T-MSIS Data Dictionary Appendices

Version: v4.0.0

Preface

Appendices B, C, G, I, and J have been retired from the T-MSIS specifications Appendix artifact in v4.0.0 because they were redundant to the Valid Value List (VVL) artifact. Appendices H, K, L, and P.02 have been retired from the T-MSIS specifications Appendix artifact in v4.0.0 because they have been determined to be outdated and/or obsolete. Appendices A, M, O, P.04, and P.06 were retired from previous versions of the T-MSIS specifications Appendix artifact.

Appendix D: Types of Service (TOS) Reference

Definitions of Types of Service

Type of Service values are predominantly defined in the Code of Federal Regulations (CFR). Clarification of the definitions are provided below to aid in the classification of medical care and services for T-MSIS reporting purposes. They do not modify any requirements of the Social Security Act or supersede in any way the definitions included in the Code of Federal Regulations.

Institutional Inpatient Facility Services

1. **Inpatient Hospital Services (TOS Code=001)** include services referenced in the following regulatory contexts:

Term	Description
Inpatient hospital services, other than services in an institution for mental diseases	42 CFR § 440.10
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage.	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

NOTE: 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.

2. **Mental Health Facility Services**
   a. ***Inpatient Psychiatric Facility Services for Individuals Age 21 and Under*** **(TOS Code=048)** include services referenced in the following regulatory contexts:

Term	Description
Inpatient psychiatric services for individuals under age 21	42 CFR § 440.160
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent cover coverage.	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

   b. ***Other Mental Health Facility Services (Individuals Age 65 or Older)*** **(TOS Code= 044 and 045)** include services referenced in the following regulatory context:

Term	Description
Inpatient hospital services, nursing facility services, and intermediate care facility services for	42 CFR 440.140

Term	Description
individuals aged 65 or older in institutions for mental diseases	

3. **Nursing Facilities (NF) Services (TOS Code=009 and 047)** include services referenced in the following regulatory contexts:

Term	Description
Nursing facility services for individuals aged 21 or older (other than services in an institution for mental disease), EPSDT, and family planning services and supplies	42 CFR § 440.40
Nursing facility services, other than in institutions for mental diseases	42 CFR § 440.155

NOTE: ICF Services for individuals without intellectual disabilities. This is combined with nursing facility services.

4. **ICF Services for Individuals with Intellectual Disabilities (TOS Code=046)** include services referenced in the following regulatory context:

Term	Description
Intermediate care facility (ICF/IID) services	42 CFR 440.150

Institutional Outpatient Facility Services

5. **Outpatient Hospital Services (TOS Code=002)** include services referenced in the following regulatory contexts:

Term	Description
Outpatient hospital services and rural health clinic services	42 CFR § 440.20
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

Practitioner Services

6. **Physicians' Services (TOS Code=012)** include services referenced in the following regulatory contexts:

Term	Description
Physicians' services and medical and surgical services of a dentist.	42 CFR § 440.50
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440

Secretary-approved coverage	42 CFR § 457.450

7. Dental Services (TOS Code=029) include services referenced in the following regulatory contexts:

Term	Description
Dental services	42 CFR § 440.100
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

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).

8. Other Licensed Practitioners' Services (TOS Code=015) include services referenced in the following regulatory contexts:

Term	Description
Medical or other remedial care provided by licensed practitioners	42 CFR § 440.60
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

NOTE: 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.

9. **Clinic Services (TOS Code=028**) include services referenced in the following regulatory contexts:

Term	Description
Clinic services	42 CFR § 440.90
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

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

10. **Laboratory and X-Ray Services (TOS Code=005, 006, 007, and 008)** include services referenced in the following regulatory contexts:

Term	Description
Other laboratory and X-ray services	42 CFR § 440.30
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

NOTE: X-ray services provided by dentists are reported under dental services.

Personal Care and Home Health Services

11. **Home Health Services (TOS Code=016,017, 018, 019, 020, and 021)** include services referenced in the following regulatory contexts:

Term	Description
Other laboratory and X-ray services	42 CFR § 440.70
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431

Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

12. Personal Support Services

a. ***Personal Care Services (TOS Code=051)*** include services referenced in the following regulatory contexts:

Term	Description
Personal care services	42 CFR § 440.167

b. ***Targeted Case Management Services (TOS Code=053)*** include services referenced in the following regulatory contexts:

Term	Description
Case management services	42 CFR § 440.169
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

c. ***Rehabilitative Services (TOS Code=043)*** include services referenced in the following regulatory context:

Term	Description
Diagnostic, screening, preventive, and rehabilitative services	42 CFR 440.130

d. ***Physical Therapy, Occupational Therapy, and Services For Individuals with Speech, Hearing, and Language Disorders* (*TOS Codes=030, 031, and 032)*** include services referenced in the following regulatory contexts:

Term	Description
Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders	42 CFR § 440.110
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

e. ***Hospice Services (TOS Code=087)*** include services referenced in the following regulatory contexts:

Term	Description
Hospice care	SSA §1905(o)
Definition of child health assistance	42 CFR § 457.402

Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

f. ***Nurse Midwife (TOS Code=025)*** include services referenced in the following regulatory contexts:

Term	Description
Nurse-midwife service	42 CFR § 440.165
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

g. ***Nurse Practitioner (TOS Code=026)*** include services referenced in the following regulatory contexts:

Term	Description
Nurse practitioner services	42 CFR § 440.166
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

h. ***Private Duty Nursing (TOS Code=022)*** include services referenced in the following regulatory contexts:

Term	Description
Private duty nursing services	42 CFR § 440.80
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

i. ***Religious Non-Medical Health Care Institutions (TOS Code=058)*** include services referenced in the following regulatory context:

Term	Description

Any other medical care or remedial care recognized under State law and specified by the Secretary	42 CFR § 440.170

Other Services

13. Other Services

a. ***Prescribed Drugs (TOS Code=033)*** include services referenced in the following regulatory contexts:

Term	Description
Prescribed drugs, dentures, prosthetic devices, and eyeglasses	42 CFR § 440.120
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450
Health benefits coverage options	42 CFR § 457.410

b. ***Sterilizations (TOS Code=084)*** include services referenced in the following statutory contexts:

Term	Description
Sterilizations	42 CFR § 441, Subpart F

c. ***Transportation (TOS Code=056)*** include services referenced in the following regulatory contexts:

Term	Description
Any other medical care or remedial care recognized under State law and specified by the Secretary	42 CFR 440.170
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

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.

d. ***Other Pregnancy-related Procedures (TOS Code=086)*** include services referenced in the following regulatory contexts:

Term	Description
Abortions	42 CFR Subpart E
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420

Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

e. ***Other Services – Continued (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. These include, but are not limited to services referenced in the following regulatory contexts:

Term	Description
Prescribed drugs, dentures, prosthetic devices, and eyeglasses	42 CFR § 440.120
Definition of child health assistance	42 CFR § 457.402
Benchmark health benefits coverage	42 CFR § 457.420
Benchmark-equivalent health benefits coverage	42 CFR § 457.430
Actuarial report for benchmark-equivalent coverage	42 CFR § 457.431
Existing comprehensive State-based coverage	42 CFR § 457.440
Secretary-approved coverage	42 CFR § 457.450

14. **COVID-19 Testing** 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.
    a. ***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.
    a. ***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.
15. **Medication Assisted Treatment (MAT) services and drugs for evidenced-based treatment of Opioid Use Disorder (OUD) (*TOS Code=145*)** include services referenced in the following regulatory context:

Term	Description
Medication-assisted treatment	SSA §1905(a)(29)

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 T-MSIS purposes. These programs tend to cover bands of services that cut across many types of service.

Program Type 01. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (See 42 CFR § 440.40(b)).

Program Type 02. Family Planning (See 42 CFR § 440.40(c)).

Program Type 03. Rural Health Clinics (RHC) (See 42 CFR § 440.20(b)).

Program Type 04. Federally Qualified Health Center (FQHC) (See SSA § 1905(a)(2)).

Program Type 05. Indian Health Services (See SSA §1911) (See 42 CFR § 431.110).

Program Type 07. Home and Community Based Waivers (See SSA § 1915(c) and 42 CFR § 440.180).

Program Type 08. Money Follows the Person (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]).

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. Community First Choice (See SSA § 1915(k)).

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 (See SSA § 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. State Plan CHIP (See 42 CRF § 457).

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. SSA § 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. 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

MEDICAID MANDATORY COVERAGE

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

Code	Eligibility Group	Short Description	Citation	Type	Category
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

Code	Eligibility Group	Short Description	Citation	Type	Category
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

Code	Eligibility Group	Short Description	Citation	Type	Category
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

Code	Eligibility Group	Short Description	Citation	Type	Category
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

Code	Eligibility Group	Short Description	Citation	Type	Category
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 OPTIONS FOR 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

Code	Eligibility Group	Short Description	Citation	Type	Category
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

Code	Eligibility Group	Short Description	Citation	Type	Category
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

Code	Eligibility Group	Short Description	Citation	Type	Category
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

Code	Eligibility Group	Short Description	Citation	Type	Category
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

Code	Eligibility Group	Short Description	Citation	Type	Category
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

Code	Eligibility Group	Short Description	Citation	Type	Category
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]	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

[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.

Code	Eligibility Group	Short Description	Citation	Type	Category
*73[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
*74[1]	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
*75[1]	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

[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.

Code	Eligibility Group	Short Description	Citation	Type	Category
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 MEDICALLY NEEDY

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

Code	Eligibility Group	Short Description	Citation	Type	Category
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

CHIP COVERAGE

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

Code	Eligibility Group	Short Description	Citation	Type	Category
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 ADDITIONAL OPTIONS FOR 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

Code	Eligibility Group	Short Description	Citation	Type	Category
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

1115 EXPANSION ELIGIBILITY GROUPS

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

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 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 its subsequent adjustment and/or void claims shows the progression of changes that have occurred since it was first submitted.

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.

Refer to T-MSIS Coding Blog entry "Reporting Adjustment Indicator (ADJUSTMENT-IND) for Financial Transactions (Claims)" for additional detailed information.

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 3 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 3: 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 4 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 4: 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.

Refer to T-MSIS Coding Blog entry "Populating T-MSIS Claims File Data Elements on Void/Reversal/Cancel Records" for additional detailed information.

Table 5 illustrates an example of how the dollar and quantity fields on the members of a claim family are populated when the state wishes to void a claim.

Table 5: 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 6 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 6: 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

Event	ADJUDICATION-DATE	ICN-ORIG	ICN-ADJ	ADJUSTMENT-IND	Dollar Fields	Quantity Fields
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 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:

   a. 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.

   b. 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.

   c. 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.

   d. 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.

   e. 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.

   f. 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.

   g. 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.

   h. 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.

   i. 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 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.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

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
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

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
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	MANAGED-CARE-ID (MCR00010)	MANAGED-CARE-PLAN-OTHER-ID-TYPE	01 – Federal Tax ID; 02 – State Tax ID	MANAGED-CARE-ID (MCR00010)	MANAGED-CARE-PLAN-OTHER-ID, MANAGED-CARE-PLAN-ID-EFF-DATE, MANAGED-CARE-PLAN-ID-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

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
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; 9 - Old State Provider ID	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; 6 – Sub-capitated Entity; 7 – Fee-for-service (FFS)	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.07: Finding Provider Roles on Standard 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
- Ordering 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-to-X-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.

Appendix P.07

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	N/A
Referring	REFERRING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-IP-CIP00002	5010 A2 837-I Institutional Claim	NM109	Referring Provider Identifier	2310F	N/A

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
Referring	REFERRING-PROV-NPI-NUM	CLAIM-LINE-RECORD-IP-CIP00003	5010 A2 837-I Institutional Claim	NM109	Referring Provider Identifier	2420D	N/A
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.

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	N/A
Admitting (Attending)	ADMITTING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-LT-CLT00002	5010 A2 837-I Institutional Claim	PRV03	Provider Taxonomy Code	2310A	N/A
Billing	BILLING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-LT-CLT00002	5010 A2 837-I Institutional Claim	NM109	Billing Provider Identifier	2010AA	N/A

Appendix P.07

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
Billing	BILLING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-LT-CLT00002	5010 A2 837-I Institutional Claim	PRV03	Provider Taxonomy Code	2000A	N/A
Referring	REFERRING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-LT-CLT00002	5010 A2 837-I Institutional Claim	NM109	Referring Provider Identifier	2310F	N/A
Referring	REFERRING-PROV-NPI-NUM	CLAIM-LINE-RECORD-LT-CLT00003	5010 A2 837-I Institutional Claim	NM109	Referring Provider Identifier	2420D	N/A
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.

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	N/A

Appendix P.07

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-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	5010 A2 837-I Institutional Claim	PRV03	Provider Taxonomy Code	2000A	N/A
Referring	REFERRING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-OT-COT00002	5010 A2 837-I Institutional Claim	NM109	Referring Provider Identifier	2310F	N/A
Referring	REFERRING-PROV-NPI-NUM	CLAIM-LINE-RECORD-OT-COT00003	5010 A2 837-I Institutional Claim	NM109	Referring Provider Identifier	2420D	N/A
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. If 2310D and 2420C are not populated but 2310A is populated, then apply 2310D here.

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	N/A
Billing	BILLING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-P Professional Claim	PRV03	Provider Taxonomy Code	2000A	N/A
Referring	REFERRING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-P Professional Claim	NM109	Referring Provider Identifier	2310A	N/A
Referring	REFERRING-PROV-NPI-NUM	CLAIM-LINE-RECORD-OT-COT00003	5010 A1 837-P Professional Claim	NM109	Referring Provider Identifier	2420F	N/A
Referring	REFERRING-PROV-NPI-NUM-2	CLAIM-LINE-RECORD-OT-COT00003	5010 A1 837-P Professional Claim	NM109	Referring Provider Identifier	2420F	If there is a 2nd loop of 2420F containing an NPI for a given claim, apply the NPI from that second loop here.

Appendix P.07

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
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.
Ordering	ORDERING-PROV-NPI-NUM	CLAIM-LINE-RECORD-OT-COT00003	5010 A1 837-P Professional Claim	NM109	Ordering Provider Identifier	2420E	N/A

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	N/A

Appendix P.07

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-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-D Dental Claim	PRV03	Provider Taxonomy Code	2000A	N/A
Referring	REFERRING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-D Dental Claim	NM109	Referring Provider Identifier	2310A	N/A
Referring	REFERRING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	N/A
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.

Appendix P.07

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
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
Prescribing	PRESCRIBING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-RX-CRX00002	NCPDP D.0 - Prescriber Segment	411-DB	Prescriber ID	ID assigned to the prescriber

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