
| --- | --- | --- |
| 1 | Aged individuals made eligible under the authority of a §1115 waiver due to poverty-level related eligibility expansions. | §1115(a)(1), (a)(2) & (b)(1) of the Act, §1902(a)(10), and §1903(m) of the Act. |

**MAS/BOE - SECTION 1115 DEMONSTRATION MEDICAID EXPANSION MSIS Coding (MAS-5, BOE-2)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATION** |
| --- | --- | --- |
| 1 | Blind and/or disabled individuals made eligible under the authority of a §1115 waiver due to poverty-level-related eligibility | §1115(a)(1), (a)(2) & (b)(1) of the Act, §1902(a)(10), and §1903(m) of the Act. |

**MAS/BOE - SECTION 1115 DEMONSTRATION MEDICAID EXPANSION MSIS Coding (MAS-5, BOE-4)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATION** |
| --- | --- | --- |
| 1 | Children made eligible under the authority of a §1115 waiver due to poverty-level-related eligibility expansions. | §1115(a)(1), (a)(2) & (b)(1) of the Act, §1902(a)(10), and §1903(m) of the Act. |

**MAS/BOE - SECTION 1115 DEMONSTRATION MEDICAID EXPANSION MSIS Coding (MAS-5, BOE-5)**

| **ITEM** | **DESCRIPTION** | **CFR/PL CITATION** |
| --- | --- | --- |
| 1 | Caretaker relatives, pregnant women and/or adults without dependent children made eligible under the authority of at §1115 waiver due to poverty-level-related eligibility expansions. | §1115(a)(1) and (a)(2) of the Act, §1902(a)(10), §1903(m). |

# Appendix D: Types of Service (TOS) Reference

## Definitions of Types of Service

The following definitions are adaptations of those given in the Code of Federal Regulations. These definitions, although abbreviated, are intended to facilitate the classification of medical care and services for reporting purposes. They do not modify any requirements of the Act or supersede in any way the definitions included in the Code of Federal Regulations (CFR).

Effective FY 1999, services provided under Family Planning, EPSDT, Rural Health Clinics, FQHC’s, and Home-and-Community-Based Waiver programs will be coded according to the types of services listed below. Specific programs with which these services are associated will be identified using the program type coding as defined in Attachment 5.

1. Unduplicated Total.--Report the unduplicated total of recipients by maintenance assistance status (MAS) and by basis of eligibility (BOE). A recipient receiving more than one type of service is reported only once in the unduplicated total.

## Facilities

1. Inpatient Hospital Services (TOS Code=001)(See 42 CFR 440.10; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--These are services that are:

* Ordinarily furnished in a hospital for the care and treatment of inpatients;
* Furnished under the direction of a physician or dentist (except in the case of nurse‑midwife services per 42 CFR 440.165); and
* Furnished in an institution that:

- Is maintained primarily for the care and treatment of patients with disorders other than mental health conditions;

- Is licensed or formally approved as a hospital by an officially designated authority for State standard setting;

- Meets the requirements for participation in Medicare (except in the case of medical supervision of nurse‑midwife services per 42 CFR 440.165); and

- Has in effect a utilization review plan applicable to all Medicaid patients that meets the requirements in 42 CFR 482.30 unless a waiver has been granted by the Secretary of Health and Human Services.

Inpatient hospital services do not include nursing facility services furnished by a hospital with swing‑bed approval. However, include services provided in a psychiatric wing of a general hospital if the psychiatric wing is not administratively separated from the general hospital.

1. Mental Health Facility Services (See 42 CFR 440.140, 440.160, and 435.1009).--An institution for mental health conditions is a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment or care of individuals with mental health conditions, including medical care, nursing care, and related services. Report totals for services defined under 3a and 3b.

3a. Inpatient Psychiatric Facility Services for Individuals Age 21 and Under (TOS Code=048)(See 42 CFR 440.160; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450). --These are services that:

* Are provided under the direction of a physician;
* Are provided in a psychiatric facility or inpatient program accredited by the Joint Commission on the Accreditation of Hospitals; and,
* Meet the requirements set forth in 42 CFR Part 441, Subpart D (inpatient psychiatric services for individuals age 21 and under in psychiatric facilities or programs).

3b. Other Mental Health Facility Services (Individuals Age 65 or Older) (TOS Code= 044 and 045)(See 42 CFR 440.140).--These are services provided under the direction of a physician for the care and treatment of recipients in an institution for mental health conditions that meets the requirements specified in 42 CFR 440.140.

1. Nursing Facilities (NF) Services (TOS Code=009 and 047)(See 42 CFR 440.40 and 440.155).--These are services provided in an institution (or a distinct part of an institution) which:

* Is primarily engaged in providing to residents:

- Skilled nursing care and related services for residents who require medical or nursing care;

- Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

- On a regular basis, health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental health conditions; and;

* Meet the requirements for a nursing facility described in subsections 1919(b), (c), and (d) of the Act regarding:

- Requirements relating to provision of services;

- Requirements relating to residents’ rights; and

- Requirements relating to administration and other matters.

NOTE: ICF Services - All Other.--This is combined with nursing facility services.

1. ICF Services for the Intellectually Disabled (TOS Code=046) (See 42 CFR 440.150).--These are services provided in an institution for individuals with intellectual disabilities persons or persons with related conditions if the:

* Primary purpose of the institution is to provide health or rehabilitative services to such individuals;
* Institution meets the requirements in 42 CFR 442, Subpart C (certification of ICF/IID); and
* The individuals with intellectual disabilities recipients for whom payment is requested are receiving active treatment as defined in 42 CFR 483.440(a).

## Services

1. Physicians' Services (TOS Code=012) (See 42 CFR 440.50; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--Whether furnished in a physician's office, a recipient's home, a hospital, a NF, or elsewhere, these are services provided:

* Within the scope of practice of medicine or osteopathy as defined by State law; and
* By, or under, the personal supervision of an individual licensed under State law to practice medicine or osteopathy, or dental medicine or dental surgery if State law allows such services to be provided by either a physician or dentist.

1. Outpatient Hospital Services (TOS Codes=002) (See 42 CFR 440.20; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--These are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished:

* To outpatients;
* Except in the case of nurse-midwife services (see 42 CFR 440.165), under the direction of a physician or dentist; and
* By an institution that:

- Is licensed or formally approved as a hospital by an officially designated authority for State standard setting; and

- Except in the case of medical supervision of nurse midwife services (see 42 CFR 440.165), meets the requirements for participation in Medicare as a hospital.

1. Prescribed Drugs (TOS Code=033) (See 42 CFR 440.120; 42 CFR § 457.402; 42 CFR § 457.410; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--These are simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease or for health maintenance that are:

* Prescribed by a physician or other licensed practitioner within the scope of professional practice as defined and limited by Federal and State law;
* Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and
* Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner’s records.

1. Dental Services (TOS Code=029) (See 42 CFR 440.100; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--These are diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession, including treatment of:

* The teeth and associated structures of the oral cavity; and
* Disease, injury, or an impairment that may affect the oral or general health of the recipient.

A dentist is an individual licensed to practice dentistry or dental surgery. Dental services include dental screening and dental clinic services.

NOTE: Include services related to providing and fitting dentures as dental services. Dentures mean artificial structures made by, or under the direction of, a dentist to replace a full or partial set of teeth.

Dental services do not include services provided as part of inpatient hospital, outpatient hospital, non-dental clinic, or laboratory services and billed by the hospital, non‑dental clinic, or laboratory or services which meet the requirements of 42 CFR 440.50(b) (i.e., are provided by a dentist but may be provided by either a dentist or physician under State law).

## Other Services

1. Other Licensed Practitioners' Services (TOS Code=015)(See 42 CFR 440.60; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--These are medical or remedial care or services, other than physician services or services of a dentist, provided by licensed practitioners within the scope of practice as defined under State law. The category “Other Licensed Practitioners' Services” is different than the “Other Care” category. Examples of other practitioners (if covered under State law) are:

* Chiropractors;
* Podiatrists;
* Psychologists; and
* Optometrists.

Other Licensed Practitioners' Services include hearing aids and eyeglasses only if they are billed directly by the professional practitioner. If billed by a physician, they are reported as Physicians' Services. Otherwise, report them under Other Care.

Other Licensed Practitioners' Services do not include prosthetic devices billed by physicians, laboratory or X-ray services provided by other practitioners, or services of other practitioners that are included in inpatient or outpatient hospital bills. These services are counted under the related type of service as appropriate. Devices billed by providers not included under the listed types of service are counted under Other Care.

Report Other Licensed Practitioners' Services that are billed by a hospital as inpatient or outpatient services, as appropriate.

Speech therapists, audiologists, opticians, physical therapists, and occupational therapists are not included within Other Licensed Practitioners' Services.

Chiropractors' services include only services that are provided by a chiropractor (who is licensed by the State) and consist of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.

1. Clinic Services (TOS Code=028(See 42 CRF 440.90; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are provided:

* To outpatients;
* By a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients including services furnished outside the clinic by clinic personnel to individuals without a fixed home or mailing address. For reporting purposes, consider a group of physicians who share, only for mutual convenience, space, services of support staff, etc., as physicians, rather than a clinic, even though they practice under the name of the clinic; and
* Except in the case of nurse-midwife services (see 42 CFR 440.165), are furnished by, or under, the direction of a physician.

NOTE: Place dental clinic services under dental services. Report any services not included above under other care. A clinic staff may include practitioners with different specialties.

1. Laboratory and X‑Ray Services (TOS Code=005, 006, 007, and 008) (See 42 CFR 440.30; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--These are professional or technical laboratory and radiological services that are:

* Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law or ordered and billed by a physician but provided by referral laboratory
* Provided by a laboratory that meets the requirements for participation in Medicare.
* X-ray services provided by dentists are reported under dental services.

1. Sterilizations (TOS Code=084) (See 42 CFR 441, Subpart F).--These are medical procedures, treatment or operations for the purpose of rendering an individual permanently incapable of reproducing.
2. Home Health Services (TOS Code=016,017, 018, 019, 020, and 021) (See 42 CFR 440.70; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--These are services provided at the patient's place of residence, in compliance with a physician's written plan of care that is reviewed every 62 days. The following items and services are mandatory.

* Nursing services, as defined in the State Nurse Practice Act that is provided on a part‑time or intermittent basis by a home health agency (a public or private agency or organization, or part of any agency or organization that meets the requirements for participation in Medicare). If there is no agency in the area, a registered nurse who:

- Is licensed to practice in the State;

- Receives written orders from the patient's physician;

- Documents the care and services provided; and

- Has had orientation to acceptable clinical and administrative record keeping from a health department nurse;

* Home health aide services provided by a home health agency; and
* Medical supplies, equipment, and appliances suitable for use in the home.

The following therapy services are optional: physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or by a facility licensed by the State to provide these medical rehabilitation services. (See 42 CFR 441.15.)

Place of residence is normally interpreted to mean the patient's home and does not apply to hospitals or NFs. Services received in a NF that are different from those normally provided as part of the institution's care may qualify as home health services. For example, a registered nurse may provide short‑term care for a recipient in a NF during an acute illness to avoid the recipient's transfer to another NF.

## Personal Services

1. Personal Support Services.--Report total unduplicated recipients and payments for services defined in 15a through 15i.

15a. Personal Care Services (TOS Code=051)(See 42 CFR 440.167).--These are services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental health conditions that are:

* Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State; and
* Provided by an individual who is qualified to provide such services and who is not a member of the individual’s family.

15b. Targeted Case Management Services (TOS Code=053)(See 42 CFR § 440.169; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--These are services that are furnished to individuals eligible under the plan to gain access to needed medical, social, educational, and other services. The agency may make available case management services to:

* Specific geographic areas within a State, without regard to statewide requirement in 42 CFR 431.50; and
* Specific groups of individuals eligible for Medicaid, without regard to the comparability requirements in 42 CFR 440.240.

The agency must permit individuals to freely choose any qualified Medicaid provider except when obtaining case management services in accordance with 42 CFR 431.51.

15c. Rehabilitative Services (TOS Code=043)(See 42 CFR 440.130).--These include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under State law for maximum reduction of physical or mental health condition and restoration of a recipient to his/her best possible functional level.

15d. Physical Therapy, Occupational Therapy, and Services For Individuals With Speech, Hearing, and Language Disorders (TOS Codes=030, 031, and 032)(See 42 CFR 440.110; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--These are services prescribed by a physician or other licensed practitioner within the scope of his or her practice under State law and provided to a recipient by, or under the direction of, a qualified physical therapist, occupational therapist, speech pathologist, or audiologist. It includes any necessary supplies and equipment.

15e. Hospice Services (TOS Code=087) (See 42 CFR 418.202; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--Whether received in a hospice facility or elsewhere, these are services that are:

* Furnished to a terminally ill individual, as defined in 42 CFR 418.3;
* Furnished by a hospice, as defined in 42 CFR 418.3, that meets the requirements for participation in Medicare specified in 42 CFR 418, Subpart C or by others under an arrangement made by a hospice program that meets those requirements and is a participating Medicaid provider; and
* Furnished under a written plan that is established and periodically reviewed by:
* The attending physician;
* The medical director or physician designee of the program, as described in 42 CFR 418.54; and
* The interdisciplinary group described in 42 CFR 418.68.

15f. Nurse Midwife (TOS Code=025) (See 42 CFR 440.165; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--These are services that are concerned with management and the care of mothers and newborns throughout the maternity cycle and are furnished within the scope of practice authorized by State law or regulation.

15g. Nurse Practitioner (TOS Code=026) (See 42 CFR 440.166; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--These are services furnished by a registered professional nurse who meets State’s advanced educational and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses.

15h. Private Duty Nursing (TOS Code=022) (See 42 CFR 440.80; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--When covered in the State plan, these are services of registered nurses or licensed practical nurses provided under direction of a physician to recipients in their own homes, hospitals or nursing facilities (as specified by the State).

15i. Religious Non-Medical Health Care Institutions (TOS Code=058) (See 42 CFR 440.170).--These are non-medical health care services equivalent to a hospital or extended care level of care provided in facilities that meet the requirements of Section 1861(ss)(1) of the Act.

## Other Care

1. Other Care (See 42 CFR 440.120(b), (c), and (d), and 440.170(a)).--Report total unduplicated recipients and payments for services in sections 16a, 16b, and 16c. Such services do not meet the definition of, and are not classified under, any of the previously described categories.

16a. Transportation (TOS Code=056) (See 42 CFR 440.170; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--Report totals for services provided under this title to include transportation and other related travel services determined necessary by you to secure medical examinations and treatment for a recipient.

NOTE: Transportation, as defined above, is furnished only by a provider to whom a direct vendor payment can appropriately be made. If other arrangements are made to assure transportation under 42 CFR 431.53, FFP is available as an administrative cost.

16b. Other Pregnancy-related Procedures (TOS Code=086) (See 42 CFR 441, Subpart E; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--In accordance with the terms of the DHHS Appropriations Bill and 42 CFR 441, Subpart E, FFP is available for other pregnancy-related procedures:

* When a physician has certified in writing to the Medicaid agency that, on the basis of his or her professional judgment, the life of the mother would be endangered if the fetus were carried to term; or
* When the other pregnancy-related procedure is performed to terminate a pregnancy resulting from an act of rape or incest. FFP is not available for the other pregnancy-related procedure under any other circumstances.

16c. Other Services (TOS Code= 035, 036, 037, 062, 063, 064, 065, 066, 067, 068, 069, 073, 074, 075, 076, 077, 078, 079, 080, 081, 082, 083).--These services do not meet the definitions of any of the previously described service categories. They may include, but are not limited to:

* Prosthetic devices (see 42 CFR 440.120; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450) which are replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice as defined by State law to:

- Artificially replace a missing portion of the body;

- Prevent or correct physical deformity or malfunctions; or

- Support a weak or deformed portion of the body.

* Eyeglasses (see 42 CFR 440.120; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450). Eyeglasses mean lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optician. It includes optician fees for services.
* Home and Community‑Based Waiver services (See §1915(c) of the Act and 42 CFR 440.180) that cannot be associated with other TYPE-OF-SERVICE codes (e.g., community homes for the disabled and adult day care.)

1. Capitated Care (See 42 CFR Part 434).--This includes enrollees and capitated payments for the plan types defined in 17a and b below. Report unduplicated enrolled eligibles and payments for 17a and b.

17a. Health Maintenance Organization (HMO) and Health Insuring Organization (HIO) (TOS Code=119).--These include plans contracted to provide capitated comprehensive services. An HMO is a public or private organization that contracts on a prepaid capitated risk basis to provide a comprehensive set of services and is federally qualified or State-plan defined. An HIO is an entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

17b. Prepaid Health Plans (PHP) (TOS Code=122).--These include plans that are contracted to provide less than comprehensive services. Under a non-risk or risk arrangement, the State may contract with (but not limited to these entities) a physician, physician group, or clinic for a limited range of services under capitation. A PHP is an entity that provides a non-comprehensive set of services on either capitated risk or non-risk basis or the entity provides comprehensive services on a non-risk basis.

NOTE: Include dental, mental health, and other plans covering limited services under PHP.

1. Primary Care Case Management (PCCM) (TOS Code=120) (See §1915(b)(1) of the Act).--The State contracts directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee. Report these recipients and associated PCCM fees in this section.

NOTE: Where the fee includes services beyond case management, report the enrollees and fees under prepaid health plans (17b).

1. COVID-19 Testing (See §1902(a)(10)(G) of the act). --This includes in vitro diagnostic products for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and any visit for COVID–19 testing-related services for which payment may be made under the State plan.

19a. COVID-19 Testing (TOS Code 136) should be reported for any COVID-19 diagnostic product that is administered during any portion of the emergency period, beginning March 18, 2020, to an uninsured individual who receives limited Medicaid coverage for COVID-19 testing and testing-related services.

19b. COVID-19 Testing-Related Services (TOS Code 137) should be reported for any COVID–19 testing-related services provided to an uninsured individual who receives limited Medicaid coverage for COVID-19 testing and testing-related services for which payment may be made under the State plan.

1. Per member per month (PMPM) payments for health home services (TOS 138)
2. Per member per month (PMPM) payments for Medicare Part A premiums (TOS 139)
3. Per member per month (PMPM) payments for Medicare Part B premiums (TOS 140)
4. Per member per month (PMPM) payments for Medicare Advantage Dual Special Needs Plans (D-SNP) –Medicare Part C (TOS 141)
5. Per member per month (PMPM) payments for Medicare Part D premiums (TOS 142)
6. Per member per month (PMPM) payments for other payments (TOS 143)
7. Payments to individuals for personal assistance services under 1915(j) (TOS 144)
8. Medication Assisted Treatment (MAT) services and drugs for evidenced-based treatment of Opioid Use Disorder (OUD) (TOS 145) (§1905(a)(29) of the Social Security Act) Effective October 1, 2020, state Medicaid programs are required to provide coverage of Medication Assisted Treatment (MAT) services and drugs under a new mandatory benefit. The SUPPORT Act of 2018 (P.L. 115-271) amended the Social Security Act (the Act) to add this new mandatory benefit. The purpose of the new mandatory MAT benefit found at section 1905(a)(29) of the Act is to increase access to evidenced-based treatment for Opioid Use Disorder (OUD) for all Medicaid beneficiaries and to allow patients to seek the best course of treatment and particular medications that may not have been previously covered. CMS interprets sections 1905(a)(29) and 1905(ee) of the Act to require that, as of October 1, 2020, states must include as part of the new MAT mandatory benefit all forms of drugs and biologicals that the Food and Drug Administration (FDA) has approved or licensed for MAT to treat OUD. More specifically, under the new mandatory MAT benefit, states are required to cover such FDA approved or licensed drugs and biologicals used for indications for MAT to treat OUD. States currently cover many of these MAT drugs and biologicals (for all medically-accepted indications) under the optional benefit for prescribed drugs described at section 1905(a)(12) of the Act

# Appendix E: Program Type Reference

## Definitions of Program Type Reference

The following definitions describe special Medicaid/CHIP programs that are coded independently of type of service for MSIS purposes. These programs tend to cover bands of services that cut across many types of service.

## Program Type 1-3

Program Type 01. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (See 42 CFR 440.40(b)).--This includes either general health screening services and vision, dental, and hearing services furnished to Medicaid eligibles under age 21 to fulfill the requirements of the EPSDT program or services rendered based on referrals from EPSDT visits. The Act specifies two sets of EPSDT screenings:

* Periodic screenings, which are provided at distinct intervals determined by the State, and which must include the following services:

- A comprehensive health and developmental history assessment (including assessment of both physical and mental health development);

- A comprehensive unclothed physical exam;

- Appropriate immunizations according to the Advisory Committee on Immunization Practices schedule;

- Laboratory tests (including blood lead level assessment); and

- Health education (including anticipatory guidance); and

* Interperiodic screenings, which are provided when medically necessary to determine the existence of suspected physical or mental illness or conditions.

Program Type 02. Family Planning (See 42 CFR 440.40(c)).-- Only items and procedures clearly provided or performed for family planning purposes and matched at the 90 percent FFP rate should be included as Family Planning. Services covered under this program include, but are not limited to:

* Counseling and patient education and treatment furnished by medical professionals in accordance with State law;
* Laboratory and X-ray services;
* Medically approved methods, procedures, pharmaceutical supplies, and devices to prevent conception;
* Natural family planning methods; and
* Diagnosis and treatment for infertility.

Program Type 03. Rural Health Clinics (RHC) (See 42 CFR 440.20(b)).--These include services (as allowed by State law) furnished by a rural health clinic which has been certified in accordance with the conditions of 42 CFR Part 491 (certification of certain health facilities). Services performed in RHCs include, but are not limited to:

* Services furnished by a physician within the scope of his or her profession as defined by State law. The physician performs these services in or away from the clinic and has an agreement with the clinic providing that he or she will be paid for these services;
* Services furnished by a physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner (as defined in 42 CFR 405.2401 and 491.2) if the services are furnished in accordance with the requirements specified in 42 CFR 405.2412(a);

* Services and supplies provided in conjunction with professional services furnished by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner. (See 42 CFR 405.2413 and 405.2415 for the criteria determining whether services and supplies are included here.); or
* Part‑time or intermittent visiting nurse care and related medical supplies (other than drugs and biologicals) if:

- The clinic is located in an area in which the Secretary has determined that there is a shortage of home health agencies (see 42 CFR 405.2417);

- The services are furnished by a registered nurse or licensed practical or vocational nurse employed, or otherwise compensated for the services, by the clinic;

- The services are furnished under a written plan of treatment that is either established and reviewed at least every 60 days by a supervising physician of the clinic, or that is established by a physician, physician's assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner and reviewed and approved at least every 60 days by a supervising physician of the clinic; and

- The services are furnished to a homebound patient. For purposes of visiting nurse services, a homebound recipient means one who is permanently or temporarily confined to a place of residence because of a medical or health condition and leaves the place of residence infrequently. For this purpose, a place of residence does not include a hospital or nursing facility.

## Program Type 4-5

Program Type 04. Federally Qualified Health Center (FQHC) (See §1905(a)(2) of the Act).--FQHCs are facilities or programs more commonly known as community health centers, migrant health centers, and health care for the homeless programs. A facility or program qualifies as a FQHC providing services covered under Medicaid if:

* They receive grants under §§329, 330, or 340 of the Public Health Service Act (PHS);
* The Health Resources and Services Administration, PHS, certifies the center as meeting FQHC requirements; or
* The Secretary determines that the center qualifies through waiver of the requirements.

Services performed in FHQCs are defined the same as the services provided by rural health clinics. They may include physician services, services provided by physician assistants, nurse practitioners, clinical psychologists, clinical social workers, and services and supplies incident to such services as are otherwise covered if furnished by a physician or as incident to a physician's services. In certain cases, services to a homebound Medicaid patient may be provided. Any other ambulatory service included in the State's Medicaid plan is considered covered by a FQHC program if the center offers it.

Program Type 05. Indian Health Services (See §1911 of the Act) (See 42 CFR 431.110).—

Indian Health Services (See §1911 of the Act) (See 42 CFR 431.110).--These are services provided by a program of the Indian Health Services (IHS), tribe or tribal organization under the Indian Self-Determination and Education Assistance Act, and an urban Indian organization under title V of the Indian Health Care Improvement Act.  A State plan must provide that an IHS, tribal or urban facility, meeting State plan requirements for Medicaid participants, must be accepted as a Medicaid provider on the same basis as any other qualified provider.

## Program Type 6-10

Program Type 06. Home and Community-Based Services for Disabled and Elderly (See §1929 of the Act) and for Individuals Age 65 and Older (MSIS) (See 42 CFR 441, Subpart H).--This program is for §1915(d) recipients of home and community-based services for individuals age 65 or older. This is an option within the Medicaid program to provide home and community-based care to functionally disabled individuals age 65 or older who are otherwise eligible for Medicaid or for non-disabled elderly individuals.

Program Type 07. Home and Community Based Waivers (See §1915(c) of the Act and 42 CFR 440.180).--This program includes services furnished under a waiver approved under the provisions in 42 CFR Part 441, Subpart G (home and community-based services; waiver requirements).

Program Type 08. Money Follows Patient (MFP) service package (established by Section 6071 of Deficit Reduction Act of 2005 [Public Law 109-171] and extended by Section 2403 off the Patient Protection and Affordable Care Act of 2010 [Public Law 111-148]) helps States rebalance their long-term care systems through the development of transition programs that move people with Medicaid from institutional-based long-term care to community-based long-term care. To qualify for MFP, Medicaid recipients need to have been in institutional care for at least 90 days, exclusive of Medicare-paid rehabilitation days. Upon the initial transition to community-based long-term care, MFP participants are eligible for MFP benefits for up to 365 days. At the conclusion of MFP eligibility, the person continues as a typical Medicaid beneficiary. While eligible for MFP benefits, the restricted benefits flag in the eligibility file should be set to value 08 whenever the beneficiary has a single day of MFP eligibility during the month.

Any service financed with MFP grant funds is considered an MFP service. MFP services are home- and community-based services (HCBS) financed with MFP grant funds. They can be 1915(c) waiver services or HCBS state plan services. The program has three classes of HCBS, including qualified HCBS (HCBS that the person would have been eligible for regardless of participation in MFP), demonstration HCBS (HCBS that are above and beyond what they would have qualified for as a regular Medicaid beneficiary), and supplemental services (which are typically one-time services someone needs to make the transition to community-based long-term care). States received enhanced matching funds for the qualified and demonstration services, and their regular mating rate for the supplemental services. Examples of MFP-financed services include, but are not limited to:

* 1915(c) waiver services
* Personal care assistance services provided through the state plan
* Behavioral health services, including psychosocial rehabilitation

Program Type 10. Balancing Incentive Payments (BIP). The Balancing Incentive Program authorizes grants to States to increase access to non-institutional long-term services and supports (LTSS) as of October 1, 2011.

The Balancing Incentive Program will help States transform their long-term care systems by:

• Lowering costs through improved systems performance & efficiency

• Creating tools to help consumers with care planning & assessment

• Improving quality measurement & oversight

The Balancing Incentive Program also provides new ways to serve more people in home and community-based settings, in keeping with the integration mandate of the Americans with Disabilities Act (ADA), as required by the Olmstead decision. The Balancing Incentive Program was created by the Affordable Care Act of 2010 (Section 10202).

## Program Type 11-13

Program Type 11. Community First Choice (1915(k). The “Community First Choice Option” lets States provide home and community-based attendant services to Medicaid enrollees with disabilities under their State Plan.

This option became available on October 1, 2011 and provides a 6 % increase in Federal matching payments to States for expenditures related to this option.

Program Type 12. Psychiatric Rehab Facility for Children. Under the authority of section 2707 of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), the Centers for Medicare & Medicaid Services (CMS) is funding the Medicaid Emergency Psychiatric Demonstration, which will be conducted by participating States. This is a 3-year Demonstration that permits participating States to provide payment under the State Medicaid plan to certain non-government psychiatric hospitals for inpatient emergency psychiatric care to Medicaid recipients aged 21 to 64 who have expressed suicidal or homicidal thoughts or gestures, and are determined to be dangerous to themselves or others.

Program Type 13. Home and Community-Based Services (HCBS) State Plan Option (1915(i)). States can offer a variety of services under a State Plan Home and Community-Based Services (HCBS) benefit. People must meet State-defined criteria based on need and typically get a combination of acute-care medical services (like dental services, skilled nursing services) and long-term services (like respite, case management, supported employment and environmental modifications).

1915(i) State plan HCBS: State Options

• Target the HCBS benefit to one or more specific populations

• Establish separate additional needs-based criteria for individual HCBS

• Establish a new Medicaid eligibility group for people who get State plan HCBS

• Define the HCBS included in the benefit, including State- defined and CMS-approved “other services” applicable to the population

• Option to allow any or all HCBS to be self-directed

## Program Type 14

### Program Type 14 (a)–(m)

**Program Type 14. State Plan CHIP** (See 42 CRF 457) ‘This program is for Title XXI recipients (children age 0 through 18, children receiving prenatal care through the conception to birth option, pregnant women), “Child health assistance” services (as allowed by State law and defined at § 457.402) means payment for part or all of the cost of health benefits coverage provided to targeted low-income children for the following services:

(a) Inpatient hospital services.

(b) Outpatient hospital services.

(c) Physician services.

(d) Surgical services.

(e) Clinic services (including health center services) and other ambulatory health care services.

(f) Prescription drugs and biologicals and the administration of these drugs and biologicals, only if these drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

(g) Over-the-counter medications.

(h) Laboratory and radiological services.

(i) Prenatal care and pre-pregnancy family planning services and supplies.

(j) Inpatient mental health services, other than services described in paragraph (r) of this section but including services furnished in a state-operated mental health hospital and including residential or other 24-hour therapeutically planned structured services.

(k) Outpatient mental health services, other than services described in paragraph (s) of this section but including services furnished in a State-operated mental health hospital and including community-based services.

(l) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices and adaptive devices).

(m) Disposable medical supplies.

### Program Type 14 (n)–(bb)

(n) Home and community-based health care services and related supportive services (such as home health nursing services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members and minor modification to the home.)

(o) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing, pediatric nurse services and respiratory care services) in a home, school, or other setting.

(p) Other pregnancy-related procedure only if necessary to save the life of the mother or if the pregnancy is the result of rape or incest.

(q) Dental services.

(r) Inpatient substance abuse treatment services and residential substance abuse treatment services.

(s) Outpatient substance abuse treatment services.

(t) Case management services.

(u) Care coordination services.

(v) Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.

(w) Hospice care.

(x) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is—

(1) Prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law;

(2) Performed under the general supervision or at the direction of a physician; or

(3) Furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

(y) Premiums for private health care insurance coverage.

(z) Medical transportation.

(aa) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

(bb) Any other health care services or items specified by the Secretary and not excluded under this subchapter.

## Program Type 15-16

Program Type 15. Psychiatric Residential Treatment Facilities Demonstration Grant Program. The Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration Grant Program was authorized by Section 6063 of the Deficit Reduction Act of 2005 to provide up to $218 million to up to 10 states to develop 5-year demonstration programs that provide home and community-based services to children as alternatives to PRTF's. Nine states implemented demonstration grants. These projects were designed to test the cost-effectiveness of providing services in a child’s home or community rather than in a PRTF and whether the services improve or maintain the child’s functioning.

Program Type 16. 1915(j) (Self-directed personal assistance services/personal care under State Plan or 1915(c) waiver). Self-directed personal assistance services (PAS) are personal care and related services provided under the Medicaid State plan and/or section 1915(c) waivers the State already has in place.

• Participation in self-directed PAS is voluntary

• Participants set their own provider qualifications and train their PAS providers Participants determine how much they pay for a service, support or item

## Program Type 17

**Program Type 17.** **COVID-19 Testing Services Section 6004(a)(3) of the Families First Coronavirus Response Act (FFCRA) added Section 1902(a)(10)(A)(ii)(XXIII) to the Social Security Act (the Act).** During any portion of the public health emergency period beginning March 18, 2020, this provision permits states to temporarily cover uninsured individuals through an optional Medicaid eligibility group for the limited purpose of COVID-19 testing. Such medical assistance, as limited by clause XVIII in the text following Section 1902(a)(10)(G) of the Act, includes: in vitro diagnostic products for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and any visit for COVID–19 testing-related services for which payment may be made under the State plan. For the purposes of this eligibility group, please reference the COVID-19 FAQs on implementation of Section 6008 of the Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security (CARES) Act for the definition of an uninsured individual.[4] States can claim 100 percent FMAP for services provided to an individual enrolled in the COVID-19 testing group. The 100 percent match is only available for the testing and testing-related services provided to beneficiaries enrolled in the new COVID-19 testing group (and for related administrative expenditures).

# Appendix F: Eligibility Group Table

| **Code** | **Eligibility Group** | **Short Description** | **Citation** | **Type** | **Category** |
| --- | --- | --- | --- | --- | --- |
| 01 | Parents and Other Caretaker Relatives | Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state. | 42 CFR 435.110; 1902(a)(10)(A)(i)(I); 1931(b) and (d) | Family/Adult | Mandatory Coverage |
| 02 | Transitional Medical Assistance | Families with Medicaid eligibility extended for up to 12 months because of earnings. | 408(a)(11)(A); 1902(a)(52); 1902(e)(1)(B); 1925; 1931(c)(2) | Family/Adult | Mandatory Coverage |
| 03 | Extended Medicaid due to Earnings | Families with Medicaid eligibility extended for 4 months because of increased earnings. | 42 CFR 435.112; 408(a)(11)(A); 1902 (e)(1)(A); 1931 (c)(2) | Family/Adult | Mandatory Coverage |
| 04 | Extended Medicaid due to Spousal Support Collections | Families with Medicaid eligibility extended for 4 months as the result of the collection of spousal support. | 42 CFR 435.115; 408(a)(11)(B); 1931 (c)(1) | Family/Adult | Mandatory Coverage |
| 05 | Pregnant Women | Women who are pregnant or post-partum, with household income at or below a standard established by the state. | 42 CFR 435.116; 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV) and (IX); 1931(b) and (d); | Family/Adult | Mandatory Coverage |
| 06 | Deemed Newborns | Children born to women covered under Medicaid or a separate CHIP for the date of the child's birth, who are deemed eligible for Medicaid until the child turns age 1 | 42 CFR 435.117; 1902(e)(4) and 2112€ | Family/Adult | Mandatory Coverage |
| 07 | Infants and Children under Age 19 | Infants and children under age 19 with household income at or below standards established by the state based on age group. | 42 CFR 435.118 1902(a)(10)(A)(i)(III), (IV), (VI) and (VII); 1902(a)(10)(A)(ii)(IV) and (IX); 1931(b) and (d) | Family/Adult | Mandatory Coverage |
| 08 | Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care | Individuals for whom an adoption assistance agreement is in effect or foster care or kinship guardianship assistance maintenance payments are made under Title IV-E of the Act. | 42 CFR 435.145; 473(b)(3); 1902(a)(10)(A)(i)(I) | Family/Adult | Mandatory Coverage |
| 09 | Former Foster Care Children | Individuals under the age of 26, not otherwise mandatorily eligible, who were in foster care and on Medicaid either when they turned age 18 or aged out of foster care. | 42 CFR 435.150; 1902(a)(10)(A)(i)(IX) | Family/Adult | Mandatory Coverage |
| 11 | Individuals Receiving SSI | Individuals who are aged, blind or disabled who receive SSI. | 42 CFR 435.120; 1902(a)(10)(A)(i)(II)(aa) | ABD | Mandatory Coverage |
| 12 | Aged, Blind and Disabled Individuals in 209(b) States | In 209(b) states, aged, blind and disabled individuals who meet more restrictive criteria than used in SSI. | 42 CFR 435.121; 1902(f) | ABD | Mandatory Coverage |
| 13 | Individuals Receiving Mandatory State Supplements | Individuals receiving mandatory State Supplements to SSI benefits. | 42 CFR 435.130 | ABD | Mandatory Coverage |
| 14 | Individuals Who Are Essential Spouses | Individuals who were eligible as essential spouses in 1973 and who continue be essential to the well-being of a recipient of cash assistance. | 42 CFR 435.131; 1905(a) | ABD | Mandatory Coverage |
| 15 | Institutionalized Individuals Continuously Eligible Since 1973 | Institutionalized individuals who were eligible for Medicaid in 1973 as inpatients of Title XIX medical institutions or intermediate care facilities, and who continue to meet the 1973 requirements. | 42 CFR 435.132 | ABD | Mandatory Coverage |
| 16 | Blind or Disabled Individuals Eligible in 1973 | Blind or disabled individuals who were eligible for Medicaid in 1973 who meet all current requirements for Medicaid except for the blindness or disability criteria. | 42 CFR 435.133 | ABD | Mandatory Coverage |
| 17 | Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972 | Individuals who would be eligible for SSI/SSP except for the increase in OASDI benefits in 1972, who were entitled to and receiving cash assistance in August, 1972. | 42 CFR 435.134 | ABD | Mandatory Coverage |
| 18 | Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977 | Individuals who are receiving OASDI and became ineligible for SSI/SSP after April, 1977, who would continue to be eligible if the cost of living increases in OASDI since their last month of eligibility for SSI/SSP/OASDI were deducted from income. | 42 CFR 435.135; | ABD | Mandatory Coverage |
| 19 | Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI | Disabled widows and widowers who would be eligible for SSI /SSP, except for the increase in OASDI benefits due to the elimination of the reduction factor in P.L. 98-21, who therefore are deemed to be SSI or SSP recipients. | 42 CFR 435.137; 1634(b) | ABD | Mandatory Coverage |
| 20 | Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security | Disabled widows and widowers who would be eligible for SSI/SSP, except for the early receipt of OASDI benefits, who are not entitled to Medicare Part A, who therefore are deemed to be SSI recipients. | 42 CFR 435.138; 1634(d) | ABD | Mandatory Coverage |
| 21 | Working Disabled under 1619(b) | Blind or disabled individuals who participated in Medicaid as SSI cash recipients or who were considered to be receiving SSI, who would still qualify for SSI except for earnings. | 1619(b); 1902(a)(10)(A)(i)(II)(bb); 1905(q) | ABD | Mandatory Coverage |
| 22 | Disabled Adult Children | Individuals who lose eligibility for SSI at age 18 or older due to receipt of or increase in Title II OASDI child benefits. | 1634(c) | ABD | Mandatory Coverage |
| 23 | Qualified Medicare Beneficiaries | Individuals with income equal to or less than 100% of the FPL who are entitled to Medicare Part A, who qualify for Medicare cost-sharing. | 1902(a)(10)(E)(i);  1905(p) | ABD | Mandatory Coverage |
| 24 | Qualified Disabled and Working Individuals | Working, disabled individuals with income equal to or less than 200% of the FPL, who are entitled to Medicare Part A under section 1818A, who qualify for payment of Medicare Part A premiums. | 1902(a)(10)(E)(ii); 1905(p)(3)(A)(i); 1905(s) | ABD | Mandatory Coverage |
| 25 | Specified Low Income Medicare Beneficiaries | Individuals with income between 100% and 120% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums. | 1902(a)(10)(E)(iii); 1905(p)(3)(A)(ii) | ABD | Mandatory Coverage |
| 26 | Qualifying Individuals | Individuals with income between 120% and 135% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums. | 1902(a)(10)(E)(iv); 1905(p)(3)(A)(ii) | ABD | Mandatory Coverage |

**MEDICAID MANDATORY COVERAGE**

| **Code** | **Eligibility Group** | **Short Description** | **Citation** | **Type** | **Category** |
| --- | --- | --- | --- | --- | --- |
| 27 | Optional Coverage of Parents and Other Caretaker Relatives | Individuals qualifying as parents or caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the State. | 42 CFR 435.220; 1902(a)(10)(A)(ii)(I) | Family/Adult | Options for Coverage |
| 28 | Reasonable Classifications of Individuals under Age 21 | Individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the State. | 42 CFR 435.222; 1902(a)(10)(A)(ii)(I) and (IV) | Family/Adult | Options for Coverage |
| 29 | Children with Non-IV-E Adoption Assistance | Children with special needs for whom there is a non-IV-E adoption assistance agreement in effect with a state, who either were eligible for Medicaid or had income at or below a standard established by the state. | 42 CFR 435.227; 1902(a)(10)(A)(ii)(VIII); | Family/Adult | Options for Coverage |
| 30 | Independent Foster Care Adolescents | Individuals under an age specified by the State, less than age 21, who were in State-sponsored foster care on their 18th birthday and who meet the income standard established by the State. | 42 CFR 435.226; 1902(a)(10)(A)(ii)(XVII) | Family/Adult | Options for Coverage |
| 31 | Optional Targeted Low Income Children | Uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the State. | 42 CFR 435.229 and 435.4; 1902(a)(10)(A)(ii)(XIV); 1905(u)(2)(B) | Family/Adult | Options for Coverage |
| 32 | Individuals Electing COBRA Continuation Coverage | Individuals choosing to continue COBRA benefits with income equal to or less than 100% of the FPL. | 1902(a)(10)(F); 1902(u)(1) | Family/Adult | Options for Coverage |
| 33 | Individuals above 133% FPL under Age 65 | Individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the State. | CFR 435.218; 1902(hh); 1902(a)(10)(A)(ii)(XX) | Family/Adult | Options for Coverage |
| 34 | Certain Individuals Needing Treatment for Breast or Cervical Cancer | Individuals under the age of 65 who have been screened for breast or cervical cancer and need treatment. | 42 CFR 435.213; 1902(a)(10)(A)(ii)(XVIII); 1902(aa) | Family/Adult | Options for Coverage |
| 35 | Individuals Eligible for Family Planning Services | Individuals who are not pregnant, with income equal to or below the highest standard for pregnant women, as specified by the State, limited to family planning and related services. | 42 CFR 435.214; 1902(a)(10)(A)(ii)(XXI) | Family/Adult | Options for Coverage |
| 36 | Individuals with Tuberculosis | Individuals infected with tuberculosis whose income does not exceed established standards, limited to tuberculosis-related services. | 42 CFR 435.215; 1902(a)(10)(A)(ii)(XII); 1902(z) | Family/Adult | Options for Coverage |
| 37 | Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash Assistance | Individuals who meet the requirements of SSI or Optional State Supplement, but who do not receive cash. | 42 CFR 435.210 & 230; 1902(a)(10)(A)(ii)(I); | ABD | Options for Coverage |
| 38 | Individuals Eligible for Cash Assistance except for Institutionalization | Individuals who meet the requirements of AFDC, SSI or Optional State Supplement, and would be eligible if they were not living in a medical institution. | 42 CFR 435.211; 1902(a)(10)(A)(ii)(IV); | ABD | Options for Coverage |
| 39 | Individuals Receiving Home and Community Based Services under Institutional Rules | Individuals who would be eligible for Medicaid under the State Plan if in a medical institution, who would live in an institution if they did not receive home and community based services. | 42 CFR 435.217; 1902(a)(10)(A)(ii)(VI) | ABD | Options for Coverage |
| 40 | Optional State Supplement Recipients - 1634 States, and SSI Criteria States with 1616 Agreements | Individuals in 1634 States and in SSI Criteria States with agreements under 1616, who receive a state supplementary payment (but not SSI). | 42 CFR 435.232; 1902(a)(10)(A)(ii)(IV) | ABD | Options for Coverage |
| 41 | Optional State Supplement Recipients - 209(b) States, and SSI Criteria States without 1616 Agreements | Individuals in 209(b) States and in SSI Criteria States without agreements under 1616, who receive a state supplementary payment (but not SSI). | 42 CFR 435.234; 1902(a)(10)(A)(ii)(XI) | ABD | Options for Coverage |
| 42 | Institutionalized Individuals Eligible under a Special Income Level | Individuals who are in institutions for at least 30 consecutive days who are eligible under a special income level. | 42 CFR 435.236; 1902(a)(10)(A)(ii)(V) | ABD | Options for Coverage |
| 43 | Individuals participating in a PACE Program under Institutional Rules | Individuals who would be eligible for Medicaid under the State Plan if in a medical institution, who would require institutionalization if they did not participate in the PACE program. | 1934 | ABD | Options for Coverage |
| 44 | Individuals Receiving Hospice Care | Individuals who would be eligible for Medicaid under the State Plan if they were in a medical institution, who are terminally ill, and who will receive hospice care. | 1902(a)(10)(A)(ii)(VII); 1905(o) | ABD | Options for Coverage |
| 45 | Qualified Disabled Children under Age 19 | Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution. | 1902(e)(3) | ABD | Options for Coverage |
| 46 | Poverty Level Aged or Disabled | Individuals who are aged or disabled with income equal to or less than a percentage of the FPL, established by the state (no higher than 100%). | 1902(a)(10)(A)(ii)(X); 1902(m)(1) | ABD | Options for Coverage |
| 47 | Work Incentives Eligibility Group | Individuals with a disability with income below 250% of the FPL, who would qualify for SSI except for earned income. | 1902(a)(10)(A)(ii)(XIII) | ABD | Options for Coverage |
| 48 | Ticket to Work Basic Group | Individuals with earned income between ages 16 and 64 with a disability, with income and resources equal to or below a standard specified by the State. | 1902(a)(10)(A)(ii)(XV) | ABD | Options for Coverage |
| 49 | Ticket to Work Medical Improvements Group | Individuals with earned income between ages 16 and 64 who are no longer disabled but still have a medical impairment, with income and resources equal to or below a standard specified by the State. | 1902(a)(10)(A)(ii)(XVI) | ABD | Options for Coverage |
| 50 | Family Opportunity Act Children with Disabilities | Children under 19 who are disabled, with income equal to or less than a standard specified by the State (no higher than 300% of the FPL). | 1902(a)(10)(A)(ii)(XIX); 1902(cc)(1) | ABD | Options for Coverage |
| 51 | Individuals Eligible for Home and Community-Based Services | Individuals with income equal to or below 150% of the FPL, who qualify for home and community based services without a determination that they would otherwise live in an institution. | 1902(a)(10)(A)(ii)(XXII); 1915(i) | ABD | Options for Coverage |
| 52 | Individuals Eligible for Home and Community-Based Services - Special Income Level | Individuals with income equal to or below 300% of the SSI federal benefit rate, who meet the eligibility requirements for a waiver approved for the State under 1915(c), (d) or (e), or 1115. | 1902(a)(10)(A)(ii)(XXII); 1915(i) | ABD | Options for Coverage |
| \*72[[1]](#footnote-1) | Adult Group - Individuals at or below 133% FPL Age 19 through 64 - newly eligible for all states | Non-pregnant individuals aged 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL. | 42 CFR 435.119; 1902(a)(10)(A)(i)(VIII) | Family/Adult | Mandatory Coverage |
| \*73[[2]](#footnote-2) | Adult Group - Individuals at or below 133% FPL Age 19 through 64- not newly eligible for non 1905z(3) states | Non-pregnant individuals aged 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL. | 42 CFR 435.119; 1902(a)(10)(A)(i)(VIII) 1905z(3) | Family/Adult | Mandatory Coverage |
| \*741 | Adult Group - Individuals at or below 133% FPL Age 19 through 64 – not newly eligible parent/ caretaker-relative(s) in 1905z(3) states | Non-pregnant individuals aged 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL. | 42 CFR 435.119; 1902(a)(10)(A)(i)(VIII)  1905z(3) | Family/Adult | Mandatory Coverage |
| \*751 | Adult Group - Individuals at or below 133% FPL Age 19 through 64- not newly eligible non-parent/ caretaker-relative(s) in 1905z(3) states | Non-pregnant individuals aged 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL. | 42 CFR 435.119; 1902(a)(10)(A)(i)(VIII)  1905z(3) | Family/Adult | Mandatory Coverage |
| 76 | Uninsured Individual eligible for COVID-19 testing | Uninsured individuals who are eligible for medical assistance for COVID-19 diagnostic products and any visit described as a COVID–19 testing-related service for which payment may be made under the State plan during any portion of the public health emergency period, beginning March 18, 2020. | 1902(a)(10) (A)(ii)(XXIII) | Family/Adult | Optional |

**MEDICAID OPTIONS FOR COVERAGE**

| **Code** | **Eligibility Group** | **Short Description** | **Citation** | **Type** | **Category** |
| --- | --- | --- | --- | --- | --- |
| 53 | Medically Needy Pregnant Women | Women who are pregnant, who would qualify as categorically needy, except for income. | 42 CFR 435.301(b)(1)(i) and (iv); 1902(a)(10)(C)(ii)(II) | Family/Adult | Medically Needy |
| 54 | Medically Needy Children under Age 18 | Children under 18 who would qualify as categorically needy, except for income. | 42 CFR 435.301(b)(1)(ii); 1902(a)(10)(C)(ii)(II) | Family/Adult | Medically Needy |
| 55 | Medically Needy Children Age 18 through 20 | Children over 18 and under an age established by the State (less than age 21), who would qualify as categorically needy, except for income. | 42 CFR 435.308; 1902(a)(10)(C)(ii)(II) | Family/Adult | Medically Needy |
| 56 | Medically Needy Parents and Other Caretakers | Parents and other caretaker relatives of dependent children, eligible as categorically needy except for income. | 42 CFR 435.310 | Family/Adult | Medically Needy |
| 59 | Medically Needy Aged, Blind or Disabled | Individuals who are age 65 or older, blind or disabled, who are not eligible as categorically needy, who meet income and resource standards specified by the State, or who meet the income standard using medical and remedial care expenses to offset excess income. | 42 CFR 435.320, 435.322, 435.324, and 435.330; 1902(a)(10)(C) | ABD | Medically Needy |
| 60 | Medically Needy Blind or Disabled Individuals Eligible in 1973 | Blind or disabled individuals who were eligible for Medicaid as Medically Needy in 1973 who meet all current requirements for Medicaid except for the blindness or disability criteria. | 42 CFR 435.340 | ABD | Medically Needy |

**MEDICAID MEDICALLY NEEDY**

| **Code** | **Eligibility Group** | **Short Description** | **Citation** | **Type** | **Category** |
| --- | --- | --- | --- | --- | --- |
| 61 | Targeted Low-Income Children | Uninsured children under age 19 who do not have access to public employee coverage and whose household income is within standards established by the state. | 42 CFR 457.310; 2102(b)(1)(B)(v) | Children | Optional |
| 62 | Deemed Newborn | Children born to targeted low-income pregnant women who are deemed eligible for CHIP or Medicaid for one year. | 2112(e) | Children | Optional |
| 63 | Children Ineligible for Medicaid Due to Loss of Income Disregards | Children determined to be ineligible for Medicaid as a result of the elimination of income disregards under the MAGI income methodology. | 42 CFR 457.340(d) Section 2101(f) of the ACA | Children | Mandatory |

**CHIP COVERAGE**

| **Code** | **Eligibility Group** | **Short Description** | **Citation** | **Type** | **Category** |
| --- | --- | --- | --- | --- | --- |
| 64 | Coverage from Conception to Birth | Uninsured children from conception to birth who do not have access to public employee coverage and whose household income is within standards established by the state. | 42 CFR 457.310 2102(b)(1)(B)(v) | Children | Option for Coverage |
| 65 | Children with Access to Public Employee Coverage | Uninsured children under age 19 having access to public employee coverage and whose household income is within standards established by the state. | 2110(b)(2)(B) and (b)(6) | Children | Option for Coverage |
| 66 | Children Eligible for Dental Only Supplemental Coverage | Children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. Coverage is limited to dental services. | 2110(b)(5) | Children | Option for Coverage |
| 67 | Targeted Low-Income Pregnant Women | Uninsured pregnant women who do not have access to public employee coverage and whose household income is within standards established by the state. | 2112 | Pregnant Women | Option for Coverage |
| 68 | Pregnant Women with Access to Public Employee Coverage | Uninsured pregnant women having access to public employee coverage and whose household income is within standards established by the state. | 2110(b)(2)(B) and (b)(6) | Pregnant Women | Option for Coverage |

**CHIP ADDITIONAL OPTIONS FOR COVERAGE**

| **Code** | **Eligibility Group** | **Short Description** | **Citation** | **Type** | **Category** |
| --- | --- | --- | --- | --- | --- |
| 69 | Individuals with Mental Health Conditions (expansion group) | Individuals with mental health conditions who do not qualify for Medicaid due to the severity or duration of their disability or due to other eligibility factors; and/or those who are otherwise eligible but require benefits or services that are not comparable to those provided to other Medicaid beneficiaries. | 1115 expansion | N/A | N/A |
| 70 | Family Planning Participants (expansion group) | Individuals of child bearing age who require family planning services and supplies and for which the state does not choose to, or cannot provide, optional eligibility coverage under the Individuals Eligible for Family Planning Services eligibility group (1902(a)(10)(A)(ii)(XXI)). | 1115 expansion | N/A | N/A |
| 71 | Other expansion group | Individuals who do not qualify for Medicaid or CHIP under a mandatory eligibility or coverage group and for whom the state chooses to provide eligibility and/or benefits in a manner not permitted by title XIX or XXI of the Social Security Act. | 1115 expansion | N/A | N/A |

**1115 EXPANSION ELIGIBILITY GROUPS**

# Appendix G: ISO 639 Language Codes Reference

| **ISO 639-2 Code** | **Language** | **ISO 639-2 Code** | **Language** |
| --- | --- | --- | --- |
| abk | Abkhazian | kut | Kutenai |
| ace | Achinese | lad | Ladino |
| ach | Acoli | lah | Lahnda |
| ada | Adangme | lam | Lamba |
| ady | Adyghe; Adygei | day | Land Dayak languages |
| aar | Afar | lao | Lao |
| afh | Afrihili | lat | Latin |
| afr | Afrikaans | lav | Latvian |
| afa | Afro-Asiatic languages | lez | Lezghian |
| ain | Ainu | lim | Limburgan; Limburger; Limburgish |
| aka | Akan | lin | Lingala |
| akk | Akkadian | lit | Lithuanian |
| alb | Albanian | jbo | Lojban |
| alb | Albanian | nds | Low German; Low Saxon; German, Low; Saxon, Low |
| ale | Aleut | dsb | Lower Sorbian |
| alg | Algonquian languages | loz | Lozi |
| tut | Altaic languages | lub | Luba-Katanga |
| amh | Amharic | lua | Luba-Lulua |
| anp | Angika | lui | Luiseno |
| apa | Apache languages | smj | Lule Sami |
| ara | Arabic | lun | Lunda |
| arg | Aragonese | luo | Luo (Kenya and Tanzania) |
| arp | Arapaho | lus | Lushai |
| arw | Arawak | ltz | Luxembourgish; Letzeburgesch |
| arm | Armenian | mac | Macedonian |
| rup | Aromanian; Arumanian; Macedo-Romanian | mad | Madurese |
| art | Artificial languages | mag | Magahi |
| asm | Assamese | mai | Maithili |
| ast | Asturian; Bable; Leonese; Asturleonese | mak | Makasar |
| ath | Athapascan languages | mlg | Malagasy |
| aus | Australian languages | may | Malay |
| map | Austronesian languages | mal | Malayalam |
| ava | Avaric | mlt | Maltese |
| ave | Avestan | mnc | Manchu |
| awa | Awadhi | mdr | Mandar |
| aym | Aymara | man | Mandingo |
| aze | Azerbaijani | mni | Manipuri |
| ban | Balinese | mno | Manobo languages |
| bat | Baltic languages | glv | Manx |
| bal | Baluchi | mao | Maori |
| bam | Bambara | arn | Mapudungun; Mapuche |
| bai | Bamileke languages | mar | Marathi |
| bad | Banda languages | chm | Mari |
| bnt | Bantu languages | mah | Marshallese |
| bas | Basa | mwr | Marwari |
| bak | Bashkir | mas | Masai |
| baq | Basque | myn | Mayan languages |
| btk | Batak languages | men | Mende |
| bej | Beja; Bedawiyet | mic | Mi'kmaq; Micmac |
| bel | Belarusian | min | Minangkabau |
| bem | Bemba | mwl | Mirandese |
| ben | Bengali | moh | Mohawk |
| ber | Berber languages | mdf | Moksha |
| bho | Bhojpuri | lol | Mongo |
| bih | Bihari languages | mon | Mongolian |
| bik | Bikol | mkh | Mon-Khmer languages |
| bin | Bini; Edo | mos | Mossi |
| bis | Bislama | mul | Multiple languages |
| byn | Blin; Bilin | mun | Munda languages |
| zbl | Blissymbols; Blissymbolics; Bliss | nah | Nahuatl languages |
| nob | Bokmål, Norwegian; Norwegian Bokmål | nau | Nauru |
| bos | Bosnian | nav | Navajo; Navaho |
| bra | Braj | nde | Ndebele, North; North Ndebele |
| bre | Breton | nbl | Ndebele, South; South Ndebele |
| bug | Buginese | ndo | Ndonga |
| bul | Bulgarian | nap | Neapolitan |
| bua | Buriat | new | Nepal Bhasa; Newari |
| bur | Burmese | nep | Nepali |
| cad | Caddo | nia | Nias |
| cat | Catalan; Valencian | nic | Niger-Kordofanian languages |
| cau | Caucasian languages | ssa | Nilo-Saharan languages |
| ceb | Cebuano | niu | Niuean |
| cel | Celtic languages | nqo | N'Ko |
| cai | Central American Indian languages | nog | Nogai |
| khm | Central Khmer | non | Norse, Old |
| chg | Chagatai | nai | North American Indian languages |
| cmc | Chamic languages | frr | Northern Frisian |
| cha | Chamorro | sme | Northern Sami |
| che | Chechen | nor | Norwegian |
| chr | Cherokee | nno | Norwegian Nynorsk; Nynorsk, Norwegian |
| chy | Cheyenne | nub | Nubian languages |
| chb | Chibcha | nym | Nyamwezi |
| nya | Chichewa; Chewa; Nyanja | nyn | Nyankole |
| chi | Chinese | nyo | Nyoro |
| chn | Chinook jargon | nzi | Nzima |
| chp | Chipewyan; Dene Suline | oci | Occitan (post 1500) |
| cho | Choctaw | arc | Official Aramaic (700-300 BCE); Imperial Aramaic (700-300 BCE) |
| chu | Church Slavic; Old Slavonic; Church Slavonic; Old Bulgarian; Old Church Slavonic | oji | Ojibwa |
| chk | Chuukese | ori | Oriya |
| chv | Chuvash | orm | Oromo |
| nwc | Classical Newari; Old Newari; Classical Nepal Bhasa | osa | Osage |
| syc | Classical Syriac | oss | Ossetian; Ossetic |
| cop | Coptic | oto | Otomian languages |
| cor | Cornish | pal | Pahlavi |
| cos | Corsican | pau | Palauan |
| cre | Cree | pli | Pali |
| mus | Creek | pam | Pampanga; Kapampangan |
| crp | Creoles and pidgins | pag | Pangasinan |
| cpe | Creoles and pidgins, English based | pan | Panjabi; Punjabi |
| cpf | Creoles and pidgins, French-based | pap | Papiamento |
| cpp | Creoles and pidgins, Portuguese-based | paa | Papuan languages |
| crh | Crimean Tatar; Crimean Turkish | nso | Pedi; Sepedi; Northern Sotho |
| hrv | Croatian | per | Persian |
| cus | Cushitic languages | peo | Persian, Old (ca.600-400 B.C.) |
| cze | Czech | phi | Philippine languages |
| dak | Dakota | phn | Phoenician |
| dan | Danish | pon | Pohnpeian |
| dar | Dargwa | pol | Polish |
| del | Delaware | por | Portuguese |
| din | Dinka | pra | Prakrit languages |
| div | Divehi; Dhivehi; Maldivian | pro | Provençal, Old (to 1500);Occitan, Old (to 1500) |
| doi | Dogri | pus | Pushto; Pashto |
| dgr | Dogrib | que | Quechua |
| dra | Dravidian languages | raj | Rajasthani |
| dua | Duala | rap | Rapanui |
| dum | Dutch, Middle (ca.1050-1350) | rar | Rarotongan; Cook Islands Maori |
| dut | Dutch; Flemish | roa | Romance languages |
| dyu | Dyula | rum | Romanian; Moldavian; Moldovan |
| dzo | Dzongkha | roh | Romansh |
| frs | Eastern Frisian | rom | Romany |
| efi | Efik | run | Rundi |
| egy | Egyptian (Ancient) | rus | Russian |
| eka | Ekajuk | sal | Salishan languages |
| elx | Elamite | sam | Samaritan Aramaic |
| eng | English | smi | Sami languages |
| enm | English, Middle (1100-1500) | smo | Samoan |
| ang | English, Old (ca.450-1100) | sad | Sandawe |
| myv | Erzya | sag | Sango |
| epo | Esperanto | san | Sanskrit |
| est | Estonian | sat | Santali |
| ewe | Ewe | srd | Sardinian |
| ewo | Ewondo | sas | Sasak |
| fan | Fang | sco | Scots |
| fat | Fanti | sel | Selkup |
| fao | Faroese | sem | Semitic languages |
| fij | Fijian | srp | Serbian |
| fil | Filipino; Pilipino | srr | Serer |
| fin | Finnish | shn | Shan |
| fiu | Finno-Ugrian languages | sna | Shona |
| fon | Fon | iii | Sichuan Yi; Nuosu |
| fre | French | scn | Sicilian |
| frm | French, Middle (ca.1400-1600) | sid | Sidamo |
| fro | French, Old (842-ca.1400) | sgn | Sign Languages |
| fur | Friulian | bla | Siksika |
| ful | Fulah | snd | Sindhi |
| gaa | Ga | sin | Sinhala; Sinhalese |
| gla | Gaelic; Scottish Gaelic | sit | Sino-Tibetan languages |
| car | Galibi Carib | sio | Siouan languages |
| glg | Galician | sms | Skolt Sami |
| lug | Ganda | den | Slave (Athapascan) |
| gay | Gayo | sla | Slavic languages |
| gba | Gbaya | slo | Slovak |
| gez | Geez | slv | Slovenian |
| geo | Georgian | sog | Sogdian |
| ger | German | som | Somali |
| gmh | German, Middle High (ca.1050-1500) | son | Songhai languages |
| goh | German, Old High (ca.750-1050) | snk | Soninke |
| gem | Germanic languages | wen | Sorbian languages |
| gil | Gilbertese | sot | Sotho, Southern |
| gon | Gondi | sai | South American Indian languages |
| gor | Gorontalo | alt | Southern Altai |
| got | Gothic | sma | Southern Sami |
| grb | Grebo | spa | Spanish; Castilian |
| grc | Greek, Ancient (to 1453) | srn | Sranan Tongo |
| gre | Greek, Modern (1453-) | suk | Sukuma |
| grn | Guarani | sux | Sumerian |
| guj | Gujarati | sun | Sundanese |
| gwi | Gwich'in | sus | Susu |
| hai | Haida | swa | Swahili |
| hat | Haitian; Haitian Creole | ssw | Swati |
| hau | Hausa | swe | Swedish |
| haw | Hawaiian | gsw | Swiss German; Alemannic; Alsatian |
| heb | Hebrew | syr | Syriac |
| her | Herero | tgl | Tagalog |
| hil | Hiligaynon | tah | Tahitian |
| him | Himachali languages; Western Pahari languages | tai | Tai languages |
| hin | Hindi | tgk | Tajik |
| hmo | Hiri Motu | tmh | Tamashek |
| hit | Hittite | tam | Tamil |
| hmn | Hmong; Mong | tat | Tatar |
| hun | Hungarian | tel | Telugu |
| hup | Hupa | ter | Tereno |
| iba | Iban | tet | Tetum |
| ice | Icelandic | tha | Thai |
| ido | Ido | tib | Tibetan |
| ibo | Igbo | tig | Tigre |
| ijo | Ijo languages | tir | Tigrinya |
| ilo | Iloko | tem | Timne |
| smn | Inari Sami | tiv | Tiv |
| inc | Indic languages | tli | Tlingit |
| ine | Indo-European languages | tpi | Tok Pisin |
| ind | Indonesian | tkl | Tokelau |
| inh | Ingush | tog | Tonga (Nyasa) |
| ina | Interlingua (International Auxiliary Language Association) | ton | Tonga (Tonga Islands) |
| ile | Interlingue; Occidental | tsi | Tsimshian |
| iku | Inuktitut | tso | Tsonga |
| ipk | Inupiaq | tsn | Tswana |
| ira | Iranian languages | tum | Tumbuka |
| gle | Irish | tup | Tupi languages |
| mga | Irish, Middle (900-1200) | tur | Turkish |
| sga | Irish, Old (to 900) | ota | Turkish, Ottoman (1500-1928) |
| iro | Iroquoian languages | tuk | Turkmen |
| ita | Italian | tvl | Tuvalu |
| jpn | Japanese | tyv | Tuvinian |
| jav | Javanese | twi | Twi |
| jrb | Judeo-Arabic | udm | Udmurt |
| jpr | Judeo-Persian | uga | Ugaritic |
| kbd | Kabardian | uig | Uighur; Uyghur |
| kab | Kabyle | ukr | Ukrainian |
| kac | Kachin; Jingpho | umb | Umbundu |
| kal | Kalaallisut; Greenlandic | mis | Uncoded languages |
| xal | Kalmyk; Oirat | und | Undetermined |
| kam | Kamba | hsb | Upper Sorbian |
| kan | Kannada | urd | Urdu |
| kau | Kanuri | uzb | Uzbek |
| krc | Karachay-Balkar | vai | Vai |
| kaa | Kara-Kalpak | ven | Venda |
| krl | Karelian | vie | Vietnamese |
| kar | Karen languages | vol | Volapük |
| kas | Kashmiri | vot | Votic |
| csb | Kashubian | wak | Wakashan languages |
| kaw | Kawi | wln | Walloon |
| kaz | Kazakh | war | Waray |
| kha | Khasi | was | Washo |
| khi | Khoisan languages | wel | Welsh |
| kho | Khotanese; Sakan | fry | Western Frisian |
| kik | Kikuyu; Gikuyu | wal | Wolaitta; Wolaytta |
| kmb | Kimbundu | wol | Wolof |
| kin | Kinyarwanda | xho | Xhosa |
| kir | Kirghiz; Kyrgyz | sah | Yakut |
| tlh | Klingon; tlhIngan-Hol | yao | Yao |
| kom | Komi | yap | Yapese |
| kon | Kongo | yid | Yiddish |
| kok | Konkani | yor | Yoruba |
| kor | Korean | ypk | Yupik languages |
| kos | Kosraean | znd | Zande languages |
| kpe | Kpelle | zap | Zapotec |
| kro | Kru languages | zza | Zaza; Dimili; Dimli; Kirdki; Kirmanjki; Zazaki |
| kua | Kuanyama; Kwanyama | zen | Zenaga |
| kum | Kumyk | zha | Zhuang; Chuang |
| kur | Kurdish | zul | Zulu |
| kru | Kurukh | zun | Zuni |

# Appendix H: Benefit Types

| **Code Value** | **Benefit** | **Short Description** | **Category** | **Type of Care** | **Long Term Care\*** | **Citations (Act and 42 CFR)** |
| --- | --- | --- | --- | --- | --- | --- |
| 001 | Inpatient Hospital Services | Services furnished in a hospital or institution (licensed or formally approved as a hospital), for the care and treatment of inpatients with disorders other than mental health disease. | Mandatory | Institutional | No | 1905(a)(1), 440.10, 440.189(g) |
| 002 | Outpatient Hospital Services | Preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished to outpatients by a hospital or institution (licensed or formally approved as a hospital). | Mandatory | Ambulatory | No | 1905(a)(2)(A), 440.20(a) |
| 003 | Rural Health Clinics | Services and supplies provided by a physician within the scope of his/her practice, a physician assistant (if not prohibited by state law), nurse practitioner (if not prohibited by state law) nurse midwife, or other specialized nurse practitioners, intermittent visiting nurse care and related medical supplies (other than drugs and biologicals), and other ambulatory services when furnished in a certified rural health clinic or away from the clinic if an agreement between the physician and clinic for payment of services by the clinic exists. | Mandatory | Ambulatory | No | 1905(a)(2)(B), 440.20(b) and (c), 1910(a) |
| 004 | Federally Qualified Health Centers | Services and related supplies provided by a physician within the scope of his/her practice, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, clinical social workers, and other ambulatory services when furnished in a federally qualified health center. | Mandatory | Ambulatory | No | 1905(a)(2)(C) |
| 005 | Other Laboratory and X-Ray Services | Technical and radiological services ordered and provided by or under direction of a physician or other licensed practitioner in an office or similar facility other than a clinic or hospital outpatient department and furnished by an approved laboratory. | Mandatory | Ambulatory | No | 1905(a)(3), 440.30 |
| 006 | Nursing Facility Services for Individuals Age 21 and Older | Services (other than services in an institution for mental health conditions), furnished to individuals age 21 and older, which are needed on a daily basis and required to be provided in an inpatient basis provided by a Medicaid-approved facility and ordered by and provided under the direction of a physician. | Mandatory | Institutional | Yes | 1905(a)(4)(A), 440.40(a) |
| 007 | Early and Periodic Screening, Diagnostic and Treatment Services | Screening and diagnostic services to determine physical or mental health condition; health care treatment and other measures to correct or ameliorate any chronic conditions discovered in recipients under age 21. | Mandatory | Both | No | 1905(a)(4)(B), 1902(a)(43), 1905(r) |
| 008 | Family Planning Services and Supplies | Family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who desire such services and supplies. | Mandatory | Ambulatory | No | 1905(a)(4)(C), 441 Subpart F |
| 009 | Cessation of Tobacco Use by Pregnant Women | Counseling and pharmacotherapy services for cessation of tobacco use by pregnant women. | Mandatory | Ambulatory | No | 1905(a)(4)(D) |
| 010 | Physician Services | Services furnished by a state-licensed physician within his or her scope of practice of medicine or osteopathy. | Mandatory | Ambulatory | No | 1905(a)(5)(A), 440.50(a) |
| 011 | Medical and Surgical Services Furnished by a Dentist | Medical and surgical services furnished by a doctor of dental medicine or dental surgery, or if permitted by state law, by a physician. | Mandatory | Ambulatory | No | 1905(a)(5)(B), 440.50(b) |
| 012 | Nurse Midwife Services | Services furnished by a licensed nurse midwife within the scope of practice authorized by State law or regulation; Inpatient or outpatient hospital services or clinic services furnished by a licensed nurse midwife under the supervision of, or associated with a physician or other health care provider. | Mandatory | Ambulatory | No | 1905(a)(17), 440.165 |
| 013 | Certified Pediatric or Family Nurse Practitioner Services | Services furnished by a certified pediatric nurse practitioner with a practice limited to providing primary health care to individuals under age 21; or a certified family nurse practitioner with a practice limited to providing primary health care to individuals and families. | Mandatory | Ambulatory | No | 1905(a)(21), 440.166 |
| 014 | Free Standing Birth Center Services | Services furnished to an individual at a freestanding birth center, which include prenatal labor and delivery, or postpartum care and other ambulatory services related to the health and safety of the individual. | Mandatory | Institutional | No | 1905(a)(28) |
| 015 | Home Health Services - Intermittent and Part-time Nursing Services Provided by a Home Health Agency | Nursing service that is provided on a part-time or intermittent basis by a home health agency or in the absence of an agency in the area, by a registered nurse. | Mandatory | Ambulatory | Yes | 1905(a)(7), 440.70(b)(1), 441.15 |
| 016 | Home Health Services - Home Health Aide Services Provided by a Home Health Agency | Home health aide services provided by a home health agency. | Mandatory | Ambulatory | Yes | 1905(a)(7), 440.70(b)(2), 441.15 |
| 017 | Home Health Services - Medical Supplies, Equipment and Appliances Suitable for Use in the Home | Services include medical supplies, equipment and appliances suitable for use in the home. | Mandatory | Ambulatory | Yes | 1905(a)(7), 440.70(b)(3), 441.15 |

**Mandatory Benefits for Categorically Needy (Mandatory and Options for Coverage) Individuals and Optional Benefits for Medically Needy Individuals**

| **Code Value** | **Benefit** | **Short Description** | **Category** | **Type of Care** | **Long Term Care\*** | **Citations (Act and 42 CFR)** |
| --- | --- | --- | --- | --- | --- | --- |
| 018 | Medical Care and Any Type of Remedial Care Recognized Under State Law - Podiatrist Services | Medical or remedial care or services provided by licensed podiatrists within the scope of practice as defined under state law. | Optional | Ambulatory | No | 1905(a)(6), 440.60 |
| 019 | Medical Care and Any Type of Remedial Care Recognized Under State Law - Optometrist Services | Medical or remedial care or services provided by licensed optometrists within the scope of practice as defined under state law | Optional | Ambulatory | No | 1905(a)(6), 440.60 |
| 020 | Medical Care and Any Type of Remedial Care Recognized Under State Law - Chiropractors' Services | Services provided by licensed chiropractors consisting of treatment by means of manual manipulation of the spine within the scope authorized by the state to perform. | Optional | Ambulatory | No | 1905(a)(6), 440.60 |
| 021 | Medical Care and Any Type of Remedial Care Recognized Under State Law - Other Licensed Practitioner Services | Medical or any other remedial care or services provided by a licensed practitioner within the scope of his/her practice as defined by state law. | Optional | Ambulatory | No | 1905(a)(6), 440.60 |
| 022 | Home Health Services - Physical Therapy, Occupational Therapy, Speech Pathology, Audiology Provided by a Home Health Agency | Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or by a facility licensed by the state to provide medical rehabilitation services. | Optional | Ambulatory | Yes | 1905(a)(7), 440.70(b)(4), 441.15 |
| 023 | Private Duty Nursing Services | Nursing services, provided by RNs or LPNs, in a home, hospital, or skilled nursing facility, to recipients who require more individual and continuous care than is available from a visiting nurse, or routinely provided by hospital or skilled nursing facility staff. | Optional | Ambulatory | Yes | 1905(a)(8), 440.80 |
| 024 | Clinic Services | Preventive, diagnostic, therapeutic, rehabilitative or palliative services furnished by a facility that is not part of a hospital, but is organized and operated to provide medical care; services provided at the clinic or outside the clinic under the direction of a physician or dentist. | Optional | Ambulatory | No | 1905(a)(9), 440.90 |
| 025 | Dental Services | Diagnostic, preventive, or corrective procedures provided by or under the supervision of a licensed dentist; treatment of the teeth and associated structures of the oral cavity; treatment of disease, injury, or impairment that my affect general health of recipient. | Optional | Ambulatory | No | 1905(a)(10), 440.100 |
| 026 | Physical Therapy and Related Services- Physical Therapy | Services prescribed by a physician or other licensed practitioner of the healing arts, and provided to a recipient by or under the direction of a qualified physical therapist; includes supplies and equipment. | Optional | Ambulatory | Yes | 1905(a)(11), 440.110(a) |
| 027 | Physical Therapy and Related Services- Occupational Therapy | Services provided by a qualified occupational therapist, which have been prescribed by a physician or practitioner of the healing arts; includes supplies and equipment. | Optional | Ambulatory | Yes | 1905(a)(11), 440.110(b) |
| 028 | Physical Therapy and Related Services - Services for Individuals with Speech, Hearing and Language Disorders | Diagnostic, screening, preventive or corrective services for individuals with speech, hearing and language disorders; provided by or under the direction of a certified speech pathologist or audiologist or other licensed practitioner of the healing arts; includes supplies and equipment. | Optional | Ambulatory | Yes | 1905(a)(11), 440.110(c ) |
| 029 | PrescribedDrugs, Dentures, and Prosthetic Devices; and Eyeglasses - Prescribed Drugs | Single or compound substances or mixture of substances prescribed by a physician or licensed practitioner, and dispensed by a licensed pharmacist or authorized practitioner, for the cure, mitigation, or prevention of disease or maintenance of health. | Optional | Ambulatory | No | 1905(a)(12), 440.120(a) |
| 030 | Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses - Dentures | Artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth. | Optional | Ambulatory | No | 1905(a)(12), 440.120(b) |
| 031 | Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses - Prosthetic Devices | Replacement, corrective or supportive devices prescribed by a physician or licensed practitioner, to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or to support a weak or deformed portion of the body. | Optional | Ambulatory | No | 1905(a)(12), 440.120(c ) |
| 032 | Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses - Eyeglasses | Lenses, including frames and other aids to vision, prescribed by a physician skilled in eye disease, or an optometrist. | Optional | Ambulatory | No | 1905(a)(12), 440.120(d) |
| 033 | Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Diagnostic Services | Medical procedures or supplies recommended by a physician or licensed practitioner to enable him/her to identify the existence, nature or extent of illness, injury or other health deviation in a recipient. | Optional | Ambulatory | No | 1905(a)(13), 440.130(a) |
| 034 | Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Screening Services | Use of standardized tests given to a designated population, to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases. | Optional | Ambulatory | No | 1905(a)(13), 440.130(b) |
| 035 | Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Preventive Services | Services provided by a physician or other licensed practitioner to prevent disease, disability or other health conditions or their progression, to prolong life and to promote physical and mental health efficiency. | Optional | Ambulatory | No | 1905(a)(13), 440.130(c ) |
| 036 | Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Rehabilitative Services | Medical or remedial services recommended by a physician or other licensed practitioner for maximum reduction of physical or mental health condition, and restoration of a recipient to his/her best possible functional level. | Optional | Ambulatory | Yes | 1905(a)(13), 440.130(d) |
| 037 | Services for Individuals Age 65 and Over in IMDs - Inpatient Hospital Services | Services for the care and treatment of recipients, age 65 and older, in an institution for mental health conditions, provided under the direction of a physician. | Optional | Institutional | Yes | 1905(a)(14), 440.140(a) |
| 038 | Services for Individuals Age 65 and Over in IMDs - Nursing Facility Services | Nursing services needed on a daily basis and required to be provided on an inpatient basis to individuals age 65 and older in an institution for mental health conditions. | Optional | Institutional | Yes | 1905(a)(14), 440.140(b) |
| 039 | Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF-IID) | Items and health rehabilitative services provided to persons with intellectual disabilities or related conditions, receiving active treatment in a licensed ICF/IID. | Optional | Institutional | Yes | 1905(a)(15), 440.150 |
| 040 | Inpatient Psychiatric Services for Individuals Under 21 | Inpatient psychiatric services provided to individuals under age 21, under the direction of a physician, furnished in an approved and accredited psychiatric hospital or facility. | Optional | Institutional | Yes | 1905(a)(16), 440.160 |
| 041 | Hospice Care Services | Items and services provided to a terminally ill individual, which includes nursing care, physical or occupational therapy, medical social services, homemaker services, medical supplies and appliances, physician services, short-term inpatient care and counseling. | Optional | Both | Yes | 1905(a)(18) |
| 042 | Case Management and TB-Related Services - Case Management and Targeted Case Management Services | Services to assist eligible individuals who reside in a community setting or are transitioning to a community setting, in gaining access to medical, social, educational, and other services. As specified in a state’s plan, may be offered to individuals within targeted groups. | Optional | Ambulatory | Yes | 1905(a)(19), 440.169, 1915(g) |
| 043 | Case Management Services and TB-Related Services -Special TB Related Services | Services for the treatment of infection with tuberculosis consisting of prescribed drugs, physicians’ services, laboratory and x-ray services (including services to confirm the presence of infection), clinic services and federally-qualified health center services, case management services, and services (other than room and board) designed to encourage completion of regimens of prescribed drugs by outpatients, including services to observe directly the intake of prescribed drugs. | Optional | Ambulatory | No | 1905(a)(19) |
| 044 | Respiratory Care Services | Services provided in home, under the direction of a physician, by a respiratory therapist or other health care professional trained in respiratory therapy, to an individual who is medically dependent on a ventilator for life support for 6 hours or more per day, has been dependent on the ventilator for at least 30 consecutive days as an inpatient in a hospital, NF or ICF/IID, has adequate social support, and wishes to be cared for at home. | Optional | Ambulatory | No | 1905(a)(20), 1902(e)(9)(A)-(C ), 440.185 |
| 045 | Personal Care Services | Services, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, or intermediate facility for individuals with intellectual and or developmental disabilities, or institution for mental health conditions, that are authorized by a physician in accordance with a plan of treatment, and provided by an individual qualified to provide such services, who is not a legally responsible relative. | Optional | Ambulatory | Yes | 1905(a)(24), 440.167 |
| 046 | Primary Care Case Management Services (Integrated Care Model) | Case management related services which include location, coordination, and monitoring of primary health care services and provider under a contract between the State and either a PCCM who is a physician, or at the State’s option, a physician assistant, nurse practitioner, certified nurse midwife, physician group practice, or an entity that employs or arranges with physicians to furnish services. | Optional | Ambulatory | No | 1905(a)(25), 440.168 |
| 047 | Special Sickle-Cell Anemia-Related Services | Primary and secondary medical strategies and treatment and services for individuals who have Sickle Cell Disease. | Optional | Ambulatory | No | 1905(a)(27) |
| 048 | Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Transportation | Expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a beneficiary. | Optional, but states are required to assure that transportation is available to and from Medicaid services, either as a State Plan benefit, an administrative activity or under a waiver | Ambulatory | No | 1905(a)(29), 440.170(a) |
| 049 | Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Services provided in religious non-medical health care facilities | Non-medical services and items, furnished in an institution that is defined in the Internal Revenue Code and is exempt from taxes, to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs. | Optional | Institutional | Yes | 1905(a)(29), 440.170(b) and (c ) |
| 050 | Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Nursing facility services for individuals under age 21 | Services (other than services in an Institution for mental health conditions), furnished to individuals under the age of 21, which are needed on a daily basis and required to be provided in an inpatient basis provided by a Medicaid-approved facility and ordered by and provided under the direction of a physician. | Optional | Institutional | Yes | 1905(a)(29), 440.170(d) |
| 051 | Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Emergency hospital services | Services that are necessary to prevent death or serious impairment of health of a recipient, and that the threat to life or health necessitates that use of the most accessible hospital available that is equipped to furnish the services, with no regard to conditions of participation under Medicare or definitions of inpatient or outpatient hospital services. | Optional | Ambulatory | No | 1905(a)(29), 440.170(e) |
| 052 | Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Critical Access Hospitals | Services that are furnished by a Medicare participating Critical Access Hospital (CAH) provider and are of a type that would be paid for by Medicare when provided to a Medicare recipient, other than nursing facility services by a CAH with a swing-bed approval. | Optional | Institutional | No | 1905(a)(29), 440.170(g) |
| 053 | Extended Services for Pregnant Women - Additional Services for Any Other Medical Conditions That May Complicate Pregnancy | Extended services for pregnant women - Additional Services for any other medical conditions that may complicate pregnancy, except Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls. (These services will fall into valid value # 71.) | Optional | Ambulatory | No | 1902(a)(10)(end)(V) |
| 054 | Community First Choice | Home and community-based attendant services and supports to assist eligible beneficiaries in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision or cueing. | Optional | Ambulatory | No | 1915(k) |
| 055 | Health Homes | Comprehensive and timely high-quality services that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team. Services include care management, care coordination and promotion, comprehensive transitional care, patient and family support, referral to community and social support services, and use of information technology to link services. | Optional | Ambulatory | No | 1945 |

**Optional Benefits for Categorically Needy (Mandatory and Options for Coverage) and Medically Needy Individuals**

| **Code Value** | **Benefit** | **Short Description** | **Category** | **Type of Care** | **Long Term Care\*** | **Citations (Act and 42 CFR)** |
| --- | --- | --- | --- | --- | --- | --- |
| 056 | Limited Pregnancy-Related Services for Pregnant Women with Income Above the Applicable Income Limit | Potentially limited services for pregnant women with income above a certain limit to pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or have become necessary as a result of the woman having been pregnant, including, but not limited to prenatal care, delivery, postpartum care, and family planning services. | N/A | N/A | No | 1902(a)(10)(end)(VII), 440.210(a)(2), 440.250(p) |
| 057 | Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period | Ambulatory prenatal care services provided to an eligible pregnant woman during the PE period, which begins on the date a pregnant woman is determined presumptively eligible by a Medicaid qualified provider based on preliminary information, and ends on the day on which a full determination of eligibility is made or at the end of the month following the month in which the PE determination was made if the woman fails to file an application for full benefits. | N/A | N/A | No | 1920, 1902(a)(47) |
| 058 | Benefits for Families Receiving Transitional Medical Assistance | Benefits provided to families who would have lost eligibility because of hours of, or income from employment of the caretaker relative. Benefits may be limited or provided through alternative methods during the second six months of the 12 month period of extended benefits. | N/A | N/A | N/A | 1925, 1902(a)(52) |
| 059 | Standards for Coverage of Transplant Services | Standards which provide that similarly situated individuals are treated alike and any restriction, on the facilities or practitioners which may provide such procedures, is consistent with accessibility to high quality care. | N/A | N/A | N/A | 1903(i)(1), 441.35 |
| 060 | School-Based Services Payment Methodologies | Provision of benefits in a school-based setting or arranged by a school to a child with a disability even if such services are included in the child's individualized education program (IEP), and to an infant or toddler with a disability even if such services are included in the child's individualized family service plan (IFSP). | N/A | N/A | N/A | 1903(c ) |
| 061 | Indian Health Services and Tribal Health Facilities | Allows for reimbursement of state plan covered services when provided by a facility of the Indian Health Service, including a hospital, nursing facility or any other type of facility which provides covered services under the state plan. | N/A | N/A | N/A | 1911, 431.110(b) |
| 062 | Methods and Standards to Assure High Quality Care | The plan must include a description of methods and standards used to assure that services are of high quality and that the care and services are available under the plan at least to the extent that such care and services are available to the general populations in the geographic area. | N/A | N/A | N/A | 1902(a)(30)(A), 440.260 |

**Special Benefit Provisions**

| **Code Value** | **Benefit** | **Short Description** | **Category** | **Type of Care** | **Long Term Care\*** | **Citations (Act and 42 CFR)** |
| --- | --- | --- | --- | --- | --- | --- |
| 063 | Medicare Premium Payments | Provisions related to payment of Medicare A, B and C premiums for qualifying Medicaid beneficiaries. | N/A | N/A | N/A | 1902(a)(10(E ), 1905(p), 1905(s), 1933, 431.625 |
| 064 | Medicare Coinsurance and Deductibles | Provisions for Medicaid payment of Medicare coinsurance and deductibles for individuals dually eligible for Medicare and Medicaid. | N/A | N/A | N/A | 1902(a)(10(E ), 1902(n), 1905(p)(3) and (4) |
| 065 | Other Medical Insurance Premium Payments | Payment of insurance premiums, if cost-effective, for eligible individuals; payment of COBRA premiums; and requirement of enrollment in an employer-sponsored insurance with payment of premiums, if cost-effective. | N/A | N/A | N/A | 1906, 1906A, 1902(a)(10)(F), 1902(u)(1) |

**Coordination of Medicaid with Medicare and Other Insurance**

| **Code Value** | **Benefit** | **Short Description** | **Category** | **Type of Care** | **Long Term Care\*** | **Citations (Act and 42 CFR)** |
| --- | --- | --- | --- | --- | --- | --- |
| 066 | Programs for Distribution of Pediatric Vaccines | The establishment of a pediatric vaccine distribution program, which provides eligible children with qualified pediatric vaccines. | Mandatory | N/A | N/A | 1928 |

**Special Benefit Programs**

| **Code Value** | **Benefit** | **Short Description** | **Category** | **Type of Care** | **Long Term Care\*** | **Citations (Act and 42 CFR)** |
| --- | --- | --- | --- | --- | --- | --- |
| 067 | Laboratory and x-ray services |  |  |  |  |  |
| 068 | Home Health Services - Home health aide services provided by a home health agency | N/A | N/A | N/A | N/A | N/A |
| 069 | Private duty nursing services | N/A | N/A | N/A | N/A | N/A |
| 070 | Physical Therapy and Related Services - Audiology services | N/A | N/A | N/A | N/A | N/A |
| 071 | Extended services for pregnant women - Additional Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls. | N/A | N/A | N/A | N/A | N/A |
| 072 | Home and Community Care for Functionally Disabled Elderly individuals as defined and described in the State Plan | N/A | N/A | N/A | N/A | N/A |
| 073 | Emergency services for certain legalized aliens and undocumented aliens | An emergency medical condition is a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. | N/A | N/A | N/A | N/A |
| 074 | Licensed or Otherwise State-Approved Free-Standing Birthing Center and other ambulatory services that are offered by a freestanding birth center | N/A | N/A | N/A | N/A | N/A |
| 075 | Homemaker | N/A | N/A | N/A | N/A | N/A |
| 076 | Home Health Aide | N/A | N/A | N/A | N/A | N/A |
| 077 | Adult Day Health services | N/A | N/A | N/A | N/A | N/A |
| 078 | Habilitation | N/A | N/A | N/A | N/A | N/A |
| 079 | Habilitation: Residential Habilitation | N/A | N/A | N/A | N/A | N/A |
| 080 | Habilitation: Supported Employment | N/A | N/A | N/A | N/A | N/A |
| 081 | Habilitation: Education (non IDEA available) | N/A | N/A | N/A | N/A | N/A |
| 082 | Habilitation: Day Habilitation | N/A | N/A | N/A | N/A | N/A |
| 083 | Habilitation: Pre-Vocational | N/A | N/A | N/A | N/A | N/A |
| 084 | Habilitation: Other Habilitative Services | N/A | N/A | N/A | N/A | N/A |
| 085 | Respite | N/A | N/A | N/A | N/A | N/A |
| 086 | Day Treatment (mental health service) | N/A | N/A | N/A | N/A | N/A |
| 087 | Psychosocial rehabilitation | N/A | N/A | N/A | N/A | N/A |
| 088 | Environmental Modifications (Home Accessibility Adaptations) | N/A | N/A | N/A | N/A | N/A |
| 089 | Vehicle Modifications | N/A | N/A | N/A | N/A | N/A |
| 090 | Non-Medical Transportation | N/A | N/A | N/A | N/A | N/A |
| 091 | Special Medical Equipment (minor assistive Devices) | N/A | N/A | N/A | N/A | N/A |
| 092 | Home Delivered meals | N/A | N/A | N/A | N/A | N/A |
| 093 | Assistive Technology (i.e., communication devices) | N/A | N/A | N/A | N/A | N/A |
| 094 | Personal Emergency Response (PERS) | N/A | N/A | N/A | N/A | N/A |
| 095 | Nursing Services | N/A | N/A | N/A | N/A | N/A |
| 096 | Community Transition Services | N/A | N/A | N/A | N/A | N/A |
| 097 | Adult Foster Care | N/A | N/A | N/A | N/A | N/A |
| 098 | Day Supports (non-habilitative) | N/A | N/A | N/A | N/A | N/A |
| 099 | Supported Employment | N/A | N/A | N/A | N/A | N/A |
| 100 | Supported Living Arrangements | N/A | N/A | N/A | N/A | N/A |
| 101 | Supports for Consumer Direction (Supports Facilitation) | N/A | N/A | N/A | N/A | N/A |
| 102 | Participant Directed Goods and Services | N/A | N/A | N/A | N/A | N/A |
| 103 | Senior Companion (Adult Companion Services) | N/A | N/A | N/A | N/A | N/A |
| 104 | Assisted Living | N/A | N/A | N/A | N/A | N/A |

**Home and Community-Based Services**

| **Code Value** | **Benefit** | **Short Description** | **Category** | **Type of Care** | **Long Term Care\*** | **Citations (Act and 42 CFR)** |
| --- | --- | --- | --- | --- | --- | --- |
| 105 | Program for All-inclusive Care for the Elderly (PACE) Services | N/A | N/A | N/A | N/A | N/A |
| 106 | Self-directed Personal Assistance Services under 1915(j) | N/A | N/A | N/A | N/A | N/A |
| 107 | COVID - 19 Testing | In vitro diagnostic products (as defined in section 809.3(a) of title 21, Code of Federal Regulations) administered during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) beginning on or after the date of the enactment of this subparagraph for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such in vitro diagnostic products | Optional | Family/Adult | N/A | Section 1902(a)(10)(G) |
| 108 | COVID - 19 Testing-related services | COVID–19 testing-related services | Optional | Family/Adult | N/A | Section 1902(a)(10)(G) |

**Other**

# Appendix I: MBES CBES Category of Service Line Definitions for the 64.9 Base Form

| **Line** | **Line - Form Display** | **Line - Definition** |
| --- | --- | --- |
| 1A | Inpatient Hospital - Reg. Payments | 1A. - Inpatient Hospital Services. -- Regular Payments.--Other than services in an institution for mental health conditions. (See 42 CFR 440.10). These are services that:   * Are ordinarily furnished in a hospital for the care and treatment of inpatients; * Are furnished under the direction of a physician or dentist (except in the case of nurse-midwife services under 42 CFR 440.165); and * Are furnished in an institution that: * Is maintained primarily for the care and treatment of patients with disorders other than mental health conditions; * Is licensed and formally approved as a hospital by an officially designated authority for State standard setting; * Meets the requirements for participation in Medicare (except in the case of medical supervision of nurse-midwife services under 42 CFR 440.165); and, * Has, in effect, a utilization review plan (that meets the requirements under 42 CFR 482.30 applicable to all Medicaid patients, unless a waiver has been granted by DHHS.   NOTE: Inpatient hospital services do not include NF services furnished by a hospital with swing-bed approval. However, include services provided in a psychiatric wing of a general hospital if the psychiatric wing is not administratively separated from the general hospital. |
| 1B | Inpatient Hospital - DSH | 1B. - Inpatient Hospital Services -- DSH Adjustment Payment. - Other than services in an institution for mental health conditions. DSH payments are for the express purpose of assisting hospitals that serve a disproportionate share of low-income patients with special needs and are made in accordance with section 1923 of the Act.  Report the total payments that were determined to be disproportionate share payments to the hospital by entering the amounts on the pop-up feeder form which in turn will pre-fill the Form CMS-64.9D as well as the appropriate lines on the Forms CMS-64.9, CMS-64.9P, CMS-64.21, CMS-64.21P, CMS-6421U or CMS-64.21UPs. |
| 1C | Inpatient Hospital - Sup. Payments | 1C. - Inpatient Hospital Services. - Supplemental Payments.--Other than services in an institution for mental health conditions. (Refer to the definition on Line 1A above). These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272. Address supplemental payments for inpatient hospitals associated with (1) state government operated facilities, (2) non-state government operated facilities, and (3) privately operated facilities by entering payments on the pop-up feeder form. |
| 1D | Inpatient Hospital - GME Payments | 1D. - Inpatient Hospital Services.—Graduate Medical Education (GME) Payments.-- GME payments include supplemental payments for direct medical education (DME) (i.e. costs of training physicians such as resident and teaching physician salaries/benefits, overhead and other costs directly related to the program) and indirect medical education (IME) costs hospitals incur for operating teaching programs. Report all supplemental payments for DME and IME that are provided for in the State plan. |
| 2A | Mental Health Facility Services - Reg. Payments | 2A. Mental Health Facility Services - Report Institution for Mental Disease (IMD) (or mental health conditions) services for individuals age 65 or older and/or under age 21 (See 42 CFR 440.140 and 440.160.).  Report Other Mental Services which are not provided in an inpatient setting in the Other Appropriate Service categories, e.g., Physician Services, Clinic Services.  1. Mental Health Hospital Services for the Aged. Refers to those inpatient hospital services provided under the direction of a physician for the care and treatment of recipients in an institution for mental health conditions that meets the Conditions of Participation under 42 CFR Part 482. Institution for mental health conditions means an institution that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental health conditions, including medical care, nursing care, and related services. (See 42 CFR 440.140(a)(2).)  2. NF Services for the Aged. Means those NF services (as defined at 42 CFR 440.40) and those ICF services (as defined at 42 CFR 483, Subpart B) provided in an institution for mental health conditions to recipients determined to be in need of such services. (See 42 CFR 440.140.)  3. Inpatient Psychiatric Facility Services for Individuals Age 21 and Under. (See 42 CFR 441.151) --Means those services that:   * Are provided under the direction of a physician; * Are provided in a facility or program accredited by the Joint Commission on the Accreditation of Health Care Organizations; and * Meet the requirements set forth at Subpart D of Part 441 (Inpatient Psychiatric Services for Individuals Age 21 and under in Psychiatric Facilities or Programs). |
| 2B | Mental Health Facility - DSH | 2B. Mental Health Facility Services -- DSH Adjustment Payments. - (See 42 CFR 440.140 and 440.160). DSH payments are for the express purpose of assisting hospitals that serve a disproportionate share of low-income patients with special needs and are made in accordance with section 1923 of the Act.  Report the total payments that were determined to be disproportionate share payments to the hospital by entering the amounts on the pop-up feeder form which in turn will pre-fill the Form CMS-64.9D as well as the appropriate lines on the Forms CMS-64.9, CMS-64.9P, CMS-64.21, CMS-64.21P, CMS-6421U or CMS-64.21UPs. |
| 3A | Nursing Facility Services - Reg. Payments | 3A. - Nursing Facility Services.--Regular Payments. -- (Other than services in an institution for mental health conditions). (See 42 CFR 483.5 and 440.155).  These are services provided by an institution (or a distinct part of an institution) which:   * Is primarily engaged in providing to residents: * Skilled nursing care and related services for residents who require medical or nursing care; * Rehabilitation services for the rehabilitation of injured, disabled or sick persons; or * On a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental health conditions; and, * Meet the requirements for a nursing facility described in subsections 1919 (b), (c) and (d) of the Act regarding: * Requirements relating to Provision of Services, * Requirements relating to Residences Rights, and, * Requirements relating to Administration and Other Matters. |
| 3B | Nursing Facility Services - Sup. Payments | 3B. - Nursing Facility Services - Supplemental Payments. -- (Other than services in an institution for mental health conditions). (Refer to the definition on Line 3A above). These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272.  Address supplemental payments for nursing facility services associated with   1. state government operated facilities, 2. non-state government operated facilities, and 3. Privately operated facilities by entering payments on the pop-up feeder form. |
| 4A | Intermediate Care Facility Services – Individuals with Intellectual Disabilities: Public Providers | 4A Intermediate Care Facility Services - Public Providers – Individuals with Intellectual Disabilities (ICF/IID) (See 42 CFR 440.150).  These include services provided in an institution for individuals with intellectual disabilities or persons with related conditions if:   * The primary purpose of the institution is to provide health or rehabilitative services to such individuals; * The institution meets the standards in 42 CFR 442, Subpart C (Intermediate Care Facility Requirements; All Facilities); and, * Individuals with intellectual disabilities recipient for whom payment is requested is receiving active treatment as defined in 42 CFR 435.1009.   NOTE: Line 4 is divided into sections for public providers (Line 4.A.) and private providers (Line 4.B.). Public providers are owned or operated by a State, county, city or other local governmental agency or instrumentality. Increasing adjustments related to private providers are considered current expenditures for the quarter in which the expenditure was made and are matched at the FMAP rate for that quarter. Increasing adjustments related to public providers are considered adjustments to prior period claims and are matched using the FMAP rate in effect at the earlier of the time the expenditure was paid or recorded by any State agency. (See 45 CFR Part 95 and §2560.) |
| 4B | Intermediate Care Facility Services - Individuals with Intellectual Disabilities: Private Providers | 4B --Intermediate Care Facility Services - Private Providers - Individuals with Intellectual Disabilities (ICF/IID). (See 42 CFR 440.150).  These include services provided in an institution for individuals with intellectual disabilities or persons with related conditions if:   * The primary purpose of the institution is to provide health or rehabilitative services to such individuals; * The institution meets the standards in 42 CFR 442, Subpart C (Intermediate Care Facility Requirements; All Facilities); and * Individuals with intellectual disabilities recipient for whom payment is requested is receiving active treatment as defined in 42 CFR 435.1009. * NOTE: Line 4 is divided into sections for public providers (Line 4.A.) and private providers (Line 4.B.). Public providers are owned or operated by a State, county, city or other local governmental agency or instrumentality. Increasing adjustments related to private providers are considered current expenditures for the quarter in which the expenditure was made and are matched at the FMAP rate for that quarter. Increasing adjustments related to public providers are considered adjustments to prior period claims and are matched using the FMAP rate in effect at the earlier of the time the expenditure was paid or recorded by any State agency. (See 45 CFR Part 95 and §2560.) |
| 4C | Intermediate Care Facility Services – Individuals with Intellectual Disabilities: Supplemental Payments | Line 4C. Intermediate Care Facility Services (ICF/IID) - Supplemental Payments (Refer to the definition on Line 4A above). These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272. Address supplemental payments for ICF/IID services associated with (1) state government operated facilities, (2) non-state government operated facilities, and (3) privately operated facilities by entering payments on the pop-up feeder form. |
| 5A | Physician & Surgical Services - Reg. Payments | 5A. - Physician and Surgical Services.--Regular Payments. -- (See 42 CFR 440.50.).--Whether furnished in the office, the recipient's home, a hospital, a NF, or elsewhere, physicians' services are services provided:   * Within the scope of practice of medicine or osteopathy as defined by State law; and * By, or under, the personal supervision of an individual licensed under State law to practice medicine or osteopathy. * NOTE: Exclude all services provided and billed for by a hospital, clinic, or laboratory. Include any services provided and billed by a physician under physician services with the exception of lab and X-ray services. Include such services provided and billed for by a physician under the lab and X-ray services category. In a primary care case management system under a Freedom of Choice waiver, you sometimes use a physician as the case manager. In these situations, the physician is allowed to charge a flat fee for each person. Although this fee is not truly a physician service, report the expenditures for the fee on this line. |
| 5B | Physician & Surgical Services - Sup. Payments | 5B. - Physician and Surgical Services.--Supplemental Payments.-- (refer to definition for Line 5A above) Payments for physician and other practitioner services as defined in Line 5A that are made in addition to the standard fee schedule payment for those services. When combined with regular payments, these supplemental payments are equal to or less than the Federal upper payment limit. Address supplemental payments for physicians and practitioners associated with   1. governmental hospitals or university teaching hospitals, 2. private hospitals, and 3. other supplemental payments by entering payment information on the pop-up feeder sheet. |
| 5C | Physician & Surgical Services - Evaluation and Management | 5C. Physician & Surgical Services - Evaluation and Management -- ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching. |
| 5D | Physician & Surgical Services - Vaccine codes | 5D. Physician & Surgical Services - Vaccine codes -- ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share Matching Rate |
| 6A | Outpatient Hospital Services - Reg. Payments | 6A. - Outpatient Hospital Services.--Regular Payments. -- (See 42 CFR 440.20.).--These are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:   * Are furnished to outpatients; * Except in the case of nurse-midwife services (see 42 CFR 440.165), are furnished by, or under the direction of, a physician or dentist; and * Are furnished by an institution that: * Is licensed or formally approved as a hospital by an officially designated authority for State standard setting; and * Except in the case of medical supervision of nurse-midwife services, meets the requirements for participation in Medicare. (See 42 CFR 440.165.) |
| 6B | Outpatient Hospital Services - Sup. Payments | 6B. - Outpatient Hospital Services.--Supplemental Payments.-- (refer to definition for Line 6A above) Payments for outpatient hospital services as defined in line 6A that are made in addition to the base fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. The combined standard payment and supplemental payment cannot exceed the Federal upper payment limit. Address outpatient hospital services supplemental payments associated with (1) state owned or operated hospitals, (2) non state government owned or operated hospitals and (3) private hospitals by entering payment information on the pop-up feeder sheet. |
| 7 | Prescribed Drugs | 7 - Prescribed Drugs. (See 42 CFR 440.120(a).).--These are simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:   * Prescribed by a physician or other licensed practitioner of the healing arts within the scope of a professional practice as defined and limited by Federal and State law; * Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and * Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's record. |
| 7A1 | Drug Rebate Offset - National | 7A.1. Drug Rebate Offset.--This is a refund from the manufacturer to the State Medical Assistance plan for single source drugs, innovator multiple source drugs, and non-innovator multiple source drugs that are dispensed to Medicaid recipients. Rebates are to take place quarterly. Report these offsets as (1) National Agreement or (2) State Sidebar Agreement. National Agreement refers to rebates manufacturers pay your State pursuant to the manufacturers' agreements with CMS under OBRA 1990 provisions. State Sidebar Agreements refer to rebates manufacturers pay under an agreement directly with your State. These may have been entered into before January 1, 1991, the effective date of the OBRA rebate program. Or they may represent agreements your State entered into with a given manufacturer on or after January 1, 1991, under which the manufacturer pays at least as great a rebate as it would under the National Agreement. All States receive rebates under the National Agreements. A few States receive most of their rebates under the National Agreement, but some States receive other rebates under their State Sidebar Agreement with specific manufacturers. All manufacturer rebates received under CMS's National Agreement are reported on Line 7.A.1, National Agreement. All rebates received under State Sidebar Agreements are reported on Line 7.A.2, State Sidebar Agreement.  NOTE: Vaccines are not subject to the rebate agreements. |
| 7A2 | Drug Rebate Offset - State Sidebar Agreement | 7A2. Drug Rebate Offset.--This is the rebate collected under a separate State agreement Sidebar Agreement. These are rebates received that do not fall under 7A1 (National Drug Rebate). |
| 7A3 | MCO - National Agreement | 7A.3. National Agreement 7A3. Managed Care Organizations (MCO) – National Agreement: The Affordable Care Act requires manufacturers that participate in the Medicaid Drug Rebate Program to pay rebates for drugs dispensed to individuals enrolled with a Medicaid MCO if the MCO is responsible for coverage of such drugs, effective March 23, 2010. This is a refund from the manufacturer to the State Medical Assistance plan for single source drugs, innovator multiple source drugs, and non-innovator multiple source drugs that are dispensed to Medicaid recipients who are enrolled in a Medicaid MCO. Rebates are to take place quarterly. Report these offsets as MCO National Agreement. National Agreement refers to rebates manufacturers pay your State pursuant to the manufacturers agreements with CMS under OBRA 1990 provisions. All States receive rebates under the National Agreement. For rebates for Medicaid MCO drugs, there will be no rebates under their State Sidebar Agreement with specific manufacturers. All MCO manufacturer rebates received under CMS National Agreement are reported on Line 7.A.3, National Agreement  NOTE: Vaccines are not subject to the National agreement. |
| 7A4 | MCO - State Sidebar Agreement | 7A.4. MCO State Sidebar Agreement. This is the rebate collected under a separate State agreement Sidebar Agreement. These are rebates received that do not fall under 7A3 (National Drug Rebate). |
| 7A5 | Increased ACA OFFSET - Fee for Service - 100% | Brand name drugs that are blood clotting factors and drugs approved by the FDA exclusively for pediatric indications are subject to a minimum rebate percentage of 17.1 percent of AMP:   * If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 2 percent of AMP (the difference between 17.1 percent of AMP and 15.1 percent of AMP). * If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 17.1 percent of AMP, then we plan to offset the difference between 17.1 percent of AMP and AMP minus BP. * If the difference between AMP and BP is greater than or equal to 17.1 percent of AMP, then we do not plan to take any offset amount.   For a drug that is a line extension of a brand name drug that is an oral solid dosage form, we plan to apply the same offset calculation as described above to the basic rebate. Further, we plan to offset only the difference in the additional rebate of the reformulated drug based on the calculation methodology of the additional rebate for the drug preceding the requirements of the Affordable Care Act and the calculation of the additional rebate for the reformulated drug, if greater, in accordance with the Affordable Care Act. If there is no difference in the additional rebate amount in accordance with the Affordable Care Act, then we do not plan to take any offset amount.  For a noninnovator multiple source drug, we plan to offset an amount equal to two percent of the AMP (the difference between 13 percent of AMP and 11 percent of AMP). |
| 7A6 | Increased ACA OFFSET - MCO - 100% | 7A.6. Increased ACA OFFSET - MCO - 100% 7A6. Increased ACA OFFSET – MCO: Similar to the increased ACA offset for fee-for-service, for covered outpatient drugs that are dispensed to Medicaid MCO enrollees, the Affordable Care Act also required that amounts “attributable” to the increased rebates be remitted to the Federal Government. Below is a description of how the offset is calculated: Brand name drugs other than blood clotting factors and drugs approved by the Food and Drug Administration (FDA) exclusively for pediatric indications are subject to a minimum rebate percentage of 23.1 percent of AMP:   * If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 8 percent of AMP (the difference between 23.1 percent of AMP and 15.1 percent of AMP). * If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 23.1 percent of AMP, then we plan to offset the difference between 23.1 percent of AMP and AMP minus BP. * If the difference between AMP and BP is greater than or equal to 23.1 percent of AMP, then we do not plan to take any offset amount.   Brand name drugs that are blood clotting factors and drugs approved by the FDA exclusively for pediatric indications are subject to a minimum rebate percentage of 17.1 percent of AMP:   * If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 2 percent of AMP (the difference between 17.1 percent of AMP and 15.1 percent of AMP). * If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 17.1 percent of AMP, then we plan to offset the difference between 17.1 percent of AMP and AMP minus BP. * If the difference between AMP and BP is greater than or equal to 17.1 percent of AMP, then we do not plan to take any offset amount.   For a drug that is a line extension of a brand name drug that is an oral solid dosage form, we plan to apply the same offset calculation as described above to the basic rebate. Further, we plan to offset only the difference in the additional rebate of the reformulated drug based on the calculation methodology of the additional rebate for the drug preceding the requirements of the Affordable Care Act and the calculation of the additional rebate for the reformulated drug, if greater, in accordance with the Affordable Care Act. If there is no difference in the additional rebate amount in accordance with the Affordable Care Act, then we do not plan to take any offset amount.  For a noninnovator multiple source drug, we plan to offset an amount equal to two percent of the AMP (the difference between 13 percent of AMP and 11 percent of AMP). |
| 8 | Dental Services | 8. Dental Services (See 42 CFR 440.100.).--These are services that are diagnostic, preventive, or corrective procedures provided by, or under the supervision of, a dentist in the practice of his/her profession including treatment of:   * The teeth and associated structures of the oral cavity; and, * Disease, injury, or impairment that may affect the oral or general health of the recipient.   Report all EPSDT dental services on this line.  Dentist means an individual licensed to practice dentistry or dental surgery.  NOTE: Exclude all such services provided as part of inpatient hospital, outpatient hospital, nondental, clinic or laboratory services and billed for by the hospital, nondental clinic, or laboratory. |
| 9A | Other Practitioners Services - Reg. Payments | 9A. - Other Practitioners Services - Regular Payments (see CFR 440.60). Any medical or remedial care or services, other than physicians' services, provided by licensed practitioners with the scope of practice defined under State law. Chiropractors' services may be included here as long as the services that (1) are provided by a chiropractor who is licensed by the State and meets standards issued by the Secretary under section 405.232(b), and (2) consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform. |
| 9B | Other Practitioners Services - Sup. Payments | 9B. - Other Practitioners Services - Supplemental Payments. Payments for other practitioner services as defined in Line 9A that are made in addition to the standard fee schedule payment for those services. When combined with regular payments, these supplemental payments are equal to or less than the Federal upper payment limit. Address supplemental payments for other practitioners associated with (1) governmental hospitals or university medical schools, and (2) private hospitals or university medical schools, and (3) other supplemental payments by entering payment information on the pop-up feeder sheet. |
| 10 | Clinic Services | 10. Clinic Services (See 42 CFR 440.90.).--These are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:  Are provided to outpatients;   * Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. For reporting purposes, consider a group of physicians who share, only for mutual convenience, space, services of supporting staff, etc., as physicians, rather than a clinic, even though they practice under the name of a clinic; and * Except in the case of nurse-midwife services (see 42 CFR 440.165), are furnished by, or under, the direction of a physician.   NOTE: Place dental clinics under Dental Services. Report any services not included above under Other Care Services. A clinic staff may include practitioners with different specialties. |
| 11 | Laboratory/Radiological | 11. Laboratory And Radiological Services (See 42 CFR 440.30.).--These are professional, technical laboratory and radiological services:   * Ordered and provided by, or under, the direction of a physician or other licensed practitioner of the healing arts within the scope of a practice as defined by State law or ordered and billed by a physician but provided by an independent laboratory; * Provided in an office or similar facility other than a hospital inpatient or outpatient department or clinic; and * Provided by a laboratory that meets the requirements for participation in Medicare. * NOTE: Report X-rays by dentists under Dental Services, Line 8. |
| 12 | Home Health Services | 12, Home Health Services (See 42 CFR 440.70.).--These are services provided at the patient's place of residence in compliance with a physician's written plan of care that is renewed every 60 days and includes the following items and services:   * Nursing service as defined in the State Nurse Practice Act that is provided on a part-time or intermittent basis by a home health agency (HHA) (a public or private agency or organization, or part of an agency or organization that meets the requirements for participation in Medicare). If there is no agency in the area, a registered nurse who: * Is licensed to practice in the State; * Receives written orders from the patient's physician; * Documents the case and services provided; and * Has had orientation to acceptable clinical and administrative record keeping from a health department nurse.   Home health aide services provided by an HHA;   * Medical supplies, equipment, and appliances suitable for use in the home; and * Physical therapy, occupational therapy, or speech pathology and audiology services provided by an HHA or by a facility licensed by the State to provide medical rehabilitation services. (See 42 CFR 441.15 - Home Health Services.)   Place of residence is normally interpreted to mean the patient's home, and does not apply to hospitals or NFs. Services received in a NF that are different from those normally provided as part of the institution's care may qualify as Home Health Services. For example, a registered nurse may provide short-term care for a recipient in a NF during an acute illness to avoid the recipient's transfer to another NF. |
| 13 | Sterilizations | 13. Sterilizations (See 42 CFR 441, Subpart F.).--These are medical procedures, treatments, or operations for the primary purpose of rendering an individual permanently incapable of reproducing. |
| 14 | Other Pregnancy-related Procedures | 14. Other Pregnancy-related Procedures (See 42 CFR 441, Subpart E.).--FFP is available when a physician has certified, in writing, to the Medicaid agency, that on the basis of professional judgment the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless a termination is performed. The certification must contain the name and address of the patient.  The revision to the Hyde Amendment, P.L. 103-112, Health and Human Services Appropriations Bill, made FFP available for expenditures for other pregnancy-related procedures when the pregnancy is a result of an act of rape or incest. This reimbursement is effective for dates of service October 1, 1993 and thereafter.  Provide a breakout of the number of other pregnancy-related procedures and associated expenditures in the following cases:   * Procedures performed to save the life of the mother, * Procedures performed in the case of pregnancies resulting from incest, and * Procedures performed in the case of pregnancies resulting from rape.   NOTE 1: Report all other pregnancy-related procedures on this line regardless of the type of provider. For prior period adjustments, only include any entry in number of procedures if, for increasing claims, it is a new pregnancy-related procedure that has not been previously reported, or, for decreasing claims, you want to remove a procedure previously claimed. Make no entry in number of procedures if all you are changing is the dollar amount claimed.  NOTE 2: The "morning after pill" (ECP) is not considered a termination as it is a contraceptive to prevent pregnancy. However, the drug Mifepristone (RU486) should be counted as another pregnancy-related procedure as long as all Hyde amendment and other federal requirements are met. |
| 15 | EPSDT Screening | 15. EPSDT Screening Services - Physical and mental assessment given to Medicaid eligibles under age 21 to carry out the screening provisions of the EPSDT program. However, the agency must provide at least the following services through consultation with health experts, determine the specific health evaluation procedures to be used, and the mechanisms needed to carry out the screening program.   * A comprehensive health and developmental history (including assessment of both physical and mental health development); * A comprehensive unclothed physical exam; * Appropriate immunizations according to the Advisory Committee on Immunization Practices * Laboratory tests (including blood lead level assessment according to age/risk factors); * Health education (including anticipatory guidance); and * Dental Services - Referral to a dentist in accordance with the States’ periodicity schedule. * Vision Services   The above services may be provided by any qualified Medicaid provider. NOTE: Do not include data for dental, hearing, or vision services here. Report dental examinations and preventative dental services on Line 8, Dental Services. Report hearing services, including hearing aids, on Line 32, Services for Speech, Hearing and Language. Report vision services rendered by professionals (e.g. – examinations, etc.) on Line 9, Other Practitioners' Services. Note that the cost of eyeglasses and other aids to vision is to be reported on Line 33, Prosthetic Devices, Dentures, and Eyeglasses. Report other necessary health care according to the appropriate category. |
| 16 | Rural Health | 16. Rural Health Clinic (RHC) Services (See 42 CFR 440.20(b).).--If a State permits the delivery of primary care by a nurse practitioner (NP) or physician's assistant (PA), rural health clinic (RHC) means the following services furnished by a RHC that has been certified in accordance with the conditions of 42 CFR Part 491 (Certification of Certain Health Facilities):   * Services furnished by a physician within a professional scope under State law, whether the physician performs these services in or away from the clinic and the physician has an agreement with the clinic to be paid by it for such services. * Services furnished by a PA, NP, nurse midwife or other specialized NP (as defined in 42 CFR 405.2401 and 491.2) if they are furnished in accordance with the requirements specified in 42 CFR 405.2414(a). * Services and supplies that are furnished as incident to professional services furnished by a physician, PA, NP, nurse midwife, or specialized NP. (See 42 CFR 405.2413 and 405.2415 for the criteria determining whether services and supplies are included.) * Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biological) if: * The clinic is located in an area in which the Secretary has determined that there is a shortage of HHAs (see 42 CFR 405.2417); * The services are furnished by an RN or licensed PN or a licensed vocational nurse employed by, or otherwise compensated for the services by, the clinic; * The services are furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician of the clinic or that is established by a physician, PA, NP, nurse midwife, or specialized NP and reviewed and approved at least every 60 days by a supervising physician of the clinic; and * The services are furnished to a homebound recipient. For purposes of visiting nurse services, a homebound recipient means one who is permanently or temporarily confined to a place of residence because of a medical or health condition, and leaves the place of residence infrequently. For this purpose, place of residence does not include a hospital or an NF.Rural Health Clinic (RHC) Services (See 42 CFR 440.20(b).).--If a State permits the delivery of primary care by a nurse practitioner (NP) or physician's assistant (PA), rural health clinic (RHC) means the following services furnished by a RHC that has been certified in accordance with the conditions of 42 CFR Part 491 (Certification of Certain Health Facilities): |
| 16 | Rural Health | * Services furnished by a physician within a professional scope under State law, whether the physician performs these services in or away from the clinic and the physician has an agreement with the clinic to be paid by it for such services. * Services furnished by a PA, NP, nurse midwife or other specialized NP (as defined in 42 CFR 405.2401 and 491.2) if they are furnished in accordance with the requirements specified in 42 CFR 405.2414(a). * Services and supplies that are furnished as incident to professional services furnished by a physician, PA, NP, nurse midwife, or specialized NP. (See 42 CFR 405.2413 and 405.2415 for the criteria determining whether services and supplies are included.) * Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biological) if: * The clinic is located in an area in which the Secretary has determined that there is a shortage of HHAs (see 42 CFR 405.2417); * The services are furnished by an RN or licensed PN or a licensed vocational nurse employed by, or otherwise compensated for the services by, the clinic; * The services are furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician of the clinic or that is established by a physician, PA, NP, nurse midwife, or specialized NP and reviewed and approved at least every 60 days by a supervising physician of the clinic; and * The services are furnished to a homebound recipient. For purposes of visiting nurse services, a homebound recipient means one who is permanently or temporarily confined to a place of residence because of a medical or health condition, and leaves the place of residence infrequently. For this purpose, place of residence does not include a hospital or an NF. |
| 17A | Medicare - Part A | 17A. Part A Premiums--(See §301 P.L. 100-360 and §1902 (a)(10) (E)(ii) of the Act) -- Include Part A premiums paid for Qualified Disabled and Working Individuals (QWDIs) under §1902(a)(10)(E)(ii) of the Act. |
| 17B | Medicare - Part B | 17B. Part B Premiums--(See §1902(a). Part B Premiums - Include premiums paid through Medicare buy-in under 1843 for Qualified Medicare Beneficiaries (QMBs) under 1902(a)(10)(E)(i),Specified Low-Income Medicare Beneficiaries (SLMBs) under 1902(a)(10)(E)(iii),and other Medicare/Medicaid dual eligibles covered in 1902(a)(10) of the Act. Do not include part B premiums for line 17C (Qualifying Individuals). This amount is shown on the bottom of each monthly bill sent to you on the summary accounting statement Form CMS-1604. |
| 17C1 | 120% - 134% Of Poverty | Line 17C.1. - 120% - 134% of Poverty - Include premiums paid for Medicare Part B under §1902(a)(10)(E)(iv)(I). |
| 17D | Coinsurance | 17D. Coinsurance and Deductibles-- Include Medicare deductibles and coinsurance required to be paid for QMBs under §1905 (p)(3). (Do not include any Medicare deductibles and coinsurance for other Medicare/Medicaid dual eligibles. Report expenditures for Medicaid services also covered by Medicare under the appropriate Medicaid service category.) Coinsurance is a joint assumption of risk by the insured and the insurer, whereby each shares on a specific basis, the applicable medical expenses of the insured. The insured's share of coinsurance may be paid on his/her behalf. For example, under part B of Medicare, the beneficiary's coinsurance responsibility is a percent of reasonable and customary expenses greater than the stipulated deductible. A deductible is that portion of applicable medical expenses which must be borne by the insured (or be paid on his/her behalf) before insurance benefits for the calendar year begin.  EXCEPTION: REPORT ALL OTHER PREGNANCY-RELATED PROCEDURES ON LINE 14. |
| 18A | Medicaid - MCO | 18A. Managed Care Organizations (MCOs) -- (See §1903(m)(1)(A) of the Act revised by BBA §4701(b)). - Include capitated payments made to a Medicaid Managed Care Organization which is defined as follows:  A Medicaid Managed Care Organization (MCO) means a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare+ Choice organization with a contract under part C of title XVIII, a provider sponsored organization, which meets the requirements of §1902(w)and -   1. makes services it provides to individuals eligible for benefits under this title accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for Medical Assistance under the State plan) not enrolled with the organization, and 2. has made adequate provision against the risk of insolvency, which provision is satisfactory to the State and which assures that individuals eligible for benefits under this title are in no case held liable for debts of the organization in case of the organization's insolvency.   An organization that is a qualified health maintenance organization (as defined in §1310(d) of the Public Health Service Act) is deemed to meet the requirements of clauses (i) and (ii). |
| 18A1 | Medicaid MCO - Evaluation and Management | 18A1. Medicaid MCO - Evaluation and Management -- ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching. |
| 18A2 | Medicaid MCO - Vaccine codes | 18A2. Medicaid MCO - Vaccine codes -- ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share matching rate |
| 18A3 | Medicaid MCO - Community First Choice | 18A3. Medicaid MCO - Community First Choice -- 6% FMAP rate for Total Computable entered at the FMAP Federal Share rate. ACA Section 2401 - The provision established a new Medicaid State Plan option effective October 1, 2011 to allow States to cover HCBS and supports for individuals with incomes not exceeding 150 percent of the FPL, or, if greater, who have been determined to require an institutional level of care. States are provided an additional 6% increase in the FMAP matching funds for services and supports provided to such individuals. |
| 18A4 | Medicaid MCO - Preventive Services Grade A OR B, ACIP Vaccines and their Admin | 18A4. Medicaid MCO - Preventive Services Grade A or B, ACIP Vaccines and their Admin -- 1% FMAP rate for Total Computable entered at the FMAP Federal Share rate. As a result of ACA 4106 Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. States get the 1% additional FMAP upon an approved SPA. Effective January 1, 2013 |
| 18B1 | Prepaid Ambulatory Health Plan | A Prepaid Ambulatory Health Plan (PAHP) means an entity that provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates. A PAHP does not provide or arrange for the provision of any inpatient hospital or institutional services for its enrollees, and does not have a comprehensive risk contract.  NOTE: Include dental, mental health, transportation and other plans covering limited services (without inpatient hospital or institutional services) under PAHP. |
| 18B1a | MCO PAHP - Evaluation and Management | 18B1a. MCO PAHP - Evaluation and Management -- ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching. |
| 18B1b | MCO PAHP - Vaccine codes | 18B1b. MCO PAHP - Vaccine codes -- ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share matching rate |
| 18B1c | MCO PAHP - Community First Choice | 18B1c. MCO PAHP - Community First Choice -- 6% FMAP rate for Total Computable entered at the FMAP Federal Share rate. ACA Section 2401 - The provision established a new Medicaid State Plan option effective October 1, 2011 to allow States to cover HCBS and supports for individuals with incomes not exceeding 150 percent of the FPL, or, if greater, who have been determined to require an institutional level of care. States are provided an additional 6% increase in the FMAP matching funds for services and supports provided to such individuals. |
| 18B1d | MCO PAHP - Preventive Services Grade A OR B, ACIP Vaccines and their Admin | 18B1d. MCO PAHP. Preventive Services Grade A OR B, ACIP Vaccines and their Admin -- 1% FMAP rate for Total Computable entered at the FMAP Federal Share rate. As a result of ACA 4106 Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. States get the 1% additional FMAP upon an approved SPA. Effective January 1, |
| 18B2 | Prepaid Inpatient Health Plan | A Prepaid Inpatient Health Plan (PIHP) means an entity that provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates. A PIHP provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees. A PIHP does not have a comprehensive risk contract.  NOTE: Include dental, mental health, transportation and other plans covering limited services (with inpatient hospital or institutional services) under PIHP. |
| 18B2a | MCO PIHP - Evaluation and Management | 18B2a. MCO PIHP - Evaluation and Management -- ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching. |
| 18B2b | MCO PIHP - Vaccine codes | 18B2b. MCO PIHP - Vaccine codes -- ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share matching rate |
| 18B2c | MCO PIHP - Community First Choice | 18B2c. MCO PIHP - Community First Choice -- 6% FMAP rate for Total Computable entered at the FMAP Federal Share rate. ACA Section 2401 - The provision establishes a new Medicaid State Plan option effective October 1, 2011 to allow States to cover HCBS and supports for individuals with incomes not exceeding 150 percent of the FPL, or, if greater, who have been determined to require an institutional level of care. States are provided an additional 6% increase in the FMAP matching funds for services and supports provided to such individuals. |
| 18B2d | MCO PIHP - Preventive Services Grade A OR B, ACIP Vaccines and their Admin | 18B2d. MCO PIHP. Preventive Services Grade A OR B, ACIP Vaccines and their Admin -- 1% FMAP rate for Total Computable entered at the FMAP Federal Share rate. As a result of ACA 4106 Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. States get the 1% additional FMAP upon an approved SPA. Effective January 1, |
| 18C | Medicaid - Group Health | 18C. Group Health Plan Payments-- Include payments for premiums for cost effective employer group health insurance under §1906 of the Act. |
| 18D | Medicaid - Coinsurance | 18D. Coinsurance and Deductibles-- Include payments for coinsurance and deductibles for cost employer group health insurance under §1906 of the Act. |
| 18E | Medicaid - Other | 18E. Other--Include premiums paid for other insurance for medical or any other type of remedial care in order to maintain a third party resource under §1905(a). (Report expenditures here only if you have elected to pay these premiums in item 3.2(a)(2) on page 29b of your State Plan Preprint.)  EXCEPTION: REPORT ALL OTHER PREGNANCY-RELATED PROCEDURES ON LINE 14. |
| 19A | Home & Community-Based Services - Reg. Pay. (Waiv) | 19A. Home and Community-Based Services (See 42 CFR 440.180.(a).).--These are services furnished under a 1915(c) waiver approved under the provisions in 42 CFR 441, Subpart G (Home and Community-Based Services; Waiver Requirements).  NOTE: Report only approved waiver services as designated in the State's approved waiver applications which are provided to eligible waiver recipients. |
| 19B | Home & Community-Based Services - St. Plan 1915(i) Only Pay. | 19B. - Other Practitioners Services - State Plan 1915(i) Only Payment. Only the home and community based services elected and defined in the approved State plan may be claimed on this line and form. Enter cost data on the lines in the pop-up feeder sheet that match the services approved in the State plan. |
| 19C | Home & Community-Based Services - St. Plan 1915(j) Only Pay. | 19C Home and Community Based Services – State Plan 1915(j) Only Payment – 42 CFR Part 441 – Self-Directed Personal Assistance Services Program State Plan Option. These are PAS services provided under the self-directed service delivery model authorized by 1915(j) including any approved home and community-based services otherwise available under a 1915(c) waiver. The MBES will automatically enter in row 19C the totals from the pop-up 1915(j) Self-Directed Personal Assistance Services Feeder Form. Expenditures for 1915(c) waiver like services provided under 1915(j) Self Direction are entered on the line 19C Feeder Form rather than on the Line 19A Waiver Form which is reserved for approved waiver expenditures.  NOTE: 1915(j) services that are using the self-directed service delivery model for State Plan Personal Care and related services should be claimed separately on Line 23B. |
| 19D | Home & Community Based Services State Plan 1915(k) Community First Choice | 19D Home and Community Based Services State Plan 1915(k) Community First Choice ACA Section 2401 - The provision established a new Medicaid State Plan option effective October 1, 2011 to allow States to cover HCBS and supports for individuals with incomes not exceeding 150 percent of the FPL, or, if greater, who have been determined to require an institutional level of care. States are provided an additional 6% increase in the FMAP matching funds for services and supports provided to such individuals. |
| 22 | All-Inclusive Care Elderly | 22. Programs of All-Inclusive Care for the Elderly (PACE)(See 42 CFR Part 460).--PACE provides pre-paid, capitated, comprehensive health care services designed to enhance the quality of life and autonomy for frail, older adults. Required services (See 42 CFR 460.92) The PACE benefit package for all participants, must include:   1. All Medicaid-covered services, as specified in the State's approved Medicaid plan.   NOTE: This is an option within the Medicaid Program to establish Programs of All-Inclusive Care for the Elderly beginning August 5, 1998. (See §1905(a)(26) and §1934 of the Act.) Do not report payments for PACE programs which continue to operate under §1115 authority on this line. Report payments for PACE programs continuing to operate under §1115 waiver authority on the appropriate waiver forms under the appropriate categories of services. |
| 23A | Personal Care Services - Reg. Payments | 23A. - Personal Care Services.--Regular Payment.-- (See 42 CFR 440.167).-- Unless defined differently by a State agency for purposes of a waiver granted under Part 441, subpart G of this chapter  Personal care services means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental health conditions that are--   1. Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State; 2. Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and 3. Furnished in a home, and at the State's option in another location. |
| 23B | Personal Care Services - SDS 1915(j) | 23B. - Personal Care Services.--SDS 1915(j). -- (See 42 CFR Part 441). -- Self-Directed Personal Assistance Services (PAS) State Plan Option. These are PAS provided under the self-directed service delivery model authorized by 1915(j) for State plan personal care and related services.  NOTE: 1915(j) PAS that are using the self-directed service delivery model for section 1915(c) home and community-based services should be claimed separately on line 19C. |
| 24A | Targeted Case Management Services - Com. Case-Man. | 24A. - Targeted Case Management Services (see section 1915(g)(1) of the Social Security Act) are case management services that are furnished without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B) to specific classes of individuals or to individuals who reside in specified areas. Case management services means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services (See section 1915(g)(2) of the Act). |
| 24B | Case Management - State Wide | 24B. - Case Management.--State Wide. -- (See §1915(g)(2) of the Act.).--These are services that assist individuals eligible under the State plan in gaining access to needed medical, social, educational and other services. The agency must permit individuals to freely choose any qualified Medicaid provider when obtaining case management services in accordance with 42 CFR 431.51. |
| 25 | Primary Care Case Management | 25. Primary Care Case Management Services (PCCM) (See §1905(a)(25) and §1905 (t)--These are case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract. Currently most PCCM programs pay the primary care case manager a monthly case management fee. Report service costs and/or related fees on this line. Report other service costs and/or related fees on the appropriate type of service line.  NOTE: Where the fee includes services beyond case management, report the fees under line 18B. |
| 26 | Hospice Benefits | 26 - Hospice Benefits (See Section 1905(o)(1)(A) of the Act.).--The care described in section 1861(dd)(1) furnished by a hospice program (as defined in section 1861(dd)(2)) to a terminally ill individual who has voluntarily elected to have payment made for hospice care instead of having payment made for certain benefits described under 1812(d)(2)(A) and for which payment may otherwise be made under Title XVIII and intermediate care facility services under the plan. Hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care.  NOTE: These are services that are:   * Covered in 42 CFR 418.202; * Furnished to a terminally ill individual, as defined in 42 CFR 418.3; * Furnished by a hospice, as defined in 42 CFR 418.3, that: * Meets the requirements for participation in Medicare specified in 42 CFR 418, Subpart C or by others under an arrangement made by a hospice program that meets those requirements; and * Is a participating Medicaid provider; * Furnished under a written plan that is established and periodically reviewed by: * The attending physician; * The medical director of the program, as described in 42 CFR 418.54; or * The interdisciplinary group described in 42 CFR 418.68. |
| 27 | Emergency Services for Undocumented Aliens | 27. Emergency Services Undocumented Aliens Pursuant to the Act  The Medicaid program pays for emergency medical services provided to certain aliens. Section §1903(v) of the Act sates that "...no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted... "The only exception is if such care and services are for   1. an emergency medical condition, 2. if such alien otherwise meets the eligibility requirements for medical assistance under the State Plan, and 3. such care and services are not related to an organ transplant procedure. |
| 28 | Federally-Qualified Health Center | 28. Federally-Qualified Health Center (FQHC) (See §1905(a)(2) of the Act.) --These are services performed by facilities or programs more commonly known as Community Health Centers, Migrant Health Centers, and Health Care for the Homeless Programs. FQHCs qualify to provide covered services under Medicaid if:   * They receive grants under §§329, 330, or 340 of the Public Health Service (PHS) Act; * The Health Resources and Services Administration, PHS certifies the center as meeting FQHC requirements; or * The Secretary determines that the center qualifies through waiver of the requirements. |
| 29 | Non-Emergency Medical Transportation | 29. - Non-Emergency Medical Transportation (see 42CFR431.53; 440.170; 440.170(a); 440.170(a)(4))--A ride, or reimbursement for a ride, provided so that a Medicaid beneficiary with no other transportation resources can receive services from a medical provider. (NEMT does not include transportation provided on an emergency basis, such as trips to the emergency room for life-threatening situations.  NOTE: Transportation provided via the State is consider an administrative cost and should be reported on the form CMS-64.10. |
| 30 | Physical Therapy | 30. - Physical Therapy (See 42CFR440.110(a)(1)).--Services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment.  NOTE: Do not include any costs for physical therapy services provided under the school based environment. Those costs should be reported on the pop-up feeder form for Line 39 below.  NOTE: Do not include any costs for physical therapy services provided under the rehabilitative services option. Those costs should be reported on the pop-up feeder form for Line 40 below. |
| 31 | Occupational Therapy | 31. - Occupational Therapy (see 42CFR440.110(b))--Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.  NOTE: Do not include any costs for occupational therapy services provided under the school based environment. Those costs should be reported on the pop-up feeder form for Line 39 below.  NOTE: Do not include any costs for occupational therapy services provided under the rehabilitative services option. Those costs should be reported on the pop-up feeder form for Line 40 below. |
| 32 | Services for Speech, Hearing & Language | 32. - Services for Speech, Hearing and Language--Services for individuals with speech, hearing, and language disorders (See 42CFR440.110(c)). Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or correction services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment, including hearing aids.  NOTE: Do not include any costs for speech and language services provided under the school based environment. Those costs should be reported on the pop-up feeder form for Line 39 below.  NOTE: Do not include any costs for speech / language therapy services provided under the rehabilitative services option. Those costs should be reported on the pop-up feeder form for Line 40 below. It includes any necessary supplies and equipment. |
| 33 | Prosthetic Devices, Dentures, Eyeglasses | Line 33 - Prosthetic Devices, Dentures, Eyeglasses (See 42 CFR 440.120)  Prosthetic devises means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner to:  1. Artificially replace a missing portion of the body;  2. Prevent or correct physical deformity or malfunction;  3. Support a weak or deformed portion of the body.  Dentures are artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth.  Eyeglasses means lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist. |
| 34 | Diagnostic Screening & Preventive Services | 34. - Diagnostic Screening & Preventive Services (see 42CFR440.130)   1. "Diagnostic services", except as otherwise provided under this subpart, includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient. 2. "Screening services" means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases. 3. "Preventive services" means services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to:    1. Prevent disease, disability, and other health conditions or their progression;    2. Prolong life; and    3. Promote physical and mental health and efficiency.   NOTE: This does not include Rehabilitative services - those services are reported on the pop-up feeder sheet for line 40 below. |
| 34A | Preventive Services Grade A OR B, ACIP Vaccines and their Admin | 34A. Preventive Services Grade A OR B, ACIP Vaccines and their Admin -- 1% FMAP rate for Total Computable entered at the FMAP Federal Share rate. As a result of ACA 4106- Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. States get the 1% additional FMAP upon an approved SPA. Effective January 1, 2013 |
| 35 | Nurse Mid-Wife | Line 35 - Nurse Mid-Wife (See 42 CFR 440.165) "Nurse-midwife services" means services that are furnished within the scope or practice authorized by State law or regulation and, in the case of inpatient or outpatient hospital services or clinic services, are furnished by or under the direction of a nurse mid-wife to the extent permitted by the facility. Unless required by required by State law or regulations or a facility, are reimbursed without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider. See 42 CFR 441.21 for provisions on independent provider agreements for nurse-midwives. |
| 36 | Emergency Hospital Services | 36. - Emergency Hospital Services (See 42 CFR 440.170) Emergency hospital services means services that:   1. Are necessary to prevent the death or serious impairment of the health of the recipient; and 2. Because of the threat to the life or health of the recipient necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet- (i) The conditions for participation under Medicare; or (ii) The definitions of inpatient or outpatient hospital services under 42 CFR 440.10 and 440.20. NOTE: Emergency health services provided to undocumented aliens and funded under an allotment established under §4723 of the Balanced Budget Act of 1997 P.L. 105-33 should be reported on Line 27. |
| 37 | Critical Access Hospitals | Line 37 - Critical Access Hospitals (See 42 CFR 440.170) -- Critical access hospital services that are furnished by a provider that meet the requirements for participation in Medicare as a CAH (see subpart F of 42 CFR part 485), and (ii) are of a type that would be paid for by Medicare when furnished to a Medicare beneficiary. Inpatient CAH services do not include nursing facility services furnished by a CAH with a swing-bed approval. |
| 38 | Nurse Practitioner Services | Line 38 - Nurse Practitioner Services (See 42 CFR 440.166) Nurse practitioner services means services that are furnished by a registered professional nurse who meets a State's advanced educational and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses. See 42 CFR 440.166 for requirements related to certified pediatric nurse practitioner and certified family nurse practitioner. |
| 39 | School Based Services | 39. - School Based Services (See section 1903(c) of the Act)--These services include medical assistance for covered services (see section 1905(a)) furnished to a child with a disability because such services are included in the child's individualized educational program established pursuant to Part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan. |
| 40 | Rehabilitative Services (non-school-based) | 40. - Rehabilitative Services (non-school-based) (see 42CFR440.130(d))--Except as otherwise provided under this subpart, rehabilitative services includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, with the scope of his practice under State law, for maximum reduction of physical or mental health condition and restoration of a recipient to his best possible functional level.  NOTE: Do not include any costs for rehabilitative services provided under the school based environment which should be reported on Line 39. |
| 41 | Private Duty Nursing | 41. - Private Duty Nursing (see 42CFR440.80)--Nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided:   1. by a registered nurse or a licensed practical nurse; 2. under the direction of the recipient's physician; and 3. to a recipient in one or more of the following locations at the option of the State:    1. his or her own home;    2. a hospital; or    3. a skilled nursing facility. |
| 42 | Freestanding Birth Center | Line 42 - Freestanding Birth Center COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES Section 2301 of the Affordable Care Act amended section 1905(a) of the Social Security Act (the Act) to provide coverage for freestanding birth center services, as defined in section 1905(l)(3)(A) of the Act. In that provision, the benefit is defined as services furnished at a freestanding birth center, which is defined in new subparagraph 1905(l)(3)(B) as a health facility:   * that is not a hospital; * where childbirth is planned to occur away from the pregnant woman’s residence; * that is licensed or otherwise approved by the State to provide prenatal, labor and delivery, or postpartum care and other ambulatory services included in the State plan; and * that must comply with a State’s requirements relating to the health and safety of individuals receiving services delivered by the facility.   In addition to payment for freestanding birth center facilities, section 1905(l)(3)(C) of the Act requires separate payment for the services furnished by practitioners providing prenatal, labor and delivery, or postpartum care in a freestanding birth center facility, such as nurse midwives and birth attendants. Payment must be made to these practitioners directly, regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. It is important to note that section 2301 of the Affordable Care Act does not require States to license or otherwise recognize freestanding birth centers or practitioners who provide services in these facilities if they do not already do so. Coverage and payment are limited to only those facilities and practitioners licensed or otherwise recognized under State law. |
| 42 | Freestanding Birth Center | Prior to passage of the Affordable Care Act, only nurse midwife services were mandatory services under section 1905(a)(17) of the Act and implementing regulations at 42 CFR 440.165. In addition, States had the option to cover the services of other practitioners who are licensed by the State to provide midwifery services such as Certified Professional Midwives (CPM) under section 1905(a)(6) of the Act and implementing regulations at 42 CFR 440.60. These practitioner services are now mandatory when provided in a freestanding birth center as defined above. Further, other practitioner services, such as those furnished by so-called direct entry or lay midwives or birth attendants, who are not licensed but are recognized under State law to provide these services, are now required to be covered when provided in the freestanding birth center.  Submission of State Plan Amendments These provisions became effective with the enactment of the Affordable Care Act, beginning March 23, 2010. To implement these provisions, States will need to submit amendments to their State plans that specify coverage and separate reimbursement of freestanding birth center facility services and professional services. Unless the compliance exception discussed below applies, or the State does not license or otherwise recognize freestanding birth centers or practitioners who provide services in these facilities, States must submit a State plan amendment (SPA) not later than the end of the next calendar quarter that follows the date of this guidance. In accordance with section 2301(c) of the Affordable Care Act, States that require State legislation (other than appropriation legislation) to meet the new requirements related to their Medicaid coverage of freestanding birth center services will not be regarded as out of compliance with the standards governing this coverage option as long as they come into compliance not later than the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of the Affordable Care Act. For example, if the next regular legislative session beginning after March 23, 2010, is from January 1 through April 30, 2011, then the State would have until September 30, 2011, to submit the required SPA with an effective date of July 1, 2011. In the case of the State that has a 2-year legislative session, each year is treated as a separate regular session of the State legislature. For example, if a legislature is in session from January 1, 2010, through December 31, 2012, then the State would have until March 31, 2011, to submit a SPA with an effective date that is no later than January 1, 2011. A State should promptly notify its CMS regional office if this compliance exception is applicable. |
| 43 | Health Home for Enrollees w Chronic Conditions | 43. Health Home for Enrollees w Chronic Conditions - Health Home services which includes - Comprehensive care Management - Care Coordination - Health promotion - Comprehensive transitional care (Planning and coordination) - Individual and Family Support - Referral to community/social supports - Use of Health Information Technology to link services as feasible and appropriate |
| 44 | Tobacco Cessation for Pregnant Women | 44. Tobacco Cessation for Preg Women - ACA Section 4107 Payments for tobacco cessation counseling services for pregnant women and smoking/tobacco cessation outpatient drugs for pregnant women. |
| 45 | Health Homes for Substance-Use-Disorder Enrollees | Health Homes for Substance-Use-Disorder Enrollees per section 1006 of the SUPPORT for Patients and Communities Act |
| 49 | Other Care Services | 49 -- Other Care Services --These are any medical or remedial care services recognized under State law and authorized by the approved Medicaid State Plan. Such services do not meet the definition of, and are not classified under, any category of service included on Lines 1 through 41. |

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# Appendix J: MBES CBES Category of Service Line Definitions for the 21 Form

| **Line** | **Line - Form Display** | **Line - Definition** |
| --- | --- | --- |
| 1A | Premiums - Up To 150%: Gross Premiums Paid | Line 1.A. Gross Premiums Paid.--Report on line 1.A. the amount of expenditures related to premiums paid for children whose family income is up to 150 percent of the Federal poverty level. Use the definition as contained in Part 2 Section 2500.2.E., lines 18.A. -18.E. (Medicaid Health Insurance Payments-Health Maintenance Organizations (HMO), Health Insuring Organization (HIO), Prepaid Health Plans (PHP), Group Health Plan Payments, and Other, respectively) of the State Medicaid Manual. Remember to report the total amount of the premiums. DO NOT NET THE OFFSETS WITH THE PREMIUMS. For example, it costs the State 500 per month per person and there are 100 people under this plan. Assume that the state receives $20 from one of the individuals covered for his share of the cost. Report $50,000 (500 x 100) on Line 1.A. and $20 on Line 1.B. |
| 1B | Premiums - Up To 150%: Cost Sharing Offset | Line 1.B. Cost Sharing Offsets.--Report any cost sharing offset amounts received with respect to the amounts reported on Line 1.A. for children whose family income is up to 150 percent of the Federal poverty level. As indicated above, for line 1.A, the cost sharing offset amounts relate to the expenditures reported on line 1.A. should be reported separately on line 1.B. |
| 1C | I Premiums - Over 150%: Gross Premiums Paid | Line 1.C. Gross Premiums Paid.--For children above 150% of poverty, premiums may be imposed on a sliding scale related to family income. Use the definition as contained in Part 2 Section 2500.2.E., lines 18.A. -.18.E (Medicaid Health Insurance Payments-Health Maintenance Organizations (HMO), Health Insuring Organization (HIO), Prepaid Health Plans (PHP), Group Health Plan Payments, and Other, respectively) of the State Medicaid Manual. DO NOT NET THE OFFSETS WITH THE PREMIUMS For an example see item 1.A. |
| 1D | Premiums - Over 150%: Cost Sharing Offset | Line 1.D. Cost Sharing Offsets.--Report any cost sharing offset amounts received with respect to the amounts reported on line 1.C. for children whose family income is above 150 percent of the Federal poverty level. As indicated above for line 1.A, the cost sharing offset amounts related to the expenditures reported on line 1.A. should be reported separately on line 1.B. NOTE: Line items 1.A. - D. above relate to capitated payments on behalf of CHIP recipients in Managed Care Arrangements. Do not breakout out the amounts reported on lines 1.A. - 1.D. in lines 2 - 26 below, as they relate to expenditures for CHIP recipients in Fee-For-Service Plans. |
| 2 | Inpatient Hospital | Line 2. Inpatient Hospital Services - Regular Payments.--Use the definition as contained in Part 2 Section 2500.2.E., line 1.A. (Inpatient Hospital Services - Regular Payments) of the State Medicaid Manual. |
| 3 | Inpatient Mental Health | Line 3. Inpatient Mental Health Facility Services - Regular Payments.---Use the definition as contained in Part 2 Section 2500.2.E., line 2.A. (Mental Health Facility Services-Regular Payments) of the State Medicaid Manual. |
| 4 | Nursing Care Services | Line 4. Nursing Care Services. - (Other than services in an institution for mental health conditions).---Use the definition as contained in Part 2 Section 2500.2.E., line 29 paragraph g., (Other Care Services- nurse midwife services), of the State Medicaid Manual. |
| 5 | Physician/Surgical | Line 5. Physician and Surgical Services.--Use the definition as contained in Part 2 Section 2500.2.E., line 5. (Physicians’ Services) of the State Medicaid Manual. |
| 6 | Outpatient Hospital | Line 6. Outpatient Hospital Services. .-:-Use the definition as contained in Part 2 Section 2500.2.E., line 6. (Outpatient Hospital Services) of the State Medicaid Manual for services related to non-mental health facilities which are reported on line 7 below. |
| 7 | Outpatient Mental Health | Line 7. Outpatient Mental Health Facility Services.---Use the definition as contained in Part 2 Section 2500.2.E., line 6 (Outpatient Hospital Services) of the State Medicaid Manual for services related to mental health facilities only. |
| 8 | Prescribed Drugs | Line 8. Prescribed Drugs.--Use the definition as contained in Part 2 Section 2500.2.E., line 7. (Prescribed Drugs) of the State Medicaid Manual. |
| 8A | Drug Rebate | 8A.1. Drug Rebate Offset.--This is a refund from the manufacturer for single source drugs, innovator multiple source drugs, and non-innovator multiple source drugs. |
| 9 | Dental Services | Line 9. Dental Services.--Use the definition as contained in Part 2 Section 2500.2.E., lines 8 (Dental Services) and 29 paragraph e. (Other Care Services-Dentures) of the State Medicaid Manual |
| 10 | Vision Services | Line 10. Vision Services...--Use the definition as contained in Part 2 Section 2500.2.E., line 29 paragraph e., (Other Care Services-eyeglasses) of the State Medicaid Manual. |
| 11 | Other Practitioners | Line 11. Other Practitioners' Services. ---Use the definition as contained in Part 2 Section 2500.2.E., lines 9. (Other Practitioners’ Services) and 29 paragraph f. (Other Care Services--diagnostic, screening, rehabilitative, and preventive services) of the State Medicaid Manual. |
| 12 | Clinic Services | Line 12. Clinic Services.--Use the definition as contained in Part 2 Section 2500.2.E., lines 10. (Clinic Services) and 16. (Rural Health Clinic Services) of the State Medicaid Manual. |
| 13 | Therapy Services | Line 13. Therapy Services. ---Use the definition as contained in Part 2 Section 2500.2.E., line 29 (Other Care Services) paragraphs b. (Physical Therapy), c. (Occupational Therapy), and d. (Services for individuals with speech, hearing, and language disorders) of the State Medicaid Manual. |
| 14 | Laboratory/Radiological | Line 14. Laboratory And Radiological Services.--Use the definition as contained in Part 2 Section 2500.2.E., line 11. (Laboratory and Radiological Services of the State Medicaid Manual. |
| 15 | Medical Equipment | Line 15. Durable and Disposable Medical Equipment. -Use the definition as contained in Part 2 Section 2500.2.E., line 29. paragraph e. (Other Care Services-prosthetic devices) of the State Medicaid Manual |
| 16 | Family Planning | Line 16.Family Planning. --On the Form HCFA-64.21 series, the reporting on the family planning line 16 is blocked. This is because of the way family planning services are treated with respect to the available FMAP rate and the application of payments against the States’ FY CHIP allotments (refer to SMM §2500.9.I.1. and .2). |
| 17 | Other Pregnancy-related Procedures | Line 17. Other Pregnancy-related Procedures.--Use the definition as contained in Part 2 Section 2500.2.E., line 14 of the State Medicaid Manual. |
| 18 | Screening Services | Line 18. Screening Services.--Use the definition as contained in Part 2 Section 2500.2.E., line 15. (EPSDT Screening Services) of the State Medicaid Manual. |
| 19 | Home Health | Line 19. Home Health Services. --Use the definition as contained in Part 2 Section 2500.2.E., line 12. (Home Health Services) of the State Medicaid Manual. |
| 20 | Health Services Initiatives | Line 20. Health Services Initiatives States may use funds available under their 10 percent administrative cap to fund Health Service Initiatives (HSIs). An HSI is an activity that protects public health, protects the health of individuals, improves or promotes a state's capacity to deliver public health services, or strengthens the human and material resources necessary to accomplish public health goals relating to improving the health of children, including targeted low-income children and other low-income children. States are not limited in the number of different HSIs they may fund, as long as the state ensures that title XXI funding, within the state's 10 percent limit, is sufficient to continue the proper administration of the CHIP program. If such funds become less than sufficient, the state agrees to redirect title XXI funds from the support of HSIs to the administration of the CHIP program. |
| 21 | Home and Community | Line 21. Home and Community-Based Services. --Use the definition as contained in Part 2 Section 2500.2.E., lines 19. (Home and Community-Based Services) and 23. (Personal Care Services) of the State Medicaid Manual. |
| 22 | Hospice | Line 22. Hospice Care Services. --Use the definition as contained in Part 2 Section 2500.2.E., line 26. (Hospice Benefits) of the State Medicaid Manual. |
| 23 | Medical Transportation | Line 23. Medical Transportation Services. --Use the definition as contained in Part 2 Section 2500.2.E., line 29 paragraph a. (Other Care Services-Transportation) of the State Medicaid Manual. |
| 24 | Case Management | Line 24. Case Management Services. --Use the definition as contained in Part 2 Section 2500.2.E., lines 24. (Targeted Case Management Services) and 25 (Primary Care Case Management Services) of the State Medicaid Manual. |
| 25 | Translation and Interpretation | Line 25. Translation and Interpretation (Section 201 CHIPRA) Translation may be allowable as an administrative activity if it is not included and paid for as part of a direct medical service and if it is necessary for the proper and efficient administration of the State plan. However, in order for translation to be claimable as administration, it must be provided either by separate units or separate employees performing solely translation activities and it must facilitate access |
| 31 | Other Services | Line 31. Other Services |
| 32 | Outreach | Outreach Amounts reported on this line should NOT include any amounts reported on Lines 32A or 32B |
| 32A | Increased Outreach and Enrollment of Indians | Line 32.A - Increased Outreach and Enrollment of Indians (Section 202 CHIPRA) )--Enter in Column (a) the total computable amount of expenditures for the Increased Outreach and Enrollment of Indians  The MBES will automatically calculate the Federal Share in Columns (b) and (e) at the CHIP rate. These expenditures are NOT applicable to the 10% limit on Outreach and Certain other expenditures. Amounts reported on this line should NOT include any amounts reported on Lines 32 or 32B |
| 32B | Increase outreach and enrollment of children through premium subsidies | Line 32.B - Increase Outreach and Enrollment of children through premium subsidies Amounts reported on this line should NOT include any amounts reported on Lines 32 or 32A |
| 33 | Administration | Line 33. Administration. (Section 2105(a)(2)(D) of the Act).--Enter the amount of other reasonable costs incurred by the State to administer the plan. NOTE: All of these administrative activities are subject to the 10 percent limit and must be entered in Column(c). See Section 2115 K above for a discussion of administrative costs and Section 2115 J above for a discussion of the 10 percent limit. |
| 34 | PERM Administration | Line 34 - PERM Administration - (Section 601 CHIPRA)--Enter in Column (a) the total computable amount of expenditures for the administration of PERM. The MBES will automatically enter in Columns (b) and (e) 90 percent of the amount reported in Column (a). |
| 35 | Citizenship Verification Technology CHIPRA | Line 35. Citizenship Verification Technology- (Section 211 CHIPRA) |
| 35A | CVT Development | Line 35A. CVT Development: (Section 211 CHIPRA)--Enter in Column (a) the total computable amount of expenditures for the design, development, or installation of Citizenship Verification technology.  The MBES will automatically enter in Columns (b) and (e) 90 percent of the amount reported in Column (a). |
| 35B | CVT Operation | Line 35B. CVT Operation (Section 211 CHIPRA)--Enter in Column (a) the total computable amount of expenditures for the operation of Citizenship Verification technology. The MBES will automatically enter in Columns (b) and (e) 75 percent of the amount reported in Column (a). |

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# Appendix K: Crosswalk of T-MSIS to MSIS Type of Service Values

| **MSIS Code Definitions** | **MSIS Valid Values** | **T-MSIS 2.4 Valid Values** | **T-MSIS v2.4 Code Definitions** |
| --- | --- | --- | --- |
| Inpatient Hospital | 01 | 001 | Inpatient hospital services, other than services in an institution for mental diseases |
| Inpatient Hospital | 01 | 090 | Critical access hospital services – IP |
| Inpatient Hospital | 01 | 091 | Skilled care – hospital residing |
| Inpatient Hospital | 01 | 092 | Exceptional care – hospital residing |
| Inpatient Hospital | 01 | 093 | Non-acute care – hospital residing |
| Mental Health Hospital Services for the Aged | 02 | 044 | Inpatient hospital services for individuals age 65 or older in institutions for mental diseases |
| Mental Health Hospital Services for the Aged | 02 | 045 | Nursing facility services for individuals age 65 or older in institutions for mental diseases |
| Disproportionate Share Hospital (DSH) | 03 | 123 | Disproportionate share hospital (DSH) payments |
| Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under | 04 | 048 | Inpatient psychiatric services for individuals under age 21 |
| ICF Services for Individuals with Mental Health Condition | 05 | 046 | Intermediate care facility (ICF/IIDICF/IID) services |
| NF'S - All Other | 07 | 009 | Nursing facility services for individuals age 21 or older (other than services in an institution for mental disease) |
| NF'S - All Other | 07 | 047 | Nursing facility services, other than in institutions for mental diseases |
| NF'S - All Other | 07 | 059 | Skilled nursing facility services for individuals under age 21 |
| Physicians | 08 | 012 | Physicians' services |
| Physicians | 08 | 042 | Well-baby and well-child care services as defined by the State. |
| Dental | 09 | 029 | Dental Services |
| Dental | 09 | 013 | Medical and surgical services of a dentist |
| Other Practitioners | 10 | 015 | Medical or other remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law |
| Other Practitioners | 10 | 010 | Early and periodic screening and diagnosis and treatment (EPSDT) services |
| Outpatient Hospital | 11 | 002 | Outpatient hospital services |
| Outpatient Hospital | 11 | 061 | Critical access hospital services – OT |
| Clinic | 12 | 028 | Clinic services |
| Clinic | 12 | 041 | Preventive Services |
| Clinic | 12 | 014 | Outpatient substance abuse treatment services. |
| Clinic | 12 | 003 | Rural health clinic services |
| Home Health | 13 | 016 | Home health services - Nursing services |
| Home Health | 13 | 017 | Home health services - Home health aide services |
| Home Health | 13 | 018 | Home health services - Medical supplies, equipment, and appliances suitable for use in the home |
| Home Health | 13 | 019 | Home health services - Physical therapy provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services |
| Home Health | 13 | 020 | Home health services - Occupational therapy provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services |
| Home Health | 13 | 021 | Home health services - Speech pathology and audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services |
| Lab and X-Ray | 15 | 005 | Professional laboratory services, Technical laboratory services |
| Lab and X-Ray | 15 | 006 | Technical laboratory services |
| Lab and X-Ray | 15 | 007 | Professional radiological services |
| Lab and X-Ray | 15 | 008 | Technical radiological services |
| Prescribed Drugs | 16 | 033 | Prescribed drugs |
| Prescribed Drugs | 16 | 033 | Over-the-counter medications. |
| Prescribed Drugs | 16 | 036 | Medical Equipment/Prosthetic devices |
| Prescribed Drugs | 16 | 131 | Drug Rebates |
| Other Services | 19 | 064 | HCBS - Home health aide services |
| Other Services | 19 | 035 | Dentures |
| Other Services | 19 | 037 | Eyeglasses |
| Other Services | 19 | 062 | HCBS - Case management services |
| Other Services | 19 | 063 | HCBS - Homemaker services |
| Other Services | 19 | 065 | HCBS - Personal care services |
| Other Services | 19 | 066 | HCBS - Adult day health services |
| Other Services | 19 | 067 | HCBS - Habilitation services |
| Other Services | 19 | 068 | HCBS - Respite care services |
| Other Services | 19 | 069 | HCBS - Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness |
| Other Services | 19 | 073 | HCBS - Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization |
| Other Services | 19 | 074 | HCBS - Expanded habilitation services - Prevocational services |
| Other Services | 19 | 075 | HCBS - Expanded habilitation services - Educational services |
| Other Services | 19 | 076 | HCBS - Expanded habilitation services - Supported employment services, which facilitate paid employment |
| Other Services | 19 | 077 | HCBS-65-plus - Case management services |
| Other Services | 19 | 078 | HCBS-65-plus - Homemaker services |
| Other Services | 19 | 079 | HCBS-65-plus - Home health aide services |
| Other Services | 19 | 080 | HCBS-65-plus - Personal care services |
| Other Services | 19 | 081 | HCBS-65-plus - Adult day health services |
| Other Services | 19 | 082 | HCBS-65-plus - Respite care services |
| Other Services | 19 | 083 | HCBS-65-plus - Other medical and social services |
| Other Services | 19 | 034 | Over-the-counter medications. |
| Other Services | 19 | 039 | Diagnostic services |
| Other Services | 19 | 040 | Screening services |
| Other Services | 19 | 050 | Inpatient substance abuse treatment services and residential substance abuse treatment services. |
| Other Services | 19 | 057 | Enabling services |
| Other Services | 19 | 060 | Emergency hospital services |
| Other Services | 19 | 071 | HCBS - Training for family members |
| Other Services | 19 | 072 | HCBS - Minor modification to the home |
| Other Services | 19 | 085 | Prenatal care and pre-pregnancy family planning services and supplies. |
| Other Services | 19 | 088 | Any other health care services or items specified by the Secretary and not excluded under regulations. |
| Other Services | 19 | 089 | Disposable medical supplies. |
| Other Services | 19 | 135 | EHR payments to provider |
| Capitated Payment s to HMO, HIO or PACE Plan | 20 | 119 | Capitated payments to HMOs, HIOs, or PACE plans |
| Capitated Payments to Prepaid Health Plans (PHPs) | 21 | 122 | Capitated payments to prepaid health plans (PHPs) |
| Capitated Payments for Primary Care Case Management (PCCM) | 22 | 120 | Capitated payments for primary care case management (PCCM) |
| Capitated Payments for Private Health Insurance | 23 | 121 | Premium payments for private health insurance |
| Sterilizations | 24 | 084 | Sterilizations |
| Other Pregnancy-related Procedures | 25 | 086 | Other Pregnancy-related Procedures |
| Transportation Services | 26 | 056 | Transportation services |
| Personal Care Services | 30 | 051 | Personal care services |
| Targeted Case Management | 31 | 053 | Targeted case management services |
| Targeted Case Management | 31 | 052 | Primary care case management services |
| Targeted Case Management | 31 | 054 | Case Management services other than those that meet the definition of primary care case management services or targeted case management services |
| Targeted Case Management | 31 | 055 | Care coordination services |
| Rehabilitation Services | 33 | 043 | Rehabilitative services |
| PT, OT, Speech, Hearing Language | 34 | 030 | Physical therapy services (when not provided under home health services) |
| PT, OT, Speech, Hearing Language | 34 | 031 | Occupational therapy services (when not provided under home health services) |
| PT, OT, Speech, Hearing Language | 34 | 032 | Speech, hearing, and language disorders services (when not provided under home health services) |
| PT, OT, Speech, Hearing Language | 34 | 038 | Hearing Aids |
| Hospice Benefits | 35 | 087 | Hospice Benefits |
| Nurse Midwife Services | 36 | 025 | Nurse-midwife service |
| Nurse Practitioner Services | 37 | 026 | Nurse practitioner services |
| Nurse Practitioner Services | 37 | 023 | Advanced practice nurse services |
| Private Duty Nursing | 38 | 022 | Private duty nursing services |
| Private Duty Nursing | 38 | 024 | Pediatric nurse |
| Religious Non-Medical Health Care Institutions | 39 | 058 | Services furnished in a religious nonmedical health care institution |
| Supplemental Payment - Inpatient | 40 | 132 | Supplemental payment – inpatient |
| Supplemental Payment - Nursing | 41 | 133 | Supplemental payment – nursing |
| Supplemental Payment - Outpatient | 42 | 134 | Supplemental payment – outpatient |
| Durable Medical Equipment and Supplies (including emergency response systems and home modifications) | 51 | 018 | Home health services - Medical supplies, equipment, and appliances suitable for use in the home |
| Durable Medical Equipment and Supplies (including emergency response systems and home modifications) | 51 | 027 | Respiratory care for ventilator-dependent individuals |
| Residential Care | 52 | 115 | Residential Care |
| Psychiatric services (excluding adult day care) | 53 | 048 | Inpatient psychiatric services for individuals under age 21 |
| Psychiatric services (excluding adult day care) | 53 | 049 | Outpatient mental health services, other than Outpatient substance abuse treatment services. This TOS includes services furnished in a State-operated mental hospital and including community-based services. |
| Adult Day Care | 54 | 066 | HCBS - Adult day health services |
| Adult Day Care | 54 | 069 | HCBS - Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness |
| Adult Day Care | 54 | 070 | HCBS - Day Care |
| Indian Health Service (IHS) - Family Plan | 60 | 011 | Family planning services and supplies for individuals of child-bearing age |
| Indian Health Service (IHS) - Family Plan | 60 | 127 | Indian Health Service (IHS) - Family Plan |
| Indian Health Service (IHS) - BCC | 61 | 004 | Other ambulatory services furnished by a rural health clinic |
| Indian Health Service (IHS) - BIP | 62 | 004 | Other ambulatory services furnished by a rural health clinic |

# Appendix L: Crosswalk of WPC Provider Taxonomy Codes to Provider Facility Type Categories

Source: [X12 Reference Page](http://www.wpc-edi.com/reference/)

## Table Pages 1 – 20

| **Provider Taxonomy Code** | **Provider Taxonomy Description** | **Provider Facility Type Code** | **Provider Facility Type Description** |
| --- | --- | --- | --- |
| 193200000X | Unspecified Multi-Specialty Group | 100000000 | Individuals or Groups (of Individuals) |
| 193400000X | Unspecified Single Specialty Group | 100000000 | Individuals or Groups (of Individuals) |
| 207K00000X | Allergy & Immunology | 100000000 | Individuals or Groups (of Individuals) |
| 207KA0200X | Allergy | 100000000 | Individuals or Groups (of Individuals) |
| 207KI0005X | Clinical & Laboratory Immunology | 100000000 | Individuals or Groups (of Individuals) |
| 207L00000X | Anesthesiology | 100000000 | Individuals or Groups (of Individuals) |
| 207LA0401X | Addiction Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207LC0200X | Critical Care Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207LH0002X | Hospice and Palliative Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207LP2900X | Pain Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207LP3000X | Pediatric Anesthesiology | 100000000 | Individuals or Groups (of Individuals) |
| 208U00000X | Clinical Pharmacology | 100000000 | Individuals or Groups (of Individuals) |
| 208C00000X | Colon & Rectal Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 207N00000X | Dermatology | 100000000 | Individuals or Groups (of Individuals) |
| 207NI0002X | Clinical & Laboratory Dermatological Immunology | 100000000 | Individuals or Groups (of Individuals) |
| 207ND0900X | Dermatopathology | 100000000 | Individuals or Groups (of Individuals) |
| 207ND0101X | MOHS-Micrographic Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 207NP0225X | Pediatric Dermatology | 100000000 | Individuals or Groups (of Individuals) |
| 207NS0135X | Procedural Dermatology | 100000000 | Individuals or Groups (of Individuals) |
| 204R00000X | Electrodiagnostic Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207P00000X | Emergency Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207PE0004X | Emergency Medical Services | 100000000 | Individuals or Groups (of Individuals) |
| 207PH0002X | Hospice and Palliative Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207PT0002X | Medical Toxicology | 100000000 | Individuals or Groups (of Individuals) |
| 207PP0204X | Pediatric Emergency Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207PS0010X | Sports Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207PE0005X | Undersea and Hyperbaric Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207Q00000X | Family Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207QA0401X | Addiction Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207QA0000X | Adolescent Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207QA0505X | Adult Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207QB0002X | Bariatric Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207QG0300X | Geriatric Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207QH0002X | Hospice and Palliative Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207QS1201X | Sleep Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207QS0010X | Sports Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 208D00000X | General Practice | 100000000 | Individuals or Groups (of Individuals) |
| 208M00000X | Hospitalist | 100000000 | Individuals or Groups (of Individuals) |
| 202C00000X | Independent Medical Examiner | 100000000 | Individuals or Groups (of Individuals) |
| 207R00000X | Internal Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207RA0401X | Addiction Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207RA0000X | Adolescent Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207RA0201X | Allergy & Immunology | 100000000 | Individuals or Groups (of Individuals) |
| 207RB0002X | Bariatric Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207RC0000X | Cardiovascular Disease | 100000000 | Individuals or Groups (of Individuals) |
| 207RI0001X | Clinical & Laboratory Immunology | 100000000 | Individuals or Groups (of Individuals) |
| 207RC0001X | Clinical Cardiac Electrophysiology | 100000000 | Individuals or Groups (of Individuals) |
| 207RC0200X | Critical Care Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207RE0101X | Endocrinology, Diabetes & Metabolism | 100000000 | Individuals or Groups (of Individuals) |
| 207RG0100X | Gastroenterology | 100000000 | Individuals or Groups (of Individuals) |
| 207RG0300X | Geriatric Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207RH0000X | Hematology | 100000000 | Individuals or Groups (of Individuals) |
| 207RH0003X | Hematology & Oncology | 100000000 | Individuals or Groups (of Individuals) |
| 207RI0008X | Hepatology | 100000000 | Individuals or Groups (of Individuals) |
| 207RH0002X | Hospice and Palliative Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207RH0005X | Hypertension Specialist | 100000000 | Individuals or Groups (of Individuals) |
| 207RI0200X | Infectious Disease | 100000000 | Individuals or Groups (of Individuals) |
| 207RI0011X | Interventional Cardiology | 100000000 | Individuals or Groups (of Individuals) |
| 207RM1200X | Magnetic Resonance Imaging (MRI) | 100000000 | Individuals or Groups (of Individuals) |
| 207RX0202X | Medical Oncology | 100000000 | Individuals or Groups (of Individuals) |
| 207RN0300X | Nephrology | 100000000 | Individuals or Groups (of Individuals) |
| 207RP1001X | Pulmonary Disease | 100000000 | Individuals or Groups (of Individuals) |
| 207RR0500X | Rheumatology | 100000000 | Individuals or Groups (of Individuals) |
| 207RS0012X | Sleep Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207RS0010X | Sports Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207RT0003X | Transplant Hepatology | 100000000 | Individuals or Groups (of Individuals) |
| 209800000X | Legal Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207SG0202X | Clinical Biochemical Genetics | 100000000 | Individuals or Groups (of Individuals) |
| 207SC0300X | Clinical Cytogenetic | 100000000 | Individuals or Groups (of Individuals) |
| 207SG0201X | Clinical Genetics (M.D.) | 100000000 | Individuals or Groups (of Individuals) |
| 207SG0203X | Clinical Molecular Genetics | 100000000 | Individuals or Groups (of Individuals) |
| 207SM0001X | Molecular Genetic Pathology | 100000000 | Individuals or Groups (of Individuals) |
| 207SG0205X | Ph.D. Medical Genetics | 100000000 | Individuals or Groups (of Individuals) |
| 207T00000X | Neurological Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 207U00000X | Nuclear Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207UN0903X | In Vivo & In Vitro Nuclear Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207UN0901X | Nuclear Cardiology | 100000000 | Individuals or Groups (of Individuals) |
| 207UN0902X | Nuclear Imaging & Therapy | 100000000 | Individuals or Groups (of Individuals) |
| 204D00000X | Neuromusculoskeletal Medicine & OMM | 100000000 | Individuals or Groups (of Individuals) |
| 204C00000X | Neuromusculoskeletal Medicine, Sports Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207V00000X | Obstetrics & Gynecology | 100000000 | Individuals or Groups (of Individuals) |
| 207VB0002X | Bariatric Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207VC0200X | Critical Care Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207VF0040X | Female Pelvic Medicine and Reconstructive Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 207VX0201X | Gynecologic Oncology | 100000000 | Individuals or Groups (of Individuals) |
| 207VG0400X | Gynecology | 100000000 | Individuals or Groups (of Individuals) |
| 207VH0002X | Hospice and Palliative Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207VM0101X | Maternal & Fetal Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207VX0000X | Obstetrics | 100000000 | Individuals or Groups (of Individuals) |
| 207VE0102X | Reproductive Endocrinology | 100000000 | Individuals or Groups (of Individuals) |
| 207W00000X | Ophthalmology | 100000000 | Individuals or Groups (of Individuals) |
| 204E00000X | Oral & Maxillofacial Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 207X00000X | Orthopaedic Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 207XS0114X | Adult Reconstructive Orthopaedic Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 207XX0004X | Foot and Ankle Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 207XS0106X | Hand Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 207XS0117X | Orthopaedic Surgery of the Spine | 100000000 | Individuals or Groups (of Individuals) |
| 207XX0801X | Orthopaedic Trauma | 100000000 | Individuals or Groups (of Individuals) |
| 207XP3100X | Pediatric Orthopaedic Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 207XX0005X | Sports Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207Y00000X | Otolaryngology | 100000000 | Individuals or Groups (of Individuals) |
| 207YS0123X | Facial Plastic Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 207YX0602X | Otolaryngic Allergy | 100000000 | Individuals or Groups (of Individuals) |
| 207YX0905X | Otolaryngology/Facial Plastic Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 207YX0901X | Otology & Neurotology | 100000000 | Individuals or Groups (of Individuals) |
| 207YP0228X | Pediatric Otolaryngology | 100000000 | Individuals or Groups (of Individuals) |
| 207YX0007X | Plastic Surgery within the Head & Neck | 100000000 | Individuals or Groups (of Individuals) |
| 207YS0012X | Sleep Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207ZP0101X | Anatomic Pathology | 100000000 | Individuals or Groups (of Individuals) |
| 207ZP0102X | Anatomic Pathology & Clinical Pathology | 100000000 | Individuals or Groups (of Individuals) |
| 207ZB0001X | Blood Banking & Transfusion Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207ZP0104X | Chemical Pathology | 100000000 | Individuals or Groups (of Individuals) |
| 207ZC0006X | Clinical Pathology | 100000000 | Individuals or Groups (of Individuals) |
| 207ZP0105X | Clinical Pathology/Laboratory Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 207ZC0500X | Cytopathology | 100000000 | Individuals or Groups (of Individuals) |
| 207ZD0900X | Dermatopathology | 100000000 | Individuals or Groups (of Individuals) |
| 207ZF0201X | Forensic Pathology | 100000000 | Individuals or Groups (of Individuals) |
| 207ZH0000X | Hematology | 100000000 | Individuals or Groups (of Individuals) |
| 207ZI0100X | Immunopathology | 100000000 | Individuals or Groups (of Individuals) |
| 207ZM0300X | Medical Microbiology | 100000000 | Individuals or Groups (of Individuals) |
| 207ZP0007X | Molecular Genetic Pathology | 100000000 | Individuals or Groups (of Individuals) |
| 207ZN0500X | Neuropathology | 100000000 | Individuals or Groups (of Individuals) |
| 207ZP0213X | Pediatric Pathology | 100000000 | Individuals or Groups (of Individuals) |
| 208000000X | Pediatrics | 100000000 | Individuals or Groups (of Individuals) |
| 2080A0000X | Adolescent Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2080C0008X | Child Abuse Pediatrics | 100000000 | Individuals or Groups (of Individuals) |
| 2080I0007X | Clinical & Laboratory Immunology | 100000000 | Individuals or Groups (of Individuals) |
| 2080P0006X | Developmental – Behavioral Pediatrics | 100000000 | Individuals or Groups (of Individuals) |
| 2080H0002X | Hospice and Palliative Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2080T0002X | Medical Toxicology | 100000000 | Individuals or Groups (of Individuals) |
| 2080N0001X | Neonatal-Perinatal Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2080P0008X | Neurodevelopmental Disabilities | 100000000 | Individuals or Groups (of Individuals) |
| 2080P0201X | Pediatric Allergy/Immunology | 100000000 | Individuals or Groups (of Individuals) |
| 2080P0202X | Pediatric Cardiology | 100000000 | Individuals or Groups (of Individuals) |
| 2080P0203X | Pediatric Critical Care Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2080P0204X | Pediatric Emergency Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2080P0205X | Pediatric Endocrinology | 100000000 | Individuals or Groups (of Individuals) |
| 2080P0206X | Pediatric Gastroenterology | 100000000 | Individuals or Groups (of Individuals) |
| 2080P0207X | Pediatric Hematology-Oncology | 100000000 | Individuals or Groups (of Individuals) |
| 2080P0208X | Pediatric Infectious Diseases | 100000000 | Individuals or Groups (of Individuals) |
| 2080P0210X | Pediatric Nephrology | 100000000 | Individuals or Groups (of Individuals) |
| 2080P0214X | Pediatric Pulmonology | 100000000 | Individuals or Groups (of Individuals) |
| 2080P0216X | Pediatric Rheumatology | 100000000 | Individuals or Groups (of Individuals) |
| 2080T0004X | Pediatric Transplant Hepatology | 100000000 | Individuals or Groups (of Individuals) |
| 2080S0012X | Sleep Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2080S0010X | Sports Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 202K00000X | Phlebology | 100000000 | Individuals or Groups (of Individuals) |
| 208100000X | Physical Medicine & Rehabilitation | 100000000 | Individuals or Groups (of Individuals) |
| 2081H0002X | Hospice and Palliative Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2081N0008X | Neuromuscular Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2081P2900X | Pain Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2081P0010X | Pediatric Rehabilitation Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2081P0004X | Spinal Cord Injury Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2081S0010X | Sports Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 208200000X | Plastic Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 2082S0099X | Plastic Surgery Within the Head and Neck | 100000000 | Individuals or Groups (of Individuals) |
| 2082S0105X | Surgery of the Hand | 100000000 | Individuals or Groups (of Individuals) |
| 2083A0100X | Aerospace Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2083T0002X | Medical Toxicology | 100000000 | Individuals or Groups (of Individuals) |
| 2083X0100X | Occupational Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2083P0500X | Preventive Medicine/Occupational Environmental Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2083P0901X | Public Health & General Preventive Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2083S0010X | Sports Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2083P0011X | Undersea and Hyperbaric Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2084A0401X | Addiction Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2084P0802X | Addiction Psychiatry | 100000000 | Individuals or Groups (of Individuals) |
| 2084B0002X | Bariatric Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2084B0040X | Behavioral Neurology & Neuropsychiatry | 100000000 | Individuals or Groups (of Individuals) |
| 2084P0804X | Child & Adolescent Psychiatry | 100000000 | Individuals or Groups (of Individuals) |
| 2084N0600X | Clinical Neurophysiology | 100000000 | Individuals or Groups (of Individuals) |
| 2084D0003X | Diagnostic Neuroimaging | 100000000 | Individuals or Groups (of Individuals) |
| 2084F0202X | Forensic Psychiatry | 100000000 | Individuals or Groups (of Individuals) |
| 2084P0805X | Geriatric Psychiatry | 100000000 | Individuals or Groups (of Individuals) |
| 2084H0002X | Hospice and Palliative Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2084P0005X | Neurodevelopmental Disabilities | 100000000 | Individuals or Groups (of Individuals) |
| 2084N0400X | Neurology | 100000000 | Individuals or Groups (of Individuals) |
| 2084N0402X | Neurology with Special Qualifications in Child Neurology | 100000000 | Individuals or Groups (of Individuals) |
| 2084N0008X | Neuromuscular Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2084P2900X | Pain Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2084P0800X | Psychiatry | 100000000 | Individuals or Groups (of Individuals) |
| 2084P0015X | Psychosomatic Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2084S0012X | Sleep Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2084S0010X | Sports Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2084V0102X | Vascular Neurology | 100000000 | Individuals or Groups (of Individuals) |
| 208VP0014X | Interventional Pain Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 208VP0000X | Pain Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2085B0100X | Body Imaging | 100000000 | Individuals or Groups (of Individuals) |
| 2085D0003X | Diagnostic Neuroimaging | 100000000 | Individuals or Groups (of Individuals) |
| 2085R0202X | Diagnostic Radiology | 100000000 | Individuals or Groups (of Individuals) |
| 2085U0001X | Diagnostic Ultrasound | 100000000 | Individuals or Groups (of Individuals) |
| 2085H0002X | Hospice and Palliative Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2085N0700X | Neuroradiology | 100000000 | Individuals or Groups (of Individuals) |
| 2085N0904X | Nuclear Radiology | 100000000 | Individuals or Groups (of Individuals) |
| 2085P0229X | Pediatric Radiology | 100000000 | Individuals or Groups (of Individuals) |
| 2085R0001X | Radiation Oncology | 100000000 | Individuals or Groups (of Individuals) |
| 2085R0205X | Radiological Physics | 100000000 | Individuals or Groups (of Individuals) |
| 2085R0203X | Therapeutic Radiology | 100000000 | Individuals or Groups (of Individuals) |
| 2085R0204X | Vascular & Interventional Radiology | 100000000 | Individuals or Groups (of Individuals) |
| 208600000X | Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 2086H0002X | Hospice and Palliative Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 2086S0120X | Pediatric Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 2086S0122X | Plastic and Reconstructive Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 2086S0105X | Surgery of the Hand | 100000000 | Individuals or Groups (of Individuals) |
| 2086S0102X | Surgical Critical Care | 100000000 | Individuals or Groups (of Individuals) |
| 2086X0206X | Surgical Oncology | 100000000 | Individuals or Groups (of Individuals) |
| 2086S0127X | Trauma Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 2086S0129X | Vascular Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 208G00000X | Thoracic Surgery (Cardiothoracic Vascular Surgery) | 100000000 | Individuals or Groups (of Individuals) |
| 204F00000X | Transplant Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 208800000X | Urology | 100000000 | Individuals or Groups (of Individuals) |
| 2088F0040X | Female Pelvic Medicine and Reconstructive Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 2088P0231X | Pediatric Urology | 100000000 | Individuals or Groups (of Individuals) |
| 103K00000X | Behavioral Analyst | 100000000 | Individuals or Groups (of Individuals) |
| 103G00000X | Clinical Neuropsychologist | 100000000 | Individuals or Groups (of Individuals) |
| 103GC0700X | Clinical | 100000000 | Individuals or Groups (of Individuals) |
| 101Y00000X | Counselor | 100000000 | Individuals or Groups (of Individuals) |
| 101YA0400X | Addiction (Substance Use Disorder) | 100000000 | Individuals or Groups (of Individuals) |
| 101YM0800X | Mental Health | 100000000 | Individuals or Groups (of Individuals) |
| 101YP1600X | Pastoral | 100000000 | Individuals or Groups (of Individuals) |
| 101YP2500X | Professional | 100000000 | Individuals or Groups (of Individuals) |
| 101YS0200X | School | 100000000 | Individuals or Groups (of Individuals) |
| 106H00000X | Marriage & Family Therapist | 100000000 | Individuals or Groups (of Individuals) |
| 102X00000X | Poetry Therapist | 100000000 | Individuals or Groups (of Individuals) |
| 102L00000X | Psychoanalyst | 100000000 | Individuals or Groups (of Individuals) |
| 103T00000X | Psychologist | 100000000 | Individuals or Groups (of Individuals) |
| 103TA0400X | Addiction (Substance Use Disorder) | 100000000 | Individuals or Groups (of Individuals) |
| 103TA0700X | Adult Development & Aging | 100000000 | Individuals or Groups (of Individuals) |
| 103TC0700X | Clinical | 100000000 | Individuals or Groups (of Individuals) |
| 103TC2200X | Clinical Child & Adolescent | 100000000 | Individuals or Groups (of Individuals) |
| 103TB0200X | Cognitive & Behavioral | 100000000 | Individuals or Groups (of Individuals) |
| 103TC1900X | Counseling | 100000000 | Individuals or Groups (of Individuals) |
| 103TE1000X | Educational | 100000000 | Individuals or Groups (of Individuals) |
| 103TE1100X | Exercise & Sports | 100000000 | Individuals or Groups (of Individuals) |
| 103TF0000X | Family | 100000000 | Individuals or Groups (of Individuals) |
| 103TF0200X | Forensic | 100000000 | Individuals or Groups (of Individuals) |
| 103TP2701X | Group Psychotherapy | 100000000 | Individuals or Groups (of Individuals) |
| 103TH0004X | Health | 100000000 | Individuals or Groups (of Individuals) |
| 103TH0100X | Health Service | 100000000 | Individuals or Groups (of Individuals) |
| 103TM1700X | Men & Masculinity | 100000000 | Individuals or Groups (of Individuals) |
| 103TM1800X | Mental Retardation & Developmental Disabilities | 100000000 | Individuals or Groups (of Individuals) |
| 103TP0016X | Prescribing (Medical) | 100000000 | Individuals or Groups (of Individuals) |
| 103TP0814X | Psychoanalysis | 100000000 | Individuals or Groups (of Individuals) |
| 103TP2700X | Psychotherapy | 100000000 | Individuals or Groups (of Individuals) |
| 103TR0400X | Rehabilitation | 100000000 | Individuals or Groups (of Individuals) |
| 103TS0200X | School | 100000000 | Individuals or Groups (of Individuals) |
| 103TW0100X | Women | 100000000 | Individuals or Groups (of Individuals) |
| 104100000X | Social Worker | 100000000 | Individuals or Groups (of Individuals) |
| 1041C0700X | Clinical | 100000000 | Individuals or Groups (of Individuals) |
| 1041S0200X | School | 100000000 | Individuals or Groups (of Individuals) |
| 111N00000X | Chiropractor | 100000000 | Individuals or Groups (of Individuals) |
| 111NI0013X | Independent Medical Examiner | 100000000 | Individuals or Groups (of Individuals) |
| 111NI0900X | Internist | 100000000 | Individuals or Groups (of Individuals) |
| 111NN0400X | Neurology | 100000000 | Individuals or Groups (of Individuals) |
| 111NN1001X | Nutrition | 100000000 | Individuals or Groups (of Individuals) |
| 111NX0100X | Occupational Health | 100000000 | Individuals or Groups (of Individuals) |
| 111NX0800X | Orthopedic | 100000000 | Individuals or Groups (of Individuals) |
| 111NP0017X | Pediatric Chiropractor | 100000000 | Individuals or Groups (of Individuals) |

## Table Pages 21 - 40

| **Provider Taxonomy Code** | **Provider Taxonomy Description** | **Provider Facility Type Code** | **Provider Facility Type Description** |
| --- | --- | --- | --- |
| 111NR0200X | Radiology | 100000000 | Individuals or Groups (of Individuals) |
| 111NR0400X | Rehabilitation | 100000000 | Individuals or Groups (of Individuals) |
| 111NS0005X | Sports Physician | 100000000 | Individuals or Groups (of Individuals) |
| 111NT0100X | Thermography | 100000000 | Individuals or Groups (of Individuals) |
| 125K00000X | Advanced Practice Dental Therapist | 100000000 | Individuals or Groups (of Individuals) |
| 126800000X | Dental Assistant | 100000000 | Individuals or Groups (of Individuals) |
| 124Q00000X | Dental Hygienist | 100000000 | Individuals or Groups (of Individuals) |
| 126900000X | Dental Laboratory Technician | 100000000 | Individuals or Groups (of Individuals) |
| 125J00000X | Dental Therapist | 100000000 | Individuals or Groups (of Individuals) |
| 122300000X | Dentist | 100000000 | Individuals or Groups (of Individuals) |
| 1223D0001X | Dental Public Health | 100000000 | Individuals or Groups (of Individuals) |
| 1223D0004X | Dentist Anesthesiologist | 100000000 | Individuals or Groups (of Individuals) |
| 1223E0200X | Endodontics | 100000000 | Individuals or Groups (of Individuals) |
| 1223G0001X | General Practice | 100000000 | Individuals or Groups (of Individuals) |
| 1223P0106X | Oral and Maxillofacial Pathology | 100000000 | Individuals or Groups (of Individuals) |
| 1223X0008X | Oral and Maxillofacial Radiology | 100000000 | Individuals or Groups (of Individuals) |
| 1223S0112X | Oral and Maxillofacial Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 1223X0400X | Orthodontics and Dentofacial Orthopedics | 100000000 | Individuals or Groups (of Individuals) |
| 1223P0221X | Pediatric Dentistry | 100000000 | Individuals or Groups (of Individuals) |
| 1223P0300X | Periodontics | 100000000 | Individuals or Groups (of Individuals) |
| 1223P0700X | Prosthodontics | 100000000 | Individuals or Groups (of Individuals) |
| 122400000X | Denturist | 100000000 | Individuals or Groups (of Individuals) |
| 132700000X | Dietary Manager | 100000000 | Individuals or Groups (of Individuals) |
| 136A00000X | Dietetic Technician, Registered | 100000000 | Individuals or Groups (of Individuals) |
| 133V00000X | Dietitian, Registered | 100000000 | Individuals or Groups (of Individuals) |
| 133VN1006X | Nutrition, Metabolic | 100000000 | Individuals or Groups (of Individuals) |
| 133VN1004X | Nutrition, Pediatric | 100000000 | Individuals or Groups (of Individuals) |
| 133VN1005X | Nutrition, Renal | 100000000 | Individuals or Groups (of Individuals) |
| 133N00000X | Nutritionist | 100000000 | Individuals or Groups (of Individuals) |
| 133NN1002X | Nutrition, Education | 100000000 | Individuals or Groups (of Individuals) |
| 146N00000X | Emergency Medical Technician, Basic | 100000000 | Individuals or Groups (of Individuals) |
| 146M00000X | Emergency Medical Technician, Intermediate | 100000000 | Individuals or Groups (of Individuals) |
| 146L00000X | Emergency Medical Technician, Paramedic | 100000000 | Individuals or Groups (of Individuals) |
| 146D00000X | Personal Emergency Response Attendant | 100000000 | Individuals or Groups (of Individuals) |
| 152W00000X | Optometrist | 100000000 | Individuals or Groups (of Individuals) |
| 152WC0802X | Corneal and Contact Management | 100000000 | Individuals or Groups (of Individuals) |
| 152WL0500X | Low Vision Rehabilitation | 100000000 | Individuals or Groups (of Individuals) |
| 152WX0102X | Occupational Vision | 100000000 | Individuals or Groups (of Individuals) |
| 152WP0200X | Pediatrics | 100000000 | Individuals or Groups (of Individuals) |
| 152WS0006X | Sports Vision | 100000000 | Individuals or Groups (of Individuals) |
| 152WV0400X | Vision Therapy | 100000000 | Individuals or Groups (of Individuals) |
| 156F00000X | Technician/Technologist | 100000000 | Individuals or Groups (of Individuals) |
| 156FC0800X | Contact Lens | 100000000 | Individuals or Groups (of Individuals) |
| 156FC0801X | Contact Lens Fitter | 100000000 | Individuals or Groups (of Individuals) |
| 156FX1700X | Ocularist | 100000000 | Individuals or Groups (of Individuals) |
| 156FX1100X | Ophthalmic | 100000000 | Individuals or Groups (of Individuals) |
| 156FX1101X | Ophthalmic Assistant | 100000000 | Individuals or Groups (of Individuals) |
| 156FX1800X | Optician | 100000000 | Individuals or Groups (of Individuals) |
| 156FX1201X | Optometric Assistant | 100000000 | Individuals or Groups (of Individuals) |
| 156FX1202X | Optometric Technician | 100000000 | Individuals or Groups (of Individuals) |
| 156FX1900X | Orthoptist | 100000000 | Individuals or Groups (of Individuals) |
| 164W00000X | Licensed Practical Nurse | 100000000 | Individuals or Groups (of Individuals) |
| 167G00000X | Licensed Psychiatric Technician | 100000000 | Individuals or Groups (of Individuals) |
| 164X00000X | Licensed Vocational Nurse | 100000000 | Individuals or Groups (of Individuals) |
| 163W00000X | Registered Nurse | 100000000 | Individuals or Groups (of Individuals) |
| 163WA0400X | Addiction (Substance Use Disorder) | 100000000 | Individuals or Groups (of Individuals) |
| 163WA2000X | Administrator | 100000000 | Individuals or Groups (of Individuals) |
| 163WP2201X | Ambulatory Care | 100000000 | Individuals or Groups (of Individuals) |
| 163WC3500X | Cardiac Rehabilitation | 100000000 | Individuals or Groups (of Individuals) |
| 163WC0400X | Case Management | 100000000 | Individuals or Groups (of Individuals) |
| 163WC1400X | College Health | 100000000 | Individuals or Groups (of Individuals) |
| 163WC1500X | Community Health | 100000000 | Individuals or Groups (of Individuals) |
| 163WC2100X | Continence Care | 100000000 | Individuals or Groups (of Individuals) |
| 163WC1600X | Continuing Education/Staff Development | 100000000 | Individuals or Groups (of Individuals) |
| 163WC0200X | Critical Care Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 163WD0400X | Diabetes Educator | 100000000 | Individuals or Groups (of Individuals) |
| 163WD1100X | Dialysis, Peritoneal | 100000000 | Individuals or Groups (of Individuals) |
| 163WE0003X | Emergency | 100000000 | Individuals or Groups (of Individuals) |
| 163WE0900X | Enterostomal Therapy | 100000000 | Individuals or Groups (of Individuals) |
| 163WF0300X | Flight | 100000000 | Individuals or Groups (of Individuals) |
| 163WG0100X | Gastroenterology | 100000000 | Individuals or Groups (of Individuals) |
| 163WG0000X | General Practice | 100000000 | Individuals or Groups (of Individuals) |
| 163WG0600X | Gerontology | 100000000 | Individuals or Groups (of Individuals) |
| 163WH0500X | Hemodialysis | 100000000 | Individuals or Groups (of Individuals) |
| 163WH0200X | Home Health | 100000000 | Individuals or Groups (of Individuals) |
| 163WH1000X | Hospice | 100000000 | Individuals or Groups (of Individuals) |
| 163WI0600X | Infection Control | 100000000 | Individuals or Groups (of Individuals) |
| 163WI0500X | Infusion Therapy | 100000000 | Individuals or Groups (of Individuals) |
| 163WL0100X | Lactation Consultant | 100000000 | Individuals or Groups (of Individuals) |
| 163WM0102X | Maternal Newborn | 100000000 | Individuals or Groups (of Individuals) |
| 163WM0705X | Medical-Surgical | 100000000 | Individuals or Groups (of Individuals) |
| 163WN0002X | Neonatal Intensive Care | 100000000 | Individuals or Groups (of Individuals) |
| 163WN0003X | Neonatal, Low-Risk | 100000000 | Individuals or Groups (of Individuals) |
| 163WN0300X | Nephrology | 100000000 | Individuals or Groups (of Individuals) |
| 163WN0800X | Neuroscience | 100000000 | Individuals or Groups (of Individuals) |
| 163WM1400X | Nurse Massage Therapist (NMT) | 100000000 | Individuals or Groups (of Individuals) |
| 163WN1003X | Nutrition Support | 100000000 | Individuals or Groups (of Individuals) |
| 163WX0002X | Obstetric, High-Risk | 100000000 | Individuals or Groups (of Individuals) |
| 163WX0003X | Obstetric, Inpatient | 100000000 | Individuals or Groups (of Individuals) |
| 163WX0106X | Occupational Health | 100000000 | Individuals or Groups (of Individuals) |
| 163WX0200X | Oncology | 100000000 | Individuals or Groups (of Individuals) |
| 163WX1100X | Ophthalmic | 100000000 | Individuals or Groups (of Individuals) |
| 163WX0800X | Orthopedic | 100000000 | Individuals or Groups (of Individuals) |
| 163WX1500X | Ostomy Care | 100000000 | Individuals or Groups (of Individuals) |
| 163WX0601X | Otorhinolaryngology & Head-Neck | 100000000 | Individuals or Groups (of Individuals) |
| 163WP0000X | Pain Management | 100000000 | Individuals or Groups (of Individuals) |
| 163WP0218X | Pediatric Oncology | 100000000 | Individuals or Groups (of Individuals) |
| 163WP0200X | Pediatrics | 100000000 | Individuals or Groups (of Individuals) |
| 163WP1700X | Perinatal | 100000000 | Individuals or Groups (of Individuals) |
| 163WS0121X | Plastic Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 163WP0808X | Psychiatric/Mental Health | 100000000 | Individuals or Groups (of Individuals) |
| 163WP0809X | Psychiatric/Mental Health, Adult | 100000000 | Individuals or Groups (of Individuals) |
| 163WP0807X | Psychiatric/Mental Health, Child & Adolescent | 100000000 | Individuals or Groups (of Individuals) |
| 163WR0006X | Registered Nurse First Assistant | 100000000 | Individuals or Groups (of Individuals) |
| 163WR0400X | Rehabilitation | 100000000 | Individuals or Groups (of Individuals) |
| 163WR1000X | Reproductive Endocrinology/Infertility | 100000000 | Individuals or Groups (of Individuals) |
| 163WS0200X | School | 100000000 | Individuals or Groups (of Individuals) |
| 163WU0100X | Urology | 100000000 | Individuals or Groups (of Individuals) |
| 163WW0101X | Women's Health Care, Ambulatory | 100000000 | Individuals or Groups (of Individuals) |
| 163WW0000X | Wound Care | 100000000 | Individuals or Groups (of Individuals) |
| 372600000X | Adult Companion | 100000000 | Individuals or Groups (of Individuals) |
| 372500000X | Chore Provider | 100000000 | Individuals or Groups (of Individuals) |
| 373H00000X | Day Training/Habilitation Specialist | 100000000 | Individuals or Groups (of Individuals) |
| 374J00000X | Doula | 100000000 | Individuals or Groups (of Individuals) |
| 374U00000X | Home Health Aide | 100000000 | Individuals or Groups (of Individuals) |
| 376J00000X | Homemaker | 100000000 | Individuals or Groups (of Individuals) |
| 376K00000X | Nurse's Aide | 100000000 | Individuals or Groups (of Individuals) |
| 376G00000X | Nursing Home Administrator | 100000000 | Individuals or Groups (of Individuals) |
| 374T00000X | Religious Nonmedical Nursing Personnel | 100000000 | Individuals or Groups (of Individuals) |
| 374K00000X | Religious Nonmedical Practitioner | 100000000 | Individuals or Groups (of Individuals) |
| 374700000X | Technician | 100000000 | Individuals or Groups (of Individuals) |
| 3747A0650X | Attendant Care Provider | 100000000 | Individuals or Groups (of Individuals) |
| 3747P1801X | Personal Care Attendant | 100000000 | Individuals or Groups (of Individuals) |
| 171100000X | Acupuncturist | 100000000 | Individuals or Groups (of Individuals) |
| 171M00000X | Case Manager/Care Coordinator | 100000000 | Individuals or Groups (of Individuals) |
| 174V00000X | Clinical Ethicist | 100000000 | Individuals or Groups (of Individuals) |
| 172V00000X | Community Health Worker | 100000000 | Individuals or Groups (of Individuals) |
| 171W00000X | Contractor | 100000000 | Individuals or Groups (of Individuals) |
| 171WH0202X | Home Modifications | 100000000 | Individuals or Groups (of Individuals) |
| 171WV0202X | Vehicle Modifications | 100000000 | Individuals or Groups (of Individuals) |
| 172A00000X | Driver | 100000000 | Individuals or Groups (of Individuals) |
| 176P00000X | Funeral Director | 100000000 | Individuals or Groups (of Individuals) |
| 170300000X | Genetic Counselor, MS | 100000000 | Individuals or Groups (of Individuals) |
| 174H00000X | Health Educator | 100000000 | Individuals or Groups (of Individuals) |
| 175L00000X | Homeopath | 100000000 | Individuals or Groups (of Individuals) |
| 171R00000X | Interpreter | 100000000 | Individuals or Groups (of Individuals) |
| 174N00000X | Lactation Consultant, Non-RN | 100000000 | Individuals or Groups (of Individuals) |
| 173000000X | Legal Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 172M00000X | Mechanotherapist | 100000000 | Individuals or Groups (of Individuals) |
| 170100000X | Medical Genetics, Ph.D. Medical Genetics | 100000000 | Individuals or Groups (of Individuals) |
| 176B00000X | Midwife | 100000000 | Individuals or Groups (of Individuals) |
| 175M00000X | Midwife, Lay | 100000000 | Individuals or Groups (of Individuals) |
| 171000000X | Military Health Care Provider | 100000000 | Individuals or Groups (of Individuals) |
| 1710I1002X | Independent Duty Corpsman | 100000000 | Individuals or Groups (of Individuals) |
| 1710I1003X | Independent Duty Medical Technicians | 100000000 | Individuals or Groups (of Individuals) |
| 172P00000X | Naprapath | 100000000 | Individuals or Groups (of Individuals) |
| 175F00000X | Naturopath | 100000000 | Individuals or Groups (of Individuals) |
| 173C00000X | Reflexologist | 100000000 | Individuals or Groups (of Individuals) |
| 173F00000X | Sleep Specialist, PhD | 100000000 | Individuals or Groups (of Individuals) |
| 174400000X | Specialist | 100000000 | Individuals or Groups (of Individuals) |
| 1744G0900X | Graphics Designer | 100000000 | Individuals or Groups (of Individuals) |
| 1744P3200X | Prosthetics Case Management | 100000000 | Individuals or Groups (of Individuals) |
| 1744R1103X | Research Data Abstracter/Coder | 100000000 | Individuals or Groups (of Individuals) |
| 1744R1102X | Research Study | 100000000 | Individuals or Groups (of Individuals) |
| 174M00000X | Veterinarian | 100000000 | Individuals or Groups (of Individuals) |
| 174MM1900X | Medical Research | 100000000 | Individuals or Groups (of Individuals) |
| 183500000X | Pharmacist | 100000000 | Individuals or Groups (of Individuals) |
| 1835G0000X | General Practice | 100000000 | Individuals or Groups (of Individuals) |
| 1835G0303X | Geriatric | 100000000 | Individuals or Groups (of Individuals) |
| 1835N0905X | Nuclear | 100000000 | Individuals or Groups (of Individuals) |
| 1835N1003X | Nutrition Support | 100000000 | Individuals or Groups (of Individuals) |
| 1835X0200X | Oncology | 100000000 | Individuals or Groups (of Individuals) |
| 1835P0018X | Pharmacist Clinician (PhC)/ Clinical Pharmacy Specialist | 100000000 | Individuals or Groups (of Individuals) |
| 1835P1200X | Pharmacotherapy | 100000000 | Individuals or Groups (of Individuals) |
| 1835P1300X | Psychiatric | 100000000 | Individuals or Groups (of Individuals) |
| 183700000X | Pharmacy Technician | 100000000 | Individuals or Groups (of Individuals) |
| 367A00000X | Advanced Practice Midwife | 100000000 | Individuals or Groups (of Individuals) |
| 367H00000X | Anesthesiologist Assistant | 100000000 | Individuals or Groups (of Individuals) |
| 364S00000X | Clinical Nurse Specialist | 100000000 | Individuals or Groups (of Individuals) |
| 364SA2100X | Acute Care | 100000000 | Individuals or Groups (of Individuals) |
| 364SA2200X | Adult Health | 100000000 | Individuals or Groups (of Individuals) |
| 364SC2300X | Chronic Care | 100000000 | Individuals or Groups (of Individuals) |
| 364SC1501X | Community Health/Public Health | 100000000 | Individuals or Groups (of Individuals) |
| 364SC0200X | Critical Care Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 364SE0003X | Emergency | 100000000 | Individuals or Groups (of Individuals) |
| 364SE1400X | Ethics | 100000000 | Individuals or Groups (of Individuals) |
| 364SF0001X | Family Health | 100000000 | Individuals or Groups (of Individuals) |
| 364SG0600X | Gerontology | 100000000 | Individuals or Groups (of Individuals) |
| 364SH1100X | Holistic | 100000000 | Individuals or Groups (of Individuals) |
| 364SH0200X | Home Health | 100000000 | Individuals or Groups (of Individuals) |
| 364SI0800X | Informatics | 100000000 | Individuals or Groups (of Individuals) |
| 364SL0600X | Long-Term Care | 100000000 | Individuals or Groups (of Individuals) |
| 364SM0705X | Medical-Surgical | 100000000 | Individuals or Groups (of Individuals) |
| 364SN0000X | Neonatal | 100000000 | Individuals or Groups (of Individuals) |
| 364SN0800X | Neuroscience | 100000000 | Individuals or Groups (of Individuals) |
| 364SX0106X | Occupational Health | 100000000 | Individuals or Groups (of Individuals) |
| 364SX0200X | Oncology | 100000000 | Individuals or Groups (of Individuals) |
| 364SX0204X | Oncology, Pediatrics | 100000000 | Individuals or Groups (of Individuals) |
| 364SP0200X | Pediatrics | 100000000 | Individuals or Groups (of Individuals) |
| 364SP1700X | Perinatal | 100000000 | Individuals or Groups (of Individuals) |
| 364SP2800X | Perioperative | 100000000 | Individuals or Groups (of Individuals) |
| 364SP0808X | Psychiatric/Mental Health | 100000000 | Individuals or Groups (of Individuals) |
| 364SP0809X | Psychiatric/Mental Health, Adult | 100000000 | Individuals or Groups (of Individuals) |
| 364SP0807X | Psychiatric/Mental Health, Child & Adolescent | 100000000 | Individuals or Groups (of Individuals) |
| 364SP0810X | Psychiatric/Mental Health, Child & Family | 100000000 | Individuals or Groups (of Individuals) |
| 364SP0811X | Psychiatric/Mental Health, Chronically Ill | 100000000 | Individuals or Groups (of Individuals) |
| 364SP0812X | Psychiatric/Mental Health, Community | 100000000 | Individuals or Groups (of Individuals) |
| 364SP0813X | Psychiatric/Mental Health, Geropsychiatric | 100000000 | Individuals or Groups (of Individuals) |
| 364SR0400X | Rehabilitation | 100000000 | Individuals or Groups (of Individuals) |
| 364SS0200X | School | 100000000 | Individuals or Groups (of Individuals) |
| 364ST0500X | Transplantation | 100000000 | Individuals or Groups (of Individuals) |
| 364SW0102X | Women's Health | 100000000 | Individuals or Groups (of Individuals) |
| 367500000X | Nurse Anesthetist, Certified Registered | 100000000 | Individuals or Groups (of Individuals) |
| 363L00000X | Nurse Practitioner | 100000000 | Individuals or Groups (of Individuals) |
| 363LA2100X | Acute Care | 100000000 | Individuals or Groups (of Individuals) |
| 363LA2200X | Adult Health | 100000000 | Individuals or Groups (of Individuals) |
| 363LC1500X | Community Health | 100000000 | Individuals or Groups (of Individuals) |
| 363LC0200X | Critical Care Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 363LF0000X | Family | 100000000 | Individuals or Groups (of Individuals) |
| 363LG0600X | Gerontology | 100000000 | Individuals or Groups (of Individuals) |
| 363LN0000X | Neonatal | 100000000 | Individuals or Groups (of Individuals) |
| 363LN0005X | Neonatal, Critical Care | 100000000 | Individuals or Groups (of Individuals) |
| 363LX0001X | Obstetrics & Gynecology | 100000000 | Individuals or Groups (of Individuals) |
| 363LX0106X | Occupational Health | 100000000 | Individuals or Groups (of Individuals) |
| 363LP0200X | Pediatrics | 100000000 | Individuals or Groups (of Individuals) |
| 363LP0222X | Pediatrics, Critical Care | 100000000 | Individuals or Groups (of Individuals) |
| 363LP1700X | Perinatal | 100000000 | Individuals or Groups (of Individuals) |
| 363LP2300X | Primary Care | 100000000 | Individuals or Groups (of Individuals) |
| 363LP0808X | Psychiatric/Mental Health | 100000000 | Individuals or Groups (of Individuals) |
| 363LS0200X | School | 100000000 | Individuals or Groups (of Individuals) |
| 363LW0102X | Women's Health | 100000000 | Individuals or Groups (of Individuals) |
| 363A00000X | Physician Assistant | 100000000 | Individuals or Groups (of Individuals) |
| 363AM0700X | Medical | 100000000 | Individuals or Groups (of Individuals) |
| 363AS0400X | Surgical | 100000000 | Individuals or Groups (of Individuals) |
| 211D00000X | Assistant, Podiatric | 100000000 | Individuals or Groups (of Individuals) |
| 213E00000X | Podiatrist | 100000000 | Individuals or Groups (of Individuals) |
| 213ES0103X | Foot & Ankle Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 213ES0131X | Foot Surgery | 100000000 | Individuals or Groups (of Individuals) |
| 213EG0000X | General Practice | 100000000 | Individuals or Groups (of Individuals) |
| 213EP1101X | Primary Podiatric Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 213EP0504X | Public Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 213ER0200X | Radiology | 100000000 | Individuals or Groups (of Individuals) |
| 213ES0000X | Sports Medicine | 100000000 | Individuals or Groups (of Individuals) |
| 229N00000X | Anaplastologist | 100000000 | Individuals or Groups (of Individuals) |
| 221700000X | Art Therapist | 100000000 | Individuals or Groups (of Individuals) |
| 224Y00000X | Clinical Exercise Physiologist | 100000000 | Individuals or Groups (of Individuals) |
| 225600000X | Dance Therapist | 100000000 | Individuals or Groups (of Individuals) |
| 222Q00000X | Developmental Therapist | 100000000 | Individuals or Groups (of Individuals) |
| 226300000X | Kinesiotherapist | 100000000 | Individuals or Groups (of Individuals) |
| 225700000X | Massage Therapist | 100000000 | Individuals or Groups (of Individuals) |
| 224900000X | Mastectomy Fitter | 100000000 | Individuals or Groups (of Individuals) |
| 225A00000X | Music Therapist | 100000000 | Individuals or Groups (of Individuals) |
| 225X00000X | Occupational Therapist | 100000000 | Individuals or Groups (of Individuals) |
| 225XR0403X | Driving and Community Mobility | 100000000 | Individuals or Groups (of Individuals) |
| 225XE0001X | Environmental Modification | 100000000 | Individuals or Groups (of Individuals) |
| 225XE1200X | Ergonomics | 100000000 | Individuals or Groups (of Individuals) |
| 225XF0002X | Feeding, Eating & Swallowing | 100000000 | Individuals or Groups (of Individuals) |
| 225XG0600X | Gerontology | 100000000 | Individuals or Groups (of Individuals) |
| 225XH1200X | Hand | 100000000 | Individuals or Groups (of Individuals) |
| 225XH1300X | Human Factors | 100000000 | Individuals or Groups (of Individuals) |
| 225XL0004X | Low Vision | 100000000 | Individuals or Groups (of Individuals) |
| 225XM0800X | Mental Health | 100000000 | Individuals or Groups (of Individuals) |
| 225XN1300X | Neurorehabilitation | 100000000 | Individuals or Groups (of Individuals) |
| 225XP0200X | Pediatrics | 100000000 | Individuals or Groups (of Individuals) |
| 225XP0019X | Physical Rehabilitation | 100000000 | Individuals or Groups (of Individuals) |
| 224Z00000X | Occupational Therapy Assistant | 100000000 | Individuals or Groups (of Individuals) |
| 224ZR0403X | Driving and Community Mobility | 100000000 | Individuals or Groups (of Individuals) |
| 224ZE0001X | Environmental Modification | 100000000 | Individuals or Groups (of Individuals) |
| 224ZF0002X | Feeding, Eating & Swallowing | 100000000 | Individuals or Groups (of Individuals) |

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| **Provider Taxonomy Code** | **Provider Taxonomy Description** | **Provider Facility Type Code** | **Provider Facility Type Description** |
| --- | --- | --- | --- |
| 224ZL0004X | Low Vision | 100000000 | Individuals or Groups (of Individuals) |
| 225000000X | Orthotic Fitter | 100000000 | Individuals or Groups (of Individuals) |
| 222Z00000X | Orthotist | 100000000 | Individuals or Groups (of Individuals) |
| 224L00000X | Pedorthist | 100000000 | Individuals or Groups (of Individuals) |
| 225100000X | Physical Therapist | 100000000 | Individuals or Groups (of Individuals) |
| 2251C2600X | Cardiopulmonary | 100000000 | Individuals or Groups (of Individuals) |
| 2251E1300X | Electrophysiology, Clinical | 100000000 | Individuals or Groups (of Individuals) |
| 2251E1200X | Ergonomics | 100000000 | Individuals or Groups (of Individuals) |
| 2251G0304X | Geriatrics | 100000000 | Individuals or Groups (of Individuals) |
| 2251H1200X | Hand | 100000000 | Individuals or Groups (of Individuals) |
| 2251H1300X | Human Factors | 100000000 | Individuals or Groups (of Individuals) |
| 2251N0400X | Neurology | 100000000 | Individuals or Groups (of Individuals) |
| 2251X0800X | Orthopedic | 100000000 | Individuals or Groups (of Individuals) |
| 2251P0200X | Pediatrics | 100000000 | Individuals or Groups (of Individuals) |
| 2251S0007X | Sports | 100000000 | Individuals or Groups (of Individuals) |
| 225200000X | Physical Therapy Assistant | 100000000 | Individuals or Groups (of Individuals) |
| 224P00000X | Prosthetist | 100000000 | Individuals or Groups (of Individuals) |
| 225B00000X | Pulmonary Function Technologist | 100000000 | Individuals or Groups (of Individuals) |
| 225800000X | Recreation Therapist | 100000000 | Individuals or Groups (of Individuals) |
| 225C00000X | Rehabilitation Counselor | 100000000 | Individuals or Groups (of Individuals) |
| 225CA2400X | Assistive Technology Practitioner | 100000000 | Individuals or Groups (of Individuals) |
| 225CA2500X | Assistive Technology Supplier | 100000000 | Individuals or Groups (of Individuals) |
| 225CX0006X | Orientation and Mobility Training Provider | 100000000 | Individuals or Groups (of Individuals) |
| 225400000X | Rehabilitation Practitioner | 100000000 | Individuals or Groups (of Individuals) |
| 227800000X | Respiratory Therapist, Certified | 100000000 | Individuals or Groups (of Individuals) |
| 2278C0205X | Critical Care | 100000000 | Individuals or Groups (of Individuals) |
| 2278E1000X | Educational | 100000000 | Individuals or Groups (of Individuals) |
| 2278E0002X | Emergency Care | 100000000 | Individuals or Groups (of Individuals) |
| 2278G1100X | General Care | 100000000 | Individuals or Groups (of Individuals) |
| 2278G0305X | Geriatric Care | 100000000 | Individuals or Groups (of Individuals) |
| 2278H0200X | Home Health | 100000000 | Individuals or Groups (of Individuals) |
| 2278P3900X | Neonatal/Pediatrics | 100000000 | Individuals or Groups (of Individuals) |
| 2278P3800X | Palliative/Hospice | 100000000 | Individuals or Groups (of Individuals) |
| 2278P4000X | Patient Transport | 100000000 | Individuals or Groups (of Individuals) |
| 2278P1004X | Pulmonary Diagnostics | 100000000 | Individuals or Groups (of Individuals) |
| 2278P1006X | Pulmonary Function Technologist | 100000000 | Individuals or Groups (of Individuals) |
| 2278P1005X | Pulmonary Rehabilitation | 100000000 | Individuals or Groups (of Individuals) |
| 2278S1500X | SNF/Subacute Care | 100000000 | Individuals or Groups (of Individuals) |
| 227900000X | Respiratory Therapist, Registered | 100000000 | Individuals or Groups (of Individuals) |
| 2279C0205X | Critical Care | 100000000 | Individuals or Groups (of Individuals) |
| 2279E1000X | Educational | 100000000 | Individuals or Groups (of Individuals) |
| 2279E0002X | Emergency Care | 100000000 | Individuals or Groups (of Individuals) |
| 2279G1100X | General Care | 100000000 | Individuals or Groups (of Individuals) |
| 2279G0305X | Geriatric Care | 100000000 | Individuals or Groups (of Individuals) |
| 2279H0200X | Home Health | 100000000 | Individuals or Groups (of Individuals) |
| 2279P3900X | Neonatal/Pediatrics | 100000000 | Individuals or Groups (of Individuals) |
| 2279P3800X | Palliative/Hospice | 100000000 | Individuals or Groups (of Individuals) |
| 2279P4000X | Patient Transport | 100000000 | Individuals or Groups (of Individuals) |
| 2279P1004X | Pulmonary Diagnostics | 100000000 | Individuals or Groups (of Individuals) |
| 2279P1006X | Pulmonary Function Technologist | 100000000 | Individuals or Groups (of Individuals) |
| 2279P1005X | Pulmonary Rehabilitation | 100000000 | Individuals or Groups (of Individuals) |
| 2279S1500X | SNF/Subacute Care | 100000000 | Individuals or Groups (of Individuals) |
| 225500000X | Specialist/Technologist | 100000000 | Individuals or Groups (of Individuals) |
| 2255A2300X | Athletic Trainer | 100000000 | Individuals or Groups (of Individuals) |
| 2255R0406X | Rehabilitation, Blind | 100000000 | Individuals or Groups (of Individuals) |
| 231H00000X | Audiologist | 100000000 | Individuals or Groups (of Individuals) |
| 231HA2400X | Assistive Technology Practitioner | 100000000 | Individuals or Groups (of Individuals) |
| 231HA2500X | Assistive Technology Supplier | 100000000 | Individuals or Groups (of Individuals) |
| 237600000X | Audiologist-Hearing Aid Fitter | 100000000 | Individuals or Groups (of Individuals) |
| 237700000X | Hearing Instrument Specialist | 100000000 | Individuals or Groups (of Individuals) |
| 235500000X | Specialist/Technologist | 100000000 | Individuals or Groups (of Individuals) |
| 2355A2700X | Audiology Assistant | 100000000 | Individuals or Groups (of Individuals) |
| 2355S0801X | Speech-Language Assistant | 100000000 | Individuals or Groups (of Individuals) |
| 235Z00000X | Speech-Language Pathologist | 100000000 | Individuals or Groups (of Individuals) |
| 390200000X | Student in an Organized Health Care Education/Training Program | 100000000 | Individuals or Groups (of Individuals) |
| 242T00000X | Perfusionist | 100000000 | Individuals or Groups (of Individuals) |
| 247100000X | Radiologic Technologist | 100000000 | Individuals or Groups (of Individuals) |
| 2471B0102X | Bone Densitometry | 100000000 | Individuals or Groups (of Individuals) |
| 2471C1106X | Cardiac-Interventional Technology | 100000000 | Individuals or Groups (of Individuals) |
| 2471C1101X | Cardiovascular-Interventional Technology | 100000000 | Individuals or Groups (of Individuals) |
| 2471C3401X | Computed Tomography | 100000000 | Individuals or Groups (of Individuals) |
| 2471M1202X | Magnetic Resonance Imaging | 100000000 | Individuals or Groups (of Individuals) |
| 2471M2300X | Mammography | 100000000 | Individuals or Groups (of Individuals) |
| 2471N0900X | Nuclear Medicine Technology | 100000000 | Individuals or Groups (of Individuals) |
| 2471Q0001X | Quality Management | 100000000 | Individuals or Groups (of Individuals) |
| 2471R0002X | Radiation Therapy | 100000000 | Individuals or Groups (of Individuals) |
| 2471C3402X | Radiography | 100000000 | Individuals or Groups (of Individuals) |
| 2471S1302X | Sonography | 100000000 | Individuals or Groups (of Individuals) |
| 2471V0105X | Vascular Sonography | 100000000 | Individuals or Groups (of Individuals) |
| 2471V0106X | Vascular-Interventional Technology | 100000000 | Individuals or Groups (of Individuals) |
| 243U00000X | Radiology Practitioner Assistant | 100000000 | Individuals or Groups (of Individuals) |
| 246X00000X | Specialist/Technologist Cardiovascular | 100000000 | Individuals or Groups (of Individuals) |
| 246XC2901X | Cardiovascular Invasive Specialist | 100000000 | Individuals or Groups (of Individuals) |
| 246XS1301X | Sonography | 100000000 | Individuals or Groups (of Individuals) |
| 246XC2903X | Vascular Specialist | 100000000 | Individuals or Groups (of Individuals) |
| 246Y00000X | Specialist/Technologist, Health Information | 100000000 | Individuals or Groups (of Individuals) |
| 246YC3301X | Coding Specialist, Hospital Based | 100000000 | Individuals or Groups (of Individuals) |
| 246YC3302X | Coding Specialist, Physician Office Based | 100000000 | Individuals or Groups (of Individuals) |
| 246YR1600X | Registered Record Administrator | 100000000 | Individuals or Groups (of Individuals) |
| 246Z00000X | Specialist/Technologist, Other | 100000000 | Individuals or Groups (of Individuals) |
| 246ZA2600X | Art, Medical | 100000000 | Individuals or Groups (of Individuals) |
| 246ZB0500X | Biochemist | 100000000 | Individuals or Groups (of Individuals) |
| 246ZB0301X | Biomedical Engineering | 100000000 | Individuals or Groups (of Individuals) |
| 246ZB0302X | Biomedical Photographer | 100000000 | Individuals or Groups (of Individuals) |
| 246ZB0600X | Biostatistician | 100000000 | Individuals or Groups (of Individuals) |
| 246ZC0007X | Certified First Assistant | 100000000 | Individuals or Groups (of Individuals) |
| 246ZE0500X | EEG | 100000000 | Individuals or Groups (of Individuals) |
| 246ZE0600X | Electroneurodiagnostic | 100000000 | Individuals or Groups (of Individuals) |
| 246ZG1000X | Geneticist, Medical (PhD) | 100000000 | Individuals or Groups (of Individuals) |
| 246ZG0701X | Graphics Methods | 100000000 | Individuals or Groups (of Individuals) |
| 246ZI1000X | Illustration, Medical | 100000000 | Individuals or Groups (of Individuals) |
| 246ZN0300X | Nephrology | 100000000 | Individuals or Groups (of Individuals) |
| 246ZS0400X | Surgical | 100000000 | Individuals or Groups (of Individuals) |
| 246Q00000X | Specialist/Technologist, Pathology | 100000000 | Individuals or Groups (of Individuals) |
| 246QB0000X | Blood Banking | 100000000 | Individuals or Groups (of Individuals) |
| 246QC1000X | Chemistry | 100000000 | Individuals or Groups (of Individuals) |
| 246QC2700X | Cytotechnology | 100000000 | Individuals or Groups (of Individuals) |
| 246QH0401X | Hemapheresis Practitioner | 100000000 | Individuals or Groups (of Individuals) |
| 246QH0000X | Hematology | 100000000 | Individuals or Groups (of Individuals) |
| 246QH0600X | Histology | 100000000 | Individuals or Groups (of Individuals) |
| 246QI0000X | Immunology | 100000000 | Individuals or Groups (of Individuals) |
| 246QL0900X | Laboratory Management | 100000000 | Individuals or Groups (of Individuals) |
| 246QL0901X | Laboratory Management, Diplomate | 100000000 | Individuals or Groups (of Individuals) |
| 246QM0706X | Medical Technologist | 100000000 | Individuals or Groups (of Individuals) |
| 246QM0900X | Microbiology | 100000000 | Individuals or Groups (of Individuals) |
| 246W00000X | Technician, Cardiology | 100000000 | Individuals or Groups (of Individuals) |
| 247000000X | Technician, Health Information | 100000000 | Individuals or Groups (of Individuals) |
| 2470A2800X | Assistant Record Technician | 100000000 | Individuals or Groups (of Individuals) |
| 247200000X | Technician, Other | 100000000 | Individuals or Groups (of Individuals) |
| 2472B0301X | Biomedical Engineering | 100000000 | Individuals or Groups (of Individuals) |
| 2472D0500X | Darkroom | 100000000 | Individuals or Groups (of Individuals) |
| 2472E0500X | EEG | 100000000 | Individuals or Groups (of Individuals) |
| 2472R0900X | Renal Dialysis | 100000000 | Individuals or Groups (of Individuals) |
| 2472V0600X | Veterinary | 100000000 | Individuals or Groups (of Individuals) |
| 246R00000X | Technician, Pathology | 100000000 | Individuals or Groups (of Individuals) |
| 247ZC0005X | Clinical Laboratory Director, Non-physician | 100000000 | Individuals or Groups (of Individuals) |
| 246RH0600X | Histology | 100000000 | Individuals or Groups (of Individuals) |
| 246RM2200X | Medical Laboratory | 100000000 | Individuals or Groups (of Individuals) |
| 246RP1900X | Phlebotomy | 100000000 | Individuals or Groups (of Individuals) |
| 251300000X | Local Education Agency (LEA) | 250000000 | Non-Individual - Agencies |
| 251B00000X | Case Management | 250000000 | Non-Individual - Agencies |
| 251S00000X | Community/Behavioral Health | 250000000 | Non-Individual - Agencies |
| 251C00000X | Day Training, Developmentally Disabled Services | 250000000 | Non-Individual - Agencies |
| 252Y00000X | Early Intervention Provider Agency | 250000000 | Non-Individual - Agencies |
| 253J00000X | Foster Care Agency | 250000000 | Non-Individual - Agencies |
| 251E00000X | Home Health | 250000000 | Non-Individual - Agencies |
| 251F00000X | Home Infusion | 250000000 | Non-Individual - Agencies |
| 251G00000X | Hospice Care, Community Based | 250000000 | Non-Individual - Agencies |
| 253Z00000X | In Home Supportive Care | 250000000 | Non-Individual - Agencies |
| 251J00000X | Nursing Care | 250000000 | Non-Individual - Agencies |
| 251T00000X | Program of All-Inclusive Care for the Elderly (PACE) Provider Organization | 250000000 | Non-Individual - Agencies |
| 251K00000X | Public Health or Welfare | 250000000 | Non-Individual - Agencies |
| 251X00000X | Supports Brokerage | 250000000 | Non-Individual - Agencies |
| 251V00000X | Voluntary or Charitable | 250000000 | Non-Individual - Agencies |
| 261Q00000X | Clinic/Center | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QM0855X | Adolescent and Children Mental Health | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QA0600X | Adult Day Care | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QM0850X | Adult Mental Health | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QA0005X | Ambulatory Family Planning Facility | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QA0006X | Ambulatory Fertility Facility | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QA1903X | Ambulatory Surgical | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QA0900X | Amputee | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QA3000X | Augmentative Communication | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QB0400X | Birthing | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QC1500X | Community Health | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QC1800X | Corporate Health | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QC0050X | Critical Access Hospital | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QD0000X | Dental | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QD1600X | Developmental Disabilities | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QE0002X | Emergency Care | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QE0800X | Endoscopy | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QE0700X | End-Stage Renal Disease (ESRD) Treatment | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QF0050X | Family Planning, Non-Surgical | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QF0400X | Federally Qualified Health Center (FQHC) | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QG0250X | Genetics | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QH0100X | Health Service | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QH0700X | Hearing and Speech | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QI0500X | Infusion Therapy | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QL0400X | Lithotripsy | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QM1200X | Magnetic Resonance Imaging (MRI) | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QM2500X | Medical Specialty | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QM3000X | Medically Fragile Infants and Children Day Care | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QM0801X | Mental Health (Including Community Mental Health Center) | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QM2800X | Methadone | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QM1000X | Migrant Health | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QM1103X | Military Ambulatory Procedure Visits Operational (Transportable) | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QM1101X | Military and U.S. Coast Guard Ambulatory Procedure | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QM1102X | Military Outpatient Operational (Transportable) Component | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QM1100X | Military/U.S. Coast Guard Outpatient | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QM1300X | Multi-Specialty | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QX0100X | Occupational Medicine | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QX0200X | Oncology | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QX0203X | Oncology, Radiation | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QS0132X | Ophthalmologic Surgery | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QS0112X | Oral and Maxillofacial Surgery | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QP3300X | Pain | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QP2000X | Physical Therapy | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QP1100X | Podiatric | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QP2300X | Primary Care | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QP2400X | Prison Health | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QP0904X | Public Health, Federal | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QP0905X | Public Health, State or Local | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QR0200X | Radiology | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QR0206X | Radiology, Mammography | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QR0208X | Radiology, Mobile | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QR0207X | Radiology, Mobile Mammography | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QR0800X | Recovery Care | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QR0400X | Rehabilitation | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QR0404X | Rehabilitation, Cardiac Facilities | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QR0401X | Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QR0405X | Rehabilitation, Substance Use Disorder | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QR1100X | Research | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QR1300X | Rural Health | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QS1200X | Sleep Disorder Diagnostic | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QS1000X | Student Health | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QU0200X | Urgent Care | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 261QV0200X | VA | 260000000 | Non-Individual - Ambulatory Health Care Facilities |
| 273100000X | Epilepsy Unit | 270000000 | Non-Individual - Hospital Units |
| 275N00000X | Medicare Defined Swing Bed Unit | 270000000 | Non-Individual - Hospital Units |
| 273R00000X | Psychiatric Unit | 270000000 | Non-Individual - Hospital Units |
| 273Y00000X | Rehabilitation Unit | 270000000 | Non-Individual - Hospital Units |
| 276400000X | Rehabilitation, Substance Use Disorder Unit | 270000000 | Non-Individual - Hospital Units |
| 287300000X | Christian Science Sanitorium | 280000000 | Non-Individual - Hospitals |
| 281P00000X | Chronic Disease Hospital | 280000000 | Non-Individual - Hospitals |
| 281PC2000X | Children | 280000000 | Non-Individual - Hospitals |
| 282N00000X | General Acute Care Hospital | 280000000 | Non-Individual - Hospitals |
| 282NC2000X | Children | 280000000 | Non-Individual - Hospitals |
| 282NC0060X | Critical Access | 280000000 | Non-Individual - Hospitals |
| 282NR1301X | Rural | 280000000 | Non-Individual - Hospitals |
| 282NW0100X | Women | 280000000 | Non-Individual - Hospitals |
| 282E00000X | Long Term Care Hospital | 280000000 | Non-Individual - Hospitals |
| 286500000X | Military Hospital | 280000000 | Non-Individual - Hospitals |
| 2865C1500X | Community Health | 280000000 | Non-Individual - Hospitals |
| 2865M2000X | Military General Acute Care Hospital | 280000000 | Non-Individual - Hospitals |
| 2865X1600X | Military General Acute Care Hospital. Operational (Transportable) | 280000000 | Non-Individual - Hospitals |
| 283Q00000X | Psychiatric Hospital | 280000000 | Non-Individual - Hospitals |
| 283X00000X | Rehabilitation Hospital | 280000000 | Non-Individual - Hospitals |
| 283XC2000X | Children | 280000000 | Non-Individual - Hospitals |
| 282J00000X | Religious Nonmedical Health Care Institution | 280000000 | Non-Individual - Hospitals |
| 284300000X | Special Hospital | 280000000 | Non-Individual - Hospitals |
| 291U00000X | Clinical Medical Laboratory | 290000000 | Non-Individual - Laboratories |
| 292200000X | Dental Laboratory | 290000000 | Non-Individual - Laboratories |
| 291900000X | Military Clinical Medical Laboratory | 290000000 | Non-Individual - Laboratories |
| 293D00000X | Physiological Laboratory | 290000000 | Non-Individual - Laboratories |
| 302F00000X | Exclusive Provider Organization | 300000000 | Non-Individual - Managed Care Organizations |
| 302R00000X | Health Maintenance Organization | 300000000 | Non-Individual - Managed Care Organizations |
| 305S00000X | Point of Service | 300000000 | Non-Individual - Managed Care Organizations |
| 305R00000X | Preferred Provider Organization | 300000000 | Non-Individual - Managed Care Organizations |
| 311500000X | Alzheimer Center (Dementia Center) | 310000000 | Non-Individual - Nursing & Custodial Care Facilities |
| 310400000X | Assisted Living Facility | 310000000 | Non-Individual - Nursing & Custodial Care Facilities |
| 3104A0630X | Assisted Living, Behavioral Disturbances | 310000000 | Non-Individual - Nursing & Custodial Care Facilities |
| 3104A0625X | Assisted Living, Mental Illness | 310000000 | Non-Individual - Nursing & Custodial Care Facilities |
| 317400000X | Christian Science Facility | 310000000 | Non-Individual - Nursing & Custodial Care Facilities |
| 311Z00000X | Custodial Care Facility | 310000000 | Non-Individual - Nursing & Custodial Care Facilities |
| 311ZA0620X | Adult Care Home | 310000000 | Non-Individual - Nursing & Custodial Care Facilities |
| 315D00000X | Hospice, Inpatient | 310000000 | Non-Individual - Nursing & Custodial Care Facilities |
| 310500000X | Intermediate Care Facility, Mental Illness | 310000000 | Non-Individual - Nursing & Custodial Care Facilities |
| 315P00000X | Intermediate Care Facility, Mentally Retarded | 310000000 | Non-Individual - Nursing & Custodial Care Facilities |
| 313M00000X | Nursing Facility/Intermediate Care Facility | 310000000 | Non-Individual - Nursing & Custodial Care Facilities |
| 314000000X | Skilled Nursing Facility | 310000000 | Non-Individual - Nursing & Custodial Care Facilities |
| 3140N1450X | Nursing Care, Pediatric | 310000000 | Non-Individual - Nursing & Custodial Care Facilities |
| 177F00000X | Lodging | 170000000 | Non-Individual - Other Service Providers |
| 174200000X | Meals | 170000000 | Non-Individual - Other Service Providers |
| 320800000X | Community Based Residential Treatment Facility, Mental Illness | 320000000 | Non-Individual - Residential Treatment Facilities |
| 320900000X | Community Based Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities | 320000000 | Non-Individual - Residential Treatment Facilities |
| 323P00000X | Psychiatric Residential Treatment Facility | 320000000 | Non-Individual - Residential Treatment Facilities |
| 322D00000X | Residential Treatment Facility, Emotionally Disturbed Children | 320000000 | Non-Individual - Residential Treatment Facilities |
| 320600000X | Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities | 320000000 | Non-Individual - Residential Treatment Facilities |
| 320700000X | Residential Treatment Facility, Physical Disabilities | 320000000 | Non-Individual - Residential Treatment Facilities |
| 324500000X | Substance Abuse Rehabilitation Facility | 320000000 | Non-Individual - Residential Treatment Facilities |
| 3245S0500X | Substance Abuse Treatment, Children | 320000000 | Non-Individual - Residential Treatment Facilities |
| 385H00000X | Respite Care | 380000000 | Non-Individual - Respite Care Facility |
| 385HR2050X | Respite Care Camp | 380000000 | Non-Individual - Respite Care Facility |
| 385HR2055X | Respite Care, Mental Illness, Child | 380000000 | Non-Individual - Respite Care Facility |
| 385HR2060X | Respite Care, Mental Retardation and/or Developmental Disabilities | 380000000 | Non-Individual - Respite Care Facility |
| 385HR2065X | Respite Care, Physical Disabilities, Child | 380000000 | Non-Individual - Respite Care Facility |
| 331L00000X | Blood Bank | 330000000 | Non-Individual - Suppliers |
| 332100000X | Department of Veterans Affairs (VA) Pharmacy | 330000000 | Non-Individual - Suppliers |
| 332B00000X | Durable Medical Equipment & Medical Supplies | 330000000 | Non-Individual - Suppliers |
| 332BC3200X | Customized Equipment | 330000000 | Non-Individual - Suppliers |
| 332BD1200X | Dialysis Equipment & Supplies | 330000000 | Non-Individual - Suppliers |
| 332BN1400X | Nursing Facility Supplies | 330000000 | Non-Individual - Suppliers |
| 332BX2000X | Oxygen Equipment & Supplies | 330000000 | Non-Individual - Suppliers |
| 332BP3500X | Parenteral & Enteral Nutrition | 330000000 | Non-Individual - Suppliers |
| 333300000X | Emergency Response System Companies | 330000000 | Non-Individual - Suppliers |
| 332G00000X | Eye Bank | 330000000 | Non-Individual - Suppliers |
| 332H00000X | Eyewear Supplier (Equipment, not the service) | 330000000 | Non-Individual - Suppliers |
| 332S00000X | Hearing Aid Equipment | 330000000 | Non-Individual - Suppliers |
| 332U00000X | Home Delivered Meals | 330000000 | Non-Individual - Suppliers |
| 332800000X | Indian Health Service/Tribal/Urban Indian Health (I/T/U) Pharmacy | 330000000 | Non-Individual - Suppliers |
| 335G00000X | Medical Foods Supplier | 330000000 | Non-Individual - Suppliers |
| 332000000X | Military/U.S. Coast Guard Pharmacy | 330000000 | Non-Individual - Suppliers |
| 332900000X | Non-Pharmacy Dispensing Site | 330000000 | Non-Individual - Suppliers |
| 335U00000X | Organ Procurement Organization | 330000000 | Non-Individual - Suppliers |
| 333600000X | Pharmacy | 330000000 | Non-Individual - Suppliers |
| 3336C0002X | Clinic Pharmacy | 330000000 | Non-Individual - Suppliers |
| 3336C0003X | Community/Retail Pharmacy | 330000000 | Non-Individual - Suppliers |
| 3336C0004X | Compounding Pharmacy | 330000000 | Non-Individual - Suppliers |
| 3336H0001X | Home Infusion Therapy Pharmacy | 330000000 | Non-Individual - Suppliers |
| 3336I0012X | Institutional Pharmacy | 330000000 | Non-Individual - Suppliers |
| 3336L0003X | Long Term Care Pharmacy | 330000000 | Non-Individual - Suppliers |
| 3336M0002X | Mail Order Pharmacy | 330000000 | Non-Individual - Suppliers |
| 3336M0003X | Managed Care Organization Pharmacy | 330000000 | Non-Individual - Suppliers |
| 3336N0007X | Nuclear Pharmacy | 330000000 | Non-Individual - Suppliers |
| 3336S0011X | Specialty Pharmacy | 330000000 | Non-Individual - Suppliers |
| 335V00000X | Portable X-Ray Supplier | 330000000 | Non-Individual - Suppliers |
| 335E00000X | Prosthetic/Orthotic Supplier | 330000000 | Non-Individual - Suppliers |
| 344800000X | Air Carrier | 340000000 | Non-Individual - Transportation Services |
| 341600000X | Ambulance | 340000000 | Non-Individual - Transportation Services |
| 3416A0800X | Air Transport | 340000000 | Non-Individual - Transportation Services |
| 3416L0300X | Land Transport | 340000000 | Non-Individual - Transportation Services |
| 3416S0300X | Water Transport | 340000000 | Non-Individual - Transportation Services |
| 347B00000X | Bus | 340000000 | Non-Individual - Transportation Services |
| 341800000X | Military/U.S. Coast Guard Transport | 340000000 | Non-Individual - Transportation Services |
| 3418M1120X | Military or U.S. Coast Guard Ambulance, Air Transport | 340000000 | Non-Individual - Transportation Services |
| 3418M1110X | Military or U.S. Coast Guard Ambulance, Ground Transport | 340000000 | Non-Individual - Transportation Services |
| 3418M1130X | Military or U.S. Coast Guard Ambulance, Water Transport | 340000000 | Non-Individual - Transportation Services |
| 343900000X | Non-emergency Medical Transport (VAN) | 340000000 | Non-Individual - Transportation Services |
| 347C00000X | Private Vehicle | 340000000 | Non-Individual - Transportation Services |
| 343800000X | Secured Medical Transport (VAN) | 340000000 | Non-Individual - Transportation Services |
| 344600000X | Taxi | 340000000 | Non-Individual - Transportation Services |
| 347D00000X | Train | 340000000 | Non-Individual - Transportation Services |
| 347E00000X | Transportation Broker | 340000000 | Non-Individual - Transportation Services |

# Appendix M

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# Appendix N: Coding Specific Data Elements for Claim Files

**Clarification of the use of the PROCEDURE-CODE, REVENUE-CODE, HCPCS-RATE, BEGINNING-DATE-OF-SERVICE, and ENDING-DATE-OF-SERVICE fields in the CLAIMOT File.**

Because the CLAIMOT file is a catch-all file that includes outpatient facility claims, professional claims and financial transactions, states are having confusion over when to populate the PROCEDURE-CODE, REVENUE-CODE, HCPCS-RATE , BEGINNING-DATE-OF-SERVICE, ENDING-DATE-OF-SERVICE, PROCEDURE-CODE-DATE, PROCEDURE-CODE-FLAG, and PROCEDURE-CODE-MOD-1 thru -4 fields. To assist them we have prepared the following guidelines.

*For professional claims:*

* **REVENUE-CODE** should be 8-filled, left blank or space-filled.
* **HCPCS-RATE** should be 8-filled, left blank or space-filled.
* **PROCEDURE-CODE-FLAG** should be populated with either “01 (CPT-4), “06” (HCPCS), or “10” through “87” (to indicate other coding schemas).
* **PROCEDURE-CODE** should be used to capture the CPT/HCPCS service codes.
* **PROCEDURE-CODE-MOD-1 thru -4** should be populated as needed.
* **BEGINNING-DATE-OF-SERVICE** should show the 1st DOS associated with the service code in the PROCEDURE-CODE field.
* **ENDING-DATE-OF-SERVICE** should show the last DOS associated with the service code in the PROCEDURE-CODE field.
* **PROCEDURE-CODE-DATE** should be 8-filled, left blank or space-filled (This field is superfluous. Beginning-/Ending-Date-of-Service captures the same information and provides more flexibility if the service is provided repeatedly over a period of time.)

*For institutional claims for ambulatory care (****reported on CLAIMOT file)****:*

* **REVENUE-CODE** should be used to capture the services provided.
* **HCPCS-RATE** should be used to capture HCPCS details whenever they are needed to support the value in the REVENUE-CODE field. Otherwise, the field should be 8-filled, left blank or space-filled.
* **PROCEDURE-CODE-FLAG** should be 8-filled, left blank or space-filled.
* **PROCEDURE-CODE** field should be 8-filled, left blank or space-filled.
* **PROCEDURE-CODE-MOD-1 thru -4** should be 8-filled, left blank or space-filled.
* **BEGINNING-DATE-OF-SERVICE** should show the 1st DOS associated with the service code in the REVENUE-CODE field.
* **ENDING-DATE-OF-SERVICE** should show the last DOS associated with the service code in the REVENUE-CODE field.
* **PROCEDURE-CODE-DATE** should be 8-filled, left blank or space-filled (This field is superfluous. Beginning-/Ending-Date-of-Service captures the same information and provides more flexibility if the service is provided repeatedly over a period of time.)

*For financial transactions[[3]](#footnote-3):*

* **REVENUE-CODE** field should be 8-filled, left blank or space-filled.
* **HCPCS-RATE** should be 8-filled, left blank or space-filled.
* **PROCEDURE-CODE-FLAG** should be 8-filled, left blank or space-filled, or populated with “10” through “87” (to indicate other coding schemas if state-specific codes are used).
* **PROCEDURE-CODE** field should be 8-filled, left blank or space-filled unless the State has state-specific codes it uses to provide further detail (e.g., codes to split capitation payments into subcategories).
* **PROCEDURE-CODE-MOD-1 thru -4** should be 8-filled, left blank or space-filled.
* **BEGINNING-DATE-OF-SERVICE** should show the 1st day of the time period covered by this financial transaction.
* **ENDING-DATE-OF-SERVICE** should show the last day of the time period covered by this financial transaction.
* **PROCEDURE-CODE-DATE** should be 8-filled, left blank or space-filled (This field is superfluous. Beginning-/Ending-Date-of-Service captures the same information and provides more flexibility if the service is provided repeatedly over a period of time.)

# Appendix O

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# Appendix P: CMS Guidance Library

## Appendix P.01: Submitting Adjustment Claims to T-MSIS

### Brief Issue Description

There are two ways original claims and their subsequent adjustments can be linked into a claim family – either through all adjustments linking back to the original claim or each subsequent adjustment linking back to the prior claim (i.e. “daisy chain”). Identifying the members of a claim family is necessary in order to evaluate the changes to a claim that occur throughout its life.

### Background Discussion

Before delving into CMS’ guidance on how to populate the ICN-ORIG and ICN-ADJ fields, some background discussion is needed on terminology and concepts.

### What claim transactions should be submitted to T-MSIS?

Every “final adjudicated version of the claim/encounter” should be submitted to T-MSIS.

A “final adjudicated version of the claim/encounter” is a claim that has completed the adjudication process and the paid/denied process.  The claim and each claim line will have one of the finalized claim status categories listed in Table 1, below.  The actual disposition of the claim can be either “paid” or “denied.”

*Table 1: Finalized Claim Status Categories*

| **Code** | **Finalized Claim Status Category Description** |
| --- | --- |
| F0 | Finalized-The encounter has completed the adjudication cycle and no more action will be taken. (Used on encounter records) |
| F1 | Finalized/Payment-The claim/line has been paid. |
| F2 | Finalized/Denial-The claim/line has been denied. |
| F3 | Finalized/Revised - Adjudication information has been changed. |

Both original claims (or encounters) and adjusted claims (or encounters) can be a “final adjudicated version of the claim/encounter.”  Whenever a claim/encounter flows through the adjudication and payment processes (if applicable) and falls into one of the claim status categories in Table 1, the state should send the claim/encounter to T-MSIS.

If a claim flows through the adjudication and payment processes and falls into one of the finalized claim status categories multiple times within a single T-MSIS reporting period, CMS expects each of these final adjudicated versions of the claim/encounter to be submitted to T-MSIS, not just the one effective on the last day of the reporting period.

If the claim has not been through the final adjudication process or is “pending” (or in “suspense”), the claim should not be sent to T-MSIS until disposition has been settled to one of the finalized claim status categories. Table 2 provides examples and CMS’ expectations.

*Table 2: Scenarios for When to Submit Claims*

| **Claim Submission Scenario** | **CMS’ Expectation** |
| --- | --- |
| Adjudicated and paid in the same reporting month | CMS expects the claim to be sent to T-MSIS in the reporting month. |
| Adjudicated in one reporting period, but paid in another reporting month | CMS expects the claim to be sent to T-MSIS in the month that the claim was paid. |
| Adjudicated and paid in one reporting month, and then re-adjudicated and paid in a subsequent month | The claim should be reported in the month it is paid, regardless of whether it is an original claim or an adjustment. Therefore, in this scenario, CMS expects the original to be reported in month one and the adjustment to be reported in the subsequent month. |
| Adjudicated and paid, and then re-adjudicated and paid in the same reporting month | In this scenario, if a claim flows through the adjudication and payment processes and falls into one of the claim status categories in Table 1 multiple times within a single T-MSIS reporting period, CMS expects each of these final adjudicated versions of the claim/encounter to be submitted to T-MSIS, not just the one effective on the last day of the reporting period. |
| Re-adjudicated and paid multiple times in the same reporting month | In this scenario, if a claim flows through the adjudication and payment processes and falls into one of the claim status categories in Table 1 multiple times within a single T-MSIS reporting period, CMS expects each of these final adjudicated versions of the claim/encounter to be submitted to T-MSIS, not just the one effective on the last day of the reporting period. |

### What is a claim family?

A “claim family” (a.k.a. “adjustment set”) is defined as a set of post-adjudication claim transactions in paid or denied status that relate to the same provider/enrollee/services/dates of service. This grouping of the original claim and all of its subsequent adjustment and/or void claims shows the progression of changes that have occurred since it was first submitted.

### How should ADJUSTMENT-IND codes be used?

The table below lists each of the adjustment indicator codes contained in the T-MSIS Data Dictionary version 1.1 and describes when it should be used.

*Table 3: Adjustment Indicator Codes and Their Uses*

| **Code** | **Description of Use** |
| --- | --- |
| 0 | Original Claim/Encounter/Payment – Indicates that this is the first (and, when applicable, only) fully adjudicated transaction in a claim family (one or more claims with the related ICN-ORIG and/or ICN-ADJ and typically the same MSIS ID and provider ID(s) also). |
| 1 | Void/Reversal/Cancel of a prior submission – Use this code to convey that the purpose of the transaction is to void/reverse/cancel a previously paid/approved claim/encounter/payment where the claim/encounter/payment is not being replaced by a new paid/approved version of the claim/encounter/payment.  Typically this would be the last claim/encounter/payment that would ever be associated with a given claim family.  These records must have the same ICN-ORIG or ICN-ADJ as the claim/encounter being voided. CMS expects a void transaction to also have the same MSIS ID and provider ID(s) as the claim/encounter/payment being voided/reversed/canceled. |
| 4 | Replacement/Resubmission of a previously paid/approved claim/encounter/payment – Use when the purpose of the transaction is to replace a previously paid/approved claim/encounter/payment with a new paid/approved version of the claim/encounter/payment.  These records must have the same ICN-ORIG or ICN-ADJ as the claim/encounter being replaced.  CMS expects a replacement transaction to also have the same MSIS ID and provider ID(s) as the claim/encounter/payment being replaced/resubmitted. |
| 5 | Credit Gross Adjustment – Use this code to indicate an aggregate provider-level recoupment of payments (e.g., not attributable to a single beneficiary).  Amounts on these claims should be expressed as negative numbers. If a credit gross adjustment is reported with an ICN that is related to an ICN(s) of another gross adjustment (credit or debit) then CMS will interpret this to mean that the credit gross adjustment with the more recent adjudication date should completely replace the preceding related gross adjustment. If the ICNs of a credit gross adjustment are not related to any other gross adjustments (credit or debit) then the credit gross adjustment will always be treated as a distinct financial transaction. |
| 6 | Debit Gross Adjustment – Use this code to indicate an aggregate provider-level payment to a provider (e.g., not attributable to a single beneficiary).  Amounts on these claims should be expressed as positive numbers.   If a debit gross adjustment is reported with an ICN that is related to an ICN(s) of another gross adjustment (credit or debit) then CMS will interpret this to mean that the credit gross adjustment with the more recent adjudication date should completely replace the preceding related gross adjustment. If the ICNs of a debit gross adjustment are not related to any other gross adjustments (credit or debit) then the debit gross adjustment will always be treated as a distinct financial transaction. |

### Are gross adjustments considered claims/encounters?

While the gross adjustment adjudication indicator codes (values “5” and “6” in Table 3) are reported to T-MSIS in the CLAIM-OT file, they are not technically “claims” or “encounters.” Each of these transactions does not relate to a specific service-provider/enrollee episode of care. Instead, these transactions represent payments made by the state for services rendered to multiple enrollees (as in the case of a provider providing screening services for a group of enrollees), DSH payments, or a recoupment of funds previously dispensed in a debit gross adjustment. Therefore, the concept of “claims family” does not apply. Each of these transactions stands on its own, and does not constitute a subsequent transaction being a replacement of the earlier transaction.

### What alternatives are there for tying the members of a claim family together?

#### The Original ICN Approach

Under this approach, the state assigns an ICN to the initial final adjudicated version of the claim/encounter and records this identifier in the ICN-ORIG field. If adjustment claims subsequently are created, the ICN assigned to the initial final adjudicated version of the claim/encounter is carried forward on every subsequent adjustment claim. Table 4 illustrates how the ICN-ORIG and ICN-ADJ values on the members of a claim family are populated when the original ICN approach is used.

*Table 4: ICN-ORIG/ICN-ADJ Relationships Under the Original ICN Approach*

| **Event** | **ADJUDICATION-DATE** | **ICN-ORIG** | **ICN-ADJ** | **ADJUSTMENT-IND** |
| --- | --- | --- | --- | --- |
| On 5/1/2014, the state completes the adjudication process on the initial version of the claim | 5/1/2014 | 1 | - | 0 |
| On 7/15/2014, the state completes a claim re-adjudication / adjustment | 7/15/2014 | 1 | 2 | 4 |
| On 8/12/2014, the state completes a 2nd claim re-adjudication / adjustment | 8/12/2014 | 1 | 3 | 4 |
| On 9/5/2014, the state completes a 3rd claim re-adjudication / adjustment | 9/5/2014 | 1 | 4 | 4 |

#### The Daisy-Chain ICN Approach

Under this approach, the state records the ICN of the previous final adjudicated version of the claim/encounter in the ICN-ORIG field of the adjustment claim record. If additional adjustment claims are subsequently created, the ICN-ORIG on the new adjustment claim only points back one generation. Table 5 illustrates how the ICN-ORIG and ICN-ADJ values on the members of a claim family are populated when the daisy-chain ICN approach is used.

*Table 5: ICN-ORIG/ICN-ADJ Relationships Under the Daisy-Chain ICN Approach*

| **Event** | **ADJUDICATION-DATE** | **ICN-ORIG** | **ICN-ADJ** | **ADJUSTMENT-IND** |
| --- | --- | --- | --- | --- |
| On 6/1/2014, the state completes the adjudication process on the initial version of the claim | 6/1/2014 | 11 | - | 0 |
| On 8/15/2014, the state completes a claim re-adjudication/adjustment | 8/15/2014 | 11 | 12 | 4 |
| On 9/12/2014, the state completes a 2nd claim re-adjudication/adjustment | 9/12/2014 | 12 | 13 | 4 |
| On 10/5/2014, the state completes a 3rd claim re-adjudication/adjustment | 10/5/2014 | 13 | 14 | 4 |

### How are ICN-ORIG and ICN-ADJ fields impacted when voids are submitted?

The primary purpose of void transactions (ADJUSTMENT-IND = 1) is to nullify a claim/encounter from T-MSIS when the state does not wish to replace it with an adjusted claim/encounter record. These records must have the same claim key data element values as the claim/encounter being voided. Dollar and quantity fields should be set to zero. The ADJUDICATION-DATE on these records should be set to the date that the state voided the claim. Table 6 illustrates how the ICN-ORIG and ICN-ADJ values on the members of a claim family are populated when the state wishes to void a claim.

*Table 6: ICN-ORIG/ICN-ADJ – Impact of Voids*

| **Event** | **ADJUDICATION-DATE** | **ICN-ORIG** | **ICN-ADJ** | **ADJUSTMENT-IND** | **Dollar Fields** | **Quantity Fields** |
| --- | --- | --- | --- | --- | --- | --- |
| On 6/1/2014, the state completes the adjudication process on the initial version of the claim | 6/1/2014 | 51 | - | 0 | 100.00 | 5 |
| On 8/15/2014, the state completes a claim re-adjudication/adjustment | 8/15/2014 | 51 | 52 | 4 | 80.00 | 5 |
| On 8/19/2014, the claim is voided | 8/19/2014 | 51 | 52 | 1 | 0.00 | 0 |

If a state uses a process to record adjustments whereby they void the previous version of the claim and then follow-up with the creation of a new original transaction, and the state can identify that the void and the new original claim are from the same adjudication set, the state should link them together into one claims family using the ICN-ORIG. CMS recognizes that some states may not be able to link a resubmitted claim after a void to the original claim. Table 7 illustrates how CMS is expecting the states to populate the ICN-ORIG/ICN-ADJ fields when the state processes a void/new original when adjusting claims.

*Table 7: ICN-ORIG/ICN-ADJ – Keeping the Claim Family Intact When the “V*oid/New Original” Scenario Occurs

| **Event** | **ADJUDICATION-DATE** | **ICN-ORIG** | **ICN-ADJ** | **ADJUSTMENT-IND** | **Dollar Fields** | **Quantity Fields** |
| --- | --- | --- | --- | --- | --- | --- |
| On 6/1/2014, the state completes the adjudication process on the initial version of the claim | 6/1/2014 | 51 | - | 0 | 100.00 | 5 |
| On 8/15/2014, the state completes the adjudication process of a void and associated new original | 8/15/2014 | 51 | - | 1 | 0.00 | 0 |
| On 8/15/2014, the state completes the adjudication process of a void and associated new original | 8/15/2014 | 51 | - | 0 | 80.00 | 5 |
| On 9/20/2014, the state completes the adjudication process of a void and associated new original | 9/20/2014 | 51 | - | 1 | 0.00 | 0 |
| On 9/20/2014, the state completes the adjudication process of a void and associated new original | 9/20/2014 | 51 | - | 0 | 60.00 | 5 |

### How Adjustment Records will be Applied by CMS

There is an inherent limitation in the way that CMS can interpret what to do with two claim transactions having the same ICN-ORIG and ADJUDICATION-DATE when both transactions are received in a single submission file. The processing rules that T-MSIS will follow are outlined below. It is up to each state to assure that claim transactions are processed in the appropriate sequence. If the rules below do not result in the sequence of transactions that the state desires, it is up to the state to submit transactions in separate files so that the desired sequence is attained.

### Rules for inserting claim transactions into the T-MSIS database

When two or more claim transactions with the same ICN-ORIG and ADJUDICATION-DATE are in the same submission file

If two or more transactions in an incoming claim file have the same ICN-ORIG and ADJUDICATION-DATE values, T-MSIS will evaluate the ADJUSTMENT-IND values and insert the transactions into the T-MSIS database as follows:

1. If more than two transactions in the incoming claim file have the same ICN-ORIG and ADJUDICATION-DATE values, then T-MSIS will reject all of the incoming transactions;
2. If the ADJUSTMENT-IND values of both incoming transactions are the same (but not ‘5’ or ‘6’), then T-MSIS will reject both incoming transactions;
3. If the ADJUSTMENT-IND values of both incoming transactions are some combination of ‘5’ and ‘6’ and if there is no active existing transaction in the T-MSIS DB, then T-MSIS will insert both incoming transactions into the T-MSIS DB (note, since neither transaction supersedes the other, the order in which they are inserted does not matter);
4. If the ADJUSTMENT-IND values of both incoming transactions are some combination of ‘5’ and ‘6’ and if there is an active existing transaction in the T-MSIS DB with an ADJUSTMENT-IND value of ‘5’ or ‘6’, then T-MSIS will insert both incoming transactions into the T-MSIS DB (note, since neither transaction supersedes the other, the order in which they are inserted does not matter);
5. If the ADJUSTMENT-IND values of both incoming transactions is a ‘5’ or ‘6’ and if there is an active existing transaction in the T-MSIS DB with an ADJUSTMENT-IND value of ‘0’, ‘1’, or ‘4’, then T-MSIS will reject both the incoming transactions;
6. If the ADJUSTMENT-IND value of one incoming transaction is a ‘5’ or ‘6’ and the ADJUSTMENT-IND of the other transaction is ‘0’, ‘1’, or ‘4’ and if there is an active existing transaction in the T-MSIS DB with an ADJUSTMENT-IND value of ‘5’ or ‘6’, then T-MSIS will insert the incoming transaction with ADJUDICATION-IND of ‘5’ or ‘6’ and reject the incoming transaction with ADJUSTMENT-IND value ‘0’, ‘1’, or ‘4’;
7. If the ADJUSTMENT-IND value of one incoming transaction is a ‘5’ or ‘6’ and the ADJUSTMENT-IND of the other transaction is ‘0’, ‘1’, or ‘4’ and there is an active existing transaction in the T-MSIS DB with an ADJUSTMENT-IND value of ‘0’, ‘1’, or ‘4’, then T-MSIS will reject the incoming transaction with ADJUSTMENT-IND value ‘5’ or ‘6’ and evaluate the remaining incoming transaction as follows:
   1. ADJUSTMENT-IND of the remaining incoming transaction is ‘0’ and the ADJUSTMENT-IND of the active existing transaction is ‘0’, then T-MSIS will reject the incoming transaction;
   2. ADJUSTMENT-IND of the remaining incoming transaction is ‘0’ and the ADJUSTMENT-IND of the active existing transaction is ‘1’, then T-MSIS will insert the incoming transaction;
   3. ADJUSTMENT-IND of the remaining incoming transaction is ‘0’ and the ADJUSTMENT-IND of the active existing transaction is ‘4’, then T-MSIS will reject the incoming transaction;
   4. ADJUSTMENT-IND of the remaining incoming transaction is ‘1’ and the ADJUSTMENT-IND of the active existing transaction is ‘0’, then T-MSIS will insert the incoming transaction;
   5. ADJUSTMENT-IND of the remaining incoming transaction is ‘1’ and the ADJUSTMENT-IND of the active existing transaction is ‘1’, then T-MSIS will reject the incoming transaction;
   6. ADJUSTMENT-IND of the remaining incoming transaction is ‘1’ and the ADJUSTMENT-IND of the active existing transaction is ‘4’, then T-MSIS will insert the incoming transaction;
   7. ADJUSTMENT-IND of the remaining incoming transaction is ‘4’ and the ADJUSTMENT-IND of the active existing transaction is ‘0’, then T-MSIS will insert the incoming transaction;
   8. ADJUSTMENT-IND of the remaining incoming transaction is ‘4’ and the ADJUSTMENT-IND of the active existing transaction is ‘1’, then T-MSIS will insert the incoming transaction;
   9. ADJUSTMENT-IND of the remaining incoming transaction is ‘4’ and the ADJUSTMENT-IND of the active existing transaction is ‘4’, then T-MSIS will insert the incoming transaction;
8. If the ADJUSTMENT-IND value of one incoming transaction is ‘1’ and the ADJUSTMENT-IND of the other transaction is ‘0’ or ‘4’ and the ADJUSTMENT-IND of the active existing transaction in the T-MSIS DB is ‘0’ or ‘4’, then T-MSIS will insert the incoming transaction with ADJUSTMENT-IND = ‘1’ first, and then insert the other transaction;
9. If the ADJUSTMENT-IND value of one incoming transaction is ‘1’ and the ADJUSTMENT-IND of the other transaction is ‘0’ or ‘4’ and the ADJUSTMENT-IND of the active transaction in the T-MSIS DB is ‘1’, then T-MSIS will insert the incoming transaction with ADJUSTMENT-IND value of ‘0’ or ‘4’ first and then insert the incoming transaction with ADJUSTMENT-IND = ‘1’;
10. If the ADJUSTMENT-IND value of one incoming transaction is ‘0’ and the ADJUSTMENT-IND value of the other incoming transaction is ‘4’ and there is no active existing transaction in the T-MSIS DB, then T-MSIS will insert the incoming transaction with ADJUSTMENT-IND value of ‘0’ first and then insert the incoming transaction with ADJUSTMENT-IND = ‘4’;
11. If any other combination of ADJUSTMENT-IND values occurs, then T-MSIS will reject all of the transactions.

### CMS Guidance

The state can use either the original ICN approach or the daisy-chain ICN approach to populate the ICN-ORIG field on each member of the claims family. T-MSIS will group claim transactions into claim families as part of the ETL process.

## Appendix P.02: Reporting Financial Transactions in T-MSIS

**How to populate T-MSIS claim files when reporting non-claim expenditures and recoupments**

### Brief Issue Description:

The purpose of this guidance document is to clarify the appropriate way to report non-claim expenditure and recoupment transactions, since many of the data elements on the claim records (CLAIMIP, CLAIMLT, CLAIMOT, and CLAIMRX) do not seem appropriate for these types of transactions.

### Background Discussion

**Definition of a financial transaction:**

For purposes of this guidance, CMS defines a financial transaction as an expenditure transaction or a recoupment of a previously made expenditure that does not flow through the usual claim adjudication/adjustment process.

The cause or effect of this may be that these types of transactions do not contain the same level of detail as other types of transactions in the state’s system. For example, a state might not assign a service code to a capitation claim. Payments made in lump sums, such as Disproportionate Share Hospital (DSH) payments, because they cannot be attributed to a single beneficiary would not contain a beneficiary identifier.

For some states, examples of financial transactions might include capitation payments made to managed care organizations, supplemental payments (i.e., payments that are above a capitation fee or for a sum above a negotiated rate, such as an FQHC additional reimbursement), drug rebates, DSH payments, cost settlements (e.g., program cost reconciliations and settlements, year-end reconciliation of risk pools), aggregate-level payments to providers (e.g., for a set of enrollees, claims, etc.) rather than payments made on a specific claim.

Financial Transactions may be reported on CLAIMIP, CLAIMLT, CLAIMOT, or CLAIMRX depending on the type and circumstances of the financial transaction. “Table 1 – Financial Transactions and the appropriate T-MSIS file for reporting them” identifies which T-MSIS files are appropriate for the various types of financial transactions.

***Table 1 –*** *Financial transactions and the appropriate T-MSIS file for reporting them*

**At Enrollee Level (col. 1-4) For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**

| **Cap Pymt** | **Drug Rebate** | **Cost Stlmnt** | **Spplmntl Pymt** | **Cap Pymt** | **Drug Rebate** | **Cost Stlmnt** | **Spplmntl Pymt** | **DSH Pymt** | **Other Pymt** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CLAIMOT | CLAIMOT  CLAIMRX | CLAIMIP  CLAIMLT  CLAIMOT  CLAIMRX | CLAIMIP  CLAIMLT  CLAIMOT  CLAIMRX | CLAIMOT | CLAIMOT  CLAIMRX | CLAIMIP  CLAIMLT  CLAIMOT  CLAIMRX | CLAIMIP  CLAIMLT  CLAIMOT  CLAIMRX | CLAIMIP  CLAIMOT | CLAIMIP  CLAIMLT  CLAIMOT  CLAIMRX |

Financial transactions can be contained within the same files as fee-for-service claims and encounter records.

### CMS Guidance

**When and how to populate data elements for financial transactions:**

The data elements listed on the following pages are ones that should be populated on financial transactions. Additional verbiage is provided for those data elements that CMS believes need explicit instructions for building T-MSIS files. States should contact their T-MSIS technical assistant or state liaison if they have questions or concerns. Data elements not specifically listed below can be 8-filled, left blank or space-filled.

**CLAIM-HEADER-RECORD data elements**

1. RECORD-ID
2. SUBMITTING-STATE
3. RECORD-NUMBER
4. MSIS-IDENTIFICATION-NUM – Populate with beneficiary’s MSIS ID for any beneficiary-specific financial transactions. Otherwise first character of MSIS-IDENTIFICATION-NUM must be “&” to indicate that any characters that might follow do not represent an individual beneficiary’s identifier.
5. ICN-ORIG – See the document entitled CMS Guidance: T-MSIS Adjustment Claim Records- Populating ICN-ORG and ICN-ADJ Fields posted on 2/18/2014 to the T-MSIS State Support.
6. ICN-ADJ – See the document entitled CMS Guidance: T-MSIS Adjustment Claim Records- Populating ICN-ORG and ICN-ADJ Fields posted on 2/18/2014 to the T-MSIS State Support
7. ADJUDICATION-DATE – Date the transaction's approval and payment processes were completed.
8. CHECK-EFF-DATE – Populate with the date that Medicaid funds were disbursed. (Note: Even though the TOT-MEDICAID-PAID-AMT field may be set to zero in some circumstances, Medicaid funds were disbursed – and are captured in the SERVICE-TRACKING-PAYMENT-AMT data element.)
9. ADMISSION-DATE – Populate with the first day of the time period covered by this financial transaction (CLAIMIP and CLAIMLT).
10. DISCHARGE-DATE – Populate with the last day of the time period covered by this financial transaction (CLAIMIP and CLAIMLT).
11. BEGINNING-DATE-OF-SERVICE – Populate with the first day of the time period covered by this financial transaction (CLAIMOT).
12. ENDING-DATE-OF-SERVICE – Populate with the last day of the time period covered by this financial transaction (CLAIMOT).
13. DATE-PRESCRIBED – Populate with the first day of the time period covered by this financial transaction (CLAIMRX).
14. PRESCRIPTION-FILL-DATE – Populate with the last day of the time period covered by this financial transaction (CLAIMRX).
15. WAIVER-TYPE – Populate if applicable and available
16. WAIVER-ID – Populate if applicable and available
17. PLAN-ID-NUMBER – Populate with the managed care plan ID for capitation payments made to managed care plans. 8-fill, leave blank or space-fill if transaction does not involve a manage care plan.
18. BILLING-PROV-NPI-NUM – Populate with the provider or entity that the financial transaction was addressed to. 8-fill, leave blank or space-fill if transaction involves a manage care plan.
19. TOT-MEDICAID-PAID-AMT – If TYPE-OF-CLAIM is 4, D, or X, then set to zero – service tracking payment amount will be populated instead. Otherwise populate with the amount paid to the provider or health plan.
20. SERVICE-TRACKING-PAYMENT-AMT – If TYPE-OF-CLAIM is 4, D, or X, then populate this with the amount paid, otherwise 0-fill.
21. TYPE-OF-CLAIM – valid values appropriate for each type of financial transaction are shown in Table 2. (The descriptions of the TYPE-OF-CLAIM values are shown in Table 3. The values appropriate for financial transactions are highlighted in yellow.)

### Valid Values

***Table 2 –*** *TYPE-OF-CLAIM values for financial transactions*

**At Enrollee Level (col. 1-4) For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**

| **Cap Pymt** | **Drug Rebate** | **Cost Stlmnt** | **Spplmntl Pymt** | **Cap Pymt** | **Drug Rebate** | **Cost Stlmnt** | **Spplmntl Pymt** | **DSH Pymt** | **Other Pymt** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 2, B, V | 5, E, Y | 5, E, Y | 5, E, Y | 4, D, X | 4, D, X | 4, D, X | 4, D, X | 4, D, X | 4, D, X |

***Table 3 –*** Descriptions of TYPE-OF-CLAIM values

**Claim Type (col. 1-3)**

| **Medicaid or Medicaid Expansion** | **Separate CHIP (Title XXI)** | **Other** | **Description** | **Purpose** |
| --- | --- | --- | --- | --- |
| 1 | A | U | Fee-For-Service Claim | Used to report services billed & payments made for specific services rendered to a specific enrollee by a specific provider during a specific period of time. Payment is made only for services actually rendered. |
| 2 | B | V | Capitation Payment | Used to report periodic payments made in return for a contractual commitment by the recipient to provide a specified set of services to a specified set of enrollees for a specified period of time. The volume of services actually provided to any given individual is not a factor in the amount of the capitation payment. |
| 3 | C | W | Encounter Record | Used to report services provided under a capitated payment arrangement.  This includes billing records submitted by providers to non-state entities (e.g., MCOs, health plans) for which the State has no financial liability, since the risk entity has already received a capitated payment from the State. |
| 4 | D | X | Service Tracking Claim | Use to report payments made for services rendered to enrollees when the services are not billed and paid at the single enrollee/provider/visit level of detail. |
| 5 | E | Y | Supplemental Payment | Used to identify payments that are above a capitation fee or for a sum above a negotiated rate, such as an FQHC additional reimbursement. |

1. SOURCE-LOCATION– valid values appropriate for each type of financial transaction are shown in Table 4.

***Table 4 –*** Descriptions of SOURCE-LOCATION values

| **Code** | **Description** |
| --- | --- |
| 01 | MMIS |
| 02 | Non-MMIS CHIP Payment System |
| 03 | Pharmacy Benefits Manager (PBM) Vendor |
| 04 | Dental Benefits Manager Vendor |
| 05 | Transportation Provider System |
| 06 | Mental Health Claims Payment System |
| 07 | Financial Transaction/Accounting System |
| 08 | Other State Agency Claims Payment System |
| 09 | County/Local Government Claims Payment System |
| 10 | Other Vendor/Other Claims Payment System |
| 20 | Managed Care Organization (MCO) |

1. SERVICE-TRACKING-TYPE – The appropriate values for financial transactions are shown in Table 5. (The descriptions of the SERVICE-TRACKING-TYPE values are shown in Table 6.)

***Table 5*** *– SERVICE-TRACKING-TYPE values for financial transactions*

**At Enrollee Level (col. 1-4) For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**

| **Cap Pymt** | **Drug Rebate** | **Cost Stlmnt** | **Spplmntl Pymt** | **Cap Pymt** | **Drug Rebate** | **Cost Stlmnt** | **Spplmntl Pymt** | **DSH Pymt** | **Other Pymt** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 00 | 00 | 00 | 00 | 03 | 01 | 04 | 05 | 02 | 03, 06 |

***Table 6 –*** Descriptions of SERVICE-TRACKING-TYPE values

| **Code** | **Description** |
| --- | --- |
| 00 | Not a Service Tracking Claim – Use this code when codes 01 through 06 do not apply |
| 01 | Drug Rebate |
| 02 | DSH Payment |
| 03 | Lump Sum Payment (The "lump sum payment" code identifies payments made for specific services rendered to individual patients, when the state accepts a lump sum bill from a provider that covered similar services delivered to more than one patient (e.g., a group screening for EPSDT). |
| 04 | Cost Settlement |
| 05 | Supplemental (The "supplemental payment" code identifies payments that are above a capitation fee or sum above a negotiated rate (e.g., FQHC additional reimbursement).) |
| 06 | Other |

1. FUNDING-CODE – The appropriate values for financial transactions are shown in Table 7. (The descriptions of the FUNDING-CODE values are shown in Table 8.)

***Table 7*** *– FUNDING-CODE values for financial transactions*

**At Enrollee Level (col. 1-4) For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**

| **Cap Pymt** | **Drug Rebate** | **Cost Stlmnt** | **Spplmntl Pymt** | **Cap Pymt** | **Drug Rebate** | **Cost Stlmnt** | **Spplmntl Pymt** | **DSH Pymt** | **Other Pymt** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| A or B as appro-priate | A through E | A through I as appro-priate | A through I as appro-priate | A or B as appro-priate | A through E | A through I as appro-priate | A through I as appro-priate | A through I as appro-priate | A through I as appro-priate |

***Table 8*** *– Descriptions of FUNDING-CODE values*

| **Code** | **Description** |
| --- | --- |
| A | Medicaid Agency |
| B | CHIP Agency |
| C | Mental Health Service Agency |
| D | Education Agency |
| E | Child and Family Services Agency |
| F | County |
| G | City |
| H | Providers |
| I | Other |

**CLAIM-LINE-RECORD data elements**

* 1. SUBMITTING-STATE
  2. RECORD-NUMBER
  3. MSIS-IDENTIFICATION-NUM
  4. ICN-ORIG
  5. ICN-ADJ
  6. LINE-NUM-ORIG
  7. LINE-NUM-ADJ
  8. ADJUDICATION-DATE – Date the line-level transaction's approval and payment processes were completed
  9. REVENUE-CODE – 8-fill, leave blank or space-fill
  10. PROCEDURE-CODE – 8-fill, leave blank or space-fill
  11. NATIONAL-DRUG-CODE – 8-fill, leave blank or space-fill
  12. MEDICAID-PAID-AMT – Because there is no data element on the claim line record segment specifically designated to capture service tracking payment amounts at the claim line level, states should populate MEDICAID-PAID-AMT with the amount of Medicaid funds disbursed. For service tracking claims, the sum of the claim line MEDICAID-PAID-AMT values on a claim’s claim line record segments should equal the amount reported in the SERVICE-TRACKING-PAYMENT-AMT data element on the claim’s claim header record segment.
  13. TYPE-OF-SERVICE – The appropriate values for financial transactions are shown in Table 9.

***Table 9*** *– TYPE-OF-SERVICE values for financial transactions*

**At Enrollee Level (col. 1-4) For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**

| **Cap Pymt** | **Drug Rebate** | **Cost Stlmnt** | **Spplmntl Pymt** | **Cap Pymt** | **Drug Rebate** | **Cost Stlmnt** | **Spplmntl Pymt** | **DSH Pymt** | **Other Pymt** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 119, 120, 121, 122, 138, 139, 140, 141, 142, 143, 144 | 131 | 132, 133, 134, 135 | Any TOS except 119, 120, 121, 122, 123, 131, 132, 133, 134, 135, 138, 139, 140, 141, 142, 143, 144 | 119, 120, 121, 122 | 131 | 132, 133, 134, 135 | Any TOS except 119, 120, 121, 122, 123, 131, 132, 133, 134, 135, 138, 139, 140, 141, 142, 143, 144 | 123 | Any TOS except 119, 120, 121, 122, 123, 131, 132, 133, 134, 135, 138, 139, 140, 141, 142, 143, 144 |

* 1. CMS-64-CATEGORY-FOR-FEDERAL-REIMBURSEMENT – The appropriate values for financial transactions are shown in Table 10.

***Table 10*** *– CMS-64-CATEGORY-FOR-FEDERAL-REIMBURSEMENT values for financial transactions*

**At Enrollee Level (col. 1-4) For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**

| **Cap Pymt** | **Drug Rebate** | **Cost Stlmnt** | **Spplmntl Pymt** | **Cap Pymt** | **Drug Rebate** | **Cost Stlmnt** | **Spplmntl Pymt** | **DSH Pymt** | **Other Pymt** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| If TYPE-OF-CLAIM = 2, then 01 If TYPE-OF-CLAIM = B then 02 If TYPE-OF-CLAIM = V then 03 or 04 as appro-priate | If TYPE-OF-CLAIM = 5, then 01 If TYPE-OF-CLAIM = E then 02 If TYPE-OF-CLAIM = Y then 03 or 04 as appro-priate | If TYPE-OF-CLAIM = 5, then 01 If TYPE-OF-CLAIM = E then 02 If TYPE-OF-CLAIM = Y then 03 or 04 as appro-priate | If TYPE-OF-CLAIM = 5, then 01 If TYPE-OF-CLAIM = E then 02 If TYPE-OF-CLAIM = Y then 03 or 04 as appropriate | If TYPE-OF-CLAIM = 4, then 01 If TYPE-OF-CLAIM = D then 02 If TYPE-OF-CLAIM = X then 03 or 04 as appro-priate | If TYPE-OF-CLAIM = 4, then 01 If TYPE-OF-CLAIM = D then 02 If TYPE-OF-CLAIM = X then 03 or 04 as appro-priate | If TYPE-OF-CLAIM = 4, then 01 If TYPE-OF-CLAIM = D then 02 If TYPE-OF-CLAIM = X then 03 or 04 as appro-priate | If TYPE-OF-CLAIM = 4, then 01 If TYPE-OF-CLAIM = D then 02 If TYPE-OF-CLAIM = X then 03 or 04 as appropriate | If TYPE-OF-CLAIM = 4, then 01 If TYPE-OF-CLAIM = D then 02 If TYPE-OF-CLAIM = X then 03 or 04 as appro-priate | If TYPE-OF-CLAIM = 4, then 01 If TYPE-OF-CLAIM = D then 02 If TYPE-OF-CLAIM = X then 03 or 04 as appropriate |

o. XIX-MBESCBES-CATEGORY-OF-SERVICE – The appropriate values for financial transactions are shown in Table 11.

***Table 11*** *– XIX-MBESCBES-CATEGORY-OF-SERVICE values for financial transactions*

**At Enrollee Level (col. 1-4) For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**

| **Cap Pymt** | **Drug Rebate** | **Cost Stlmnt** | **Spplmntl Pymt** | **Cap Pymt** | **Drug Rebate** | **Cost Stlmnt** | **Spplmntl Pymt** | **DSH Pymt** | **Other Pymt** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 17A, 17B, 17C1, 18A, 18B1, 18B2, 18C, 18E, 22 | 7A1, 7A2, 7A3, 7A4, 7A5, 7A6 | Any code | 1C, 1D, 3B, 4C, 5B, 6B, 9B | 17A, 17B, 17C1, 18A, 18B1, 18B2, 18C, 18E, 22 | 7A1, 7A2, 7A3, 7A4, 7A5, 7A6 | Any code | 1C, 1D, 3B, 4C, 5B, 6B, 9B | 1B, 2B | Any code except 1B, 1C, 1D, 2B, 3B, 4C, 5B, 6B, 9B, 7A1, 7A2, 7A3, 7A4, 7A5, 7A6, 17A, 17B, 17C1, 18A, 18B1, 18B2 18C, 18E, 22 |

p. XXI-MBESCBES-CATEGORY-OF-SERVICE – The appropriate values for financial transactions are shown in Table 12.

***Table 12*** *– XXI-MBESCBES-CATEGORY-OF-SERVICE values for financial transactions*

**At Enrollee Level (col. 1-4) For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**

| **Cap Pymt** | **Drug Rebate** | **Cost Stlmnt** | **Spplmntl Pymt** | **Cap Pymt** | **Drug Rebate** | **Cost Stlmnt** | **Spplmntl Pymt** | **DSH Pymt** | **Other Pymt** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1A, 1B, 1C, 1D, or 32B | 8A | Any code | 8-fill, leave blank or space-fill | 1A, 1B, 1C, 1D, or 32B | 8A | Any code | 8-fill, leave blank or space-fill | 8-fill, leave blank or space-fill | Any code except 1A, 1B, 1C, 1D, 32B, or 8A |

## Appendix P.03 CMS Guidance: Revised and Consolidated Guidance for Building Non-Claims T-MSIS Files

### Brief Issue Description

CMS has made systems upgrades in T-MSIS data storage and file processing methodologies to reduce the complexity and size of full historical refresh data for months in which no data have changed. Essentially, we have removed the necessity for states to resubmit data month-after-month even though nothing changed. This has several benefits:

* Significant reduction of non-claim file sizes;
* Significant reduction in the logic necessary to compile the data required to populate the non-claim files.

There are now two methods that states can use when building their non-claim files – the “full-file refresh” method and the “changed-segments-only” method (both described below) and states can use either method. States can also change from one method to the other if they determine that it is to their advantage to do so. States that have already constructed their T-MSIS non-claim-file-building processes to generate rolling history records and wish to continue with this approach may do so as long as it is in full conformance with CMS’ T-MSIS non-claims files expectations as delineated in this document.

### CMS Guidance: Building Non-Claim Records

**Methods for Submitting non-claim files to T-MSIS**

States can utilize either the “full-file refresh” method or the “changed-segment-only” method for submitting non-claim files to T-MSIS.

**Full-File Refresh Method**

As the name suggests, “full-file refresh” files contain a complete set of historical segments for each record, regardless of whether the data on a segment has changed since the last submission, or not. The only exception to this is archived records. Archived records are ones the state considers to be permanently static, are no longer actively used in the state’s system, and which the state has moved to a separate data storage area for long-term retention. Once the state archives a record, it no longer needs to report the record in the state’s T-MSIS files. Even though these records are no longer included in the state’s “full-file refresh” submissions, they will be maintained in the underlying T-MSIS repository as active records.

**Changed-Segment-Only Method**

States that chose to use the “changed-segment-only” method only need to submit a segment when one or more of its data element values changes. Under the “changed-segment-only” method, once submitted, a segment will remain active in the T-MSIS data repository until the state takes some action to inactivate it. Under the “changed-segment-only” method, it is not necessary for a state to include unchanged segments in its T-MSIS submissions month after month.

### Important Concepts Governing the Submission of Non-Claim Files – *REGARDLESS OF SUBMISSION METHOD*

Regardless of the chosen approach, all states need to keep five important concepts in mind:

T-MSIS makes no changes to segment effective and end dates of its own volition.

If the state does not set segment effective- and end-dates appropriately, unintended overlapping segments with ambiguous data will occur.

It is the state’s responsibility to tell T-MSIS the revised segment end date on existing segments whenever values on the segment change.

Every instance of a segment has a primary key that uniquely identifies it. ***To do anything to an existing segment***, the primary key field values (***which includes the segment effective date***) on the incoming segment MUST MATCH the primary key field values of the existing segment in T-MSIS. The primary key of each segment is listed in the “Rec Segment Keys & Constraints” tab of the *T-MSIS Data Dictionary*. (See Appendix A: Examples of Non-Claim File Segment and/or Record Modification Scenarios for more information on using primary keys.)

Record segments that are not applicable to a state or to a particular entity (i.e., an eligible person, provider, managed care entity, or TPL instance) do not need to be submitted.

**Amount of Historical Data That Must Be Submitted**

CMS no longer requires states to submit seven years of rolling history in its non-claim T-MSIS files. *Table A: Minimum Historical Record Expectations for Non-Claim File Submissions* outlines CMS’ revised expectations. This is true for submissions under both the “Full-File Refresh” method and “Changed-Segment-Only” method for submitting non-claim files. If a state wishes to submit more historical data than is outlined in Table A, it may do so.

## Appendix P.04

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## Appendix P.05: Populating Qualifier Fields and Their Associated Value Fields

### Brief Issue Description

The purpose of this guidance document is to when record segments need to be created for all valid values in a qualifier field’s valid value set and when it is appropriate to create a record segment for only one of the valid values.

### Background Discussion

### Definitions

**Simple Qualifier Field** – is a data element that contains a code (a.k.a. “flag”) that defines/qualifies the coding schema used when populating a set of corresponding data elements. This is necessary because there are several different schemas that a state could use and it needs to be clear which of the schemas is actually used.

Examples of “simple qualifier fields” are the DIAGNOSIS-CODE-FLAG-1 through -12 on the CLAIM-HEADER-RECORD-IP record segment (CIP00002). The valid value set for these fields is:

1. ICD-9
2. ICD-10
3. Other

The state would indicate which coding schema is being used to populate the corresponding data elements DIAGNOSIS-CODE-1 through -12.

**Complex Qualifier Field** – is a data element that not only defines/qualifies the contents of its corresponding data elements (similar to a “simple qualifier field”), but also represents a situation where the state needs to create a record segment for each valid value that applies to the record’s subject.

An example of a “complex qualifier field is LICENSE-TYPE on the PROV-LICENSING-INFO record segment (PRV00004). The valid value set for this field is:

1. State, county, or municipality professional or business license
2. DEA license
3. Professional society accreditation
4. CLIA accreditation
5. Other

The state would create a PROV-LICENSING-INFO record segment and populate the corresponding data elements for each LICENSE-TYPE valid value that applies to the provider.

**Corresponding Data Elements** – Are data elements that contain values as defined by the qualifier field.

**Fully Populated Record Segment** – Means that all data elements in the record segment will be populated, not just the qualifier field and its corresponding data elements. These additional data elements are necessary to enable CMS to tie the record segment to its parent segment. These data elements comprise the segment’s natural key. Generally these data elements are the ones bulleted below, but there could potentially be additional ones, depending on the record segment. See the “Record Keys & Constraints” tab in the T-MSIS Data Dictionary if there are questions concerning a record segment’s natural key.

* RECORD-ID
* SUBMITTING-STATE
* RECORD-NUMBER
* MSIS-IDENTIFICATION-NUM / STATE-PLAN-ID-NUM / SUBMITTING-STATE-PROV-ID

**Record Subject** – This is the individual/entity around which the record segments in a file are built. The Medicaid/CHIP enrollee is the subject of Eligible Files. In Provider Files, the subject is the provider. The managed care entity is the subject of Managed Care Files, and third party payers and their associated beneficiaries are the subjects of TPL Files.

**Overview**

The complex qualifier fields are included in the T-MSIS record layouts so that a given record segment layout can be used to capture a standard set of data elements (i.e., the corresponding data elements) for a category of data (i.e., the complex qualifier field’s valid values list) when more than one category may be applicable to the record subject.

The complex qualifier fields’ valid values lists are not “select one value from the valid values list and provide the corresponding data element values (which is the case for simple qualifier fields).” A separate record segment should be created and fully populated for every “complex qualifier field” valid value or unique combination of “complex qualifier field” valid value and corresponding data element value (in accordance with the Record Keys & Constraints) that applies to the record subject. Table 1 illustrates what CMS is expecting, using LICENSE-TYPE in the PROV-LICENSING-INFO record segment (PRV00004) as an example.

**Example Scenario**

The purpose of the PROV-LICENSING-INFO segment is to capture licensing and accreditation information relevant to a provider. The valid value list for the LICENSE-TYPE data element shows the types of information that CMS is interested in collecting in this record segment:

1. State, county, or municipality professional or business license
2. DEA license
3. Professional society accreditation
4. CLIA accreditation
5. Other

For our example, assume three of these categories are applicable to provider # P0123: (a) a professional license issued by the state’s Board of Physicians (valid value # 1); (b.1) a board certification from the ABMS (valid value # 3); (b.2) a board certification from the AOA (also valid value # 3); and (c) a DEA number (valid value # 2). Table 1 and 1a lists the data elements in the PRV00004 record segment, and shows the contents of each data element in the four PRV00004 segments that would be required by this example.

*Table 1: Examples of fully populated record segments supplying “complex qualifier field” corresponding data. While these data elements aren't strictly "corresponding data elements," they are necessary to tie the segments to their parent segment.*

| ***Data Element Use*** | ***Data Element*** | ***Physician  License*** | ***ABMS Board  Certification*** | ***AOA Board  Certification*** | ***DEA  Number*** |
| --- | --- | --- | --- | --- | --- |
| *Tie segments to parent segment* | RECORD-ID | PRV00004 | PRV00004 | PRV00004 | PRV00004 |
| *Tie segments to parent segment* | SUBMITTING-STATE | 24 | 24 | 24 | 24 |
| *Tie segments to parent segment* | RECORD-NUMBER | 4506 | 4507 | 4508 | 4509 |
| *Tie segments to parent segment* | SUBMITTING-STATE-PROV-ID | P0123 | P0123 | P0123 | P0123 |
| *Tie segments to parent segment* | PROV-LOCATION-ID | 0 | 0 | 0 | 0 |

*Table 1a: Examples of fully populated record segments supplying “complex qualifier field” corresponding data.*

| **Data Element Use** | **Data Element** | **Physician License** | **ABMS Board Certification** | **AOA Board Certification** | **DEA Number** |
| --- | --- | --- | --- | --- | --- |
| Corresponding Data Element | PROV-LICENSE-EFF-DATE | 19921119 | 20100101 | 20120701 | 20131001 |
| Corresponding Data Element | PROV-LICENSE-END-DATE | 20150930 | 20191231 | 20150630 | 20160930 |
| "Complex Qualifier”  Data Element | LICENSE-TYPE | 1 | 3 | 3 | 2 |
| Corresponding Data Element | LICENSE-ISSUING-ENTITY-ID | 24 | American Board of Medical Specialties | American Osteopathic Association | DEA |
| Corresponding Data Element | LICENSE-OR-ACCREDITATION-NUMBER | D98765 | IM012345 | A5546 | FD1234563 |
| NA | STATE-NOTATION | NA | NA | NA | NA |
| NA | FILLER | NA | NA | NA | NA |

### CMS Guidance

CMS is instructing States to provide information corresponding to each of a complex qualifier field’s valid values to the extent that the valid value is applicable to the record subject. Additionally, States should fully populate the affected record segments.

In its first four columns, Table 2 displays the T-MSIS file name, record segment name, complex qualifier field name and the complex qualifier field’s list of valid values for each of the complex qualifier fields in the T-MSIS data set. The last two columns identify the corresponding data elements (along with the file segments where they reside) that need to be populated for every applicable valid value in the “complex qualifier field’s” valid value list.

*Table 2: “Complex Qualifier fields” their valid values, and the corresponding data elements that need to be populated*

| **File Name** | **“Complex Qualifier Field” Information:**  **Record Segment** | **“Complex Qualifier Field” Information:**  **Data Element Name** | **“Complex Qualifier Field” Information:**  **Valid Value and Description** | **Corresponding Data Elements To Be Populated:**  **Record Segment** | **Corresponding Data Elements To Be Populated:**  **Data Element Name** |
| --- | --- | --- | --- | --- | --- |
| ELIGIBLE | ELIGIBLE-CONTACT-INFORMATION (ELG00004) | ADDR-TYPE | 01 - Primary home address and contact information (used for the eligibility determination process); 02 - Primary work address and contact information; 03 - Secondary residence and contact information; 04 - Secondary work address and contact information; 05 - Other category of address and contact information; 06 - Eligible person’s official mailing address | ELIGIBLE-CONTACT-INFORMATION-ELG00004 | ELIGIBLE-ADDR-LN1; ELIGIBLE-ADDR-LN2; ELIGIBLE-ADDR-LN3; ELIGIBLE-CITY; ELIGIBLE-STATE; ELIGIBLE-ZIP-CODE; ELIGIBLE-COUNTY-CODE; ELIGIBLE-PHONE-NUM; TYPE-OF-LIVING-ARRANGEMENT; ELIGIBLE-ADDR-EFF-DATE; ELIGIBLE-ADDR-END-DATE |
| MNGDCARE | MANAGED-CARE-MAIN (MCR00002) | MANAGED-CARE-SERVICE-AREA | 1 - Statewide: The managed care entity provides services to beneficiaries throughout the entire state; 2 - County: The managed care entity provides services to beneficiaries in specified counties; 3 - City: The managed care entity provides services to beneficiaries in specified cities; 4 - Region: The managed care entity provides services to beneficiaries in specified regions, not defined by individual counties within the state (“region” is state-defined); 5 - Zip Code: The managed care entity program provides services to beneficiaries in specified zip codes; 6 - Other: The managed care entity provides services to beneficiaries in "other" area(s), not Statewide, County, City, or Region. | MANAGED-CARE-SERVICE-AREA-MCR00004 | MANAGED-CARE-SERVICE-AREA-NAME; MANAGED-CARE-SERVICE-AREA-EFF-DATE;  MANAGED-CARE-SERVICE-AREA-END-DATE |
| MNGDCARE | MANAGED-CARE-LOCATION-AND-CONTACT-INFO (MCR00003) | MANAGED-CARE-ADDR-TYPE | 1 - MCO’s corporate address and contact information; 2 - MCO’s mailing address; 3 - MCO’s service location address; 4 - MCO’s Billing address and contact information; 5 - CEO’s address and contact information; 6 - CFO’s address and contact information; 7 - Other | MANAGED-CARE-LOCATION-AND-CONTACT-INFO-MCR00003 | MANAGED-CARE-LOCATION-ID; MANAGED-CARE-ADDR-LN1; MANAGED-CARE-ADDR-LN2; MANAGED-CARE-ADDR-LN3; MANAGED-CARE-CITY; MANAGED-CARE-STATE; MANAGED-CARE-ZIP-CODE; MANAGED-CARE-COUNTY; MANAGED-CARE-TELEPHONE; MANAGED-CARE-EMAIL; MANAGED-CARE-FAX-NUMBER; MANAGED-CARE-LOCATION-AND-CONTACT-INFO-EFF-DATE |
| MNGDCARE | NATIONAL-HEALTH-CARE-ENTITY-ID-INFO (MCR00008) | NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE | 1 - Controlling Health Plan (CHP) ID; 2 - Subhealth Plan (SHP) ID; 3 - Other Entity Identifier (OEID) | NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008 | STATE-PLAN-ID-NUM; NATIONAL-HEALTH-CARE-ENTITY-ID; NATIONAL-HEALTH-CARE-ENTITY-NAME; NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-EFF-DATE; NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-END-DATE |
| PROVIDER | PROV-LOCATION-AND-CONTACT-INFO (PRV00003) | ADDR-TYPE | 1 - Billing Provider; 2 - Provider Mailing; 3 - Provider Practice; 4 - Provider Service Location | PROV-LOCATION-AND-CONTACT-INFO-PRV00003 | PROV-LOCATION-ID; ADDR-LN1; ADDR-LN2; ADDR-LN3; ADDR-CITY; ADDR-STATE; ADDR-ZIP-CODE; ADDR-TELEPHONE; ADDR-EMAIL; ADDR-FAX-NUM; ADDR-BORDER-STATE-IND; ADDR-COUNTY; PROV-LOCATION-AND-CONTACT-INFO-EFF-DATE; PROV-LOCATION-AND-CONTACT-INFO-END-DATE |
| PROVIDER | PROV-LICENSING-INFO (PRV00004) | LICENSE-TYPE | 1 - State, county, or municipality professional or business license; 2 -DEA license; 3- Professional society accreditation; 4 -CLIA accreditation; 5- Other | PROV-LICENSING-INFO-PRV00004 | LICENSE-OR-ACCREDITATION-NUMBER; LICENSE-ISSUING-ENTITY-ID; PROV-LICENSE-EFF-DATE; PROV-LICENSE-END-DATE |
| PROVIDER | PROV-IDENTIFIERS (PRV00005) | PROV-IDENTIFIER-TYPE | 1 - State-specific Medicaid Provider ID; 2 – NPI; 3 - Medicare ID; 4 - NCPDP ID; 5 - Federal Tax ID; 6 - State Tax ID; 7 – SSN; 8 - Other | PROV-IDENTIFIERS-PRV00005 | PROV-IDENTIFIER; PROV-IDENTIFIER-ISSUING-ENTITY-ID; PROV-IDENTIFIER-EFF-DATE; PROV-IDENTIFIER-END-DATE |
| PROVIDER | PROV-TAXONOMY-CLASSIFICATION (PRV00006) | PROV-CLASSIFICATION-TYPE | 1 - Taxonomy code; 2 - Provider specialty code; 3 - Provider type code; 4 - Authorized category of service code | PROV-TAXONOMY-CLASSIFICATION-PRV00006 | PROV-CLASSIFICATION-CODE; PROV-TAXONOMY-CLASSIFICATION-EFF-DATE; PROV-TAXONOMY-CLASSIFICATION-END-DATE |
| PROVIDER | PROV-AFFILIATED-PROGRAMS  (PRV00009) | AFFILIATED-PROGRAM-TYPE | 1 - Health Plan (NHP-ID); 2 - Health Plan (state-assigned health plan ID); 3 – Waiver; 4 - Health Home Entity; 5 - Other | PROV-AFFILIATED-PROGRAMS-PRV00009 | AFFILIATED-PROGRAM-ID; PROV-AFFILIATED-PROGRAM-EFF-DATE; PROV-AFFILIATED-PROGRAM-END-DATE |
| TPL | TPL-ENTITY-CONTACT-INFORMATION  (TPL00006) | TPL-ENTITY-ADDR-TYPE | 06 - TPL-Entity Corporate Location; 07 - TPL-Entity Mailing; 08 - TPL-Entity Satellite Location; 09 - TPL-Entity Billing; 10 - TPL-Entity Correspondence; 11 - TPL-Other | TPL-ENTITY-CONTACT-INFORMATION-TPL00006 | INSURANCE-CARRIER-ADDR-LN1; INSURANCE-CARRIER-ADDR-LN2; INSURANCE-CARRIER-ADDR-LN3; INSURANCE-CARRIER-CITY; INSURANCE-CARRIER-STATE; INSURANCE-CARRIER-ZIP-CODE; INSURANCE-CARRIER-PHONE-NUM; INSURANCE-CARRIER-NAIC-CODE; INSURANCE-CARRIER-NAME; NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE; NATIONAL-HEALTH-CARE-ENTITY-ID; NATIONAL-HEALTH-CARE-ENTITY-NAME; TPL-ENTITY-CONTACT-INFO-EFF-DATE; TPL-ENTITY-CONTACT-INFO-END-DATE |

## Appendix P.06

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## Appendix P.07: Finding Provider Roles on STD Transactions

### How to use this guidance document

This guidance document is not intended to slow down or derail existing state development initiatives.  The intent is to provide clarification and standardization across the nation in key areas raised by state partners.   Should guidance introduce rework in ongoing development, please bring this to the attention of your TA and CMS analyst to direct you to the most appropriate path that minimizes impact to your progress.

### Brief Issue Description

Some States have requested assistance with identifying where to find in the X-12 claim transaction sets the NPIs and taxonomy codes of providers who performed various roles associated with the claim/encounter.

### Background Discussion

### Definitions

**Provider role** – The function that a specific provider performed for a particular patient on specified dates of service, and which are contained on fee-for-service claims or reported on encounter records. The particular roles that CMS would like to track on T-MSIS claims are:

* Admitting (attending) provider
* Billing provider
* Dispensing provider
* Operating provider
* Prescribing provider
* Referring provider
* Servicing (rendering) provider
* Under supervision of provider

Provider role information needed for the T-MSIS claim files can be extracted from the standard X-12 transactions. The five tables in the “CMS Guidance” section of this document provide T-MSIS-toX-12 crosswalks for each provider role. The five tables are:

**Table A:** Provider roles on T-MSIS CLAIMIP files and their corresponding locations on the X-12 transactions

**Table B:** Provider roles on T-MSIS CLAIMLT files and their corresponding locations on the X-12 transactions

**Table C:** Provider roles on T-MSIS CLAIMOT (*facility claims*) files and their corresponding locations on the X-12 transactions

**Table D:** Provider roles on T-MSIS CLAIMOT (*professional claims*) files and their corresponding locations on the X-12 transactions

**Table E:** Provider roles on T-MSIS CLAIMOT (*dental claims*) files and their corresponding locations on the X-12 transactions

**Table F:** Provider roles on T-MSIS CLAIMRX files and their corresponding locations on the X-12 transactions

In each table, the first column identifies the provider role. The second and third columns identify the specific T-MSIS record segments and data elements used to capture the NPI and taxonomy of the provider performing the specified role. The fourth, fifth, sixth, and seventh columns in tables “A” through “E” provide the X-12 transaction name, data element identifier, data element description and loop id that map to the T-MSIS data element. The fourth, fifth, sixth, and seventh columns in table “F” provide the segment name, field identifier, field name and definition of the applicable NCPDP D.0 data set fields.

### CMS Guidance

Use tables “A” through “F” to map the provider roles that are contained in the T-MSIS claim record layouts to their corresponding X-12 standard transaction data elements.

If the T-MSIS data element does not exist in the X-12 transaction set (shown as “N/A” in the tables below), 8-fill, leave blank or space-fill the T-MSIS data element when building T-MSIS claim files.

*Table A: Provider roles on T-MSIS CLAIMIP files and their corresponding locations on the X-12 transactions*

| **Provider Role** | **IP-T-MSIS Data Element** | **IP-T-MSIS Record Segment** | **X-12 Transaction** | **X-12**  **Element Identifier** | **X-12 Description** | **X-12 Loop** | **Conditional Rules** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Admitting (Attending) | ADMITTING-PROV-NPI-NUM | CLAIM-HEADER-RECORD-IP-CIP00002 | 5010 A2 837-I Institutional Claim | NM109 | Attending Provider Identifier | 2310A | N/A |
| Admitting (Attending) | ADMITTING-PROV-TAXONOMY | CLAIM-HEADER-RECORD-IP-CIP00002 | 5010 A2 837-I Institutional Claim | PRV03 | Provider Taxonomy Code | 2310A | N/A |
| Billing | BILLING-PROV-NPI-NUM | CLAIM-HEADER-RECORD-IP-CIP00002 | 5010 A2 837-I Institutional Claim | NM109 | Billing Provider Identifier | 2010AA | N/A |
| Billing | BILLING-PROV-TAXONOMY | CLAIM-HEADER-RECORD-IP-CIP00002 | 5010 A2 837-I Institutional Claim | PRV03 | Provider Taxonomy Code | 2000A | N/A |
| Operating | OPERATING-PROV-NPI-NUM | CLAIM-LINE-RECORD-IP-CIP00003 | 5010 A2 837-I Institutional Claim | NM109 | Operating Physician Identifier | 2310B or 2420A | The identifier in the 837i loop 2310B could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420A at the line level of the 837i. If there is a different identifier in 837i loop 2420A then the identifier from loop 2420A should be reported as the operating provider identifier. |
| Operating | OPERATING-PROV-TAXONOMY | CLAIM-HEADER-RECORD-IP-CIP00002 | N/A | N/A | N/A | N/A | The identifier in the 837i loop 2310B could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420A at the line level of the 837i. If there is a different identifier in 837i loop 2420A then the identifier from loop 2420A should be reported as the operating provider identifier. |
| Referring | REFERRING-PROV-NPI-NUM | CLAIM-HEADER-RECORD-IP-CIP00002 | 5010 A2 837-I Institutional Claim | NM109 | Referring Provider Identifier | 2310F or 2420D | The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. |
| Referring | REFERRING-PROV-TAXONOMY | CLAIM-HEADER-RECORD-IP-CIP00002 | N/A | N/A | N/A | N/A | The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. |
| Servicing (Rendering) | SERVICING-PROV-NPI-NUM | CLAIM-LINE-RECORD-IP-CIP00003 | 5010 A2 837-I Institutional Claim | NM109 | Rendering Provider Identifier | 2310D or 2420C | The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier. |
| Servicing (Rendering) | SERVICING-PROV-TAXONOMY | CLAIM-LINE-RECORD-IP-CIP00003 | N/A | N/A | N/A | N/A | N/A |
| Under-Direction-of | UNDER-DIRECTION-OF-PROV-NPI | CLAIM-HEADER-RECORD-IP-CIP00002 | N/A | N/A | N/A | N/A | N/A |
| Under-Direction-of | UNDER-DIRECTION-OF-PROV-TAXONOMY | CLAIM-HEADER-RECORD-IP-CIP00002 | N/A | N/A | N/A | N/A | N/A |
| Under-Supervision-of | UNDER-SUPERVISION-OF-PROV-NPI | CLAIM-HEADER-RECORD-IP-CIP00002 | N/A | N/A | N/A | N/A | N/A |
| Under-Supervision-of | UNDER-SUPERVISION-OF-PROV-TAXONOMY | CLAIM-HEADER-RECORD-IP-CIP00002 | N/A | N/A | N/A | N/A | N/A |

*Table B: Provider roles on T-MSIS CLAIMLT files and their corresponding locations on the X-12 transactions*

| **Provider Role** | **LT-T-MSIS Data Element** | **LT-T-MSIS Record Segment** | **X-12 Transaction** | **X-12 Element Identifier** | **X-12 Description** | **X-12 Loop** | **Conditional Rules** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Admitting (Attending) | ADMITTING-PROV-NPI-NUM | CLAIM-HEADER-RECORD-LT-CLT00002 | 5010 A2 837-I Institutional Claim | NM109 | Attending Provider Identifier | 2310A | The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. |
| Admitting (Attending) | ADMITTING-PROV-TAXONOMY | CLAIM-HEADER-RECORD-LT-CLT00002 |  | PRV03 | Provider Taxonomy Code | 2310A | The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. |
| Billing | BILLING-PROV-NPI-NUM | CLAIM-HEADER-RECORD-LT-CLT00002 | 5010 A2 837-I Institutional Claim | NM109 | Billing Provider Identifier | 2010AA | The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. |
| Billing | BILLING-PROV-TAXONOMY | CLAIM-HEADER-RECORD-LT-CLT00002 |  | PRV03 | Provider Taxonomy Code | 2000A | The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. |
| Referring | REFERRING-PROV-NPI-NUM | CLAIM-HEADER-RECORD-LT-CLT00002 | 5010 A2 837-I Institutional Claim | NM109 | Referring Provider Identifier | 2310F or 2420D | The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. |
| Referring | REFERRING-PROV-TAXONOMY | CLAIM-HEADER-RECORD-LT-CLT00002 | N/A | N/A | N/A | N/A | The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. |
| Servicing (Rendering) | SERVICING-PROV-NPI-NUM | CLAIM-LINE-RECORD-LT-CLT00003 | 5010 A2 837-I Institutional Claim | NM109 | Rendering Provider Identifier | 2310D or 2420C | The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier. |
| Servicing  (Rendering) | SERVICING-PROV-TAXONOMY | CLAIM-LINE-RECORD-LT-CLT00003 | N/A | N/A | N/A | N/A | The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. |
| Under-  Direction-of | UNDER-DIRECTION-OF-PROV-NPI | CLAIM-HEADER-RECORD-LT-CLT00002 | N/A | N/A | N/A | N/A | The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. |
| Under-  Direction-of | UNDER-DIRECTION-OF-PROV-TAXONOMY | CLAIM-HEADER-RECORD-LT-CLT00002 | N/A | N/A | N/A | N/A | The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. |
| Under-Supervision-of | UNDER-SUPERVISION-OF-PROV-NPI | CLAIM-HEADER-RECORD-LT-CLT00002 | N/A | N/A | N/A | N/A | The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. |
| Under-Supervision-of | UNDER-SUPERVISION-OF-PROV-TAXONOMY | CLAIM-HEADER-RECORD-LT-CLT00002 | N/A | N/A | N/A | N/A | The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. |

*Table C: Provider roles on T-MSIS CLAIMOT (facility claims) files and their corresponding locations on the X-12 transactions*

| **Provider Role** | **OT (facility)-T-MSIS**  **Data Element** | **OT (facility)-T-MSIS**  **Record Segment** | **X-12 Transaction** | **X-12 Element Identifier** | **X-12 Description** | **X-12**  **Loop** | **Conditional Rules** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Billing | BILLING-PROV-NPI-NUM | CLAIM-HEADER-RECORD-OT-COT00002 | 5010 A2 837-I Institutional Claim | NM109 | Billing Provider Identifier | 2010AA | The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. |
| Billing | BILLING-PROV-TAXONOMY | CLAIM-HEADER-RECORD-OT-COT00002 | 5010 A2 837-I Institutional Claim | PRV03 | Provider Taxonomy Code | 2000A | The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. |
| Referring | REFERRING-PROV-NPI-NUM | CLAIM-HEADER-RECORD-OT-COT00002 | 5010 A2 837-I Institutional Claim | NM109 | Referring Provider Identifier | 2310F or 2420D | The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. |
| Referring | REFERRING-PROV-TAXONOMY | CLAIM-HEADER-RECORD-OT-COT00002 | N/A | N/A | N/A | N/A | The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier. |
| Servicing (Rendering) | SERVICING-PROV-NPI-NUM | CLAIM-LINE-RECORD-OT-COT00003 | 5010 A2 837-I Institutional Claim | NM109 | Attending Provider Identifier  Or  Rendering Provider Identifier | 2310A  Or  2310D or 2420C | The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier. |
| Service (Rendering) | SERVICING-PROV-TAXONOMY | CLAIM-LINE-RECORD-OT-COT00003 | N/A | N/A | N/A | N/A | The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier. |
| Under-Direction-of | UNDER-DIRECTION-OF-PROV-NPI | CLAIM-HEADER-RECORD-OT-COT00002 | N/A | N/A | N/A | N/A | The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier. |
| Under-Direction-of | UNDER-DIRECTION-OF-PROV-TAXONOMY | CLAIM-HEADER-RECORD-OT-COT00002 | N/A | N/A | N/A | N/A | The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier. |
| Under-Supervision-of | UNDER-SUPERVISION-OF-PROV-NPI | CLAIM-HEADER-RECORD-OT-COT00002 | N/A | N/A | N/A | N/A | The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier. |
| Under-Supervision-of | UNDER-SUPERVISION-OF-PROV-TAXONOMY | CLAIM-HEADER-RECORD-OT-COT00002 | N/A | N/A | N/A | N/A | The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier. |

*Table D: Provider roles on T-MSIS CLAIMOT (professional claims) files and their corresponding locations on the X-12 transactions*

| **Provider**  **Role** | **OT (professional)-T-MSIS Data Element** | **OT (professional)-T-MSIS**  **Record Segment** | **X-12 Transaction** | **X-12 Element Identifier** | **X-12 Description** | **X-12 Loop** | **Conditional Rules** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Billing | BILLING-PROV-NPI-NUM | CLAIM-HEADER-RECORD-OT-COT00002 | 5010 A1 837-P Professional Claim | NM109 | Billing Provider Identifier | 2010AA | The identifier in the 837p loop 2310A could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420F at the line level of the 837p. If there is a different identifier in 837p loop 2420F then the identifier from 2420F should be reported as the referring provider identifier. |
| Billing | BILLING-PROV-TAXONOMY | CLAIM-HEADER-RECORD-OT-COT00002 | 5010 A1 837-P Professional Claim | PRV03 | Provider Taxonomy Code | 2000A | The identifier in the 837p loop 2310A could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420F at the line level of the 837p. If there is a different identifier in 837p loop 2420F then the identifier from 2420F should be reported as the referring provider identifier. |
| Referring | REFERRING-PROV-NPI-NUM | CLAIM-HEADER-RECORD-OT-COT00002 | 5010 A1 837-P Professional Claim | NM109 | Referring Provider Identifier | 2310A or 2420F | The identifier in the 837p loop 2310A could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420F at the line level of the 837p. If there is a different identifier in 837p loop 2420F then the identifier from 2420F should be reported as the referring provider identifier. |
| Referring | REFERRING-PROV-TAXONOMY | CLAIM-HEADER-RECORD-OT-COT00002 | N/A | N/A | N/A | N/A | The identifier in the 837p loop 2310A could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420F at the line level of the 837p. If there is a different identifier in 837p loop 2420F then the identifier from 2420F should be reported as the referring provider identifier. |
| Servicing (Rendering) | SERVICING-PROV-NPI-NUM | CLAIM-LINE-RECORD-OT-COT00003 | 5010 A1 837-P Professional Claim | NM109 | Rendering Provider Identifier | 2310B or 2420A | The identifier in the 837p loop 2310B could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420A at the line level of the 837p. If there is a different identifier in 837p loop 2420A then the identifier from 2420A should be reported as the servicing/rendering provider identifier. |
| Servicing (Rendering) | SERVICING-PROV-TAXONOMY | CLAIM-LINE-RECORD-OT-COT00003 | 5010 A1 837-P Professional Claim | PRV03 | Provider Taxonomy Code | 2310B or 2420A | The taxonomy in the 837p loop 2310B could be applied to each line in T-MSIS except for lines where there is a different taxonomy in 2420A at the line level of the 837p. If there is a different taxonomy in 837p loop 2420A then the taxonomy from 2420A should be reported as the servicing/rendering provider taxonomy. |
| Under-Direction-of | UNDER-DIRECTION-OF-PROV-NPI | CLAIM-HEADER-RECORD-OT-COT00002 | N/A | N/A | N/A | N/A | The identifier in the 837p loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420D at the line level of the 837p. If there is a different identifier in loop 2420D then the identifier from loop 2420D should be reported as the under-supervision-of provider identifier. |
| Under-Direction-of | UNDER-DIRECTION-OF-PROV-TAXONOMY | CLAIM-HEADER-RECORD-OT-COT00002 | N/A | N/A | N/A | N/A | The identifier in the 837p loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420D at the line level of the 837p. If there is a different identifier in loop 2420D then the identifier from loop 2420D should be reported as the under-supervision-of provider identifier. |
| Under-Supervision-of | UNDER-SUPERVISION-OF-PROV-NPI | CLAIM-HEADER-RECORD-OT-COT00002 | 5010 A1 837-P Professional Claim | NM109 | Supervising Provider Identifier | 2310D or 2420D | The identifier in the 837p loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420D at the line level of the 837p. If there is a different identifier in loop 2420D then the identifier from loop 2420D should be reported as the under-supervision-of provider identifier. |
| Under-Supervision-of | UNDER-SUPERVISION-OF-PROV-TAXONOMY | CLAIM-HEADER-RECORD-OT-COT00002 | N/A | N/A | N/A | N/A | The identifier in the 837p loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420D at the line level of the 837p. If there is a different identifier in loop 2420D then the identifier from loop 2420D should be reported as the under-supervision-of provider identifier. |

*Table E: Provider roles on T-MSIS CLAIMOT (dental claims) files and their corresponding locations on the X-12 transactions*

| **Provider**  **Role** | **OT (dental)-T-MSIS**  **Data Element** | **OT (dental)-T-MSIS**  **Record Segment** | **X-12 Transaction** | **X-12**  **Element Identifier** | **X-12 Description** | **X-12 Loop** | **Conditional Rules** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Billing | BILLING-PROV-NPI-NUM | CLAIM-HEADER-RECORD-OT-COT00002 | 5010 A1 837-D Dental Claim | NM109 | Billing Provider Identifier | 2010AA | The identifier in 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420A at the line level of the 837d. If there is a different identifier in 837d) loop 2420A then the identifier from 2420A should be reported as the servicing/rendering provider identifier. |
| Billing | BILLING-PROV-TAXONOMY | CLAIM-HEADER-RECORD-OT-COT00002 | 5010 A1 837-D Dental Claim | PRV03 | Provider Taxonomy Code | 2000A | The identifier in 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420A at the line level of the 837d. If there is a different identifier in 837d) loop 2420A then the identifier from 2420A should be reported as the servicing/rendering provider identifier. |
| Referring | REFERRING-PROV-NPI-NUM | CLAIM-HEADER-RECORD-OT-COT00002 | 5010 A1 837-D Dental Claim | NM109 | Referring Provider Identifier | 2310A | The identifier in 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420A at the line level of the 837d. If there is a different identifier in 837d) loop 2420A then the identifier from 2420A should be reported as the servicing/rendering provider identifier. |
| Referring | REFERRING-PROV-TAXONOMY | CLAIM-HEADER-RECORD-OT-COT00002 | N/A | N/A | N/A | N/A | The identifier in 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420A at the line level of the 837d. If there is a different identifier in 837d) loop 2420A then the identifier from 2420A should be reported as the servicing/rendering provider identifier. |
| Servicing (Rendering) | SERVICING-PROV-NPI-NUM | CLAIM-LINE-RECORD-OT-COT00003 | 5010 A1 837-D Dental Claim | NM109 | Rendering Provider Identifier | 2310B or 2420A | The identifier in 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420A at the line level of the 837d. If there is a different identifier in 837d) loop 2420A then the identifier from 2420A should be reported as the servicing/rendering provider identifier. |
| Servicing (Rendering) | SERVICING-PROV-TAXONOMY | CLAIM-LINE-RECORD-OT-COT00003 | 5010 A1 837-D Dental Claim | PRV03 | Provider Taxonomy Code | 2310B or 2420A | The taxonomy in the 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different taxonomy in 2420A at the line level of the 837p. If there is a different taxonomy in 837p loop 2420A then the taxonomy from 2420A should be reported as the servicing/rendering provider taxonomy. |
| Under-Direction-of | UNDER-DIRECTION-OF-PROV-NPI | CLAIM-HEADER-RECORD-OT-COT00002 | N/A | N/A | N/A | N/A | The taxonomy in the 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different taxonomy in 2420A at the line level of the 837p. If there is a different taxonomy in 837p loop 2420A then the taxonomy from 2420A should be reported as the servicing/rendering provider taxonomy. |
| Under-Direction-of | UNDER-DIRECTION-OF-PROV-TAXONOMY | CLAIM-HEADER-RECORD-OT-COT00002 | N/A | N/A | N/A | N/A | The taxonomy in the 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different taxonomy in 2420A at the line level of the 837p. If there is a different taxonomy in 837p loop 2420A then the taxonomy from 2420A should be reported as the servicing/rendering provider taxonomy. |
| Under-Supervision-of | UNDER-SUPERVISION-OF-PROV-NPI | CLAIM-HEADER-RECORD-OT-COT00002 | 5010 A1 837-D Dental Claim | NM109 | Supervising Provider Identifier | 2310E or 2420C | The identifier in the 837d loop 2310E could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420C at the line level of the 837d. If there is a different identifier in loop 2420C then the identifier from loop 2420C should be reported as the under-supervision-of provider identifier. |
| Under-Supervision-of | UNDER-SUPERVISION-OF-PROV-TAXONOMY | CLAIM-HEADER-RECORD-OT-COT00002 | N/A | N/A | N/A | N/A | The identifier in the 837d loop 2310E could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420C at the line level of the 837d. If there is a different identifier in loop 2420C then the identifier from loop 2420C should be reported as the under-supervision-of provider identifier. |

*Table F: Provider roles on T-MSIS CLAIMRX (prescription drug) files and their corresponding locations on the X-12 transactions*

| **Provider**  **Role** | **RX-T-MSIS Data Element** | **RX-T-MSIS Record Segment** | **X-12 Segment** | **X-12 Field** | **X-12 Field Name** | **X-12 Definition** |
| --- | --- | --- | --- | --- | --- | --- |
| Billing | BILLING-PROV-NPI-NUM | CLAIM-HEADER-RECORD-RX-CRX00002 | NCPDP D.0 - Transaction Header Segment | 201-B1 | Service Provider ID | ID assigned to a pharmacy or provider |
| Billing | BILLING-PROV-TAXONOMY | CLAIM-HEADER-RECORD-RX-CRX00002 | N/A | N/A | N/A | N/A |
| Dispensing | DISPENSING-PRESCRIPTION-DRUG-PROV-NPI | CLAIM-HEADER-RECORD-RX-CRX00002 | NCPDP D.0 - Pharmacy Provider Segment | 444-E9 | Provider ID | ID assigned to a pharmacy or provider individual responsible for dispensing the prescription |
| Dispensing | DISPENSING-PRESCRIPTION-DRUG-PROV-TAXONOMY | CLAIM-HEADER-RECORD-RX-CRX00002 | N/A | N/A | N/A | N/A |
| Prescribing | PRESCRIBING-PROV-NPI-NUM | CLAIM-HEADER-RECORD-RX-CRX00002 | NCPDP D.0 - Prescriber Segment | 411-DB | Prescriber ID | ID assigned to the prescriber |
| Prescribing | PRESCRIBING-PROV-TAXONOMY | CLAIM-HEADER-RECORD-RX-CRX00002 | N/A | N/A | N/A | N/A |

# 

# Appendix Q: Terms and Abbreviations

## Definitions

### Acronym/Abbreviation Description

AAAHC Accreditation Association for Ambulatory Health Care, Inc.

ABD Aged, Blind and Disabled

ACA Affordable Care Act

ADA American Dental Association

ADDR Address

AFDC Aid to Families with Dependent Children

AIDS Acquired Immunodeficiency Syndrome

AMT Amount

ANSI American National Standards Institute

APC Ambulatory payment classifications

APPL Application

ARNP Advanced Registered Nurse Practitioner

ASC Ambulatory Surgical Center

ASCII American Standard Code for Information Interchange

ATP Ability-To-Pay

BIP Balancing Incentive Program

BMI Body Mass Index

BOE Basis of Eligibility

CBSA Core Based Statistical Area

CD Code

CDIB Certificate of Degree of Indian or Alaska Native Blood

CEO Chief Executive Officer

CFO Chief Financial Officer

CFR Code of Federal Regulations

CHIP Children’s Health Insurance Program

CHIPRA Children’s Health Insurance Program Reauthorization Act

### Page 2 Acronym/Abbreviation Description

CHPID Controlling Health Plan Identifiers

CLIA Clinical Laboratory Improvement Amendment

CMCS Center for Medicaid, CHIP and Surveys and Certifications

CMHC Community Mental Health Center

CMMI Center for Medicare and Medicaid Innovation

CMS Centers for Medicare & Medicaid Services

COBOL Common Business Oriented Language

COBRA Consolidated Omnibus Budget Reconciliation Act of 1986

COLA Cost-of-Living Adjustment

CORF Comprehensive Outpatient Rehabilitation Facility

COV Covered

CPE Certified Public Expenditures

CPT Current Procedural Terminology

CRNA Certified Registered Nurse Anesthetists

CRVS California Relative Value Study

CWF Common Working File

DBA Doing Business As

DEA Drug Enforcement Agency

DED Deductible

DME Durable Medical Equipment

DO Doctor of osteopathy

DRG Diagnosis Related Group

DSH Disproportionate Share Hospital

DSN Data Set Name

DTL Detail

DUR Drug Utilization Review

EBCDIC Extended Binary-Coded-Decimal Interchange Code

EDI Electronic Data Interchange

EFF Effective

EFT Electronic Funds Transfer; or Electronic File Transfer

EPSDT Early and Periodic Screening, Diagnosis, and Treatment

### Page 3 Acronym/Abbreviation Description

ESI Employer Sponsored Insurance

ESRD End Stage Renal Disease

FFP Federal Financial Participation

FFS Fee-for-Service

FFY Federal Fiscal Year

FFYQ Federal Fiscal Year Quarter

FI Fiscal Intermediary

FL Form Locator

FLF Fixed Length Format

FPL Federal Poverty Level

FQHC Federally Qualified Health Center

GME Graduate Medical Education

HCBS Home and Community-Based Services

HCC RA Hierarchical Condition Category Risk Assessment

HCFA Health Care Financing Administration

HCPCS Health Care Procedural Coding System

HETS HIPAA Eligibility Transaction System

HHA Home Health Agency

HHPPS Home Health Prospective Payment System

Hib Haemophilus influenza type b

HIC Health Insurance Claim

HICN Health Insurance Claim Number

HIFA Health Insurance and Flexibility and Accountability

HIO Health Insuring Organization

HIPAA Health Insurance Portability and Accountably Act of 1996

HIV Human immunodeficiency virus

HMO Health Maintenance Organization

HPV Human Papillomavirus

IBM International Business Machines, Inc.

ICD International Classification of Diseases

ICD-10-CM The 10th revision of the ICD

### Page 4 Acronym/Abbreviation Description

ICD-9-CM The 9th revision of the ICD

ICF Intermediate Care Facility

ICF-IID Intermediate Care Facility for Individuals with Intellectual Disabilities

ICN Item Control Number

IGT Intergovernmental Transfers

IHS Indian Health Service

IHS-BCC IHS-B

IHS-BIP IHS-B

IMD Institution for Mental Disease

INA Immigration and Nationality Act

IND Indicator

IP Inpatient

IPFPPS Inpatient Psychiatric Facility Prospective Payment System

IPPS Acute Inpatient Prospective Payment System

IRFPPS Inpatient Rehabilitation Facility Prospective Payment System

LN Line

LPN Licensed Practical Nurse

LPR Lawful permanent residents

LT Long Term

LTC Long Term Care

LTCHPPS Long Term Care Hospital Prospective Payment System

LTCLA Long Term Care Living Arrangement

LTSS Long Term Services and Support

MACPro Medicaid and CHIP Program Data System

MAGI Modified Adjusted Gross Income

MAS Maintenance Assistance Status

MBI Medicare Beneficiary Identifier

M-CHIP Medicaid Expansion CHIP

MCO Managed Care Organization

MCR Managed Care Record

MD Medical Doctor

### Page 5 Acronym/Abbreviation Description

MFP Money Follows the Person

MH Mental Health

MMA Medicare Modernization Act

MMIS Medicaid Management Information System

MOD Modifiers

MRI Magnetic resonance imaging

MS-DRG Medicare Severity – Diagnosis Related Group

MSIS Medicaid Statistical Information System

MSP Medicare Secondary Payer

NAIC National Association of Insurance Commissioners

NCPDP National Council for Prescription Drug Programs

NDC National Drug Code

NF Nursing Facility

NHP-ID National Health Plan Identifier

NPI National Provider ID

OASDI Old-Age, Survivors, and Disability Insurance

OEID Other Entity Identifier

OIG Office of Inspector General

OIS Office of Information Services

OMB Office of Management and Budget

OPPS Outpatient Prospective Payment System

ORF Other Rehabilitation Facility

OS Operating System

OT Other Type [of claim]

OTC Over the counter

PACE Program for All-Inclusive Care for the Elderly

PAHP Prepaid Ambulatory Health Plan

PBM Pharmacy Benefits Manager

PCCM Primary Care Case Management

PERS Personal Emergency Response System

PHP Prepaid Health Plan

### Page 6 Acronym/Abbreviation Description

PHS Public Health Service Act

PIHP Prepaid Inpatient Health Plan

PL Public Law

POA Present on Admission

POP Population

PPS Prospective Payment System

PROV Provider

PRTF Psychiatric Residential Treatment Facilities Demonstration Grant Program

PRWORA Personal Responsibility and Work Opportunity Reconciliation Act of 1996

PT/OT/ST Physical Therapy/Occupational Therapy/Speech Therapy

QDWI Qualified Disabled Working Individuals

QI Qualified Individual

QIO Quality Improvement Organization

QMB Qualified Medicare Beneficiaries

RA Remittance Advice

RBRVS Resource-based relative value scale

REC Record

RHC Rural health clinic

RN Registered Nurse

RRB Railroad Retirement Board

RX Prescription

SCHIP State Children’s Health Insurance Program

SHPID Sub-Health Plan Identifiers

SLMB Specified Low-Income Medicare Beneficiaries

SNF Skilled Nursing Facility

SNFPPS Skilled Nursing Facility Prospective Payment System

SPA State Plan Amendment

SSA Social Security Administration

SSDI Social Security Disability Insurance

SSI Supplemental Security Income

### Page 7 Acronym/Abbreviation Description

SSP State Supplemental Program

SSN Social Security Number

SUD Substance Use Disorders

T-18 SNF Title 18 Skilled Nursing Facility

TANF Temporary Assistance for Needy Families

TB Tuberculosis

TEFRA Tax Equity and Fiscal Responsibility Act of 1982

TIN Tax Identifier Number

T-MSIS Transformed Medicaid Statistical Information System

TOT Total

TPL Third Party Liability

TWWIIA Ticket to Work and Work Incentives Improvement Act

UB Uniform Billing

URAC Utilization Review Accreditation Commission

USC United States Code

VA Veterans Administration

**PRA Disclosure Statement** The Transformed Medicaid Statistical Information System (T-MSIS) is used to assist the Centers for Medicare & Medicaid Services (CMS) with monitoring and oversight of Medicaid and CHIP programs, to enable evaluation of demonstrations under section 1115 of the Social Security Act and to calculate quality measures and other metrics, including those reported through the new Medicaid and CHIP Scoreboard. Section 4735 of the Balanced Budget Act of 1997 included a statutory requirement for states to submit claims data, enrollee encounter data, and supporting information. Section 6504 of the Affordable Care Act strengthened this provision by requiring states to include data elements the Secretary determines necessary for program integrity, program oversight, and administration. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0345 (Expires: 07/31/2022). The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. ACA Medicaid expansion for childless adults (represented in T-MSIS by ELIGIBILITY-GROUP valid values "72" through "75") are still technically characterized as mandatory eligibility groups by Subsection 1902(a)(10)(A) of the Social Security Act (SSA) despite the U.S. Supreme Court ruling (National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012)) which ruled that states could not be required to offer such coverage. Therefore, some states may not report any of the Medicaid expansion groups to T-MSIS if these groups are not applicable to a particular state. [↑](#footnote-ref-1)
2. ACA Medicaid expansion for childless adults (represented in T-MSIS by ELIGIBILITY-GROUP valid values "72" through "75") are still technically characterized as mandatory eligibility groups by Subsection 1902(a)(10)(A) of the Social Security Act (SSA) despite the U.S. Supreme Court ruling (National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012)) which ruled that states could not be required to offer such coverage. Therefore, some states may not report any of the Medicaid expansion groups to T-MSIS if these groups are not applicable to a particular state. [↑](#footnote-ref-2)
3. *CMS Guidance – Reporting Financial Transactions in T-MSIS – 2014-04-23* [↑](#footnote-ref-3)