T-MSIS Data Dictionary Appendices

~~December 04, 2020~~

Version: ~~v2.4~~v4.0.0

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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have been retired from the T-MSIS specifications Appendix artifact in v4.0.0 because they have been determined to be outdated and/or obsolete.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.

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

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

Appendix A: Valid Values

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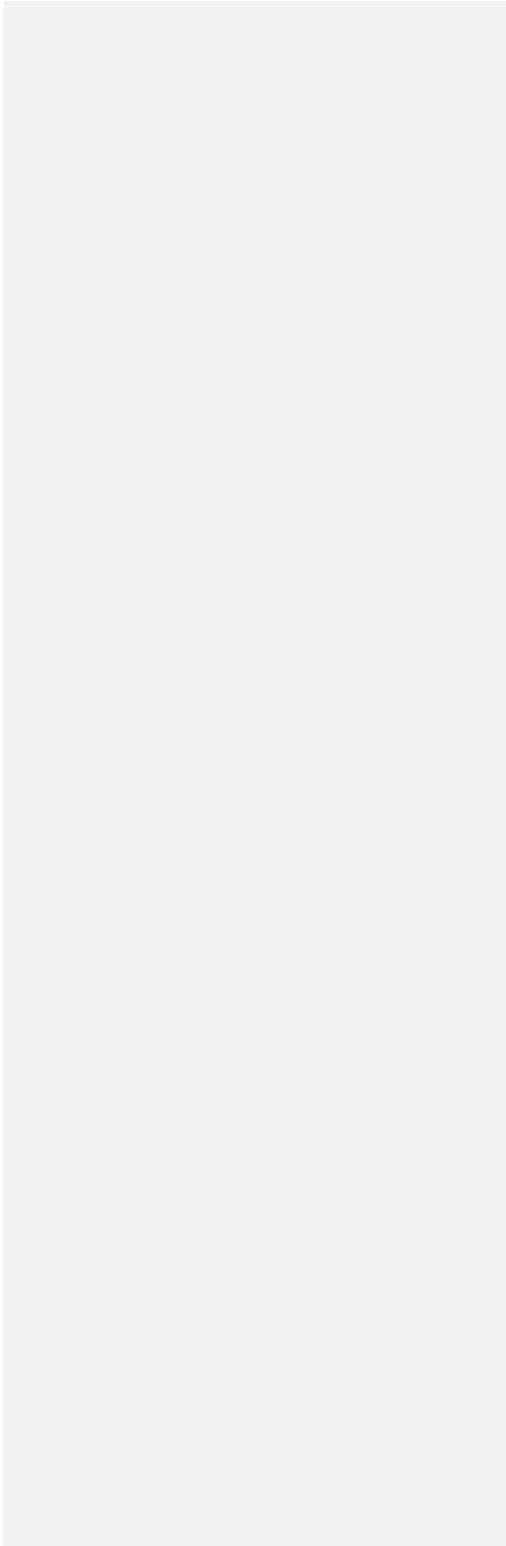
NOTE

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

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

Appendix AB



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

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

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

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

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

Appendix CAppendix B

HCBS Service Taxonomy Values:

CategoryTerm	Sub-Category (where applicable)Description	Service	Common Names (where applicable)	Definition
01 – Case Management	N/A	N/A	N/A	The development of a comprehensive, written individualized support plan. In addition, case management often includes assisting people in gaining access to necessary services, assessment of a person's needs, ongoing monitoring of service provision and/or a person's health and welfare, assistance in accessing supports to transition from an institutional setting (but not the transition services themselves); and development of a 24-hour individual back-up plan with formal and informal supports
N/A	01010 case management	N/A	care management supports coordination	Same definition as category 01.
02 Round-the-Clock Services	N/A	N/A	N/A	Services by a provider that has round-the-clock responsibility for the health and welfare of residents, except during the time other services (e.g., day services) are furnished. If these services are provided in a 1915(c) waiver, the state must complete Appendix G-3 of the 1915(c) waiver application regarding medication management and administration.
N/A	0201 group living	N/A	assisted living group home services	Round-the-clock services provided in a residence that is NOT a person's home or apartment or a single family residence where one or more people with a disability live with a person or family who furnishes services

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N/A	N/A	02011 group living, residential habilitation	N/A	Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills by a provider with round-the-clock responsibility for the residents' health and welfare in a residence that is NOT a person's own home or apartment or a single family residence where one or more people with a disability live with a person or family who furnishes services.
N/A	N/A	02012 group living, mental health services	N/A	Mental health services by a provider with round-the-clock responsibility for the residents' health and welfare in a residence that is NOT a person's own home or apartment or a single family residence where one or more people with a disability live with a person or family who furnishes services.
N/A	N/A	02013 group living, other	N/A	Health and social services not identified elsewhere in subcategory 0201 by a provider with round-the-clock responsibility for the residents' health and welfare in a residence that is NOT a person's own home or apartment or a single family residence where one or more people with a disability live with a person or family who furnishes services.
N/A	0202 shared living	N/A	adult foster care family living host homes	Round-the-clock services provided in a single family residence where one or more people with a disability live with a person or family who furnishes services.

N/A	N/A	02021 shared living, residential habilitation	N/A	Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills provided in a single family residence where one or more people with a disability live with a person or family who furnishes services and has round-the-clock responsibility for the residents' health and welfare.
N/A	N/A	02022 shared living, mental health services	N/A	Mental health services provided in a single family residence where one or more people with a disability live with a person or family who furnishes services and has round-the-clock responsibility for the residents' health and welfare.
N/A	N/A	02023 shared living, other	N/A	Health and social services not identified elsewhere in subcategory 0202 provided in a single family residence where one or more people with a disability live with a person or family who furnishes services and has round-the-clock responsibility for the residents' health and welfare.
N/A	0203 in-home round-the-clock services	N/A	supported living	Round-the-clock services provided in a person's home or apartment where a provider has round-the-clock responsibility for the person's health and welfare.
N/A	N/A	02031 in-home residential habilitation	N/A	Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills provided in a person's home or apartment where a provider has round-the-clock responsibility for the person's health and welfare.

N/A	N/A	02032 in-home round-the-clock mental health services	N/A	Mental health services provided in a person's home or apartment where a provider has round-the-clock responsibility for the person's health and welfare.
N/A	N/A	02033 in-home round-the-clock services, other	N/A	Health and social services not identified elsewhere in subcategory 0203 provided in a person's home or apartment where a provider has round-the-clock responsibility for the person's health and welfare.
03 Supported Employment	N/A	N/A	N/A	Assistance to help a person obtain or maintain paid employment or self-employment.
N/A	0301 job development	03010 job development	N/A	Assistance to locate and obtain paid employment or self-employment.
N/A	0302 ongoing supported employment	N/A	N/A	Assistance to maintain paid employment or self-employment.
N/A	N/A	03021 ongoing supported employment, individual	N/A	Assistance to maintain self-employment or paid employment in an individual job placement (i.e., person is working with people without disabilities).
N/A	N/A	03022 ongoing supported employment, group	N/A	Assistance to maintain paid employment in a group placement (i.e., person is working on a team of people with disabilities).
N/A	0303 career planning	03030 career planning	N/A	Focused, time-limited assistance to identify a career direction and develop a plan to achieve employment.

04 Day Services	N/A	N/A	N/A	Services other than supported employment typically provided outside the person's home during the working day (i.e., Monday through Friday between 8 a.m. and 5 p.m.). These services provide a range of supports and are often, but not always, provided on a regularly scheduled basis at a site specifically established to provide day services.
N/A	N/A	04010 prevocational services	N/A	Time-limited services to provide learning and work experiences, including volunteer work, to acquire general skills that help a person obtain paid employment in integrated community settings.
N/A	N/A	04020 day habilitation	N/A	Regularly scheduled activities in settings separate from the participant's residence, including assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills. This service includes community-based volunteer activities that include acquiring, retaining, and improving self-help, socialization, and adaptive skills. This service can include the supports offered in adult day health, adult day services (social model), and community integration if these supports are provided along with assistance in acquiring, retraining, and improving self-help, socialization, and/or adaptive skills.
N/A	N/A	04030 education services	N/A	Services to help a person access post-secondary education.

N/A	N/A	04040 day treatment/ partial hospitalization	N/A	Services necessary for the diagnosis or treatment of the person's mental illness provided in a fixed site facility during the working day.
N/A	N/A	04050 adult day health	N/A	Skilled health services and other support services, NOT including habilitation (i.e., assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills), provided to adults in a fixed site facility during the working day. This service can include the supports offered in adult day services (social model) if these supports are provided along with skilled health services.
N/A	N/A	04060 adult day services (social model)	N/A	Support services, NOT including skilled health services and not including habilitation (i.e., assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills), provided to adults in a fixed site facility during the working day.
N/A	N/A	04070 community integration	escort	Assistance in participating in community activities, NOT including assistance with activities of daily living or assistance in acquiring, retraining, and improving self-help, socialization, and/or adaptive skills. This service can include supports furnished in the person's residence related to community participation.
N/A	N/A	04080 medical day care for children	N/A	Medical services beyond typical day care responsibilities provided during the working day for infants, toddlers, and pre-school age children.

05 Nursing	N/A	N/A	N/A	Services within the scope of the state's nurse practices act provided by a licensed nurse.
N/A	N/A	05010 private duty nursing	N/A	Licensed nursing services provided on a continuous or full-time basis (e.g., for more than 4 consecutive hours per day and for more than 60 days). This service can include the supports offered in health assessment, health monitoring, and medication assessment if the service also includes other services within the scope of the state's nurse practices act.
N/A	N/A	05020 skilled nursing	N/A	Licensed nursing services provided on a part-time or intermittent basis. This service can include the supports offered in health assessment, health monitoring, and medication assessment if the service also includes other services within the scope of the state's nurse practices act.
06 Home delivered meals	N/A	N/A	N/A	Prepared meals sent to a person's home, which may not comprise a full nutritional regimen.
N/A	N/A	06010 home delivered meals	N/A	Same definition as category 06.
07 Rent and Food Expenses for Live-In Caregiver	N/A	N/A	N/A	Payment for the additional costs of rent and food that can be attributed to an unrelated direct support worker living with the person. This service does not include payment for the direct support worker's services, which may be covered as part of other services such as personal care.

N/A	N/A	07010 rent and food expenses for live-in caregiver	N/A	Same definition as category 07.
08 Home-Based Services	N/A	N/A	N/A	Services that support a person in his or her home or apartment, when the provider does not have round-the-clock responsibility for the person's health and welfare. These services can be provided in other community settings, but are primarily furnished in a person's home or apartment.
N/A	N/A	08010 home-based habilitation	supported living (provided on an hourly basis)	Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills provided in the person's home when the provider does NOT have round-the-clock responsibility for the person's health and welfare. This service can include the supports offered in community integration, home health aide, personal care, companion, and homemaker if these supports are provided along with assistance in acquiring, retraining, and improving self-help, socialization, and/or adaptive skills.

N/A	N/A	08020 home health aide	N/A	Assistance with activities of daily living (ADLs) and/or health-related tasks provided in a person's home and possibly other community settings that are supervised by a registered nurse or licensed therapist and provided by a licensed home health agency. Home health aide may include assistance with instrumental activities of daily living (IADLs). Home health aide may include the supports offered in companion and homemaker if these supports are provided along with assistance with ADLs and/or health-related tasks. Home health aide does NOT include habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).
N/A	N/A	08030 personal care	attendant care personal assistance personal attendant services	Assistance with ADLs and/or health-related tasks provided in a person's home and possibly other community settings, NOT including both provision by a licensed home health agency and a requirement for supervision by a licensed nurse or therapist. Personal care may include assistance with IADLs. Personal care may include the supports offered in companion and homemaker if these supports are provided along with assistance with ADLs and/or health-related tasks. Personal care does NOT include habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).

N/A	N/A	08040 companion	adult companion night supervision	Supervision and/or social support provided in a person's home and possibly other community settings. Companion may also include performance of light housekeeping tasks (the supports offered in homemaker). Companion does NOT include assistance with ADLs or habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).
N/A	N/A	08050 homemaker	N/A	Performance of light housekeeping tasks provided in a person's home and possibly other community settings NOT including supervision and social support, assistance with ADLs, or habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).
N/A	N/A	08060 chore	N/A	Performance of heavy household chores provided in a person's home and possibly other community settings NOT including supervision and social support, assistance with ADLs, or habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).
09 Caregiver Support	N/A	N/A	N/A	Assistance to people who provide ongoing support to the person with a disability when assisting the support person is the primary purpose of the service. In most cases, the support person is unpaid. However, respite can be provided to relieve providers who furnish shared living.

N/A	0901 respite	N/A	N/A	Short-term services provided because a support person is absent or needs relief when relieving the support person is the primary purpose of the service.
N/A	N/A	09011 respite, out-of-home	N/A	Short-term services provided because a support person is absent or needs relief NOT provided in a person's home or apartment when relieving the support person is the primary purpose of the service.
N/A	N/A	09012 respite, in-home	N/A	Short-term services provided because a support person is absent or needs relief provided in a person's home or apartment when relieving the support person is the primary purpose of the service.
N/A	0902 caregiver counseling and/or training	09020 caregiver counseling and/or training	N/A	Counseling, emotional support, and/or training provided to a family member or friend providing support when providing counseling or training to the support person is the primary purpose of the service. Examples of training topics include a) skills to provide specific treatment regimens or help the person improve function, b) information about the person's disability or conditions, and c) navigation of the service system.
10 Other Mental Health and Behavioral Services	N/A	N/A	N/A	Services NOT identified in previous categories that support people in improving or maintaining mental or behavioral health.
N/A	N/A	10010 mental health assessment	N/A	Assessment or evaluation of mental health status when the assessment is the primary purpose of the service. This service can include medication assessment if the assessment includes other mental health information.

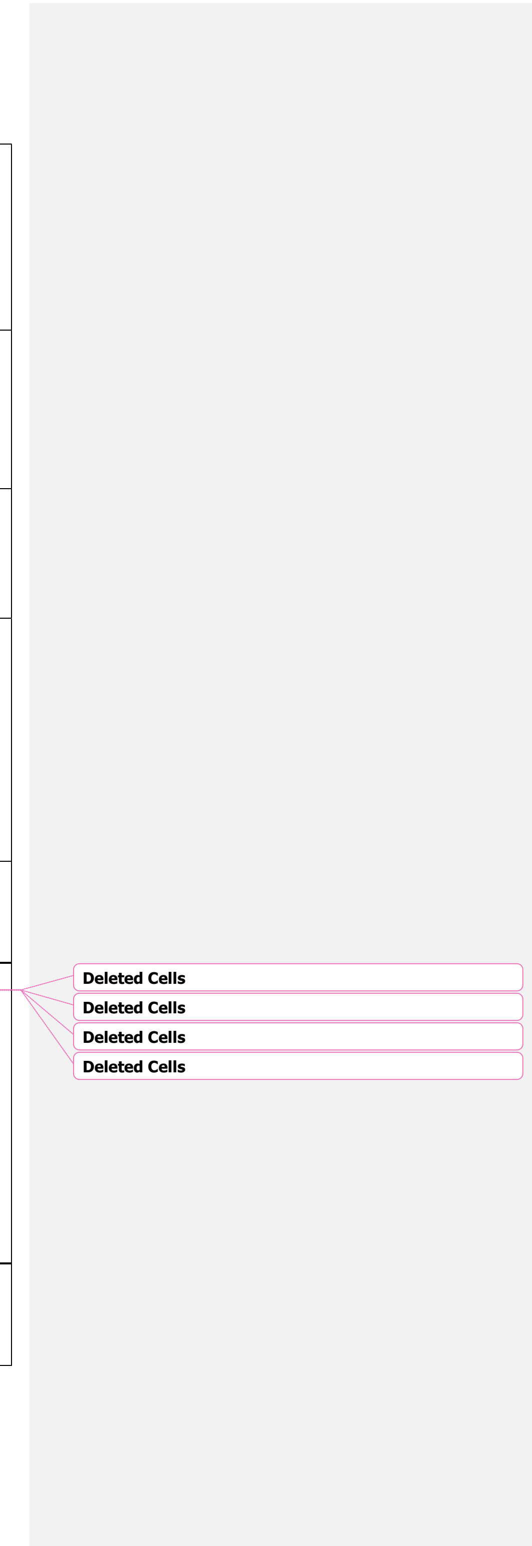
N/A	N/A	10020 assertive community treatment	N/A	A range of mental health supports characterized by assertive engagement of the person, availability 24 hours a day, and support by an interdisciplinary team.
N/A	N/A	10030 crisis intervention	crisis support	Response to stabilize a person exhibiting behavior that puts the person at risk of hospitalization or institutionalization.
N/A	N/A	10040 behavior support	behavior analysis behavior therapy	Services specifically to encourage positive behaviors and to decrease challenging behaviors, including a) assessment to identify antecedents to behaviors and b) development of a plan to improve behaviors.
N/A	N/A	10050 peer specialist	peer support	Mental health support services provided by a trained and credentialed person with a mental illness.
N/A	N/A	10060 counseling	N/A	Individual or group therapy to develop coping skills or improve mental health function.
N/A	N/A	10070 psychosocial rehabilitation	N/A	Assistance to improve or restore function in ADLs, IADLs, and social or adaptive skills NOT identified in previous categories or services.
N/A	N/A	10080 clinic services	N/A	Services for individuals with chronic mental illness furnished in a clinic or based in a clinic NOT identified in previous categories or services.
N/A	N/A	10090 other mental health and behavioral services	N/A	Services NOT identified elsewhere in category 10 that support people in improving or maintaining mental or behavioral health.

11 Other Health and Therapeutic Services	N/A	N/A	N/A	Services NOT identified in previous categories that support people in improving or maintaining health or functional capacity.
N/A	N/A	11010 health monitoring	N/A	Ongoing monitoring of physical health status when monitoring is the primary purpose of the service. This service can include medication monitoring if other aspects of a person's health also are monitored.
N/A	N/A	11020 health assessment	N/A	Assessment or evaluation of physical health status when the assessment is the primary purpose of the service. This service can include medication assessment if the assessment includes other health information.
N/A	N/A	11030 medication assessment and/or management	N/A	Assessment of medication administration and/or possible drug interactions—and/or oversight of ongoing medication administration—when the management of medications is the primary purpose of the service.
N/A	N/A	11040 nutrition consultation	N/A	Assistance to a person to help him or her plan and implement changes to nutritional intake.
N/A	N/A	11050 physician services	N/A	Services by a licensed physician. This service can include health assessment, medication assessment, and/or mental health assessment if other physician services are also provided.
N/A	N/A	11060 prescription drugs	N/A	Prescription drugs.
N/A	N/A	11070 dental services	N/A	Services by a licensed dentist.

N/A	N/A	11080 occupational therapy	N/A	Services by a licensed occupational therapist.
N/A	N/A	11090 physical therapy	N/A	Services by a licensed physical therapist.
N/A	N/A	11100 speech, hearing, and language therapy	N/A	Services by a licensed speech, hearing, and language therapist. This service includes services by a speech pathologist or a qualified audiologist.
N/A	N/A	11110 respiratory therapy	N/A	Services by a licensed respiratory therapist.
N/A	N/A	11120 cognitive rehabilitative therapy	N/A	Assistance to manage or restore cognitive function.
N/A	N/A	11130 other therapies	N/A	Therapeutic interventions to maintain or improve function NOT identified in previous categories or services. This service includes specialized interventions such as those using art, music, dance, or trained animals.
12 Services Supporting Participant Direction	N/A	N/A	N/A	Services that assist a person and/or his or her representative in managing participant-directed services, as identified in the Participant Direction of Services section of the 1915(c) waiver or 1915(i) State Plan Amendment application.

N/A	N/A	12010 financial management services in support of participant direction	N/A	Assistance to help a person and/or representative manage participant-directed services by a) performing financial tasks to facilitate the employment of staff; b) managing the disbursement of funds in a participant-directed budget; and/or c) performing fiscal accounting and making expenditure reports to the person, representative, and/or state authorities.
N/A	N/A	12020 information and assistance in support of participant direction	N/A	Training the person and/or representative in directing or managing services. Topics include: a) the person's rights and responsibilities in participant direction; b) recruiting and hiring staff; c) managing staff and solving problems regarding services; and d) managing a participant-directed budget.
13 Participant Training	N/A	N/A	N/A	Training provided to a participant when training the participant is the primary purpose of the service. Topics may include: a) specific treatment regimens, b) the person's disability or condition, and c) navigation of the service system.
N/A	N/A	13010 participant training	N/A	The same definition as category 13.
14 Equipment, Technology, and Modifications	N/A	N/A	N/A	Material goods to help a person improve or maintain function.

N/A	1401 personal emergency response system (PERS)	14010 personal emergency response system (PERS)	N/A	Devices that enable participants to signal a response center to secure help in an emergency. This service can include installation, maintenance, and monthly response center fees.
N/A	1402 home and/or vehicle accessibility adaptations	14020 home and/or vehicle accessibility adaptations	home and/or vehicle modifications	Physical changes to a private residence, automobile, or van, to accommodate the participant or improve his or her function.
N/A	1403 equipment, technology, and supplies	N/A	N/A	The purchase or rent of items, devices, product systems, and/or disposable medical supplies.
N/A	N/A	14031 equipment and technology	assistive technologyspecialized medical equipment	The purchase or rent of items, devices, or product systems to increase or maintain a person's functional status. This service can include designing, fitting, adapting, and maintaining equipment, as well as training or technical assistance to use equipment.
N/A	N/A	14032 supplies	N/A	The purchase of disposable medical supplies, including nutritional supplements.
15 Non-Medical Transportation	N/A	N/A	N/A	Transportation not provided as part of another service such as a round-the-clock service or a day service. This service may include: a) transportation to and from other HCBS services; b) transportation to community activities where HCBS services are not provided; and/or c) the purchase of public transit tokens or passes.
N/A	N/A	15010 non-medical transportation	N/A	Same definition as category 15.



Appendix CAppendix B

16 Community Transition Services	N/A	N/A	N/A	Non-recurring set-up expenses for moving to a residence where the person is responsible for living expenses.
N/A	N/A	16010 community transition services	-N/A	Same definition as category 16.
17 Other Services	N/A	N/A	N/A	Services NOT identified in previous categories.
N/A	N/A	17010 goods and services	Individually directed goods and services	Services, equipment, or supplies in the person's support plan NOT otherwise provided in the Medicaid program.
N/A	N/A	17020 interpreter	N/A	Services provided by an individual to support communication by someone who has limited English proficiency or verbal skills, such as a sign language interpreter or communicator.
N/A	N/A	17030 housing consultation	N/A	Information and assistance to help a person identify and select housing.
N/A	N/A	17990 other	N/A	Services NOT identified in previous categories and services.

Appendix C: Comprehensive Eligibility Crosswalk

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

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

8	Caretaker relatives and children covered under the authority of an 1115 waiver and a Title XXI separate CHIP	§2107(e) of the Act.

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

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

ITEM	DESCRIPTION	CFR/PL CITATIONS
4	Aged individuals who receive a State supplementary payment (but not SSI) based on need.	42 CFR 435.230, §1902(a)(10)(A)(ii) of the Act.

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

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

ITEM	DESCRIPTION	CFR/PL CITATIONS
3	Blind and/or disabled individuals receiving mandatory State supplements.	42 CFR 435.130.
4	Blind and/or disabled individuals who receive a State supplementary payment (but not SSI) based upon need.	42 CFR 435.230, §1902(a)(10)(A)(ii) of the Act.

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

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

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

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

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

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

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

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Adults deemed essential for well-being of a recipient (see 45 CFR 233.20(a)(2)(vi)) qualified under §1931 of the Act (Low Income Families with Children).	42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act, §1931 of the Act.

ITEM	DESCRIPTION	CFR/PL CITATIONS
2	3 Pregnant women who have no other eligible children. 4 Other Adults in "adult only" units.	42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act.

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

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

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

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

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

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

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

~~ITEM~~	~~DESCRIPTION~~	~~CFR/PL CITATIONS~~
~~1~~	~~Pregnant women.~~	~~42 CFR 435.301.~~

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

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

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Qualified Medicare Beneficiaries (QMBs) who are entitled to Medicare Part A, whose income does not exceed 100% of the Federal poverty level, and whose resources do not exceed twice the SSI standard.	§§1902(a)(10)(E)(I) and 1905(p)(1) of the Act, PL 100-203, §4118(p)(8), PL 100-360, §301(a) & (e), PL 100-485, §608(d)(14), PL 100-647, §8434.

ITEM	DESCRIPTION	CFR/PL CITATIONS
2	Specified Low-Income Medicare Beneficiaries (SLMBs) who meet all of the eligibility requirements for QMB status, except for the income in excess of the QMB income limit, but not exceeding 120% of the Federal poverty level.	§4501(b) of OBRA 90, as amended in §1902(a)(10)(E) of the Act.
3	Qualifying individuals having higher income than allowed for QMBs or SLMBs.	§1902(a)(10)(E)(iv) of the Act.
4	Aged individual not described in S 1902(a)(10)(A)(1) of the Act, with income below the poverty level and resources within state limits, who are entitled to full Medicaid benefits.	§1902(a)(10)(A)(ii)(X), 1902(m)(1) of the Act, PL 99-509, §§9402 (a) and (b).

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

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

ITEM	DESCRIPTION	CFR/PL CITATIONS
5	Disabled individuals not described in §1902(a)(10)(A)(1) of the Act, with income below the poverty level and resources within state limits, which are entitled to full Medicaid benefits.	§§1902(a)(10)(A)(ii)(X), 1902(m)(1) and (3) of the Act, P.L. 99-509, §§9402 (a) and (b).

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

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Infants and children up to age 6 with income at or below 133% of the Federal Poverty Level (FPL).	§§1902(a)(10)(A)(I)(IV) & (VI), 1902(l)(1)(A), (B), & (C) of the Act, PL 100-360, §302(a)(1), PL 100-485, §608(d)(15).

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

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

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

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

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

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

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Aged individuals who meet more restrictive requirements than SSI and who are either receiving or not receiving SSI; or who qualify under §1619 of the Act.	42 CFR 435.121, §1619(b)(3) of the Act, §1902(f) of the Act, PL 99-643, §7.
2	Aged individuals who are ineligible for optional State supplements or SSI due to requirements that do not apply under title XIX.	42 CFR 435.122.

ITEM	DESCRIPTION	CFR/PL CITATIONS
3	Aged essential spouses considered continuously eligible since 12/73; and some spouses who share hospital or nursing facility rooms for 6 months or more.	42 CFR 435.131.
4	Institutionalized aged individuals who have been continuously eligible since 12/73 as inpatients or residents of Title XIX facilities.	42 CFR 435.132.
5	Aged individuals who would be SSI/SSP eligible except for the 8/72 increase in OASDI benefits.	42 CFR 435.134.
6	Aged individuals who would be eligible for SSI but for title II cost-of-living adjustment(s).	42 CFR 435.135.
7	Aged aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care.	PL 99-509, §9406.

ITEM	DESCRIPTION	CFR/PL CITATIONS
8	Aged individuals who would be eligible for AFDC, SSI, or an optional State supplement if not in a medical institution.	42.CFR 435.211, §1902(a)(10)(A)(ii) and §1905(a) of the Act.
9	Aged individuals who meet income and resource requirements for AFDC, SSI, or an optional State supplement.	42 CFR 435.210, §1902(a)(10)(A)(ii) and §1905 of the Act.
10	Aged individuals who have become ineligible and who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract.	42 CFR 435.212, §1902(e)(2), PL 99-272, §9517, PL 100-203, §4113(d).
11	Aged individuals who, solely because of coverage under a home and community based waiver, are not in a medical institution, but who would be eligible if they were.	42 CFR 435.217, §1902(a)(10)(A)(ii), (VI); 50 PL 100-13.
12	Aged individuals who elect to receive hospice care who would be eligible if in a medical institution.	§1902(a)(10)(A)(ii), (VII) of the Act, PL 99-272, §9505.

ITEM	DESCRIPTION	CFR/PL CITATIONS
13	Aged individuals in institutions who are eligible under a special income level specified in Supplement 1 to Attachment 2.6-A of the State's title XIX Plan.	42 CFR 435.236, §1902(a)(10)(A)(ii) of the Act.

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

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Blind and/or disabled individuals who meet more restrictive requirements than SSI, including both those receiving and not receiving SSI payments	42 CFR 435.121, §1619(b)(3) of the Act, §1902(f) of the Act, PL 99-643, §7.
2	Blind and/or disabled individuals who are ineligible for optional State supplements or SSI due to requirements that do not apply under title XIX.	42 CFR 435.122.

ITEM	DESCRIPTION	CFR/PL CITATIONS
3	Blind and/or disabled essential spouses considered continuously eligible since 12/73; and some spouses who share hospital or nursing facility rooms for 6 months or more.	42 CFR 435.131.
4	Institutionalized blind and/or disabled individuals who have been continuously eligible since 12/73 as inpatients or residents of Title XIX facilities.	42 CFR 435.132.
5	Blind and/or disabled individuals who would be SSI/SSP, eligible except for the 8/72 increase in OASDI benefits.	42 CFR 435.134.
6	Blind and/or disabled individuals who would be eligible for SSI but for title II cost-of-living adjustment(s).	42 CFR 435.135, §503 PL 94-566.
7	Blind and/or disabled aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care.	PL 99-509, §9406.

ITEM	DESCRIPTION	CFR/PL CITATIONS
8	Blind and/or disabled individuals who meet all Medicaid requirements except current blindness, or disability criteria, who have been continuously eligible since 12/73 under the State's 12/73 requirements.	42 CFR 435.133.
9	Blind and/or disabled individuals, age 18 or older, who became blind or disabled before age 22 and who lost SSI or State supplementary payments eligibility because of an increase in their OASDI (childhood disability) benefits.	§1634(c) of the Act; PL 99-643, §6.
10	Blind and/or disabled individuals who would be eligible for AFDC, SSI, or an optional State supplement if not in a medical institution.	42 CFR 435.211, §§1902(a)(10)(A)(ii) and 1905(a) of the Act.
11	Qualified severely impaired blind or disabled individuals under age 65, who, except for earnings, are eligible for SSI.	§§1902(a)(10)(A)(I)(II) and 1905(q) of the Act, PL 99-509, §9404 and §1619(b)(8) of the Act, PL 99-643, §7

ITEM	DESCRIPTION	CFR/PL CITATIONS
12	Blind and/or disabled individuals who meet income and resource requirements for AFDC, SSI, or an optional State supplement.	42 CFR 435.210, §§1902(a)(10)(A)(ii) and 1905 of the Act.
13	Working disabled individuals who buy-in to Medicaid	§1902(a)(10)(A)(ii)(XIII).
14	Blind and/or disabled individuals who have become ineligible who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract.	42 CFR 435.212, §1902(e)(2) of the Act; PL 99-272, §9517; PL 100-203, §4113(d).
15	Blind and/or disabled individuals who, solely because of coverage under a home and community based waiver, are not in a medical institution and who would be eligible if they were.	42 CFR 435.217, §1902(a)(10)(A)(ii)(VI) of the Act, 50 PL 100-13.
16	Blind and/or disabled individuals who elect to receive hospice care, and who would be eligible if in a medical institution.	§1902(a)(10)(A)(ii)(VII), PL 99-272, §9505

ITEM	DESCRIPTION	CFR/PL CITATIONS
17	Blind and/or disabled individuals in institutions who are eligible under a special income level specified in Supplement 1 to Attachment 2.6-A of the State's title XIX Plan.	42 CFR 435.231. §1902(a)(10)(A)(ii) of the Act.
18	Blind and/or disabled widows and widowers who have lost SSI/SSP benefits but are considered eligible for Medicaid until they become entitled to Medicare Part A.	§1634 of the Act, PL 101-508, §5103.
19	Certain Disabled children, 18 or under, who live at home, but who, if in a medical institution, would be eligible for SSI or a State supplemental payment.	42 CFR 435.225; §1902(e)(3) of the Act.
20	Continuation of Medicaid eligibility for disabled children who lose SSI benefits because of changes in the definition of disability.	§1902(a)(10)(A)(ii) of the Act; P.L. 15-32, §491.

ITEM	DESCRIPTION	CFR/PL CITATIONS
21	Disabled individuals with medically improved disabilities made eligible under the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999.	§1902(a)(10)(A)(ii)(XV) of the Act.

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

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Children of families receiving up to 12 months of extended Medicaid benefits (for those eligible after 4/1/90).	§1925 of the Act, PL 100-485, §303.
2	"Qualified children" under age 19 born after 9/30/83 or at an earlier date at State option, who meet the State's AFDC income and resource requirements.	§§1902(a)(10)(A)(I)(III) and 1905(n) of the Act, PL 98-369, §2361, PL 99-272, §9511, PL 100-203, §4101.

ITEM	DESCRIPTION	CFR/PL CITATIONS
3	Children of individuals who are ineligible for AFDC-related Medicaid because of requirements that do not apply under title XIX.	42 CFR 435.113.
4	Children of individuals who would be eligible for Medicaid under §1931 of the Act (Low income families with children) except for the 7/1/72 (PL 92-325) OASDI increase and were entitled to OASDI and received cash assistance in 8/72.	42 CFR 435.114.
5	Children whose mothers were eligible for Medicaid at the time of childbirth, and are deemed eligible for one year from birth as long as the mother remained eligible, or would have if pregnant, and the child remains in the same household as the mother.	42 CFR 435.117, §1902(e)(4) of the Act, PL 98-369, §2362.
6	Children of aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care.	PL 99-509, §9406.

ITEM	DESCRIPTION	CFR/PL CITATIONS
7	Children who meet income and resource requirements for AFDC, SSI, or an optional State supplement	42 CFR 435.210, §1902(a)(10)(A)(ii) and §1905 of the Act.
8	Children who would be eligible for AFDC, SSI, or an optional State supplement if not in a medical institution.	42 CFR 435.211, §1902(a)(10)(A)(ii) and §1905(a) of the Act.
9	Children who have become ineligible who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract.	42 CFR 435.212, §1902(e)(2) of the Act, PL 99-272, §9517, PL 100-203, §4113(d).
10	Children of individuals who elect to receive hospice care, and who would be eligible if in a medical institution.	§1902(a)(10)(A)(ii)(VII), PL 99-272, §9505.
11	Children who would be eligible for AFDC if work-related child care costs were paid from earnings rather than received as a State service.	42 CFR 435.220.

ITEM	DESCRIPTION	CFR/PL CITATIONS
12	Children of individuals who would be eligible for AFDC if the State used the broadest allowable AFDC criteria.	42 CFR 435.223, §§1902(a)(10)(A)(ii) and 1905(a) of the Act.
13	Children who solely because of coverage under a home and community based waiver, are not in a medical institution, but who would be eligible if they were.	42 CFR 435.217, §1902(a)(10)(A)(ii)(VI) of the Act.
14	Children not described in §1902(a)(10)(A)(I) of the Act, "Ribikoff Kids", who meet AFDC income and resource requirements, and are under a State-established age (18-21).	§§1902(a)(10)(A)(ii) and 1905(a)(I) of the Act, PL 97-248, §137.

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

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Families receiving up to 12 months of extended Medicaid benefits (if eligible on or after 4/1/90).	§1925 of the Act, PL 100-485, §303.

ITEM	DESCRIPTION	CFR/PL CITATIONS
2	Qualified pregnant women whose pregnancies have been medically verified and who meet the State's AFDC income and resource requirements.	§§1902(a)(10)(A)(I)(III) and 1905(n) of the Act, PL 98-369, §2361, PL 99-272, §9511, PL 100-203 §4101.
3	Adults who are ineligible for AFDC-related Medicaid because of requirements that do not apply under title XIX.	42 CFR 435.113.
4	Adults who would be eligible for Medicaid under §1931 of the Act (Low income families with children) except for the 7/1/72 (PL 92-325) OASDI increase; and were entitled to OASDI and received cash assistance in 8/72.	42 CFR 435.114.
5	Women who were eligible while pregnant, and are eligible for family planning and pregnancy related services until the end of the month in which the 60th day occurs after the pregnancy	§1902(e)(5) of the Act, PL 98-369, PL 100-203, §4101, PL 100-360, §302(e).

ITEM	DESCRIPTION	CFR/PL CITATIONS
6	Adult aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care.	PL 99-509, §9406.
7	Adults who meet the income and resource requirements for AFDC, SSI, or an optional State Supplement.	42 CFR 435.210, §§1902(a)(10)(A)(ii) and 1905 of the Act.
8	Adults who would be eligible for AFDC, SSI, or an optional State Supplement if not in a medical institution.	42 CFR 435.211, §§1902(a)(10)(A)(ii) and 1905(a) of the Act.
9	Adults who have become ineligible who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract.	42 CFR 435.212, §1902(e)(2)(A) of the Act, PL 99-272, §9517, PL 100-203, §4113(d).
10	Adults who solely because of coverage under a home and community based waiver, are not in a medical institution, but who would be eligible if they were.	42 CFR 435.217, §1902(a)(10)(A)(ii)(VI) of the Act.

ITEM	DESCRIPTION	CFR/PL CITATIONS
11	Adults who elect to receive hospice care, and who would be eligible if in a medical institution.	§1902(a)(10)(A)(ii), (VII); PL 99-272, §9505.
12	Adults who would be eligible for AFDC if work-related child care costs were paid from earnings rather than received as a State service.	42 CFR 435.220.
13	Pregnant women who have been granted presumptive eligibility.	§§1902(a)(47) and 1920 of the Act, PL 99-509, §9407.
14	Adults who would be eligible for AFDC if the State used the broadest allowable AFDC criteria.	42 CFR 435.223, §§1902(a)(10)(A)(ii) and 1905(a) of the Act.

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

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

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

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

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

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

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

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

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

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

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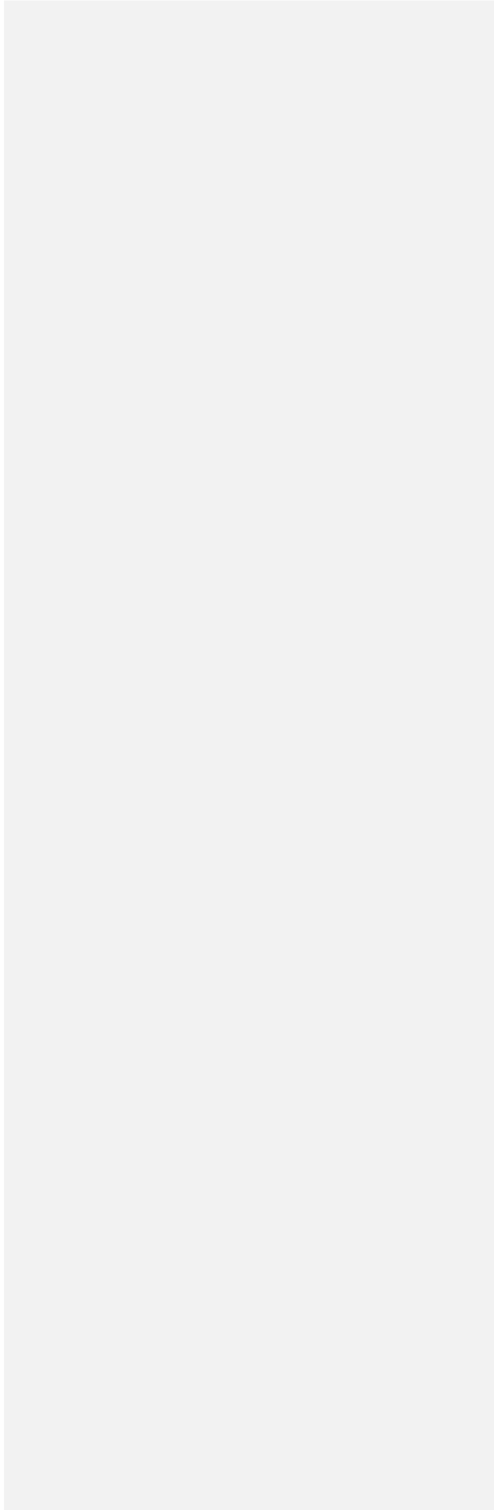
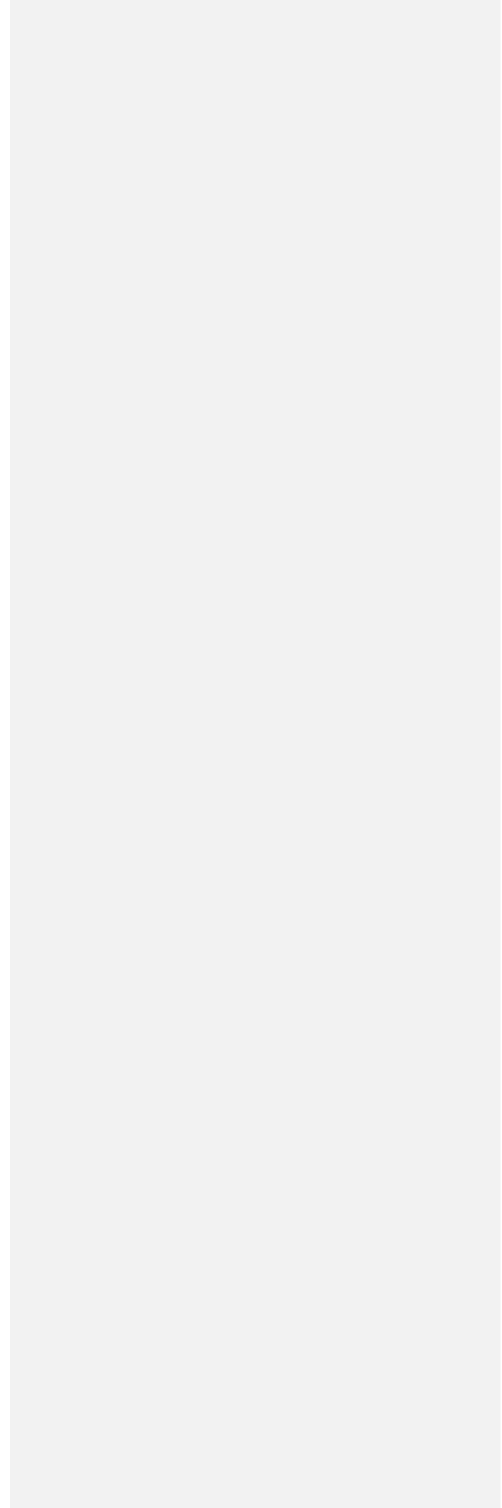


Appendix D



Appendix D: Types of Service (TOS) Reference

Definitions of Types of Service

The following definitions are adaptations of those given in theType of Service values are predominantly defined in the Code of Federal Regulations (CFR). These definitions, although abbreviated, are intendedClarification is of the definitions are provided herebelow to facilitate 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 (CFR).

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

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

Institutional Inpatient Facilityies Services

2.1. **Inpatient Hospital Services (TOS Code=001)(See 42 CFR 440.10; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).)** include services referenced in the following regulatory contexts:These are services that are:

- Ordinarily furnished in a hospital for the care and treatment of inpatients;
- Furnished under the direction of a physician or dentist (except in the case of nurse-midwife services per 42 CFR 440.165); and
- Furnished in an institution that:
  - Is maintained primarily for the care and treatment of patients with disorders other than mental health conditions;
  - Is licensed or formally approved as a hospital by an officially designated authority for State standard setting;
  - Meets the requirements for participation in Medicare (except in the case of medical supervision of nurse-midwife services per 42 CFR 440.165); and
  - Has in effect a utilization review plan applicable to all Medicaid patients that meets the requirements in 42 CFR 482.30 unless a waiver has been granted by the Secretary of Health and Human Services.

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

~~Mental Health Facility Services (See 42 CFR 440.140, 440.160, and 435.1009).--~~

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.

~~3.~~2. Mental Health Facility Services ~~(See 42 CFR 440.140, 440.160, and 435.1009).--An institution for mental health conditions is a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment or care of individuals with mental health conditions, including medical care, nursing care, and related services. Report totals for services defined under 3a and 3b.~~

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

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

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

Term	Description
Inpatient hospital services, nursing facility services, and intermediate care facility services for individuals ageaged 65 or older in institutions for mental diseases	42 CFR 440.140

4.3. **Nursing Facilities (NF) Services (TOS Code=009 and 047)**(See 42 CFR 440.40 and 440.155).--) include services referenced in the following regulatory contexts:These are services provided in an institution (or a distinct part of an institution) which: [1]

- Is primarily engaged in providing to residents:
  - Skilled nursing care and related services for residents who require medical or nursing care;
  - Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or
  - On a regular basis, health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental health conditions; and;
- Meet the requirements for a nursing facility described in subsections 1919(b), (c), and (d) of the Act regarding:
  - Requirements relating to provision of services;
  - Requirements relating to residents' rights; and
  - Requirements relating to administration and other matters.

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

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

[1] ICF Services - All Other.--This is combined with nursing facility services.

Term	Description
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.

5.4. **ICF Services for the Individuals with Intellectually Disabilitiesled (TOS Code=046)** (See 42 CFR 440.150). 42 CFR 440.150)include services referenced in the following regulatory context:.–These are services provided in an institution for individuals with intellectual disabilities persons or persons with related conditions if the:

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

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

Institutional Outpatient Facility Services

5. **Outpatient Hospital Services (TOS Codes=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)** (See 42 CFR 440.50; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450) include services referenced in the following regulatory contexts:.–Whether furnished in a physician's office, a recipient's home, a hospital, a NF, or elsewhere, these are services provided:

- Within the scope of practice of medicine or osteopathy as defined by State law; and

- ~~By, or under, the personal supervision of an individual licensed under State law to practice medicine or osteopathy, or dental medicine or dental surgery if State law allows such services to be provided by either a physician or dentist.~~

Term	Description
Physicians' services and medical and surgical services of a dentist.~~Outpatient hospital services and rural health clinic services~~	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

~~NOTE: These services may be provided in a physician's office, a recipient's home, a hospital, a nursing facility, or elsewhere.~~

~~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~~

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:

NOTE: The category “Other Licensed Practitioners' Services” is different than the “Other Care” category. Examples of other practitioners (if covered under State law) are:

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

- 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

~~7.~~ NOTE: X-ray services provided by dentists are reported under dental services.~~**Outpatient Hospital Services (TOS Codes=002)** (See 42 CFR 440.20; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450). These are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished:~~

- ~~To outpatients;~~
- ~~Except in the case of nurse-midwife services (see 42 CFR 440.165), under the direction of a physician or dentist; and~~
- ~~By an institution that:~~
  - ~~Is licensed or formally approved as a hospital by an officially designated authority for State standard setting; and~~
  - ~~Except in the case of medical supervision of nurse midwife services (see 42 CFR 440.165), meets the requirements for participation in Medicare as a hospital.~~

~~Term~~	~~Description~~
~~Outpatient hospital services and rural health clinic services~~	
~~Definition of child health assistance~~	
~~Benchmark health benefits coverage~~	
~~Benchmark-equivalent health benefits coverage~~	
~~Actuarial report for benchmark-equivalent coverage~~	
~~Existing comprehensive State-based coverage~~	
~~Secretary-approved coverage~~	

~~8. **Prescribed Drugs (TOS Code=033)** (See 42 CFR 440.120; 42 CFR § 457.402; 42 CFR § 457.410; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450). These are simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease or for health maintenance that are:~~

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

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

9. **Dental Services (TOS Code=029)** (See 42 CFR 440.100; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--These are diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession, including treatment of:[2]

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

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

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

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

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

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

Other Services

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

- Chiropractors;
- Podiatrists;
- Psychologists; and
- Optometrists.

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

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

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

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

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

11. Clinic Services (TOS Code=028(See 42 CRF 440.90; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).) Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are provided:[3]

- To outpatients;

By a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients including services furnished outside the clinic by clinic personnel to individuals without a fixed home or mailing address. For reporting purposes, consider a group of physicians who share, only for mutual convenience, space, services of support staff, etc., as physicians, rather than a clinic, even though they practice under the name of the clinic; and

- Except in the case of nurse-midwife services (see 42 CFR 440.165), are furnished by, or under, the direction of a physician.

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

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

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

- Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law or ordered and billed by a physician but provided by referral laboratory

- Provided by a laboratory that meets the requirements for participation in Medicare.

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

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	

13. Sterilizations (TOS Code=084) (See 42 CFR 441, Subpart F).-- include services referenced in the following statutory contexts:These are medical procedures, treatment or operations for the purpose of rendering an individual permanently incapable of reproducing.

Term	Description
Sterilizations	42 CFR § 441, Subpart F

14. Home Health Services (TOS Code=016,017, 018, 019, 020, and 021) (See 42 CFR 440.70; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450). These are services provided at the patient's place of residence, in compliance with a physician's written plan of care that is reviewed every 62 days. The following items and services are mandatory.

- Nursing services, as defined in the State Nurse Practice Act that is provided on a part-time or intermittent basis by a home health agency (a public or private agency or organization, or part of any agency or organization that meets the requirements for participation in Medicare). If there is no agency in the area, a registered nurse who:
  - Is licensed to practice in the State;
  - Receives written orders from the patient's physician;
  - Documents the care and services provided; and
  - Has had orientation to acceptable clinical and administrative record keeping from a health department nurse;
- Home health aide services provided by a home health agency; and
- Medical supplies, equipment, and appliances suitable for use in the home.

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

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

Term	Description
Other laboratory and X-ray services	
Definition of child health assistance	
Benchmark health benefits coverage	
Benchmark-equivalent health benefits coverage	
Actuarial report for benchmark-equivalent coverage	
Existing comprehensive State-based coverage	
Secretary-approved coverage	

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

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

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

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

Term	Description
Personal care services	42 CFR § 440.167

b. ***15b. Targeted Case Management Services (TOS Code=053)****(See 42 CFR § 440.169; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).)* include services referenced in the following regulatory contexts:These are services that are furnished to individuals

eligible under the plan to gain access to needed medical, social, educational, and other services. The agency may make available case management services to:

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

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

Term	Description
Case management servicesOther laboratory and X-ray 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. *15c.* ***Rehabilitative Services (TOS Code=043)*** (See 42 CFR 440.130).) These include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under State law for maximum reduction of physical or mental health condition and restoration of a recipient to his/her best possible functional level. include services referenced in the following regulatory context:

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

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

Term	Description
Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disordersOther laboratory and X-ray services	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. *15e.* ***Hospice Services (TOS Code=087)*** include services referenced in the following regulatory contexts: (See 42 CFR 418.202; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450). Whetherwhether received in a hospice facility or elsewhere, these are services that are:

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

Term	Description
Other laboratory and X-ray servicesHospice care	SSA §1905(o) 42 CFR § 418.202
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. *15f.* ***Nurse Midwife (TOS Code=025)*** (See 42 CFR 440.165; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450) include services referenced in the following regulatory contexts:. These are services that are concerned with management and the care of mothers and newborns throughout the maternity cycle and are furnished within the scope of practice authorized by State law or regulation.

Term	Description
Nurse-midwife serviceOther laboratory and X-ray services	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

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

g.

15g. Nurse Practitioner (TOS Code=026) (See 42 CFR 440.166; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450). --). These are services furnished by a registered

a. professional nurse who meets State's advanced educational and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses.

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

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. ***15i.*** ***Religious Non-Medical Health Care Institutions (TOS Code=058)*** (See 42 CFR 440.170). --) include services referenced in the following regulatory context:. These are non-medical health care services

equivalent to a hospital or extended care level of care provided in facilities that meet the requirements of Section 1861(ss)(1) of the Act.

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

Other CareServices

13. Other CareServices

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

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

c. *16a.* ***Transportation (TOS Code=056)*** (See 42 CFR 440.170; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).) include services referenced in the following regulatory contexts:--Report totals for services provided under this title to include transportation and other related travel services determined necessary by you to secure medical examinations and treatment for a recipient.[4]

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

[4] 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.

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.

~~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.~~

~~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~~

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

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

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. 16c. OtherOther **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:They may include, but are not limited to:

- Prosthetic devices (see 42 CFR 440.120; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450)Prosthetic devices, which are replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice as defined by State law to:
  - Artificially replace a missing portion of the body;
  - Prevent or correct physical deformity or malfunctions; or
  - Support a weak or deformed portion of the body.
- Eyeglasses (see 42 CFR 440.120; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450). Eyeglasses mean lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optician. It includes optician fees for services.
- Home and Community-Based Waiver services (See §1915(c) of the Act and 42 CFR 440.180) that cannot be associated with other TYPE-OF-SERVICE codes (e.g., community homes for the disabled and adult day care.)

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

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

Term	Description
CONTRACTS	42 CFR Part 434

17a. Health Maintenance Organization (HMO) and Health Insuring Organization (HIO) (TOS Code=119). These include plans contracted to provide capitated comprehensive services. An HMO is a public or private

organization that contracts on a prepaid capitated risk basis to provide a comprehensive set of services and is federally qualified or State-plan defined. An HIO is an entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

17b. Prepaid Health Plans (PHP) (TOS Code=122). These include plans that are contracted to provide less than comprehensive services. Under a non-risk or risk arrangement, the State may contract with (but not limited to these entities) a physician, physician group, or clinic for a limited range of services under capitation. A PHP is an entity that provides a non-comprehensive set of services on either capitated risk or non-risk basis or the entity provides comprehensive services on a non-risk basis.[5]

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

18. Primary Care Case Management (PCCM) (TOS Code=120) (See §1915(b)(1) of the Act).) The State contracts directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee. Report these recipients and associated PCCM fees in this section.[6]

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

Term	Description
Primary Care Case Management	See §1915(b)(1) of the Act

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

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

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

[5] Include dental, mental health, and other plans covering limited services under PHP.
[6] Where the fee includes services beyond case management, report the enrollees and fees under prepaid health plans (17b).

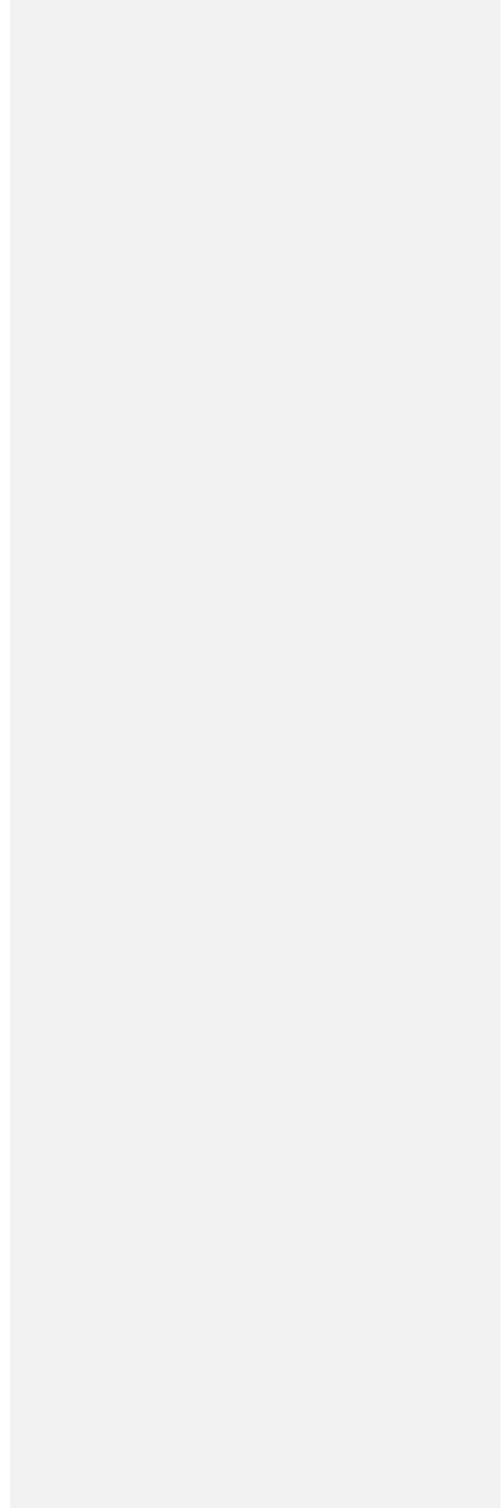
20. Per member per month (PMPM) payments for health home services (TOS 138)
21. Per member per month (PMPM) payments for Medicare Part A premiums (TOS 139)
22. Per member per month (PMPM) payments for Medicare Part B premiums (TOS 140)
23. Per member per month (PMPM) payments for Medicare Advantage Dual Special Needs Plans (D-SNP) – Medicare Part C (TOS 141)
24. Per member per month (PMPM) payments for Medicare Part D premiums (TOS 142)
25. Per member per month (PMPM) payments for other payments (TOS 143)
26. Payments to individuals for personal assistance services under 1915(j) (TOS 144)

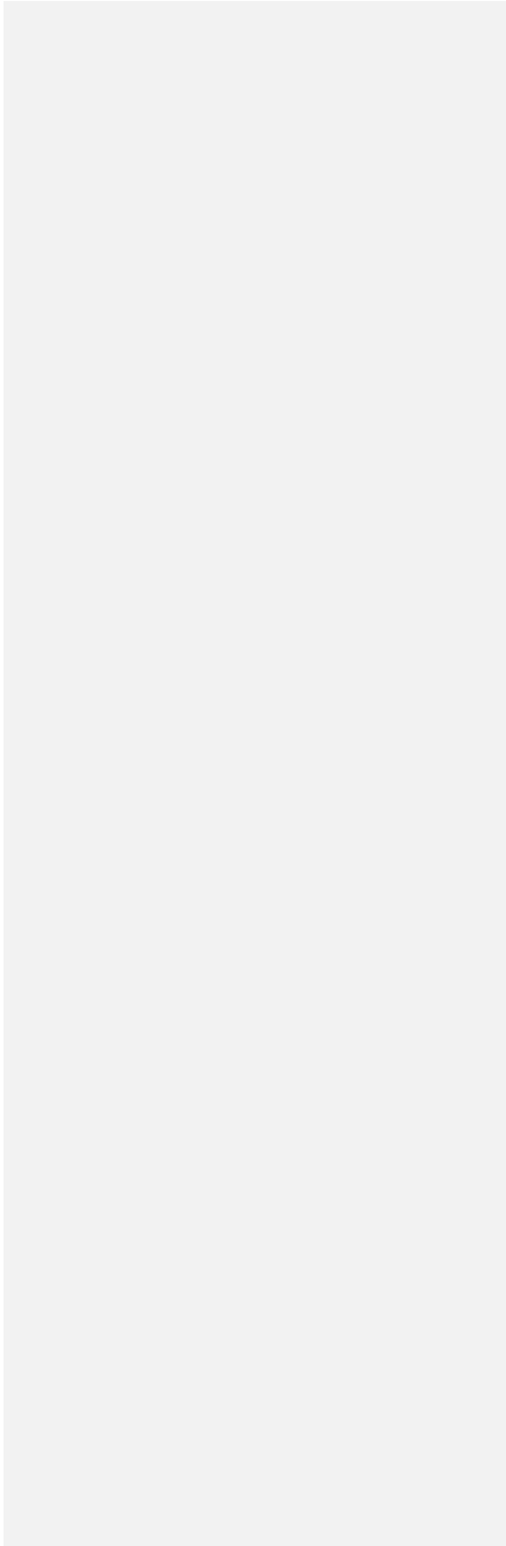
16. **Medication Assisted Treatment (MAT) services and drugs for evidenced-based treatment of Opioid Use Disorder (OUD) (*TOS Code=145*)** include services referenced in the following regulatory context:(of the Social Security Act) Effective October 1, 2020, state Medicaid programs are required to provide coverage of Medication Assisted Treatment (MAT) services and drugs under a new mandatory benefit. The SUPPORT Act of 2018 (P.L. 115-271) amended the Social Security Act (the Act) to add this new mandatory benefit. The purpose of the new mandatory MAT benefit found at section 1905(a)(29) of the Act is to increase access to evidenced-based treatment for Opioid Use Disorder (OUD) for all Medicaid beneficiaries and to allow patients to seek the best course of treatment and particular medications that may not have been previously covered. CMS interprets sections 1905(a)(29) and 1905(ee) of the Act to require that, as of October 1, 2020, states must include as part of the new MAT mandatory benefit all forms of drugs and biologicals that the Food and Drug Administration (FDA) has approved or licensed for MAT to treat OUD. More specifically, under the new mandatory MAT benefit, states are required to cover such FDA approved or licensed drugs and biologicals used for indications for MAT to treat OUD. States currently cover many of these MAT drugs and biologicals (for all medically-accepted indications) under the optional benefit for prescribed drugs described at section 1905(a)(12) of the Act

15.

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

Appendix DAppendix D





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 1-3

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

- Periodic screenings, which are provided at distinct intervals determined by the State, and which must include the following services:
  - A comprehensive health and developmental history assessment (including assessment of both physical and mental health development);
  - A comprehensive unclothed physical exam;
  - Appropriate immunizations according to the Advisory Committee on Immunization Practices schedule;
  - Laboratory tests (including blood lead level assessment); and
  - Health education (including anticipatory guidance); and
- Interperiodic screenings, which are provided when medically necessary to determine the existence of suspected physical or mental illness or conditions.

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

- Counseling and patient education and treatment furnished by medical professionals in accordance with State law;
- Laboratory and X-ray services;

- Medically approved methods, procedures, pharmaceutical supplies, and devices to prevent conception;
- Natural family planning methods; and
- Diagnosis and treatment for infertility.

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

- Services furnished by a physician within the scope of his or her profession as defined by State law. The physician performs these services in or away from the clinic and has an agreement with the clinic providing that he or she will be paid for these services;
- Services furnished by a physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner (as defined in 42 CFR 405.2401 and 491.2) if the services are furnished in accordance with the requirements specified in 42 CFR 405.2412(a);
  - Services and supplies provided in conjunction with professional services furnished by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner. (See 42 CFR 405.2413 and 405.2415 for the criteria determining whether services and supplies are included here.); or
  - Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biologicals) if:
    - The clinic is located in an area in which the Secretary has determined that there is a shortage of home health agencies (see 42 CFR 405.2417);
    - The services are furnished by a registered nurse or licensed practical or vocational nurse employed, or otherwise compensated for the services, by the clinic;
    - The services are furnished under a written plan of treatment that is either established and reviewed at least every 60 days by a supervising physician of the clinic, or that is established by a physician, physician's assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner and reviewed and approved at least every 60 days by a supervising physician of the clinic; and
    - The services are furnished to a homebound patient. For purposes of visiting nurse services, a homebound recipient means one who is permanently or temporarily confined to a place of residence because of a medical or health condition and leaves the place of residence infrequently. For this purpose, a place of residence does not include a hospital or nursing facility.

Program Type 4-5

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

- They receive grants under §§329, 330, or 340 of the Public Health Service Act (PHS);

- The Health Resources and Services Administration, PHS, certifies the center as meeting FQHC requirements; or

- The Secretary determines that the center qualifies through waiver of the requirements.

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

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

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

Program Type 6-10

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

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

Program Type 08. Money Follows Patient 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]). helps States rebalance their long-term care systems through the development of transition programs that move people with Medicaid from institutional-based long-term care to community-based long-term care. To qualify for MFP, Medicaid recipients need to have been in institutional care for at least 90 days, exclusive of Medicare-paid rehabilitation days. Upon the initial transition to community-based long-term care, MFP participants are eligible for MFP benefits for up to 365 days. At the conclusion of MFP eligibility, the person continues as a typical Medicaid beneficiary. While eligible for MFP benefits, the restricted benefits flag in the eligibility file should be set to value 08 whenever the beneficiary has a single day of MFP eligibility during the month.

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

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

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

- Lowering costs through improved systems performance & efficiency
- Creating tools to help consumers with care planning & assessment
- Improving quality measurement & oversight

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

Program Type 11-13

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

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

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

Program Type 13. Home and Community-Based Services (HCBS) State Plan Option (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

Program Type 14 (a)–(m)

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

(a) Inpatient hospital services.

(b) Outpatient hospital services.

(c) Physician services.

(d) Surgical services.

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

(f) Prescription drugs and biologicals and the administration of these drugs and

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

~~(g) Over-the-counter medications.~~

~~(h) Laboratory and radiological services.~~

~~(i) Prenatal care and pre-pregnancy family planning services and supplies.~~
~~(j) Inpatient mental health services, other than services described in paragraph (r) of this section but including services furnished in a state-operated mental health hospital and including residential or other 24-hour therapeutically planned structured services.~~

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

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

~~(m) Disposable medical supplies.~~

~~Program Type 14 (n)–(bb)~~

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

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

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

~~(q) Dental services.~~

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

~~(s) Outpatient substance abuse treatment services.~~

~~(t) Case management services.~~

~~(u) Care coordination services.~~

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

(w) Hospice care.

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

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

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

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

(y) Premiums for private health care insurance coverage.

(z) Medical transportation.

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

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

Program Type 15-16

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

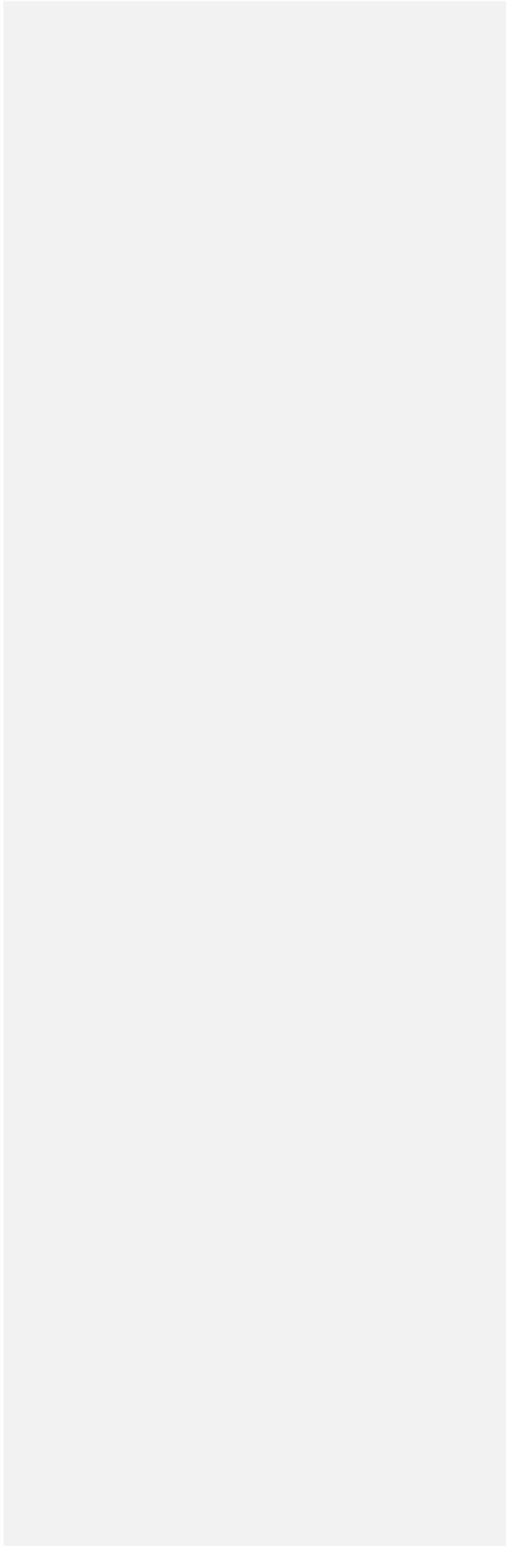
Program Type 16. SSA § 1915(j) (Self-directed personal assistance services/personal care under State Plan or 1915(c) waiver). Self-directed personal assistance services (PAS) are personal care and related services provided under the Medicaid State plan and/or section 1915(c) waivers the State already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

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 E



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)~~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

Appendix F

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

Appendix F

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

Appendix F

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

Appendix F

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

Appendix F

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 ~~MANDATORY~~OPTIONS FOR COVERAGE

~~Code~~ 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

Appendix F

~~Code~~ 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

Appendix F

~~Code~~ Code	Eligibility Group	Short Description	Citation	Type	Category
32	Individuals Electing COBRA Continuation Coverage	Individuals choosing to continue COBRA benefits with income equal to or less than 100% of the FPL.	1902(a)(10)(F); 1902(u)(1)	Family/Adult	Options for Coverage
33	Individuals above 133% FPL under Age 65	Individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the State.	CFR 435.218; 1902(hh); 1902(a)(10)(A)(ii)(XX)	Family/Adult	Options for Coverage
34	Certain Individuals Needing Treatment for Breast or Cervical Cancer	Individuals under the age of 65 who have been screened for breast or cervical cancer and need treatment.	42 CFR 435.213; 1902(a)(10)(A)(ii)(XVIII); 1902(aa)	Family/Adult	Options for Coverage
35	Individuals Eligible for Family Planning Services	Individuals who are not pregnant, with income equal to or below the highest standard for pregnant women, as specified by the State, limited to family planning and related services.	42 CFR 435.214; 1902(a)(10)(A)(ii)(XXI)	Family/Adult	Options for Coverage
36	Individuals with Tuberculosis	Individuals infected with tuberculosis whose income does not exceed established standards, limited to tuberculosis-related services.	42 CFR 435.215; 1902(a)(10)(A)(ii)(XII); 1902(z)	Family/Adult	Options for Coverage

~~Code~~ Code	Eligibility Group	Short Description	Citation	Type	Category
37	Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash Assistance	Individuals who meet the requirements of SSI or Optional State Supplement, but who do not receive cash.	42 CFR 435.210 & 230; 1902(a)(10)(A)(ii)(I);	ABD	Options for Coverage
38	Individuals Eligible for Cash Assistance except for Institutionalization	Individuals who meet the requirements of AFDC, SSI or Optional State Supplement, and would be eligible if they were not living in a medical institution.	42 CFR 435.211; 1902(a)(10)(A)(ii)(IV);	ABD	Options for Coverage
39	Individuals Receiving Home and Community Based Services under Institutional Rules	Individuals who would be eligible for Medicaid under the State Plan if in a medical institution, who would live in an institution if they did not receive home and community based services.	42 CFR 435.217; 1902(a)(10)(A)(ii)(VI)	ABD	Options for Coverage
40	Optional State Supplement Recipients - 1634 States, and SSI Criteria States with 1616 Agreements	Individuals in 1634 States and in SSI Criteria States with agreements under 1616, who receive a state supplementary payment (but not SSI).	42 CFR 435.232; 1902(a)(10)(A)(ii)(IV)	ABD	Options for Coverage
41	Optional State Supplement Recipients - 209(b) States, and SSI Criteria States without 1616 Agreements	Individuals in 209(b) States and in SSI Criteria States without agreements under 1616, who receive a state supplementary payment (but not SSI).	42 CFR 435.234; 1902(a)(10)(A)(ii)(XI)	ABD	Options for Coverage

Appendix F

~~Code~~ Code	Eligibility Group	Short Description	Citation	Type	Category
42	Institutionalized Individuals Eligible under a Special Income Level	Individuals who are in institutions for at least 30 consecutive days who are eligible under a special income level.	42 CFR 435.236; 1902(a)(10)(A)(ii)(V)	ABD	Options for Coverage
43	Individuals participating in a PACE Program under Institutional Rules	Individuals who would be eligible for Medicaid under the State Plan if in a medical institution, who would require institutionalization if they did not participate in the PACE program.	1934	ABD	Options for Coverage
44	Individuals Receiving Hospice Care	Individuals who would be eligible for Medicaid under the State Plan if they were in a medical institution, who are terminally ill, and who will receive hospice care.	1902(a)(10)(A)(ii)(VII); 1905(o)	ABD	Options for Coverage
45	Qualified Disabled Children under Age 19	Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	1902(e)(3)	ABD	Options for Coverage
46	Poverty Level Aged or Disabled	Individuals who are aged or disabled with income equal to or less than a percentage of the FPL, established by the state (no higher than 100%).	1902(a)(10)(A)(ii)(X); 1902(m)(1)	ABD	Options for Coverage

~~Code~~ Code	Eligibility Group	Short Description	Citation	Type	Category
47	Work Incentives Eligibility Group	Individuals with a disability with income below 250% of the FPL, who would qualify for SSI except for earned income.	1902(a)(10)(A)(ii)(XIII)	ABD	Options for Coverage
48	Ticket to Work Basic Group	Individuals with earned income between ages 16 and 64 with a disability, with income and resources equal to or below a standard specified by the State.	1902(a)(10)(A)(ii)(XV)	ABD	Options for Coverage
49	Ticket to Work Medical Improvements Group	Individuals with earned income between ages 16 and 64 who are no longer disabled but still have a medical impairment, with income and resources equal to or below a standard specified by the State.	1902(a)(10)(A)(ii)(XVI)	ABD	Options for Coverage
50	Family Opportunity Act Children with Disabilities	Children under 19 who are disabled, with income equal to or less than a standard specified by the State (no higher than 300% of the FPL).	1902(a)(10)(A)(ii)(XIX); 1902(cc)(1)	ABD	Options for Coverage

~~Code~~ Code	Eligibility Group	Short Description	Citation	Type	Category
51	Individuals Eligible for Home and Community-Based Services	Individuals with income equal to or below 150% of the FPL, who qualify for home and community based services without a determination that they would otherwise live in an institution.	1902(a)(10)(A)(ii)(XXII); 1915(i)	ABD	Options for Coverage
52	Individuals Eligible for Home and Community-Based Services - Special Income Level	Individuals with income equal to or below 300% of the SSI federal benefit rate, who meet the eligibility requirements for a waiver approved for the State under 1915(c), (d) or (e), or 1115.	1902(a)(10)(A)(ii)(XXII); 1915(i)	ABD	Options for Coverage
*72[7]	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

[7] 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~~ Code	Eligibility Group	Short Description	Citation	Type	Category
*73[8]	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

[8] 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~~ Code	Eligibility Group	Short Description	Citation	Type	Category
*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
76	Uninsured Individual eligible for COVID-19 testing	Uninsured individuals who are eligible for medical assistance for COVID-19 diagnostic products and any visit described as a COVID–19 testing-related service for which payment may be made under the State plan during any portion of the public health emergency period, beginning March 18, 2020.	1902(a)(10)(A)(ii)(XXIII)	Family/Adult	Optional

MEDICAID ~~OPTIONS FOR COVERAGE~~MEDICALLY NEEDY

~~Code~~ 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

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

~~Code~~ Code	Eligibility Group	Short Description	Citation	Type	Category
60	Medically Needy Blind or Disabled Individuals Eligible in 1973	Blind or disabled individuals who were eligible for Medicaid as Medically Needy in 1973 who meet all current requirements for Medicaid except for the blindness or disability criteria.	42 CFR 435.340	ABD	Medically Needy

~~MEDICAID MEDICALLY NEEDY~~

CHIP COVERAGE

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

CHIP ADDITIONAL OPTIONS FOR COVERAGE

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

~~Code~~ Code	Eligibility Group	Short Description	Citation	Type	Category
68	Pregnant Women with Access to Public Employee Coverage	Uninsured pregnant women having access to public employee coverage and whose household income is within standards established by the state.	2110(b)(2)(B) and (b)(6)	Pregnant Women	Option for Coverage

~~CHIP ADDITIONAL OPTIONS FOR COVERAGE~~

1115 EXPANSION ELIGIBILITY GROUPS

~~Code~~ 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

~~Code~~ Code	Eligibility Group	Short Description	Citation	Type	Category
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

~~Table 43-~~1115 ~~EXPANSION ELIGIBILITY GROUPS~~

Appendix G: ISO 639 Language Codes Reference

ISO 639-2 Code	Language	ISO 639-2 Code	Language
abk	Abkhazian	kut	Kutenai
ace	Achinese	lad	Ladino
ach	Acoli	lah	Lahnda
ada	Adangme	lam	Lamba
ady	Adyghe; Adygei	day	Land Dayak languages
aar	Afar	lao	Lao
afh	Afrihili	lat	Latin
afr	Afrikaans	lav	Latvian
afa	Afro-Asiatic languages	lez	Lezghian
ain	Ainu	lim	Limburgan; Limburger; Limburgish
aka	Akan	lin	Lingala
akk	Akkadian	lit	Lithuanian
alb	Albanian	jbo	Lojban
alb	Albanian	nds	Low German; Low Saxon; German, Low; Saxon, Low
ale	Aleut	dsb	Lower Sorbian
alg	Algonquian languages	loz	Lozi
tut	Altaic languages	lub	Luba-Katanga
amh	Amharic	lua	Luba-Lulua
anp	Angika	lui	Luiseno
apa	Apache languages	smj	Lule Sami
ara	Arabic	lun	Lunda

ISO 639-2 Code	Language	ISO 639-2 Code	Language
arg	Aragonese	luo	Luo (Kenya and Tanzania)
arp	Arapaho	lus	Lushai
arw	Arawak	ltz	Luxembourgish; Letzeburgesch
arm	Armenian	mac	Macedonian
rup	Aromanian; Arumanian; Macedo-Romanian	mad	Madurese
art	Artificial languages	mag	Magahi
asm	Assamese	mai	Maithili
ast	Asturian; Bable; Leonese; Asturleonese	mak	Makasar
ath	Athapascan languages	mlg	Malagasy
aus	Australian languages	may	Malay
map	Austronesian languages	mal	Malayalam
ava	Avaric	mlt	Maltese
ave	Avestan	mnc	Manchu
awa	Awadhi	mdr	Mandar
aym	Aymara	man	Mandingo
aze	Azerbaijani	mni	Manipuri
ban	Balinese	mno	Manobo languages
bat	Baltic languages	glv	Manx
bal	Baluchi	mao	Maori
bam	Bambara	arn	Mapudungun; Mapuche
bai	Bamileke languages	mar	Marathi
bad	Banda languages	chm	Mari

ISO 639-2 Code	Language	ISO 639-2 Code	Language
bnt	Bantu languages	mah	Marshallese
bas	Basa	mwr	Marwari
bak	Bashkir	mas	Masai
baq	Basque	myn	Mayan languages
btk	Batak languages	men	Mende
bej	Beja; Bedawiyet	mic	Mi'kmaq; Micmac
bel	Belarusian	min	Minangkabau
bem	Bemba	mwl	Mirandese
ben	Bengali	moh	Mohawk
ber	Berber languages	mdf	Moksha
bho	Bhojpuri	lol	Mongo
bih	Bihari languages	mon	Mongolian
bik	Bikol	mkh	Mon-Khmer languages
bin	Bini; Edo	mos	Mossi
bis	Bislama	mul	Multiple languages
byn	Blin; Bilin	mun	Munda languages
zbl	Blissymbols; Blissymbolics; Bliss	nah	Nahuatl languages
nob	Bokmål, Norwegian; Norwegian Bokmål	nau	Nauru
bos	Bosnian	nav	Navajo; Navaho
bra	Braj	nde	Ndebele, North; North Ndebele
bre	Breton	nbl	Ndebele, South; South Ndebele
bug	Buginese	ndo	Ndonga
bul	Bulgarian	nap	Neapolitan

ISO 639-2 Code	Language	ISO 639-2 Code	Language
bua	Buriat	new	Nepal Bhasa; Newari
bur	Burmese	nep	Nepali
cad	Caddo	nia	Nias
cat	Catalan; Valencian	nic	Niger-Kordofanian languages
cau	Caucasian languages	ssa	Nilo-Saharan languages
ceb	Cebuano	niu	Niuean
cel	Celtic languages	nqo	N'Ko
cai	Central American Indian languages	nog	Nogai
khm	Central Khmer	non	Norse, Old
chg	Chagatai	nai	North American Indian languages
cmc	Chamic languages	frr	Northern Frisian
cha	Chamorro	sme	Northern Sami
che	Chechen	nor	Norwegian
chr	Cherokee	nno	Norwegian Nynorsk; Nynorsk, Norwegian
chy	Cheyenne	nub	Nubian languages
chb	Chibcha	nym	Nyamwezi
nya	Chichewa; Chewa; Nyanja	nyn	Nyankole
chi	Chinese	nyo	Nyoro
chn	Chinook jargon	nzi	Nzima
chp	Chipewyan; Dene Suline	oci	Occitan (post 1500)
cho	Choctaw	arc	Official Aramaic (700-300 BCE); Imperial Aramaic (700-300 BCE)

ISO 639-2 Code	Language	ISO 639-2 Code	Language
chu	Church Slavic; Old Slavonic; Church Slavonic; Old Bulgarian; Old Church Slavonic	oji	Ojibwa
chk	Chuukese	ori	Oriya
chv	Chuvash	orm	Oromo
nwc	Classical Newari; Old Newari; Classical Nepal Bhasa	osa	Osage
syc	Classical Syriac	oss	Ossetian; Ossetic
cop	Coptic	oto	Otomian languages
cor	Cornish	pal	Pahlavi
cos	Corsican	pau	Palauan
cre	Cree	pli	Pali
mus	Creek	pam	Pampanga; Kapampangan
crp	Creoles and pidgins	pag	Pangasinan
cpe	Creoles and pidgins, English based	pan	Panjabi; Punjabi
cpf	Creoles and pidgins, French-based	pap	Papiamento
cpp	Creoles and pidgins, Portuguese-based	paa	Papuan languages
crh	Crimean Tatar; Crimean Turkish	nso	Pedi; Sepedi; Northern Sotho
hrv	Croatian	per	Persian
cus	Cushitic languages	peo	Persian, Old (ca.600-400 B.C.)
cze	Czech	phi	Philippine languages
dak	Dakota	phn	Phoenician
dan	Danish	pon	Pohnpeian

ISO 639-2 Code	Language	ISO 639-2 Code	Language
dar	Dargwa	pol	Polish
del	Delaware	por	Portuguese
din	Dinka	pra	Prakrit languages
div	Divehi; Dhivehi; Maldivian	pro	Provençal, Old (to 1500);Occitan, Old (to 1500)
doi	Dogri	pus	Pushto; Pashto
dgr	Dogrib	que	Quechua
dra	Dravidian languages	raj	Rajasthani
dua	Duala	rap	Rapanui
dum	Dutch, Middle (ca.1050-1350)	rar	Rarotongan; Cook Islands Maori
dut	Dutch; Flemish	roa	Romance languages
dyu	Dyula	rum	Romanian; Moldavian; Moldovan
dzo	Dzongkha	roh	Romansh
frs	Eastern Frisian	rom	Romany
efi	Efik	run	Rundi
egy	Egyptian (Ancient)	rus	Russian
eka	Ekajuk	sal	Salishan languages
elx	Elamite	sam	Samaritan Aramaic
eng	English	smi	Sami languages
enm	English, Middle (1100-1500)	smo	Samoan
ang	English, Old (ca.450-1100)	sad	Sandawe
myv	Erzya	sag	Sango
epo	Esperanto	san	Sanskrit

ISO 639-2 Code	Language	ISO 639-2 Code	Language
est	Estonian	sat	Santali
ewe	Ewe	srd	Sardinian
ewo	Ewondo	sas	Sasak
fan	Fang	sco	Scots
fat	Fanti	sel	Selkup
fao	Faroese	sem	Semitic languages
fij	Fijian	srp	Serbian
fil	Filipino; Pilipino	srr	Serer
fin	Finnish	shn	Shan
fiu	Finno-Ugrian languages	sna	Shona
fon	Fon	iii	Sichuan Yi; Nuosu
fre	French	scn	Sicilian
frm	French, Middle (ca.1400-1600)	sid	Sidamo
fro	French, Old (842-ca.1400)	sgn	Sign Languages
fur	Friulian	bla	Siksika
ful	Fulah	snd	Sindhi
gaa	Ga	sin	Sinhala; Sinhalese
gla	Gaelic; Scottish Gaelic	sit	Sino-Tibetan languages
car	Galibi Carib	sio	Siouan languages
glg	Galician	sms	Skolt Sami
lug	Ganda	den	Slave (Athapascan)
gay	Gayo	sla	Slavic languages
gba	Gbaya	slo	Slovak

ISO 639-2 Code	Language	ISO 639-2 Code	Language
gez	Geez	slv	Slovenian
geo	Georgian	sog	Sogdian
ger	German	som	Somali
gmh	German, Middle High (ca.1050-1500)	son	Songhai languages
goh	German, Old High (ca.750-1050)	snk	Soninke
gem	Germanic languages	wen	Sorbian languages
gil	Gilbertese	sot	Sotho, Southern
gon	Gondi	sai	South American Indian languages
gor	Gorontalo	alt	Southern Altai
got	Gothic	sma	Southern Sami
grb	Grebo	spa	Spanish; Castilian
grc	Greek, Ancient (to 1453)	srn	Sranan Tongo
gre	Greek, Modern (1453-)	suk	Sukuma
grn	Guarani	sux	Sumerian
guj	Gujarati	sun	Sundanese
gwi	Gwich'in	sus	Susu
hai	Haida	swa	Swahili
hat	Haitian; Haitian Creole	ssw	Swati
hau	Hausa	swe	Swedish
haw	Hawaiian	gsw	Swiss German; Alemannic; Alsatian
heb	Hebrew	syr	Syriac
her	Herero	tgl	Tagalog

ISO 639-2 Code	Language	ISO 639-2 Code	Language
hil	Hiligaynon	tah	Tahitian
him	Himachali languages; Western Pahari languages	tai	Tai languages
hin	Hindi	tgk	Tajik
hmo	Hiri Motu	tmh	Tamashek
hit	Hittite	tam	Tamil
hmn	Hmong; Mong	tat	Tatar
hun	Hungarian	tel	Telugu
hup	Hupa	ter	Tereno
iba	Iban	tet	Tetum
ice	Icelandic	tha	Thai
ido	Ido	tib	Tibetan
ibo	Igbo	tig	Tigre
ijo	Ijo languages	tir	Tigrinya
ilo	Iloko	tem	Timne
smn	Inari Sami	tiv	Tiv
inc	Indic languages	tli	Tlingit
ine	Indo-European languages	tpi	Tok Pisin
ind	Indonesian	tkl	Tokelau
inh	Ingush	tog	Tonga (Nyasa)
ina	Interlingua (International Auxiliary Language Association)	ton	Tonga (Tonga Islands)
ile	Interlingue; Occidental	tsi	Tsimshian
iku	Inuktitut	tso	Tsonga

ISO 639-2 Code	Language	ISO 639-2 Code	Language
ipk	Inupiaq	tsn	Tswana
ira	Iranian languages	tum	Tumbuka
gle	Irish	tup	Tupi languages
mga	Irish, Middle (900-1200)	tur	Turkish
sga	Irish, Old (to 900)	ota	Turkish, Ottoman (1500-1928)
iro	Iroquoian languages	tuk	Turkmen
ita	Italian	tvl	Tuvalu
jpn	Japanese	tyv	Tuvinian
jav	Javanese	twi	Twi
jrb	Judeo-Arabic	udm	Udmurt
jpr	Judeo-Persian	uga	Ugaritic
kbd	Kabardian	uig	Uighur; Uyghur
kab	Kabyle	ukr	Ukrainian
kac	Kachin; Jingpho	umb	Umbundu
kal	Kalaallisut; Greenlandic	mis	Uncoded languages
xal	Kalmyk; Oirat	und	Undetermined
kam	Kamba	hsb	Upper Sorbian
kan	Kannada	urd	Urdu
kau	Kanuri	uzb	Uzbek
krc	Karachay-Balkar	vai	Vai
kaa	Kara-Kalpak	ven	Venda
krl	Karelian	vie	Vietnamese
kar	Karen languages	vol	Volapük

ISO 639-2 Code	Language	ISO 639-2 Code	Language
kas	Kashmiri	vot	Votic
csb	Kashubian	wak	Wakashan languages
kaw	Kawi	wln	Walloon
kaz	Kazakh	war	Waray
kha	Khasi	was	Washo
khi	Khoisan languages	wel	Welsh
kho	Khotanese; Sakan	fry	Western Frisian
kik	Kikuyu; Gikuyu	wal	Wolaitta; Wolaytta
kmb	Kimbundu	wol	Wolof
kin	Kinyarwanda	xho	Xhosa
kir	Kirghiz; Kyrgyz	sah	Yakut
tlh	Klingon; tlhIngan-Hol	yao	Yao
kom	Komi	yap	Yapese
kon	Kongo	yid	Yiddish
kok	Konkani	yor	Yoruba
kor	Korean	ypk	Yupik languages
kos	Kosraean	znd	Zande languages
kpe	Kpelle	zap	Zapotec
kro	Kru languages	zza	Zaza; Dimili; Dimli; Kirdki; Kirmanjki; Zazaki
kua	Kuanyama; Kwanyama	zen	Zenaga
kum	Kumyk	zha	Zhuang; Chuang
kur	Kurdish	zul	Zulu
kru	Kurukh	zun	Zuni

Appendix G

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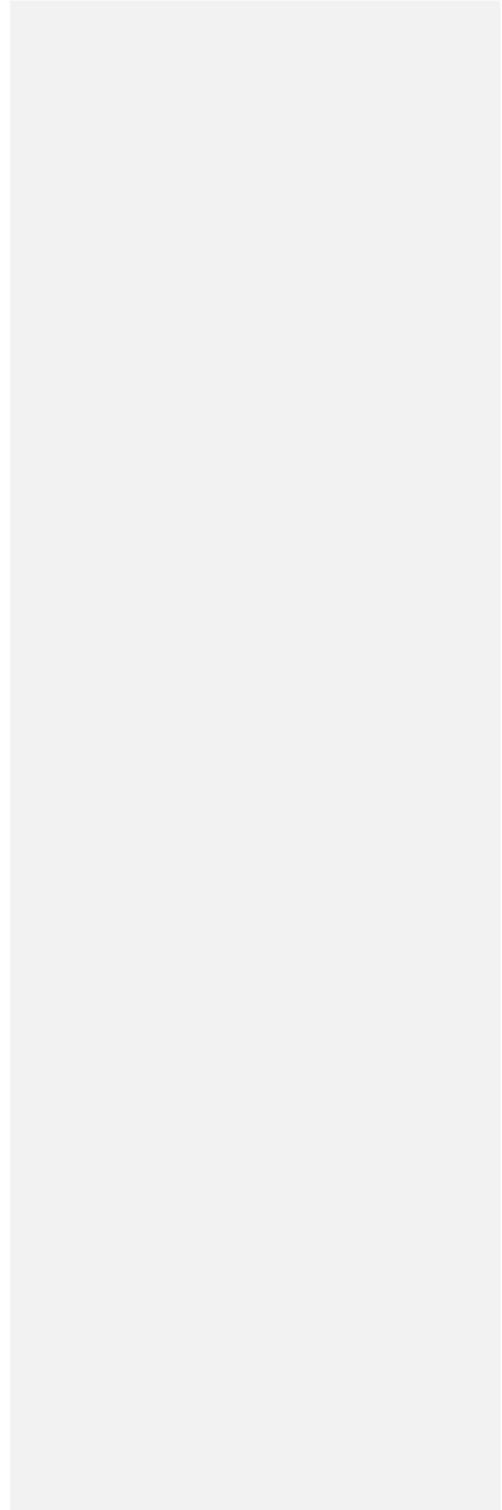

Appendix H: Benefit Types

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

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
001	Inpatient Hospital Services	Services furnished in a hospital or institution (licensed or formally approved as a hospital), for the care and treatment of inpatients with disorders other than mental health disease.	Mandatory	Institutional	No	1905(a)(1), 440.10, 440.189(g)
002	Outpatient Hospital Services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished to outpatients by a hospital or institution (licensed or formally approved as a hospital).	Mandatory	Ambulatory	No	1905(a)(2)(A), 440.20(a)

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Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
003	Rural Health Clinics	Services and supplies provided by a physician within the scope of his/her practice, a physician assistant (if not prohibited by state law), nurse practitioner (if not prohibited by state law) nurse midwife, or other specialized nurse practitioners, intermittent visiting nurse care and related medical supplies (other than drugs and biologicals), and other ambulatory services when furnished in a certified rural health clinic or away from the clinic if an agreement between the physician and clinic for payment of services by the clinic exists.	Mandatory	Ambulatory	No	1905(a)(2)(B), 440.20(b) and (c), 1910(a)
004	Federally Qualified Health Centers	Services and related supplies provided by a physician within the scope of his/her practice, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, clinical social workers, and other ambulatory services when furnished in a federally qualified health center.	Mandatory	Ambulatory	No	1905(a)(2)(C)

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Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
005	Other Laboratory and X-Ray Services	Technical and radiological services ordered and provided by or under direction of a physician or other licensed practitioner in an office or similar facility other than a clinic or hospital outpatient department and furnished by an approved laboratory.	Mandatory	Ambulatory	No	1905(a)(3), 440.30
006	Nursing Facility Services for Individuals Age 21 and Older	Services (other than services in an institution for mental health conditions), furnished to individuals age 21 and older, which are needed on a daily basis and required to be provided in an inpatient basis provided by a Medicaid-approved facility and ordered by and provided under the direction of a physician.	Mandatory	Institutional	Yes	1905(a)(4)(A), 440.40(a)
007	Early and Periodic Screening, Diagnostic and Treatment Services	Screening and diagnostic services to determine physical or mental health condition; health care treatment and other measures to correct or ameliorate any chronic conditions discovered in recipients under age 21.	Mandatory	Both	No	1905(a)(4)(B), 1902(a)(43), 1905(r)

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Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
008	Family Planning Services and Supplies	Family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who desire such services and supplies.	Mandatory	Ambulatory	No	1905(a)(4)(C), 441 Subpart F
009	Cessation of Tobacco Use by Pregnant Women	Counseling and pharmacotherapy services for cessation of tobacco use by pregnant women.	Mandatory	Ambulatory	No	1905(a)(4)(D)
010	Physician Services	Services furnished by a state-licensed physician within his or her scope of practice of medicine or osteopathy.	Mandatory	Ambulatory	No	1905(a)(5)(A), 440.50(a)
011	Medical and Surgical Services Furnished by a Dentist	Medical and surgical services furnished by a doctor of dental medicine or dental surgery, or if permitted by state law, by a physician.	Mandatory	Ambulatory	No	1905(a)(5)(B), 440.50(b)
012	Nurse Midwife Services	Services furnished by a licensed nurse midwife within the scope of practice authorized by State law or regulation; Inpatient or outpatient hospital services or clinic services furnished by a licensed nurse midwife under the supervision of, or associated with a physician or other health care provider.	Mandatory	Ambulatory	No	1905(a)(17), 440.165

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Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
013	Certified Pediatric or Family Nurse Practitioner Services	Services furnished by a certified pediatric nurse practitioner with a practice limited to providing primary health care to individuals under age 21; or a certified family nurse practitioner with a practice limited to providing primary health care to individuals and families.	Mandatory	Ambulatory	No	1905(a)(21), 440.166
014	Free Standing Birth Center Services	Services furnished to an individual at a freestanding birth center, which include prenatal labor and delivery, or postpartum care and other ambulatory services related to the health and safety of the individual.	Mandatory	Institutional	No	1905(a)(28)
015	Home Health Services - Intermittent and Part-time Nursing Services Provided by a Home Health Agency	Nursing service that is provided on a part-time or intermittent basis by a home health agency or in the absence of an agency in the area, by a registered nurse.	Mandatory	Ambulatory	Yes	1905(a)(7), 440.70(b)(1), 441.15
016	Home Health Services - Home Health Aide Services Provided by a Home Health Agency	Home health aide services provided by a home health agency.	Mandatory	Ambulatory	Yes	1905(a)(7), 440.70(b)(2), 441.15

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
017	Home Health Services - Medical Supplies, Equipment and Appliances Suitable for Use in the Home	Services include medical supplies, equipment and appliances suitable for use in the home.	Mandatory	Ambulatory	Yes	1905(a)(7), 440.70(b)(3), 441.15

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

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
018	Medical Care and Any Type of Remedial Care Recognized Under State Law - Podiatrist Services	Medical or remedial care or services provided by licensed podiatrists within the scope of practice as defined under state law.	Optional	Ambulatory	No	1905(a)(6), 440.60
019	Medical Care and Any Type of Remedial Care Recognized Under State Law - Optometrist Services	Medical or remedial care or services provided by licensed optometrists within the scope of practice as defined under state law	Optional	Ambulatory	No	1905(a)(6), 440.60

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
020	Medical Care and Any Type of Remedial Care Recognized Under State Law - Chiropractors' Services	Services provided by licensed chiropractors consisting of treatment by means of manual manipulation of the spine within the scope authorized by the state to perform.	Optional	Ambulatory	No	1905(a)(6), 440.60
021	Medical Care and Any Type of Remedial Care Recognized Under State Law - Other Licensed Practitioner Services	Medical or any other remedial care or services provided by a licensed practitioner within the scope of his/her practice as defined by state law.	Optional	Ambulatory	No	1905(a)(6), 440.60
022	Home Health Services - Physical Therapy, Occupational Therapy, Speech Pathology, Audiology Provided by a Home Health Agency	Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or by a facility licensed by the state to provide medical rehabilitation services.	Optional	Ambulatory	Yes	1905(a)(7), 440.70(b)(4), 441.15
023	Private Duty Nursing Services	Nursing services, provided by RNs or LPNs, in a home, hospital, or skilled nursing facility, to recipients who require more individual and continuous care than is available from a visiting nurse, or routinely provided by hospital or skilled nursing facility staff.	Optional	Ambulatory	Yes	1905(a)(8), 440.80

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
024	Clinic Services	Preventive, diagnostic, therapeutic, rehabilitative or palliative services furnished by a facility that is not part of a hospital, but is organized and operated to provide medical care; services provided at the clinic or outside the clinic under the direction of a physician or dentist.	Optional	Ambulatory	No	1905(a)(9), 440.90
025	Dental Services	Diagnostic, preventive, or corrective procedures provided by or under the supervision of a licensed dentist; treatment of the teeth and associated structures of the oral cavity; treatment of disease, injury, or impairment that my affect general health of recipient.	Optional	Ambulatory	No	1905(a)(10), 440.100
026	Physical Therapy and Related Services-Physical Therapy	Services prescribed by a physician or other licensed practitioner of the healing arts, and provided to a recipient by or under the direction of a qualified physical therapist; includes supplies and equipment.	Optional	Ambulatory	Yes	1905(a)(11), 440.110(a)
027	Physical Therapy and Related Services-Occupational Therapy	Services provided by a qualified occupational therapist, which have been prescribed by a physician or practitioner of the healing arts; includes supplies and equipment.	Optional	Ambulatory	Yes	1905(a)(11), 440.110(b)

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Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
028	Physical Therapy and Related Services - Services for Individuals with Speech, Hearing and Language Disorders	Diagnostic, screening, preventive or corrective services for individuals with speech, hearing and language disorders; provided by or under the direction of a certified speech pathologist or audiologist or other licensed practitioner of the healing arts; includes supplies and equipment.	Optional	Ambulatory	Yes	1905(a)(11), 440.110(c)
029	Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses - Prescribed Drugs	Single or compound substances or mixture of substances prescribed by a physician or licensed practitioner, and dispensed by a licensed pharmacist or authorized practitioner, for the cure, mitigation, or prevention of disease or maintenance of health.	Optional	Ambulatory	No	1905(a)(12), 440.120(a)
030	Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses - Dentures	Artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth.	Optional	Ambulatory	No	1905(a)(12), 440.120(b)
031	Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses - Prosthetic Devices	Replacement, corrective or supportive devices prescribed by a physician or licensed practitioner, to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or to support a weak or deformed portion of the body.	Optional	Ambulatory	No	1905(a)(12), 440.120(c)

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Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
032	Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses - Eyeglasses	Lenses, including frames and other aids to vision, prescribed by a physician skilled in eye disease, or an optometrist.	Optional	Ambulatory	No	1905(a)(12), 440.120(d)
033	Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Diagnostic Services	Medical procedures or supplies recommended by a physician or licensed practitioner to enable him/her to identify the existence, nature or extent of illness, injury or other health deviation in a recipient.	Optional	Ambulatory	No	1905(a)(13), 440.130(a)
034	Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Screening Services	Use of standardized tests given to a designated population, to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.	Optional	Ambulatory	No	1905(a)(13), 440.130(b)
035	Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Preventive Services	Services provided by a physician or other licensed practitioner to prevent disease, disability or other health conditions or their progression, to prolong life and to promote physical and mental health efficiency.	Optional	Ambulatory	No	1905(a)(13), 440.130(c)

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Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
036	Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Rehabilitative Services	Medical or remedial services recommended by a physician or other licensed practitioner for maximum reduction of physical or mental health condition, and restoration of a recipient to his/her best possible functional level.	Optional	Ambulatory	Yes	1905(a)(13), 440.130(d)
037	Services for Individuals Age 65 and Over in IMDs - Inpatient Hospital Services	Services for the care and treatment of recipients, age 65 and older, in an institution for mental health conditions, provided under the direction of a physician.	Optional	Institutional	Yes	1905(a)(14), 440.140(a)
038	Services for Individuals Age 65 and Over in IMDs - Nursing Facility Services	Nursing services needed on a daily basis and required to be provided on an inpatient basis to individuals age 65 and older in an institution for mental health conditions.	Optional	Institutional	Yes	1905(a)(14), 440.140(b)
039	Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF-IID)	Items and health rehabilitative services provided to persons with intellectual disabilities or related conditions, receiving active treatment in a licensed ICF/IID.	Optional	Institutional	Yes	1905(a)(15), 440.150
040	Inpatient Psychiatric Services for Individuals Under 21	Inpatient psychiatric services provided to individuals under age 21, under the direction of a physician, furnished in an approved and accredited psychiatric hospital or facility.	Optional	Institutional	Yes	1905(a)(16), 440.160

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Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
041	Hospice Care Services	Items and services provided to a terminally ill individual, which includes nursing care, physical or occupational therapy, medical social services, homemaker services, medical supplies and appliances, physician services, short-term inpatient care and counseling.	Optional	Both	Yes	1905(a)(18)
042	Case Management and TB-Related Services - Case Management and Targeted Case Management Services	Services to assist eligible individuals who reside in a community setting or are transitioning to a community setting, in gaining access to medical, social, educational, and other services. As specified in a state's plan, may be offered to individuals within targeted groups.	Optional	Ambulatory	Yes	1905(a)(19), 440.169, 1915(g)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
043	Case Management Services and TB-Related Services - Special TB Related Services	Services for the treatment of infection with tuberculosis consisting of prescribed drugs, physicians' services, laboratory and x-ray services (including services to confirm the presence of infection), clinic services and federally-qualified health center services, case management services, and services (other than room and board) designed to encourage completion of regimens of prescribed drugs by outpatients, including services to observe directly the intake of prescribed drugs.	Optional	Ambulatory	No	1905(a)(19)
044	Respiratory Care Services	Services provided in home, under the direction of a physician, by a respiratory therapist or other health care professional trained in respiratory therapy, to an individual who is medically dependent on a ventilator for life support for 6 hours or more per day, has been dependent on the ventilator for at least 30 consecutive days as an inpatient in a hospital, NF or ICF/IID, has adequate social support, and wishes to be cared for at home.	Optional	Ambulatory	No	1905(a)(20), 1902(e)(9)(A)-(C), 440.185

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Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
045	Personal Care Services	Services, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, or intermediate facility for individuals with intellectual and or developmental disabilities, or institution for mental health conditions, that are authorized by a physician in accordance with a plan of treatment, and provided by an individual qualified to provide such services, who is not a legally responsible relative.	Optional	Ambulatory	Yes	1905(a)(24), 440.167
046	Primary Care Case Management Services (Integrated Care Model)	Case management related services which include location, coordination, and monitoring of primary health care services and provider under a contract between the State and either a PCCM who is a physician, or at the State's option, a physician assistant, nurse practitioner, certified nurse midwife, physician group practice, or an entity that employs or arranges with physicians to furnish services.	Optional	Ambulatory	No	1905(a)(25), 440.168
047	Special Sickle-Cell Anemia-Related Services	Primary and secondary medical strategies and treatment and services for individuals who have Sickle Cell Disease.	Optional	Ambulatory	No	1905(a)(27)

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Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
048	Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Transportation	Expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a beneficiary.	Optional, but states are required to assure that transportation is available to and from Medicaid services, either as a State Plan benefit, an administrative activity or under a waiver	Ambulatory	No	1905(a)(29), 440.170(a)
049	Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Services provided in religious non-medical health care facilities	Non-medical services and items, furnished in an institution that is defined in the Internal Revenue Code and is exempt from taxes, to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs.	Optional	Institutional	Yes	1905(a)(29), 440.170(b) and (c)

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Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
050	Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Nursing facility services for individuals under age 21	Services (other than services in an Institution for mental health conditions), furnished to individuals under the age of 21, which are needed on a daily basis and required to be provided in an inpatient basis provided by a Medicaid-approved facility and ordered by and provided under the direction of a physician.	Optional	Institutional	Yes	1905(a)(29), 440.170(d)
051	Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Emergency hospital services	Services that are necessary to prevent death or serious impairment of health of a recipient, and that the threat to life or health necessitates that use of the most accessible hospital available that is equipped to furnish the services, with no regard to conditions of participation under Medicare or definitions of inpatient or outpatient hospital services.	Optional	Ambulatory	No	1905(a)(29), 440.170(e)
052	Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Critical Access Hospitals	Services that are furnished by a Medicare participating Critical Access Hospital (CAH) provider and are of a type that would be paid for by Medicare when provided to a Medicare recipient, other than nursing facility services by a CAH with a swing-bed approval.	Optional	Institutional	No	1905(a)(29), 440.170(g)

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Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
053	Extended Services for Pregnant Women – Additional Services for Any Other Medical Conditions That May Complicate Pregnancy	Extended services for pregnant women - Additional Services for any other medical conditions that may complicate pregnancy, except Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls. (These services will fall into valid value # 71.)	Optional	Ambulatory	No	1902(a)(10)(end)(V)
054	Community First Choice	Home and community-based attendant services and supports to assist eligible beneficiaries in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision or cueing.	Optional	Ambulatory	No	1915(k)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
055	Health Homes	Comprehensive and timely high-quality services that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team. Services include care management, care coordination and promotion, comprehensive transitional care, patient and family support, referral to community and social support services, and use of information technology to link services.	Optional	Ambulatory	No	1945

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

Special Benefit Provisions

Appendix H

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
056	Limited Pregnancy-Related Services for Pregnant Women with Income Above the Applicable Income Limit	Potentially limited services for pregnant women with income above a certain limit to pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or have become necessary as a result of the woman having been pregnant, including, but not limited to prenatal care, delivery, postpartum care, and family planning services.	N/A	N/A	No	1902(a)(10)(end)(VII), 440.210(a)(2), 440.250(p)
057	Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period	Ambulatory prenatal care services provided to an eligible pregnant woman during the PE period, which begins on the date a pregnant woman is determined presumptively eligible by a Medicaid qualified provider based on preliminary information, and ends on the day on which a full determination of eligibility is made or at the end of the month following the month in which the PE determination was made if the woman fails to file an application for full benefits.	N/A	N/A	No	1920, 1902(a)(47)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
058	Benefits for Families Receiving Transitional Medical Assistance	Benefits provided to families who would have lost eligibility because of hours of, or income from employment of the caretaker relative. Benefits may be limited or provided through alternative methods during the second six months of the 12 month period of extended benefits.	N/A	N/A	N/A	1925, 1902(a)(52)
059	Standards for Coverage of Transplant Services	Standards which provide that similarly situated individuals are treated alike and any restriction, on the facilities or practitioners which may provide such procedures, is consistent with accessibility to high quality care.	N/A	N/A	N/A	1903(i)(1), 441.35
060	School-Based Services Payment Methodologies	Provision of benefits in a school-based setting or arranged by a school to a child with a disability even if such services are included in the child's individualized education program (IEP), and to an infant or toddler with a disability even if such services are included in the child's individualized family service plan (IFSP).	N/A	N/A	N/A	1903(c)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
061	Indian Health Services and Tribal Health Facilities	Allows for reimbursement of state plan covered services when provided by a facility of the Indian Health Service, including a hospital, nursing facility or any other type of facility which provides covered services under the state plan.	N/A	N/A	N/A	1911, 431.110(b)
062	Methods and Standards to Assure High Quality Care	The plan must include a description of methods and standards used to assure that services are of high quality and that the care and services are available under the plan at least to the extent that such care and services are available to the general populations in the geographic area.	N/A	N/A	N/A	1902(a)(30)(A), 440.260

Coordination of Medicaid with Medicare and Other Insurance

Special Benefit Provisions

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
063	Medicare Premium Payments	Provisions related to payment of Medicare A, B and C premiums for qualifying Medicaid beneficiaries.	N/A	N/A	N/A	1902(a)(10(E), 1905(p), 1905(s), 1933, 431.625

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

Coordination of Medicaid with Medicare and Other Insurance

Special Benefit Programs

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

Home and Community-Based Services

Special Benefit Programs

Appendix H

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
067	Laboratory and x-ray services	-	-	-	-	-
068	Home Health Services - Home health aide services provided by a home health agency	N/A	N/A	N/A	N/A	N/A
069	Private duty nursing services	N/A	N/A	N/A	N/A	N/A
070	Physical Therapy and Related Services - Audiology services	N/A	N/A	N/A	N/A	N/A
071	Extended services for pregnant women - Additional Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.	N/A	N/A	N/A	N/A	N/A
072	Home and Community Care for Functionally Disabled Elderly individuals as defined and described in the State Plan	N/A	N/A	N/A	N/A	N/A

Appendix H

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
073	Emergency services for certain legalized aliens and undocumented aliens	An emergency medical condition is a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.	N/A	N/A	N/A	N/A
074	Licensed or Otherwise State-Approved Free-Standing Birthing Center and other ambulatory services that are offered by a freestanding birth center	N/A	N/A	N/A	N/A	N/A
075	Homemaker	N/A	N/A	N/A	N/A	N/A
076	Home Health Aide	N/A	N/A	N/A	N/A	N/A
077	Adult Day Health services	N/A	N/A	N/A	N/A	N/A
078	Habilitation	N/A	N/A	N/A	N/A	N/A
079	Habilitation: Residential Habilitation	N/A	N/A	N/A	N/A	N/A

Appendix H

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
080	Habilitation: Supported Employment	N/A	N/A	N/A	N/A	N/A
081	Habilitation: Education (non IDEA available)	N/A	N/A	N/A	N/A	N/A
082	Habilitation: Day Habilitation	N/A	N/A	N/A	N/A	N/A
083	Habilitation: Pre-Vocational	N/A	N/A	N/A	N/A	N/A
084	Habilitation: Other Habilitative Services	N/A	N/A	N/A	N/A	N/A
085	Respite	N/A	N/A	N/A	N/A	N/A
086	Day Treatment (mental health service)	N/A	N/A	N/A	N/A	N/A
087	Psychosocial rehabilitation	N/A	N/A	N/A	N/A	N/A
088	Environmental Modifications (Home Accessibility Adaptations)	N/A	N/A	N/A	N/A	N/A
089	Vehicle Modifications	N/A	N/A	N/A	N/A	N/A
090	Non-Medical Transportation	N/A	N/A	N/A	N/A	N/A
091	Special Medical Equipment (minor assistive Devices)	N/A	N/A	N/A	N/A	N/A
092	Home Delivered meals	N/A	N/A	N/A	N/A	N/A

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
093	Assistive Technology (i.e., communication devices)	N/A	N/A	N/A	N/A	N/A
094	Personal Emergency Response (PERS)	N/A	N/A	N/A	N/A	N/A
095	Nursing Services	N/A	N/A	N/A	N/A	N/A
096	Community Transition Services	N/A	N/A	N/A	N/A	N/A
097	Adult Foster Care	N/A	N/A	N/A	N/A	N/A
098	Day Supports (non-habilitative)	N/A	N/A	N/A	N/A	N/A
099	Supported Employment	N/A	N/A	N/A	N/A	N/A
100	Supported Living Arrangements	N/A	N/A	N/A	N/A	N/A
101	Supports for Consumer Direction (Supports Facilitation)	N/A	N/A	N/A	N/A	N/A
102	Participant Directed Goods and Services	N/A	N/A	N/A	N/A	N/A
103	Senior Companion (Adult Companion Services)	N/A	N/A	N/A	N/A	N/A
104	Assisted Living	N/A	N/A	N/A	N/A	N/A

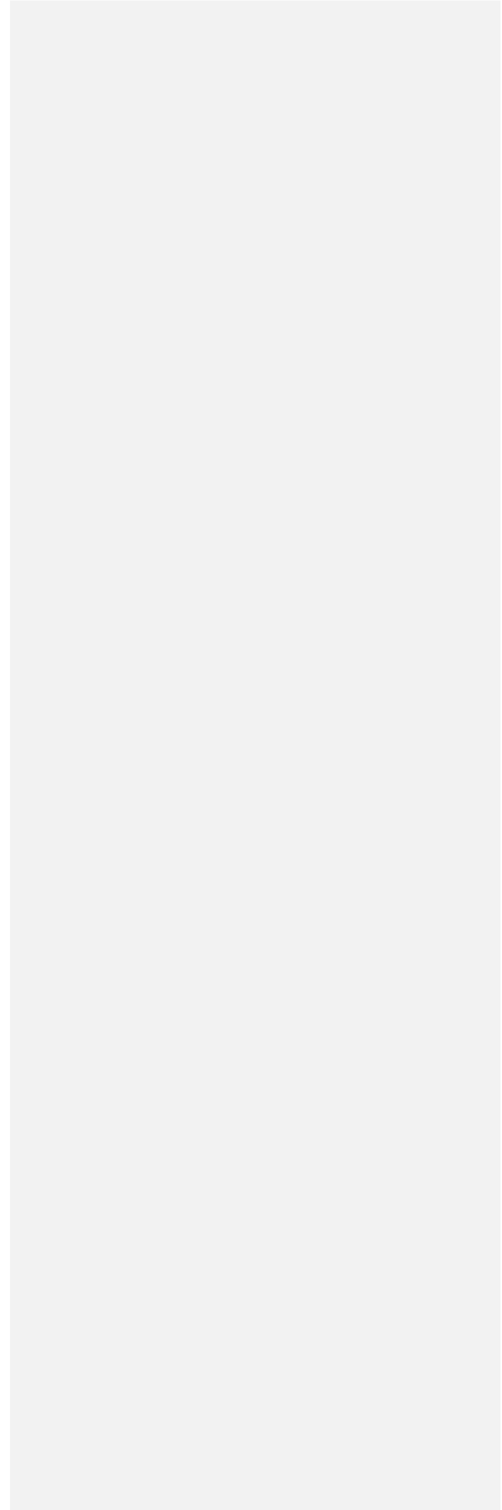
Home and Community-Based Services

Other

Appendix H

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

Appendix I



Other

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

Line	Line - Form Display	Line - Definition
1A	Inpatient Hospital - Reg. Payments	1A. - Inpatient Hospital Services. -- Regular Payments.--Other than services in an institution for mental health conditions. (See 42 CFR 440.10). These are services that: - Are ordinarily furnished in a hospital for the care and treatment of inpatients; - Are furnished under the direction of a physician or dentist (except in the case of nurse-midwife services under 42 CFR 440.165); and - Are furnished in an institution that: - Is maintained primarily for the care and treatment of patients with disorders other than mental health conditions; - Is licensed and formally approved as a hospital by an officially designated authority for State standard setting; - Meets the requirements for participation in Medicare (except in the case of medical supervision of nurse-midwife services under 42 CFR 440.165); and, - Has, in effect, a utilization review plan (that meets the requirements under 42 CFR 482.30 applicable to all Medicaid patients, unless a waiver has been granted by DHHS. NOTE: Inpatient hospital services do not include NF services furnished by a hospital with swing-bed approval. However, include services provided in a psychiatric wing of a general hospital if the psychiatric wing is not administratively separated from the general hospital.

Line	Line - Form Display	Line - Definition
1B	Inpatient Hospital - DSH	1B. - Inpatient Hospital Services -- DSH Adjustment Payment. - Other than services in an institution for mental health conditions. DSH payments are for the express purpose of assisting hospitals that serve a disproportionate share of low-income patients with special needs and are made in accordance with section 1923 of the Act. Report the total payments that were determined to be disproportionate share payments to the hospital by entering the amounts on the pop-up feeder form which in turn will pre-fill the Form CMS-64.9D as well as the appropriate lines on the Forms CMS-64.9, CMS-64.9P, CMS-64.21, CMS-64.21P, CMS-6421U or CMS-64.21UPs.
1C	Inpatient Hospital - Sup. Payments	1C. - Inpatient Hospital Services. - Supplemental Payments.--Other than services in an institution for mental health conditions. (Refer to the definition on Line 1A above). These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272. Address supplemental payments for inpatient hospitals associated with (1) state government operated facilities, (2) non-state government operated facilities, and (3) privately operated facilities by entering payments on the pop-up feeder form.
1D	Inpatient Hospital - GME Payments	1D. - Inpatient Hospital Services.—Graduate Medical Education (GME) Payments.-- GME payments include supplemental payments for direct medical education (DME) (i.e. costs of training physicians such as resident and teaching physician salaries/benefits, overhead and other costs directly related to the program) and indirect medical education (IME) costs hospitals incur for operating teaching programs. Report all supplemental payments for DME and IME that are provided for in the State plan.

Line	Line - Form Display	Line - Definition
2A	Mental Health Facility Services - Reg. Payments	2A. Mental Health Facility Services - Report Institution for Mental Disease (IMD) (or mental health conditions) services for individuals age 65 or older and/or under age 21 (See 42 CFR 440.140 and 440.160.). Report Other Mental Services which are not provided in an inpatient setting in the Other Appropriate Service categories, e.g., Physician Services, Clinic Services. 1. Mental Health Hospital Services for the Aged. Refers to those inpatient hospital services provided under the direction of a physician for the care and treatment of recipients in an institution for mental health conditions that meets the Conditions of Participation under 42 CFR Part 482. Institution for mental health conditions means an institution that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental health conditions, including medical care, nursing care, and related services. (See 42 CFR 440.140(a)(2).) 2. NF Services for the Aged. Means those NF services (as defined at 42 CFR 440.40) and those ICF services (as defined at 42 CFR 483, Subpart B) provided in an institution for mental health conditions to recipients determined to be in need of such services. (See 42 CFR 440.140.) 3. Inpatient Psychiatric Facility Services for Individuals Age 21 and Under. (See 42 CFR 441.151) --Means those services that: • Are provided under the direction of a physician; • Are provided in a facility or program accredited by the Joint Commission on the Accreditation of Health Care Organizations; and • Meet the requirements set forth at Subpart D of Part 441 (Inpatient Psychiatric Services for Individuals Age 21 and under in Psychiatric Facilities or Programs).
2B	Mental Health Facility - DSH	2B. Mental Health Facility Services -- DSH Adjustment Payments. - (See 42 CFR 440.140 and 440.160). DSH payments are for the express purpose of assisting hospitals that serve a disproportionate share of low-income patients with special needs and are made in accordance with section 1923 of the Act. Report the total payments that were determined to be disproportionate share payments to the hospital by entering the amounts on the pop-up feeder form which in turn will pre-fill the Form CMS-64.9D as well as the appropriate lines on the Forms CMS-64.9, CMS-64.9P, CMS-64.21, CMS-64.21P, CMS-6421U or CMS-64.21UPs.

Appendix I

Line	Line - Form Display	Line - Definition
2C	Certified Community Behavior Health Clinic Payments	2C - Certified Community Behavior Health Clinic Payments On April 1, 2014, the Protecting Access to Medicare Act of 2014 (Public Law 113-93) was enacted. The law included "Demonstration Programs to Improve Community Mental Health Services" at Section 223 of the Act. This eight-state demonstration will be made operational January 1, 2017 through July 1, 2017 and will serve adults with serious mental illness, children with serious emotional disturbance, and those with long term and serious substance use disorders, as well as others with mental illness and substance use disorders. The eight states selected for the demonstration (see state listing below) must pay certified clinics using a prospective payment system (PPS) that applies to fee for service (FFS) payment and payment made through managed care. Demonstration expenditures are eligible for enhanced federal matching funds. States must stop reporting demonstration expenditures eligible for enhanced FMAP at the end of their programs. In accordance with Section 1132 of the Social Security Act and the implementing regulations at 45 CFR, Part 95, Subpart A states can make claim adjustments within two years after the calendar quarter in which the state agency made the original expenditure for their demonstrations. When states end their programs, they will cease reporting demonstration expenditures on the new CMS-64/64.21 lines. A demonstration state may choose to continue services in another form through the state plan or through their managed care programs but these expenditures would be reported using the established 1905a reporting categories and existing FMAPs, not enhanced FMAP.

Line	Line - Form Display	Line - Definition
3A	Nursing Facility Services - Reg. Payments	3A. - Nursing Facility Services. -Regular Payments. -- (Other than services in an institution for mental health conditions). (See 42 CFR 483.5 and 440.155). These are services provided by an institution (or a distinct part of an institution) which: • Is primarily engaged in providing to residents: • Skilled nursing care and related services for residents who require medical or nursing care; • Rehabilitation services for the rehabilitation of injured, disabled or sick persons; or • On a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental health conditions; and, • Meet the requirements for a nursing facility described in subsections 1919 (b), (c) and (d) of the Act regarding: • Requirements relating to Provision of Services, • Requirements relating to Residences Rights, and, • Requirements relating to Administration and Other Matters.
3B	Nursing Facility Services - Sup. Payments	3B. - Nursing Facility Services - Supplemental Payments. -- (Other than services in an institution for mental health conditions). (Refer to the definition on Line 3A above). These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272. Address supplemental payments for nursing facility services associated with (1) state government operated facilities, (2) non-state government operated facilities, and (3) Privately operated facilities by entering payments on the pop-up feeder form.

Line	Line - Form Display	Line - Definition
4A	Intermediate Care Facility Services – Individuals with Intellectual Disabilities: Public Providers	4A Intermediate Care Facility Services - Public Providers – Individuals with Intellectual Disabilities (ICF/IID) (See 42 CFR 440.150). These include services provided in an institution for individuals with intellectual disabilities or persons with related conditions if: • The primary purpose of the institution is to provide health or rehabilitative services to such individuals; • The institution meets the standards in 42 CFR 442, Subpart C (Intermediate Care Facility Requirements; All Facilities); and, • Individuals with intellectual disabilities recipient for whom payment is requested is receiving active treatment as defined in 42 CFR 435.1009. NOTE: Line 4 is divided into sections for public providers (Line 4.A.) and private providers (Line 4.B.). Public providers are owned or operated by a State, county, city or other local governmental agency or instrumentality. Increasing adjustments related to private providers are considered current expenditures for the quarter in which the expenditure was made and are matched at the FMAP rate for that quarter. Increasing adjustments related to public providers are considered adjustments to prior period claims and are matched using the FMAP rate in effect at the earlier of the time the expenditure was paid or recorded by any State agency. (See 45 CFR Part 95 and §2560.)

Line	Line - Form Display	Line - Definition
4B	Intermediate Care Facility Services – Individuals with Intellectual Disabilities: Private Providers	4B - Intermediate Care Facility Services - Private Providers - Individuals with Intellectual Disabilities (ICF/IID). (See 42 CFR 440.150). These include services provided in an institution for individuals with intellectual disabilities or persons with related conditions if: • The primary purpose of the institution is to provide health or rehabilitative services to such individuals; • The institution meets the standards in 42 CFR 442, Subpart C (Intermediate Care Facility Requirements; All Facilities); and • Individuals with intellectual disabilities recipient for whom payment is requested is receiving active treatment as defined in 42 CFR 435.1009. • NOTE: Line 4 is divided into sections for public providers (Line 4.A.) and private providers (Line 4.B.). Public providers are owned or operated by a State, county, city or other local governmental agency or instrumentality. Increasing adjustments related to private providers are considered current expenditures for the quarter in which the expenditure was made and are matched at the FMAP rate for that quarter. Increasing adjustments related to public providers are considered adjustments to prior period claims and are matched using the FMAP rate in effect at the earlier of the time the expenditure was paid or recorded by any State agency. (See 45 CFR Part 95 and §2560.)
4C	Intermediate Care Facility Services – Individuals with Intellectual Disabilities: Supplemental Payments	Line 4C. Intermediate Care Facility Services (ICF/IID) - Supplemental Payments (Refer to the definition on Line 4A above). These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272. Address supplemental payments for ICF/IID services associated with (1) state government operated facilities, (2) non-state government operated facilities, and (3) privately operated facilities by entering payments on the pop-up feeder form.

Line	Line - Form Display	Line - Definition
5A	Physician & Surgical Services - Reg. Payments	5A. - Physician and Surgical Services. Regular Payments. -- (See 42 CFR 440.50.). Whether furnished in the office, the recipient's home, a hospital, a NF, or elsewhere, physicians' services are services provided: • Within the scope of practice of medicine or osteopathy as defined by State law; and • By, or under, the personal supervision of an individual licensed under State law to practice medicine or osteopathy. • NOTE: Exclude all services provided and billed for by a hospital, clinic, or laboratory. Include any services provided and billed by a physician under physician services with the exception of lab and X-ray services. Include such services provided and billed for by a physician under the lab and X-ray services category. In a primary care case management system under a Freedom of Choice waiver, you sometimes use a physician as the case manager. In these situations, the physician is allowed to charge a flat fee for each person. Although this fee is not truly a physician service, report the expenditures for the fee on this line.
5B	Physician & Surgical Services - Sup. Payments	5B. - Physician and Surgical Services. Supplemental Payments.-- (refer to definition for Line 5A above) Payments for physician and other practitioner services as defined in Line 5A that are made in addition to the standard fee schedule payment for those services. When combined with regular payments, these supplemental payments are equal to or less than the Federal upper payment limit. Address supplemental payments for physicians and practitioners associated with (1) governmental hospitals or university teaching hospitals, (2) private hospitals, and (3) other supplemental payments by entering payment information on the pop-up feeder sheet.
5C	Physician & Surgical Services - Evaluation and Management	5C. Physician & Surgical Services - Evaluation and Management -- ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching.
5D	Physician & Surgical Services - Vaccine codes	5D. Physician & Surgical Services - Vaccine codes -- ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share Matching Rate

Line	Line - Form Display	Line - Definition
6A	Outpatient Hospital Services - Reg. Payments	6A. - Outpatient Hospital Services. - Regular Payments. -- (See 42 CFR 440.20.). - These are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that: • Are furnished to outpatients; - Except in the case of nurse-midwife services (see 42 CFR 440.165), are furnished by, or under the direction of, a physician or dentist; and • Are furnished by an institution that: - Is licensed or formally approved as a hospital by an officially designated authority for State standard setting; and • Except in the case of medical supervision of nurse-midwife services, meets the requirements for participation in Medicare. (See 42 CFR 440.165.)
6B	Outpatient Hospital Services - Sup. Payments	6B. - Outpatient Hospital Services. - Supplemental Payments. -- (refer to definition for Line 6A above) Payments for outpatient hospital services as defined in line 6A that are made in addition to the base fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. The combined standard payment and supplemental payment cannot exceed the Federal upper payment limit. Address outpatient hospital services supplemental payments associated with (1) state owned or operated hospitals, (2) non state government owned or operated hospitals and (3) private hospitals by entering payment information on the pop-up feeder sheet.
7	Prescribed Drugs	7 - Prescribed Drugs. (See 42 CFR 440.120(a).). - These are simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are: • Prescribed by a physician or other licensed practitioner of the healing arts within the scope of a professional practice as defined and limited by Federal and State law; • Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and • Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's record.

Appendix I

Line	Line - Form Display	Line - Definition
7A1	Drug Rebate Offset - National	7A.1. Drug Rebate Offset. This is a refund from the manufacturer to the State Medical Assistance plan for single source drugs, innovator multiple source drugs, and non-innovator multiple source drugs that are dispensed to Medicaid recipients. Rebates are to take place quarterly. Report these offsets as (1) National Agreement or (2) State Sidebar Agreement. National Agreement refers to rebates manufacturers pay your State pursuant to the manufacturers' agreements with CMS under OBRA 1990 provisions. State Sidebar Agreements refer to rebates manufacturers pay under an agreement directly with your State. These may have been entered into before January 1, 1991, the effective date of the OBRA rebate program. Or they may represent agreements your State entered into with a given manufacturer on or after January 1, 1991, under which the manufacturer pays at least as great a rebate as it would under the National Agreement. All States receive rebates under the National Agreements. A few States receive most of their rebates under the National Agreement, but some States receive other rebates under their State Sidebar Agreement with specific manufacturers. All manufacturer rebates received under CMS's National Agreement are reported on Line 7.A.1, National Agreement. All rebates received under State Sidebar Agreements are reported on Line 7.A.2, State Sidebar Agreement. NOTE: Vaccines are not subject to the rebate agreements.
7A2	Drug Rebate Offset - State Sidebar Agreement	7A2. Drug Rebate Offset. This is the rebate collected under a separate State agreement Sidebar Agreement. These are rebates received that do not fall under 7A1 (National Drug Rebate).

Line	Line - Form Display	Line - Definition
7A3	MCO - National Agreement	7A.3. National Agreement 7A3. Managed Care Organizations (MCO) – National Agreement: The Affordable Care Act requires manufacturers that participate in the Medicaid Drug Rebate Program to pay rebates for drugs dispensed to individuals enrolled with a Medicaid MCO if the MCO is responsible for coverage of such drugs, effective March 23, 2010. This is a refund from the manufacturer to the State Medical Assistance plan for single source drugs, innovator multiple source drugs, and non-innovator multiple source drugs that are dispensed to Medicaid recipients who are enrolled in a Medicaid MCO. Rebates are to take place quarterly. Report these offsets as MCO National Agreement. National Agreement refers to rebates manufacturers pay your State pursuant to the manufacturers agreements with CMS under OBRA 1990 provisions. All States receive rebates under the National Agreement. For rebates for Medicaid MCO drugs, there will be no rebates under their State Sidebar Agreement with specific manufacturers. All MCO manufacturer rebates received under CMS National Agreement are reported on Line 7.A.3, National Agreement NOTE: Vaccines are not subject to the National agreement.
7A4	MCO - State Sidebar Agreement	7A.4. MCO State Sidebar Agreement. This is the rebate collected under a separate State agreement Sidebar Agreement. These are rebates received that do not fall under 7A3 (National Drug Rebate).

Line	Line - Form Display	Line - Definition
7A5	Increased ACA OFFSET - Fee for Service - 100%	Brand name drugs that are blood clotting factors and drugs approved by the FDA exclusively for pediatric indications are subject to a minimum rebate percentage of 17.1 percent of AMP: - If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 23.1 percent of AMP, then we plan to offset the difference between 23.1 percent of AMP and AMP minus BP. - If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 2 percent of AMP (the difference between 17.1 percent of AMP and 15.1 percent of AMP). - If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 17.1 percent of AMP, then we plan to offset the difference between 17.1 percent of AMP and AMP minus BP. - If the difference between AMP and BP is greater than or equal to 17.1 percent of AMP, then we do not plan to take any offset amount. For a drug that is a line extension of a brand name drug that is an oral solid dosage form, we plan to apply the same offset calculation as described above to the basic rebate. Further, we plan to offset only the difference in the additional rebate of the reformulated drug based on the calculation methodology of the additional rebate for the drug preceding the requirements of the Affordable Care Act and the calculation of the additional rebate for the reformulated drug, if greater, in accordance with the Affordable Care Act. If there is no difference in the additional rebate amount in accordance with the Affordable Care Act, then we do not plan to take any offset amount. For a noninnovator multiple source drug, we plan to offset an amount equal to two percent of the AMP (the difference between 13 percent of AMP and 11 percent of AMP).

7A6	Increased ACA OFFSET - MCO - 100%	7A.6. Increased ACA OFFSET - MCO - 100% 7A6. Increased ACA OFFSET – MCO: Similar to the increased ACA offset for fee-for-service, for covered outpatient drugs that are dispensed to Medicaid MCO enrollees, the Affordable Care Act also required that amounts "attributable" to the increased rebates be remitted to the Federal Government. Below is a description of how the offset is calculated: Brand name drugs other than blood clotting factors and drugs approved by the Food and Drug Administration (FDA) exclusively for pediatric indications are subject to a minimum rebate percentage of 23.1 percent of AMP: • If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 8 percent of AMP (the difference between 23.1 percent of AMP and 15.1 percent of AMP). • If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 23.1 percent of AMP, then we plan to offset the difference between 23.1 percent of AMP and AMP minus BP. • If the difference between AMP and BP is greater than or equal to 23.1 percent of AMP, then we do not plan to take any offset amount. Brand name drugs that are blood clotting factors and drugs approved by the FDA exclusively for pediatric indications are subject to a minimum rebate percentage of 17.1 percent of AMP: • If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 2 percent of AMP (the difference between 17.1 percent of AMP and 15.1 percent of AMP). • If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 17.1 percent of AMP, then we plan to offset the difference between 17.1 percent of AMP and AMP minus BP. • If the difference between AMP and BP is greater than or equal to 17.1 percent of AMP, then we do not plan to take any offset amount. For a drug that is a line extension of a brand name drug that is an oral solid dosage form, we plan to apply the same offset calculation as described above to the basic rebate. Further, we plan to offset only the difference in the additional rebate of the reformulated drug based on the calculation methodology of the additional rebate for the drug preceding the requirements of the Affordable Care Act and the calculation of the additional rebate for the reformulated drug, if greater, in accordance with the Affordable Care Act. If there is no difference in the additional rebate

Line	Line - Form Display	Line - Definition
		amount in accordance with the Affordable Care Act, then we do not plan to take any offset amount. For a noninnovator multiple source drug, we plan to offset an amount equal to two percent of the AMP (the difference between 13 percent of AMP and 11 percent of AMP).
8	Dental Services	8. Dental Services (See 42 CFR 440.100.). These are services that are diagnostic, preventive, or corrective procedures provided by, or under the supervision of, a dentist in the practice of his/her profession including treatment of: • The teeth and associated structures of the oral cavity; and, • Disease, injury, or impairment that may affect the oral or general health of the recipient. Report all EPSDT dental services on this line. Dentist means an individual licensed to practice dentistry or dental surgery. NOTE: Exclude all such services provided as part of inpatient hospital, outpatient hospital, nondental, clinic or laboratory services and billed for by the hospital, nondental clinic, or laboratory.
9A	Other Practitioners Services - Reg. Payments	9A. - Other Practitioners Services - Regular Payments (see CFR 440.60). Any medical or remedial care or services, other than physicians' services, provided by licensed practitioners with the scope of practice defined under State law. Chiropractors' services may be included here as long as the services that (1) are provided by a chiropractor who is licensed by the State and meets standards issued by the Secretary under section 405.232(b), and (2) consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.
9B	Other Practitioners Services - Sup. Payments	9B. - Other Practitioners Services - Supplemental Payments. Payments for other practitioner services as defined in Line 9A that are made in addition to the standard fee schedule payment for those services. When combined with regular payments, these supplemental payments are equal to or less than the Federal upper payment limit. Address supplemental payments for other practitioners associated with (1) governmental hospitals or university medical schools, and (2) private hospitals or university medical schools, and (3) other supplemental payments by entering payment information on the pop-up feeder sheet.

Line	Line - Form Display	Line - Definition
10	Clinic Services	10. Clinic Services (See 42 CFR 440.90.). These are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that: Are provided to outpatients; • Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. For reporting purposes, consider a group of physicians who share, only for mutual convenience, space, services of supporting staff, etc., as physicians, rather than a clinic, even though they practice under the name of a clinic; and • Except in the case of nurse-midwife services (see 42 CFR 440.165), are furnished by, or under, the direction of a physician. NOTE: Place dental clinics under Dental Services. Report any services not included above under Other Care Services. A clinic staff may include practitioners with different specialties.
11	Laboratory/Radiological	11. Laboratory And Radiological Services (See 42 CFR 440.30.). These are professional, technical laboratory and radiological services: • Ordered and provided by, or under, the direction of a physician or other licensed practitioner of the healing arts within the scope of a practice as defined by State law or ordered and billed by a physician but provided by an independent laboratory; • Provided in an office or similar facility other than a hospital inpatient or outpatient department or clinic; and • Provided by a laboratory that meets the requirements for participation in Medicare. • NOTE: Report X-rays by dentists under Dental Services, Line 8.

Line	Line - Form Display	Line - Definition
12	Home Health Services	12, Home Health Services (See 42 CFR 440.70.). These are services provided at the patient's place of residence in compliance with a physician's written plan of care that is renewed every 60 days and includes the following items and services: • Nursing service as defined in the State Nurse Practice Act that is provided on a part-time or intermittent basis by a home health agency (HHA) (a public or private agency or organization, or part of an agency or organization that meets the requirements for participation in Medicare). If there is no agency in the area, a registered nurse who: • Is licensed to practice in the State; • Receives written orders from the patient's physician; • Documents the case and services provided; and • Has had orientation to acceptable clinical and administrative record keeping from a health department nurse. Home health aide services provided by an HHA; • Medical supplies, equipment, and appliances suitable for use in the home; and • Physical therapy, occupational therapy, or speech pathology and audiology services provided by an HHA or by a facility licensed by the State to provide medical rehabilitation services. (See 42 CFR 441.15 - Home Health Services.) Place of residence is normally interpreted to mean the patient's home, and does not apply to hospitals or NFs. Services received in a NF that are different from those normally provided as part of the institution's care may qualify as Home Health Services. For example, a registered nurse may provide short-term care for a recipient in a NF during an acute illness to avoid the recipient's transfer to another NF.
13	Sterilizations	13. Sterilizations (See 42 CFR 441, Subpart F.). These are medical procedures, treatments, or operations for the primary purpose of rendering an individual permanently incapable of reproducing.

Line	Line - Form Display	Line - Definition
14	Other Pregnancy-related ProceduresAbortions	14. Other Pregnancy-related Procedures (See 42 CFR 441, Subpart E.). FFP is available when a physician has certified, in writing, to the Medicaid agency, that on the basis of professional judgment the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless a termination is performed. The certification must contain the name and address of the patient. The revision to the Hyde Amendment, P.L. 103-112, Health and Human Services Appropriations Bill, made FFP available for expenditures for other pregnancy-related procedures when the pregnancy is a result of an act of rape or incest. This reimbursement is effective for dates of service October 1, 1993 and thereafter. Provide a breakout of the number of other pregnancy-related procedures and associated expenditures in the following cases: • ProceduresAbortions performed to save the life of the mother, • ProceduresAbortions performed in the case of pregnancies resulting from incest, and • ProceduresAbortions performed in the case of pregnancies resulting from rape. NOTE 1: Report all other pregnancy-related procedures on this line regardless of the type of provider. For prior period adjustments, only include any entry in number of procedures if, for increasing claims, it is a new pregnancy-related procedure that has not been previously reported, or, for decreasing claims, you want to remove a procedure previously claimed. Make no entry in number of procedures if all you are changing is the dollar amount claimed. NOTE 2: The "morning after pill" (ECP) is not considered a termination as it is a contraceptive to prevent pregnancy. However, the drug Mifepristone (RU486) should be counted as another pregnancy-related procedure as long as all Hyde amendment and other federal requirements are met.

Line	Line - Form Display	Line - Definition
15	EPSDT Screening	15. EPSDT Screening Services - Physical and mental assessment given to Medicaid eligibles under age 21 to carry out the screening provisions of the EPSDT program. However, the agency must provide at least the following services through consultation with health experts, determine the specific health evaluation procedures to be used, and the mechanisms needed to carry out the screening program. • A comprehensive health and developmental history (including assessment of both physical and mental health development); • A comprehensive unclothed physical exam; • Appropriate immunizations according to the Advisory Committee on Immunization Practices • Laboratory tests (including blood lead level assessment according to age/risk factors); • Health education (including anticipatory guidance); and • Dental Services - Referral to a dentist in accordance with the States' periodicity schedule. • Vision Services The above services may be provided by any qualified Medicaid provider. NOTE: Do not include data for dental, hearing, or vision services here. Report dental examinations and preventative dental services on Line 8, Dental Services. Report hearing services, including hearing aids, on Line 32, Services for Speech, Hearing and Language. Report vision services rendered by professionals (e.g. – examinations, etc.) on Line 9, Other Practitioners' Services. Note that the cost of eyeglasses and other aids to vision is to be reported on Line 33, Prosthetic Devices, Dentures, and Eyeglasses. Report other necessary health care according to the appropriate category.

16	Rural Health	16. Rural Health Clinic (RHC) Services (See 42 CFR 440.20(b).). If a State permits the delivery of primary care by a nurse practitioner (NP) or physician's assistant (PA), rural health clinic (RHC) means the following services furnished by a RHC that has been certified in accordance with the conditions of 42 CFR Part 491 (Certification of Certain Health Facilities): • Services furnished by a physician within a professional scope under State law, whether the physician performs these services in or away from the clinic and the physician has an agreement with the clinic to be paid by it for such services. • Services furnished by a PA, NP, nurse midwife or other specialized NP (as defined in 42 CFR 405.2401 and 491.2) if they are furnished in accordance with the requirements specified in 42 CFR 405.2414(a). • Services and supplies that are furnished as incident to professional services furnished by a physician, PA, NP, nurse midwife, or specialized NP. (See 42 CFR 405.2413 and 405.2415 for the criteria determining whether services and supplies are included.) • Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biological) if: • The clinic is located in an area in which the Secretary has determined that there is a shortage of HHAs (see 42 CFR 405.2417); • The services are furnished by an RN or licensed PN or a licensed vocational nurse employed by, or otherwise compensated for the services by, the clinic; • The services are furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician of the clinic or that is established by a physician, PA, NP, nurse midwife, or specialized NP and reviewed and approved at least every 60 days by a supervising physician of the clinic; and • The services are furnished to a homebound recipient. For purposes of visiting nurse services, a homebound recipient means one who is permanently or temporarily confined to a place of residence because of a medical or health condition, and leaves the place of residence infrequently. For this purpose, place of residence does not include a hospital or an NF.Rural Health Clinic (RHC) Services (See 42 CFR 440.20(b).). If a State permits the delivery of primary care by a nurse practitioner (NP) or physician's assistant (PA), rural health clinic (RHC) means the following services furnished by a RHC that

Line	Line - Form Display	Line - Definition
		has been certified in accordance with the conditions of 42 CFR Part 491 (Certification of Certain Health Facilities):
16	Rural Health	• Services furnished by a physician within a professional scope under State law, whether the physician performs these services in or away from the clinic and the physician has an agreement with the clinic to be paid by it for such services. • Services furnished by a PA, NP, nurse midwife or other specialized NP (as defined in 42 CFR 405.2401 and 491.2) if they are furnished in accordance with the requirements specified in 42 CFR 405.2414(a). • Services and supplies that are furnished as incident to professional services furnished by a physician, PA, NP, nurse midwife, or specialized NP. (See 42 CFR 405.2413 and 405.2415 for the criteria determining whether services and supplies are included.) • Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biological) if: • The clinic is located in an area in which the Secretary has determined that there is a shortage of HHAs (see 42 CFR 405.2417); • The services are furnished by an RN or licensed PN or a licensed vocational nurse employed by, or otherwise compensated for the services by, the clinic; • The services are furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician of the clinic or that is established by a physician, PA, NP, nurse midwife, or specialized NP and reviewed and approved at least every 60 days by a supervising physician of the clinic; and • The services are furnished to a homebound recipient. For purposes of visiting nurse services, a homebound recipient means one who is permanently or temporarily confined to a place of residence because of a medical or health condition, and leaves the place of residence infrequently. For this purpose, place of residence does not include a hospital or an NF.
17A	Medicare - Part A	17A. Part A Premiums- (See §301 P.L. 100-360 and §1902 (a)(10) (E)(ii) of the Act) -- Include Part A premiums paid for Qualified Disabled and Working Individuals (QWDIs) under §1902(a)(10)(E)(ii) of the Act.

Line	Line - Form Display	Line - Definition
17B	Medicare - Part B	17B. Part B Premiums- (See §1902(a). Part B Premiums - Include premiums paid through Medicare buy-in under 1843 for Qualified Medicare Beneficiaries (QMBs) under 1902(a)(10)(E)(i),Specified Low-Income Medicare Beneficiaries (SLMBs) under 1902(a)(10)(E)(iii),and other Medicare/Medicaid dual eligibles covered in 1902(a)(10) of the Act. Do not include part B premiums for line 17C (Qualifying Individuals). This amount is shown on the bottom of each monthly bill sent to you on the summary accounting statement Form CMS-1604.
17C1	120% - 134% Of Poverty	Line 17C.1. 120% - 134% of Poverty - Include premiums paid for Medicare Part B under §1902(a)(10)(E)(iv)(I).
17D	Coinsurance	17D. Coinsurance and Deductibles-- Include Medicare deductibles and coinsurance required to be paid for QMBs under §1905 (p)(3). (Do not include any Medicare deductibles and coinsurance for other Medicare/Medicaid dual eligibles. Report expenditures for Medicaid services also covered by Medicare under the appropriate Medicaid service category.) Coinsurance is a joint assumption of risk by the insured and the insurer, whereby each shares on a specific basis, the applicable medical expenses of the insured. The insured's share of coinsurance may be paid on his/her behalf. For example, under part B of Medicare, the beneficiary's coinsurance responsibility is a percent of reasonable and customary expenses greater than the stipulated deductible. A deductible is that portion of applicable medical expenses which must be borne by the insured (or be paid on his/her behalf) before insurance benefits for the calendar year begin. -EXCEPTION: REPORT ALL OTHER PREGNANCY-RELATED PROCEDURES ON LINE 14.

Line	Line - Form Display	Line - Definition
18A	Medicaid - MCO	18A. Managed Care Organizations (MCOs) -- (See §1903(m)(1)(A) of the Act revised by BBA §4701(b)). - Include capitated payments made to a Medicaid Managed Care Organization which is defined as follows: A Medicaid Managed Care Organization (MCO) means a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare+ Choice organization with a contract under part C of title XVIII, a provider sponsored organization, which meets the requirements of §1902(w)and - (i) makes services it provides to individuals eligible for benefits under this title accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for Medical Assistance under the State plan) not enrolled with the organization, and (ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State and which assures that individuals eligible for benefits under this title are in no case held liable for debts of the organization in case of the organization's insolvency. An organization that is a qualified health maintenance organization (as defined in §1310(d) of the Public Health Service Act) is deemed to meet the requirements of clauses (i) and (ii).
18A1	Medicaid MCO - Evaluation and Management	18A1. Medicaid MCO - Evaluation and Management -- ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching.
18A2	Medicaid MCO - Vaccine codes	18A2. Medicaid MCO - Vaccine codes -- ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share matching rate

Appendix I

Line	Line - Form Display	Line - Definition
18A3	Medicaid MCO - Community First Choice	18A3. Medicaid MCO - Community First Choice -- 6% FMAP rate for Total Computable entered at the FMAP Federal Share rate. ACA Section 2401 - The provision established a new Medicaid State Plan option effective October 1, 2011 to allow States to cover HCBS and supports for individuals with incomes not exceeding 150 percent of the FPL, or, if greater, who have been determined to require an institutional level of care. States are provided an additional 6% increase in the FMAP matching funds for services and supports provided to such individuals.
18A4	Medicaid MCO - Preventive Services Grade A OR B, ACIP Vaccines and their Admin	18A4. Medicaid MCO - Preventive Services Grade A or B, ACIP Vaccines and their Admin -- 1% FMAP rate for Total Computable entered at the FMAP Federal Share rate. As a result of ACA 4106 Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. States get the 1% additional FMAP upon an approved SPA. Effective January 1, 2013
18A5	Medicaid MCO - Certified Community Behavior Health Clinic Payments	18A5 - Medicaid MCO - Certified Community Behavior Health Clinic Payments
18B1	Prepaid Ambulatory Health Plan	A Prepaid Ambulatory Health Plan (PAHP) means an entity that provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates. A PAHP does not provide or arrange for the provision of any inpatient hospital or institutional services for its enrollees, and does not have a comprehensive risk contract. NOTE: Include dental, mental health, transportation and other plans covering limited services (without inpatient hospital or institutional services) under PAHP.
18B1a	MCO PAHP - Evaluation and Management	18B1a. MCO PAHP - Evaluation and Management -- ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching.
18B1b	MCO PAHP - Vaccine codes	18B1b. MCO PAHP - Vaccine codes -- ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share matching rate

Line	Line - Form Display	Line - Definition
18B1c	MCO PAHP - Community First Choice	18B1c. MCO PAHP - Community First Choice -- 6% FMAP rate for Total Computable entered at the FMAP Federal Share rate. ACA Section 2401 - The provision established a new Medicaid State Plan option effective October 1, 2011 to allow States to cover HCBS and supports for individuals with incomes not exceeding 150 percent of the FPL, or, if greater, who have been determined to require an institutional level of care. States are provided an additional 6% increase in the FMAP matching funds for services and supports provided to such individuals.
18B1d	MCO PAHP - Preventive Services Grade A OR B, ACIP Vaccines and their Admin	18B1d. MCO PAHP. Preventive Services Grade A OR B, ACIP Vaccines and their Admin -- 1% FMAP rate for Total Computable entered at the FMAP Federal Share rate. As a result of ACA 4106 Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. States get the 1% additional FMAP upon an approved SPA. Effective January 1,
18B1e	Medicaid PAHP - Certified Community Behavior Health Clinic Payments	18B1e - Medicaid PAHP - Certified Community Behavior Health Clinic Payments
18B2	Prepaid Inpatient Health Plan	A Prepaid Inpatient Health Plan (PIHP) means an entity that provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates. A PIHP provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees. A PIHP does not have a comprehensive risk contract. NOTE: Include dental, mental health, transportation and other plans covering limited services (with inpatient hospital or institutional services) under PIHP.
18B2a	MCO PIHP - Evaluation and Management	18B2a. MCO PIHP - Evaluation and Management -- ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching.
18B2b	MCO PIHP - Vaccine codes	18B2b. MCO PIHP - Vaccine codes -- ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share matching rate

Line	Line - Form Display	Line - Definition
18B2c	MCO PIHP - Community First Choice	18B2c. MCO PIHP - Community First Choice -- 6% FMAP rate for Total Computable entered at the FMAP Federal Share rate. ACA Section 2401 - The provision establishes a new Medicaid State Plan option effective October 1, 2011 to allow States to cover HCBS and supports for individuals with incomes not exceeding 150 percent of the FPL, or, if greater, who have been determined to require an institutional level of care. States are provided an additional 6% increase in the FMAP matching funds for services and supports provided to such individuals.
18B2d	MCO PIHP - Preventive Services Grade A OR B, ACIP Vaccines and their Admin	18B2d. MCO PIHP. Preventive Services Grade A OR B, ACIP Vaccines and their Admin -- 1% FMAP rate for Total Computable entered at the FMAP Federal Share rate. As a result of ACA 4106 Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. States get the 1% additional FMAP upon an approved SPA. Effective January 1,
18B2e	Medicaid PIHP - Certified Community Behavior Health Clinic Payments	18B2e - Medicaid PIHP - Certified Community Behavior Health Clinic Payments
18C	Medicaid - Group Health	18C. Group Health Plan Payments-- Include payments for premiums for cost effective employer group health insurance under §1906 of the Act.
18D	Medicaid - Coinsurance	18D. Coinsurance and Deductibles-- Include payments for coinsurance and deductibles for cost employer group health insurance under §1906 of the Act.
18E	Medicaid - Other	18E. Other--Include premiums paid for other insurance for medical or any other type of remedial care in order to maintain a third party resource under §1905(a). (Report expenditures here only if you have elected to pay these premiums in item 3.2(a)(2) on page 29b of your State Plan Preprint.) EXCEPTION: REPORT ALL OTHER PREGNANCY-RELATED PROCEDURES ON LINE 14.
19A	Home & Community-Based Services - Reg. Pay. (Waiv)	19A. Home and Community-Based Services (See 42 CFR 440.180.(a).).-- These are services furnished under a 1915(c) waiver approved under the provisions in 42 CFR 441, Subpart G (Home and Community-Based Services; Waiver Requirements). NOTE: Report only approved waiver services as designated in the State's approved waiver applications which are provided to eligible waiver recipients.

Line	Line - Form Display	Line - Definition
19B	Home & Community-Based Services - St. Plan 1915(i) Only Pay.	19B. - Other Practitioners Services - State Plan 1915(i) Only Payment. Only the home and community based services elected and defined in the approved State plan may be claimed on this line and form. Enter cost data on the lines in the pop-up feeder sheet that match the services approved in the State plan.
19C	Home & Community-Based Services - St. Plan 1915(j) Only Pay.	19C Home and Community Based Services – State Plan 1915(j) Only Payment – 42 CFR Part 441 – Self-Directed Personal Assistance Services Program State Plan Option. These are PAS services provided under the self-directed service delivery model authorized by 1915(j) including any approved home and community-based services otherwise available under a 1915(c) waiver. The MBES will automatically enter in row 19C the totals from the pop-up 1915(j) Self-Directed Personal Assistance Services Feeder Form. Expenditures for 1915(c) waiver like services provided under 1915(j) Self Direction are entered on the line 19C Feeder Form rather than on the Line 19A Waiver Form which is reserved for approved waiver expenditures. NOTE: 1915(j) services that are using the self-directed service delivery model for State Plan Personal Care and related services should be claimed separately on Line 23B.
19D	Home & Community Based Services State Plan 1915(k) Community First Choice	19D Home and Community Based Services State Plan 1915(k) Community First Choice ACA Section 2401 - The provision established a new Medicaid State Plan option effective October 1, 2011 to allow States to cover HCBS and supports for individuals with incomes not exceeding 150 percent of the FPL, or, if greater, who have been determined to require an institutional level of care. States are provided an additional 6% increase in the FMAP matching funds for services and supports provided to such individuals.

Line	Line - Form Display	Line - Definition
22	All-Inclusive Care Elderly	22. Programs of All-Inclusive Care for the Elderly (PACE)(See 42 CFR Part 460). PACE provides pre-paid, capitated, comprehensive health care services designed to enhance the quality of life and autonomy for frail, older adults. Required services (See 42 CFR 460.92) The PACE benefit package for all participants, must include: (a) All Medicaid-covered services, as specified in the State's approved Medicaid plan. NOTE: This is an option within the Medicaid Program to establish Programs of All-Inclusive Care for the Elderly beginning August 5, 1998. (See §1905(a)(26) and §1934 of the Act.) Do not report payments for PACE programs which continue to operate under §1115 authority on this line. Report payments for PACE programs continuing to operate under §1115 waiver authority on the appropriate waiver forms under the appropriate categories of services.
23A	Personal Care Services - Reg. Payments	23A. - Personal Care Services. Regular Payment.-- (See 42 CFR 440.167).-- Unless defined differently by a State agency for purposes of a waiver granted under Part 441, subpart G of this chapter Personal care services means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental health conditions that are-- (1) Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State; (2) Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) Furnished in a home, and at the State's option in another location.
23B	Personal Care Services - SDS 1915(j)	23B. - Personal Care Services.--SDS 1915(j). -- (See 42 CFR Part 441). -- Self-Directed Personal Assistance Services (PAS) State Plan Option. These are PAS provided under the self-directed service delivery model authorized by 1915(j) for State plan personal care and related services. NOTE: 1915(j) PAS that are using the self-directed service delivery model for section 1915(c) home and community-based services should be claimed separately on line 19C.

Line	Line - Form Display	Line - Definition
24A	Targeted Case Management Services - Com. Case-Man.	24A. - Targeted Case Management Services (see section 1915(g)(1) of the Social Security Act) are case management services that are furnished without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B) to specific classes of individuals or to individuals who reside in specified areas. Case management services means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services (See section 1915(g)(2) of the Act).
24B	Case Management - State Wide	24B. - Case Management. State Wide. -- (See §1915(g)(2) of the Act.). These are services that assist individuals eligible under the State plan in gaining access to needed medical, social, educational and other services. The agency must permit individuals to freely choose any qualified Medicaid provider when obtaining case management services in accordance with 42 CFR 431.51.
25	Primary Care Case Management	25. Primary Care Case Management Services (PCCM) (See §1905(a)(25) and §1905 (t). These are case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract. Currently most PCCM programs pay the primary care case manager a monthly case management fee. Report service costs and/or related fees on this line. Report other service costs and/or related fees on the appropriate type of service line. NOTE: Where the fee includes services beyond case management, report the fees under line 18B.

Line	Line - Form Display	Line - Definition
26	Hospice Benefits	26 - Hospice Benefits (See Section 1905(o)(1)(A) of the Act.). The care described in section 1861(dd)(1) furnished by a hospice program (as defined in section 1861(dd)(2)) to a terminally ill individual who has voluntarily elected to have payment made for hospice care instead of having payment made for certain benefits described under 1812(d)(2)(A) and for which payment may otherwise be made under Title XVIII and intermediate care facility services under the plan. Hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care. NOTE: These are services that are: • Covered in 42 CFR 418.202; • Furnished to a terminally ill individual, as defined in 42 CFR 418.3; • Furnished by a hospice, as defined in 42 CFR 418.3, that: • Meets the requirements for participation in Medicare specified in 42 CFR 418, Subpart C or by others under an arrangement made by a hospice program that meets those requirements; and • Is a participating Medicaid provider; • Furnished under a written plan that is established and periodically reviewed by: • The attending physician; • The medical director of the program, as described in 42 CFR 418.54; or • The interdisciplinary group described in 42 CFR 418.68.
27	Emergency Services for Undocumented Aliens	27. Emergency Services Undocumented Aliens Pursuant to the Act The Medicaid program pays for emergency medical services provided to certain aliens. Section §1903(v) of the Act sates that "...no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted... "The only exception is if such care and services are for 1) an emergency medical condition, 2) if such alien otherwise meets the eligibility requirements for medical assistance under the State Plan, and 3) such care and services are not related to an organ transplant procedure.

Line	Line - Form Display	Line - Definition
28	Federally Qualified Health Center	28. Federally Qualified Health Center (FQHC) (See §1905(a)(2) of the Act.) - -These are services performed by facilities or programs more commonly known as Community Health Centers, Migrant Health Centers, and Health Care for the Homeless Programs. FQHCs qualify to provide covered services under Medicaid if: • They receive grants under §§329, 330, or 340 of the Public Health Service (PHS) Act; • The Health Resources and Services Administration, PHS certifies the center as meeting FQHC requirements; or • The Secretary determines that the center qualifies through waiver of the requirements.
29	Non-Emergency Medical Transportation	29. - Non-Emergency Medical Transportation (see 42CFR431.53; 440.170; 440.170(a); 440.170(a)(4)) -A ride, or reimbursement for a ride, provided so that a Medicaid beneficiary with no other transportation resources can receive services from a medical provider. (NEMT does not include transportation provided on an emergency basis, such as trips to the emergency room for life-threatening situations. NOTE: Transportation provided via the State is consider an administrative cost and should be reported on the form CMS-64.10.
30	Physical Therapy	30. - Physical Therapy (See 42CFR440.110(a)(1)). - Services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment. NOTE: Do not include any costs for physical therapy services provided under the school based environment. Those costs should be reported on the pop-up feeder form for Line 39 below. -NOTE: Do not include any costs for physical therapy services provided under the rehabilitative services option. Those costs should be reported on the pop-up feeder form for Line 40 below.

Line	Line - Form Display	Line - Definition
31	Occupational Therapy	31. - Occupational Therapy (see 42CFR440.110(b)) -Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment. NOTE: Do not include any costs for occupational therapy services provided under the school based environment. Those costs should be reported on the pop-up feeder form for Line 39 below. -NOTE: Do not include any costs for occupational therapy services provided under the rehabilitative services option. Those costs should be reported on the pop-up feeder form for Line 40 below.
32	Services for Speech, Hearing & Language	32. - Services for Speech, Hearing and Language -Services for individuals with speech, hearing, and language disorders (See 42CFR440.110(c)). Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or correction services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment, including hearing aids. NOTE: Do not include any costs for speech and language services provided under the school based environment. Those costs should be reported on the pop-up feeder form for Line 39 below. NOTE: Do not include any costs for speech / language therapy services provided under the rehabilitative services option. Those costs should be reported on the pop-up feeder form for Line 40 below. It includes any necessary supplies and equipment.

Line	Line - Form Display	Line - Definition
33	Prosthetic Devices, Dentures, Eyeglasses	Line 33 - Prosthetic Devices, Dentures, Eyeglasses (See 42 CFR 440.120) Prosthetic devises means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner to: 1. Artificially replace a missing portion of the body; 2. Prevent or correct physical deformity or malfunction; 3. Support a weak or deformed portion of the body. Dentures are artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth. Eyeglasses means lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist.
34	Diagnostic Screening & Preventive Services	34. - Diagnostic Screening & Preventive Services (see 42CFR440.130) (a) "Diagnostic services", except as otherwise provided under this subpart, includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient. (b) "Screening services" means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases. (c) "Preventive services" means services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to: (1) Prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health and efficiency. NOTE: This does not include Rehabilitative services - those services are reported on the pop-up feeder sheet for line 40 below.

Line	Line - Form Display	Line - Definition
34A	Preventive Services Grade A OR B, ACIP Vaccines and their Admin	34A. Preventive Services Grade A OR B, ACIP Vaccines and their Admin -- 1% FMAP rate for Total Computable entered at the FMAP Federal Share rate. As a result of ACA 4106- Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. States get the 1% additional FMAP upon an approved SPA. Effective January 1, 2013
35	Nurse Mid-Wife	Line 35 - Nurse Mid-Wife (See 42 CFR 440.165) "Nurse-midwife services" means services that are furnished within the scope or practice authorized by State law or regulation and, in the case of inpatient or outpatient hospital services or clinic services, are furnished by or under the direction of a nurse mid-wife to the extent permitted by the facility. Unless required by required by State law or regulations or a facility, are reimbursed without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider. See 42 CFR 441.21 for provisions on independent provider agreements for nurse-midwives.
36	Emergency Hospital Services	36. - Emergency Hospital Services (See 42 CFR 440.170) Emergency hospital services means services that: 1. Are necessary to prevent the death or serious impairment of the health of the recipient; and 2. Because of the threat to the life or health of the recipient necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet- (i) The conditions for participation under Medicare; or (ii) The definitions of inpatient or outpatient hospital services under 42 CFR 440.10 and 440.20. NOTE: Emergency health services provided to undocumented aliens and funded under an allotment established under §4723 of the Balanced Budget Act of 1997 P.L. 105-33 should be reported on Line 27.
37	Critical Access Hospitals	Line 37 - Critical Access Hospitals (See 42 CFR 440.170) -- Critical access hospital services that are furnished by a provider that meet the requirements for participation in Medicare as a CAH (see subpart F of 42 CFR part 485), and (ii) are of a type that would be paid for by Medicare when furnished to a Medicare beneficiary. Inpatient CAH services do not include nursing facility services furnished by a CAH with a swing-bed approval.

Line	Line - Form Display	Line - Definition
38	Nurse Practitioner Services	Line 38 - Nurse Practitioner Services (See 42 CFR 440.166) - Nurse practitioner services means services that are furnished by a registered professional nurse who meets a State's advanced educational and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses. See 42 CFR 440.166 for requirements related to certified pediatric nurse practitioner and certified family nurse practitioner.
39	School Based Services	39. - School Based Services (See section 1903(c) of the Act) - These services include medical assistance for covered services (see section 1905(a)) furnished to a child with a disability because such services are included in the child's individualized educational program established pursuant to Part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan.
40	Rehabilitative Services (non-school-based)	40. - Rehabilitative Services (non-school-based) (see 42CFR440.130(d)) - Except as otherwise provided under this subpart, rehabilitative services includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, with the scope of his practice under State law, for maximum reduction of physical or mental health condition and restoration of a recipient to his best possible functional level. -NOTE: Do not include any costs for rehabilitative services provided under the school based environment which should be reported on Line 39.
41	Private Duty Nursing	41. - Private Duty Nursing (see 42CFR440.80) - Nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided: (a) by a registered nurse or a licensed practical nurse; (b) under the direction of the recipient's physician; and (c) to a recipient in one or more of the following locations at the option of the State: (1) his or her own home; (2) a hospital; or (3) a skilled nursing facility.

Line	Line - Form Display	Line - Definition
42	Freestanding Birth Center	Line 42 - Freestanding Birth Center COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES Section 2301 of the Affordable Care Act amended section 1905(a) of the Social Security Act (the Act) to provide coverage for freestanding birth center services, as defined in section 1905(l)(3)(A) of the Act. In that provision, the benefit is defined as services furnished at a freestanding birth center, which is defined in new subparagraph 1905(l)(3)(B) as a health facility: • that is not a hospital; • where childbirth is planned to occur away from the pregnant woman's residence; • that is licensed or otherwise approved by the State to provide prenatal, labor and delivery, or postpartum care and other ambulatory services included in the State plan; and • that must comply with a State's requirements relating to the health and safety of individuals receiving services delivered by the facility. In addition to payment for freestanding birth center facilities, section 1905(l)(3)(C) of the Act requires separate payment for the services furnished by practitioners providing prenatal, labor and delivery, or postpartum care in a freestanding birth center facility, such as nurse midwives and birth attendants. Payment must be made to these practitioners directly, regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. It is important to note that section 2301 of the Affordable Care Act does not require States to license or otherwise recognize freestanding birth centers or practitioners who provide services in these facilities if they do not already do so. Coverage and payment are limited to only those facilities and practitioners licensed or otherwise recognized under State law.

Line	Line - Form Display	Line - Definition
42	Freestanding Birth Center	Prior to passage of the Affordable Care Act, only nurse midwife services were mandatory services under section 1905(a)(17) of the Act and implementing regulations at 42 CFR 440.165. In addition, States had the option to cover the services of other practitioners who are licensed by the State to provide midwifery services such as Certified Professional Midwives (CPM) under section 1905(a)(6) of the Act and implementing regulations at 42 CFR 440.60. These practitioner services are now mandatory when provided in a freestanding birth center as defined above. Further, other practitioner services, such as those furnished by so-called direct entry or lay midwives or birth attendants, who are not licensed but are recognized under State law to provide these services, are now required to be covered when provided in the freestanding birth center. Submission of State Plan Amendments These provisions became effective with the enactment of the Affordable Care Act, beginning March 23, 2010. To implement these provisions, States will need to submit amendments to their State plans that specify coverage and separate reimbursement of freestanding birth center facility services and professional services. Unless the compliance exception discussed below applies, or the State does not license or otherwise recognize freestanding birth centers or practitioners who provide services in these facilities, States must submit a State plan amendment (SPA) not later than the end of the next calendar quarter that follows the date of this guidance. In accordance with section 2301(c) of the Affordable Care Act, States that require State legislation (other than appropriation legislation) to meet the new requirements related to their Medicaid coverage of freestanding birth center services will not be regarded as out of compliance with the standards governing this coverage option as long as they come into compliance not later than the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of the Affordable Care Act. For example, if the next regular legislative session beginning after March 23, 2010, is from January 1 through April 30, 2011, then the State would have until September 30, 2011, to submit the required SPA with an effective date of July 1, 2011. In the case of the State that has a 2-year legislative session, each year is treated as a separate regular session of the State legislature. For example, if a legislature is in session from January 1, 2010, through December 31, 2012, then the State would have until March 31, 2011, to submit a SPA with an effective date that is no later than January 1, 2011. A State should promptly notify its CMS regional office if this compliance exception is applicable.

Line	Line - Form Display	Line - Definition
43	Health Home for Enrollees w Chronic Conditions	43. Health Home for Enrollees w Chronic Conditions - Health Home services which includes - Comprehensive care Management - Care Coordination - Health promotion - Comprehensive transitional care (Planning and coordination) - Individual and Family Support - Referral to community/social supports - Use of Health Information Technology to link services as feasible and appropriate
44	Tobacco Cessation for Pregnant Women	44. Tobacco Cessation for Preg Women - ACA Section 4107 Payments for tobacco cessation counseling services for pregnant women and smoking/tobacco cessation outpatient drugs for pregnant women.
45	Health HomesHome for Enrollees w Substance-Use-Disorder Enrollees	45 Health HomesHome for Enrollees with Substance-Use-Disorder Enrollees per section- Pursuant to Section 1006 of the SUPPORTrecently signed Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018. States that have an approved Health Home Spa will receive 90% FMAP for 10 consecutive quarters from Approval Date.
49	Other Care Services	49 -- Other Care Services --These are any medical or remedial care services recognized under State law and authorized by the approved Medicaid State Plan. Such services do not meet the definition of, and are not classified under, any category of service included on Lines 1 through 41.

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

Line	Line - Form Display	Line - Definition
1A	Premiums - Up To 150%: Gross Premiums Paid	Line 1.A. Gross Premiums Paid. Report on line 1.A. the amount of expenditures related to premiums paid for children whose family income is up to 150 percent of the Federal poverty level. Use the definition as contained in Part 2 Section 2500.2.E., lines 18.A. -18.E. (Medicaid Health Insurance Payments-Health Maintenance Organizations (HMO), Health Insuring Organization (HIO), Prepaid Health Plans (PHP), Group Health Plan Payments, and Other, respectively) of the State Medicaid Manual. Remember to report the total amount of the premiums. DO NOT NET THE OFFSETS WITH THE PREMIUMS. For example, it costs the State 500 per month per person and there are 100 people under this plan. Assume that the state receives $20 from one of the individuals covered for his share of the cost. Report $50,000 (500 x 100) on Line 1.A. and $20 on Line 1.B.
1B	Premiums - Up To 150%: Cost Sharing Offset	Line 1.B. Cost Sharing Offsets. Report any cost sharing offset amounts received with respect to the amounts reported on Line 1.A. for children whose family income is up to 150 percent of the Federal poverty level. As indicated above, for line 1.A, the cost sharing offset amounts relate to the expenditures reported on line 1.A. should be reported separately on line 1.B.
1C	I Premiums - Over 150%: Gross Premiums Paid	Line 1.C. Gross Premiums Paid. For children above 150% of poverty, premiums may be imposed on a sliding scale related to family income. Use the definition as contained in Part 2 Section 2500.2.E., lines 18.A. -.18.E (Medicaid Health Insurance Payments-Health Maintenance Organizations (HMO), Health Insuring Organization (HIO), Prepaid Health Plans (PHP), Group Health Plan Payments, and Other, respectively) of the State Medicaid Manual. DO NOT NET THE OFFSETS WITH THE PREMIUMS For an example see item 1.A.

Line	Line - Form Display	Line - Definition
1D	Premiums - Over 150%: Cost Sharing Offset	Line 1.D. Cost Sharing Offsets.--Report any cost sharing offset amounts received with respect to the amounts reported on line 1.C. for children whose family income is above 150 percent of the Federal poverty level. As indicated above for line 1.A, the cost sharing offset amounts related to the expenditures reported on line 1.A. should be reported separately on line 1.B. NOTE: Line items 1.A. - D. above relate to capitated payments on behalf of CHIP recipients in Managed Care Arrangements. Do not breakout out the amounts reported on lines 1.A. - 1.D. in lines 2 - 26 below, as they relate to expenditures for CHIP recipients in Fee-For-Service Plans.
2	Inpatient Hospital	Line 2. Inpatient Hospital Services - Regular Payments.--Use the definition as contained in Part 2 Section 2500.2.E., line 1.A. (Inpatient Hospital Services - Regular Payments) of the State Medicaid Manual.
3	Inpatient Mental Health	Line 3. Inpatient Mental Health Facility Services - Regular Payments.---Use the definition as contained in Part 2 Section 2500.2.E., line 2.A. (Mental Health Facility Services-Regular Payments) of the State Medicaid Manual.
4	Nursing Care Services	Line 4. Nursing Care Services. - (Other than services in an institution for mental health conditions).---Use the definition as contained in Part 2 Section 2500.2.E., line 29 paragraph g., (Other Care Services-nurse midwife services), of the State Medicaid Manual.
5	Physician/Surgical	Line 5. Physician and Surgical Services.--Use the definition as contained in Part 2 Section 2500.2.E., line 5. (Physicians' Services) of the State Medicaid Manual.
6	Outpatient Hospital	Line 6. Outpatient Hospital Services. .-:-Use the definition as contained in Part 2 Section 2500.2.E., line 6. (Outpatient Hospital Services) of the State Medicaid Manual for services related to non-mental health facilities which are reported on line 7 below.
7	Outpatient Mental Health	Line 7. Outpatient Mental Health Facility Services.---Use the definition as contained in Part 2 Section 2500.2.E., line 6 (Outpatient Hospital Services) of the State Medicaid Manual for services related to mental health facilities only.

Line	Line - Form Display	Line - Definition
8	Prescribed Drugs	Line 8. Prescribed Drugs.--Use the definition as contained in Part 2 Section 2500.2.E., line 7. (Prescribed Drugs) of the State Medicaid Manual.
8A	Drug Rebate	8A.1. Drug Rebate Offset.--This is a refund from the manufacturer for single source drugs, innovator multiple source drugs, and non-innovator multiple source drugs.
9	Dental Services	Line 9. Dental Services.--Use the definition as contained in Part 2 Section 2500.2.E., lines 8 (Dental Services) and 29 paragraph e. (Other Care Services-Dentures) of the State Medicaid Manual
10	Vision Services	Line 10. Vision Services...--Use the definition as contained in Part 2 Section 2500.2.E., line 29 paragraph e., (Other Care Services-eyeglasses) of the State Medicaid Manual.
11	Other Practitioners	Line 11. Other Practitioners' Services. ---Use the definition as contained in Part 2 Section 2500.2.E., lines 9. (Other Practitioners' Services) and 29 paragraph f. (Other Care Services--diagnostic, screening, rehabilitative, and preventive services) of the State Medicaid Manual.
12	Clinic Services	Line 12. Clinic Services.--Use the definition as contained in Part 2 Section 2500.2.E., lines 10. (Clinic Services) and 16. (Rural Health Clinic Services) of the State Medicaid Manual.
13	Therapy Services	Line 13. Therapy Services. ---Use the definition as contained in Part 2 Section 2500.2.E., line 29 (Other Care Services) paragraphs b. (Physical Therapy), c. (Occupational Therapy), and d. (Services for individuals with speech, hearing, and language disorders) of the State Medicaid Manual.
14	Laboratory/Radiological	Line 14. Laboratory And Radiological Services.--Use the definition as contained in Part 2 Section 2500.2.E., line 11. (Laboratory and Radiological Services of the State Medicaid Manual.

Line	Line - Form Display	Line - Definition
15	Medical Equipment	Line 15. Durable and Disposable Medical Equipment. -Use the definition as contained in Part 2 Section 2500.2.E., line 29. paragraph e. (Other Care Services-prosthetic devices) of the State Medicaid Manual
16	Family Planning	Line 16.Family Planning. --On the Form HCFA-64.21 series, the reporting on the family planning line 16 is blocked. This is because of the way family planning services are treated with respect to the available FMAP rate and the application of payments against the States' FY CHIP allotments (refer to SMM §2500.9.I.1. and .2).
17	Other Pregnancy-related Procedures	Line 17. Other Pregnancy-related Procedures. -Use the definition as contained in Part 2 Section 2500.2.E., line 14 of the State Medicaid Manual.
18	Screening Services	Line 18. Screening Services. -Use the definition as contained in Part 2 Section 2500.2.E., line 15. (EPSDT Screening Services) of the State Medicaid Manual.
19	Home Health	Line 19. Home Health Services. --Use the definition as contained in Part 2 Section 2500.2.E., line 12. (Home Health Services) of the State Medicaid Manual.
20	Health Services Initiatives	Line 20. Health Services Initiatives States may use funds available under their 10 percent administrative cap to fund Health Service Initiatives (HSIs). An HSI is an activity that protects public health, protects the health of individuals, improves or promotes a state's capacity to deliver public health services, or strengthens the human and material resources necessary to accomplish public health goals relating to improving the health of children, including targeted low-income children and other low-income children. States are not limited in the number of different HSIs they may fund, as long as the state ensures that title XXI funding, within the state's 10 percent limit, is sufficient to continue the proper administration of the CHIP program. If such funds become less than sufficient, the state agrees to redirect title XXI funds from the support of HSIs to the administration of the CHIP program.

Line	Line - Form Display	Line - Definition
21	Home and Community	Line 21. Home and Community-Based Services. --Use the definition as contained in Part 2 Section 2500.2.E., lines 19. (Home and Community-Based Services) and 23. (Personal Care Services) of the State Medicaid Manual.
22	Hospice	Line 22. Hospice Care Services. --Use the definition as contained in Part 2 Section 2500.2.E., line 26. (Hospice Benefits) of the State Medicaid Manual.
23	Medical Transportation	Line 23. Medical Transportation Services. --Use the definition as contained in Part 2 Section 2500.2.E., line 29 paragraph a. (Other Care Services-Transportation) of the State Medicaid Manual.
24	Case Management	Line 24. Case Management Services. --Use the definition as contained in Part 2 Section 2500.2.E., lines 24. (Targeted Case Management Services) and 25 (Primary Care Case Management Services) of the State Medicaid Manual.
25	Translation and Interpretation	Line 25. Translation and Interpretation (Section 201 CHIPRA) Translation may be allowable as an administrative activity if it is not included and paid for as part of a direct medical service and if it is necessary for the proper and efficient administration of the State plan. However, in order for translation to be claimable as administration, it must be provided either by separate units or separate employees performing solely translation activities and it must facilitate access
31	Other Services	Line 31. Other Services
32	Outreach	Outreach Amounts reported on this line should NOT include any amounts reported on Lines 32A or 32B

Line	Line - Form Display	Line - Definition
32A	Increased Outreach and Enrollment of Indians	Line 32.A - Increased Outreach and Enrollment of Indians (Section 202 CHIPRA)) Enter in Column (a) the total computable amount of expenditures for the Increased Outreach and Enrollment of Indians The MBES will automatically calculate the Federal Share in Columns (b) and (e) at the CHIP rate. These expenditures are NOT applicable to the 10% limit on Outreach and Certain other expenditures. Amounts reported on this line should NOT include any amounts reported on Lines 32 or 32B
32B	Increase outreach and enrollment of children through premium subsidies	Line 32.B - Increase Outreach and Enrollment of children through premium subsidies Amounts reported on this line should NOT include any amounts reported on Lines 32 or 32A
33	Administration	Line 33. Administration. (Section 2105(a)(2)(D) of the Act).--Enter the amount of other reasonable costs incurred by the State to administer the plan. NOTE: All of these administrative activities are subject to the 10 percent limit and must be entered in Column(c). See Section 2115 K above for a discussion of administrative costs and Section 2115 J above for a discussion of the 10 percent limit.
34	PERM Administration	Line 34 - PERM Administration - (Section 601 CHIPRA)--Enter in Column (a) the total computable amount of expenditures for the administration of PERM. The MBES will automatically enter in Columns (b) and (e) 90 percent of the amount reported in Column (a).
35	Citizenship Verification Technology CHIPRA	Line 35. Citizenship Verification Technology (Section 211 CHIPRA)
35A	CVT Development	Line 35A. CVT Development: (Section 211 CHIPRA) Enter in Column (a) the total computable amount of expenditures for the design, development, or installation of Citizenship Verification technology. The MBES will automatically enter in Columns (b) and (e) 90 percent of the amount reported in Column (a).

~~Line~~	~~Line - Form Display~~	~~Line - Definition~~
~~35B~~	~~CVT Operation~~	~~Line 35B. CVT Operation (Section 211 CHIPRA)--Enter in Column (a) the total computable amount of expenditures for the operation of Citizenship Verification technology. The MBES will automatically enter in Columns (b) and (e) 75 percent of the amount reported in Column (a).~~

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

This Section Intentionally Left Blank MSIS Code Definitions	MSIS Valid Values	T-MSIS 2.4 Valid Values	T-MSIS v2.4 Code Definitions
Inpatient Hospital	01	001	Inpatient hospital services, other than services in an institution for mental diseases
Inpatient Hospital	01	090	Critical access hospital services – IP
Inpatient Hospital	01	091	Skilled care – hospital residing
Inpatient Hospital	01	092	Exceptional care – hospital residing
Inpatient Hospital	01	093	Non-acute care – hospital residing
Mental Health Hospital Services for the Aged	02	044	Inpatient hospital services for individuals age 65 or older in institutions for mental diseases
Mental Health Hospital Services for the Aged	02	045	Nursing facility services for individuals age 65 or older in institutions for mental diseases
Disproportionate Share Hospital (DSH)	03	123	Disproportionate share hospital (DSH) payments
Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under	04	048	Inpatient psychiatric services for individuals under age 21
ICF Services for Individuals with Mental Health Condition	05	046	Intermediate care facility (ICF/IIDICF/IID) services
NF'S - All Other	07	009	Nursing facility services for individuals age 21 or older (other than services in an institution for mental disease)
NF'S - All Other	07	047	Nursing facility services, other than in institutions for mental diseases
NF'S - All Other	07	059	Skilled nursing facility services for individuals under age 21
Physicians	08	012	Physicians' services
Physicians	08	042	Well-baby and well-child care services as defined by the State.
Dental	09	029	Dental Services
Dental	09	013	Medical and surgical services of a dentist
Other Practitioners	10	015	Medical or other remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law

*This Section Intentionally Left Blank*MSIS Code Definitions	MSIS Valid Values	T-MSIS 2.4 Valid Values	T-MSIS v2.4 Code Definitions
Other Practitioners	10	010	Early and periodic screening and diagnosis and treatment (EPSDT) services
Outpatient Hospital	11	002	Outpatient hospital services
Outpatient Hospital	11	061	Critical access hospital services – OT
Clinic	12	028	Clinic services
Clinic	12	041	Preventive Services
Clinic	12	014	Outpatient substance abuse treatment services.
Clinic	12	003	Rural health clinic services
Home Health	13	016	Home health services – Nursing services
Home Health	13	017	Home health services - Home health aide services
Home Health	13	018	Home health services - Medical supplies, equipment, and appliances suitable for use in the home
Home Health	13	019	Home health services - Physical therapy provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services
Home Health	13	020	Home health services - Occupational therapy provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services
Home Health	13	021	Home health services - Speech pathology and audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services
Lab and X-Ray	15	005	Professional laboratory services, Technical laboratory services
Lab and X-Ray	15	006	Technical laboratory services
Lab and X-Ray	15	007	Professional radiological services
Lab and X-Ray	15	008	Technical radiological services
Prescribed Drugs	16	033	Prescribed drugs
Prescribed Drugs	16	033	Over-the-counter medications.
Prescribed Drugs	16	036	Medical Equipment/Prosthetic devices
Prescribed Drugs	16	131	Drug Rebates

*This Section Intentionally Left Blank*MSIS Code Definitions	MSIS Valid Values	T-MSIS 2.4 Valid Values	T-MSIS v2.4 Code Definitions
Other Services	19	064	HCBS - Home health aide services
Other Services	19	035	Dentures
Other Services	19	037	Eyeglasses
Other Services	19	062	HCBS - Case management services
Other Services	19	063	HCBS - Homemaker services
Other Services	19	065	HCBS - Personal care services
Other Services	19	066	HCBS - Adult day health services
Other Services	19	067	HCBS - Habilitation services
Other Services	19	068	HCBS - Respite care services
Other Services	19	069	HCBS - Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness
Other Services	19	073	HCBS - Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization
Other Services	19	074	HCBS - Expanded habilitation services - Prevocational services
Other Services	19	075	HCBS - Expanded habilitation services - Educational services
Other Services	19	076	HCBS - Expanded habilitation services - Supported employment services, which facilitate paid employment
Other Services	19	077	HCBS-65-plus - Case management services
Other Services	19	078	HCBS-65-plus - Homemaker services
Other Services	19	079	HCBS-65-plus - Home health aide services
Other Services	19	080	HCBS-65-plus - Personal care services
Other Services	19	081	HCBS-65-plus - Adult day health services
Other Services	19	082	HCBS-65-plus - Respite care services
Other Services	19	083	HCBS-65-plus - Other medical and social services
Other Services	19	034	Over-the-counter medications.

Appendix K

*This Section Intentionally Left Blank*MSIS Code Definitions	MSIS Valid Values	T-MSIS 2.4 Valid Values	T-MSIS v2.4 Code Definitions
Other Services	19	039	Diagnostic services
Other Services	19	040	Screening services
Other Services	19	050	Inpatient substance abuse treatment services and residential substance abuse treatment services.
Other Services	19	057	Enabling services
Other Services	19	060	Emergency hospital services
Other Services	19	071	HCBS - Training for family members
Other Services	19	072	HCBS – Minor modification to the home
Other Services	19	085	Prenatal care and pre-pregnancy family planning services and supplies.
Other Services	19	088	Any other health care services or items specified by the Secretary and not excluded under regulations.
Other Services	19	089	Disposable medical supplies.
Other Services	19	135	EHR payments to provider
Capitated Payment s to HMO, HIO or PACE Plan	20	119	Capitated payments to HMOs, HIOs, or PACE plans
Capitated Payments to Prepaid Health Plans (PHPs)	21	122	Capitated payments to prepaid health plans (PHPs)
Capitated Payments for Primary Care Case Management (PCCM)	22	120	Capitated payments for primary care case management (PCCM)
Capitated Payments for Private Health Insurance	23	121	Premium payments for private health insurance
Sterilizations	24	084	Sterilizations
Other Pregnancy-related Procedures	25	086	Other Pregnancy-related Procedures
Transportation Services	26	056	Transportation services
Personal Care Services	30	051	Personal care services
Targeted Case Management	31	053	Targeted case management services
Targeted Case Management	31	052	Primary care case management services
Targeted Case Management	31	054	Case Management services other than those that meet the definition of primary care case management services or targeted case management services
Targeted Case Management	31	055	Care coordination services

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This Section Intentionally Left Blank MSIS Code Definitions	MSIS Valid Values	T-MSIS 2.4 Valid Values	T-MSIS v2.4 Code Definitions
Rehabilitation Services	33	043	Rehabilitative services
PT, OT, Speech, Hearing Language	34	030	Physical therapy services (when not provided under home health services)
PT, OT, Speech, Hearing Language	34	031	Occupational therapy services (when not provided under home health services)
PT, OT, Speech, Hearing Language	34	032	Speech, hearing, and language disorders services (when not provided under home health services)
PT, OT, Speech, Hearing Language	34	038	Hearing Aids
Hospice Benefits	35	087	Hospice Benefits
Nurse Midwife Services	36	025	Nurse-midwife service
Nurse Practitioner Services	37	026	Nurse practitioner services
Nurse Practitioner Services	37	023	Advanced practice nurse services
Private Duty Nursing	38	022	Private duty nursing services
Private Duty Nursing	38	024	Pediatric nurse
Religious Non-Medical Health Care Institutions	39	058	Services furnished in a religious nonmedical health care institution
Supplemental Payment - Inpatient	40	132	Supplemental payment – inpatient
Supplemental Payment - Nursing	41	133	Supplemental payment – nursing
Supplemental Payment - Outpatient	42	134	Supplemental payment – outpatient
Durable Medical Equipment and Supplies (including emergency response systems and home modifications)	51	018	Home health services - Medical supplies, equipment, and appliances suitable for use in the home
Durable Medical Equipment and Supplies (including emergency response systems and home modifications)	51	027	Respiratory care for ventilator-dependent individuals
Residential Care	52	115	Residential Care
Psychiatric services (excluding adult day care)	53	048	Inpatient psychiatric services for individuals under age 21
Psychiatric services (excluding adult day care)	53	049	Outpatient mental health services, other than Outpatient substance abuse treatment services. This TOS includes services furnished in a State-operated mental hospital and including community-based services.

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*This Section Intentionally Left Blank*MSIS Code Definitions	MSIS Valid Values	T-MSIS 2.4 Valid Values	T-MSIS v2.4 Code Definitions
Adult Day Care	54	066	HCBS - Adult day health services
Adult Day Care	54	069	HCBS - Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness
Adult Day Care	54	070	HCBS - Day Care
Indian Health Service (IHS) - Family Plan	60	011	Family planning services and supplies for individuals of child-bearing age
Indian Health Service (IHS) - Family Plan	60	127	Indian Health Service (IHS) - Family Plan
Indian Health Service (IHS) - BCC	61	004	Other ambulatory services furnished by a rural health clinic
Indian Health Service (IHS) - BIP	62	004	Other ambulatory services furnished by a rural health clinic

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

Source: X12 Reference Page

Table Pages 1 – 20

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
193200000X	Unspecified Multi-Specialty Group	100000000	Individuals or Groups (of Individuals)
193400000X	Unspecified Single Specialty Group	100000000	Individuals or Groups (of Individuals)
207K00000X	Allergy & Immunology	100000000	Individuals or Groups (of Individuals)
207KA0200X	Allergy	100000000	Individuals or Groups (of Individuals)
207KI0005X	Clinical & Laboratory Immunology	100000000	Individuals or Groups (of Individuals)
207L00000X	Anesthesiology	100000000	Individuals or Groups (of Individuals)
207LA0401X	Addiction Medicine	100000000	Individuals or Groups (of Individuals)
207LC0200X	Critical Care Medicine	100000000	Individuals or Groups (of Individuals)
207LH0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
207LP2900X	Pain Medicine	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207LP3000X	Pediatric Anesthesiology	100000000	Individuals or Groups (of Individuals)
208U00000X	Clinical Pharmacology	100000000	Individuals or Groups (of Individuals)
208C00000X	Colon & Rectal Surgery	100000000	Individuals or Groups (of Individuals)
207N00000X	Dermatology	100000000	Individuals or Groups (of Individuals)
207NI0002X	Clinical & Laboratory Dermatological Immunology	100000000	Individuals or Groups (of Individuals)
207ND0900X	Dermatopathology	100000000	Individuals or Groups (of Individuals)
207ND0101X	MOHS-Micrographic Surgery	100000000	Individuals or Groups (of Individuals)
207NP0225X	Pediatric Dermatology	100000000	Individuals or Groups (of Individuals)
207NS0135X	Procedural Dermatology	100000000	Individuals or Groups (of Individuals)
204R00000X	Electrodiagnostic Medicine	100000000	Individuals or Groups (of Individuals)
207P00000X	Emergency Medicine	100000000	Individuals or Groups (of Individuals)
207PE0004X	Emergency Medical Services	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207PH0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
207PT0002X	Medical Toxicology	100000000	Individuals or Groups (of Individuals)
207PP0204X	Pediatric Emergency Medicine	100000000	Individuals or Groups (of Individuals)
207PS0010X	Sports Medicine	100000000	Individuals or Groups (of Individuals)
207PE0005X	Undersea and Hyperbaric Medicine	100000000	Individuals or Groups (of Individuals)
207Q00000X	Family Medicine	100000000	Individuals or Groups (of Individuals)
207QA0401X	Addiction Medicine	100000000	Individuals or Groups (of Individuals)
207QA0000X	Adolescent Medicine	100000000	Individuals or Groups (of Individuals)
207QA0505X	Adult Medicine	100000000	Individuals or Groups (of Individuals)
207QB0002X	Bariatric Medicine	100000000	Individuals or Groups (of Individuals)
207QG0300X	Geriatric Medicine	100000000	Individuals or Groups (of Individuals)
207QH0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207QS1201X	Sleep Medicine	100000000	Individuals or Groups (of Individuals)
207QS0010X	Sports Medicine	100000000	Individuals or Groups (of Individuals)
208D00000X	General Practice	100000000	Individuals or Groups (of Individuals)
208M00000X	Hospitalist	100000000	Individuals or Groups (of Individuals)
202C00000X	Independent Medical Examiner	100000000	Individuals or Groups (of Individuals)
207R00000X	Internal Medicine	100000000	Individuals or Groups (of Individuals)
207RA0401X	Addiction Medicine	100000000	Individuals or Groups (of Individuals)
207RA0000X	Adolescent Medicine	100000000	Individuals or Groups (of Individuals)
207RA0201X	Allergy & Immunology	100000000	Individuals or Groups (of Individuals)
207RB0002X	Bariatric Medicine	100000000	Individuals or Groups (of Individuals)
207RC0000X	Cardiovascular Disease	100000000	Individuals or Groups (of Individuals)
207RI0001X	Clinical & Laboratory Immunology	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207RC0001X	Clinical Cardiac Electrophysiology	100000000	Individuals or Groups (of Individuals)
207RC0200X	Critical Care Medicine	100000000	Individuals or Groups (of Individuals)
207RE0101X	Endocrinology, Diabetes & Metabolism	100000000	Individuals or Groups (of Individuals)
207RG0100X	Gastroenterology	100000000	Individuals or Groups (of Individuals)
207RG0300X	Geriatric Medicine	100000000	Individuals or Groups (of Individuals)
207RH0000X	Hematology	100000000	Individuals or Groups (of Individuals)
207RH0003X	Hematology & Oncology	100000000	Individuals or Groups (of Individuals)
207RI0008X	Hepatology	100000000	Individuals or Groups (of Individuals)
207RH0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
207RH0005X	Hypertension Specialist	100000000	Individuals or Groups (of Individuals)
207RI0200X	Infectious Disease	100000000	Individuals or Groups (of Individuals)
207RI0011X	Interventional Cardiology	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207RM1200X	Magnetic Resonance Imaging (MRI)	100000000	Individuals or Groups (of Individuals)
207RX0202X	Medical Oncology	100000000	Individuals or Groups (of Individuals)
207RN0300X	Nephrology	100000000	Individuals or Groups (of Individuals)
207RP1001X	Pulmonary Disease	100000000	Individuals or Groups (of Individuals)
207RR0500X	Rheumatology	100000000	Individuals or Groups (of Individuals)
207RS0012X	Sleep Medicine	100000000	Individuals or Groups (of Individuals)
207RS0010X	Sports Medicine	100000000	Individuals or Groups (of Individuals)
207RT0003X	Transplant Hepatology	100000000	Individuals or Groups (of Individuals)
209800000X	Legal Medicine	100000000	Individuals or Groups (of Individuals)
207SG0202X	Clinical Biochemical Genetics	100000000	Individuals or Groups (of Individuals)
207SC0300X	Clinical Cytogenetic	100000000	Individuals or Groups (of Individuals)
207SG0201X	Clinical Genetics (M.D.)	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207SG0203X	Clinical Molecular Genetics	100000000	Individuals or Groups (of Individuals)
207SM0001X	Molecular Genetic Pathology	100000000	Individuals or Groups (of Individuals)
207SG0205X	Ph.D. Medical Genetics	100000000	Individuals or Groups (of Individuals)
207T00000X	Neurological Surgery	100000000	Individuals or Groups (of Individuals)
207U00000X	Nuclear Medicine	100000000	Individuals or Groups (of Individuals)
207UN0903X	In Vivo & In Vitro Nuclear Medicine	100000000	Individuals or Groups (of Individuals)
207UN0901X	Nuclear Cardiology	100000000	Individuals or Groups (of Individuals)
207UN0902X	Nuclear Imaging & Therapy	100000000	Individuals or Groups (of Individuals)
204D00000X	Neuromusculoskeletal Medicine & OMM	100000000	Individuals or Groups (of Individuals)
204C00000X	Neuromusculoskeletal Medicine, Sports Medicine	100000000	Individuals or Groups (of Individuals)
207V00000X	Obstetrics & Gynecology	100000000	Individuals or Groups (of Individuals)
207VB0002X	Bariatric Medicine	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207VC0200X	Critical Care Medicine	100000000	Individuals or Groups (of Individuals)
207VF0040X	Female Pelvic Medicine and Reconstructive Surgery	100000000	Individuals or Groups (of Individuals)
207VX0201X	Gynecologic Oncology	100000000	Individuals or Groups (of Individuals)
207VG0400X	Gynecology	100000000	Individuals or Groups (of Individuals)
207VH0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
207VM0101X	Maternal & Fetal Medicine	100000000	Individuals or Groups (of Individuals)
207VX0000X	Obstetrics	100000000	Individuals or Groups (of Individuals)
207VE0102X	Reproductive Endocrinology	100000000	Individuals or Groups (of Individuals)
207W00000X	Ophthalmology	100000000	Individuals or Groups (of Individuals)
204E00000X	Oral & Maxillofacial Surgery	100000000	Individuals or Groups (of Individuals)
207X00000X	Orthopaedic Surgery	100000000	Individuals or Groups (of Individuals)
207XS0114X	Adult Reconstructive Orthopaedic Surgery	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207XX0004X	Foot and Ankle Surgery	100000000	Individuals or Groups (of Individuals)
207XS0106X	Hand Surgery	100000000	Individuals or Groups (of Individuals)
207XS0117X	Orthopaedic Surgery of the Spine	100000000	Individuals or Groups (of Individuals)
207XX0801X	Orthopaedic Trauma	100000000	Individuals or Groups (of Individuals)
207XP3100X	Pediatric Orthopaedic Surgery	100000000	Individuals or Groups (of Individuals)
207XX0005X	Sports Medicine	100000000	Individuals or Groups (of Individuals)
207Y00000X	Otolaryngology	100000000	Individuals or Groups (of Individuals)
207YS0123X	Facial Plastic Surgery	100000000	Individuals or Groups (of Individuals)
207YX0602X	Otolaryngic Allergy	100000000	Individuals or Groups (of Individuals)
207YX0905X	Otolaryngology/Facial Plastic Surgery	100000000	Individuals or Groups (of Individuals)
207YX0901X	Otology & Neurotology	100000000	Individuals or Groups (of Individuals)
207YP0228X	Pediatric Otolaryngology	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207YX0007X	Plastic Surgery within the Head & Neck	100000000	Individuals or Groups (of Individuals)
207YS0012X	Sleep Medicine	100000000	Individuals or Groups (of Individuals)
207ZP0101X	Anatomic Pathology	100000000	Individuals or Groups (of Individuals)
207ZP0102X	Anatomic Pathology & Clinical Pathology	100000000	Individuals or Groups (of Individuals)
207ZB0001X	Blood Banking & Transfusion Medicine	100000000	Individuals or Groups (of Individuals)
207ZP0104X	Chemical Pathology	100000000	Individuals or Groups (of Individuals)
207ZC0006X	Clinical Pathology	100000000	Individuals or Groups (of Individuals)
207ZP0105X	Clinical Pathology/Laboratory Medicine	100000000	Individuals or Groups (of Individuals)
207ZC0500X	Cytopathology	100000000	Individuals or Groups (of Individuals)
207ZD0900X	Dermatopathology	100000000	Individuals or Groups (of Individuals)
207ZF0201X	Forensic Pathology	100000000	Individuals or Groups (of Individuals)
207ZH0000X	Hematology	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207ZI0100X	Immunopathology	100000000	Individuals or Groups (of Individuals)
207ZM0300X	Medical Microbiology	100000000	Individuals or Groups (of Individuals)
207ZP0007X	Molecular Genetic Pathology	100000000	Individuals or Groups (of Individuals)
207ZN0500X	Neuropathology	100000000	Individuals or Groups (of Individuals)
207ZP0213X	Pediatric Pathology	100000000	Individuals or Groups (of Individuals)
208000000X	Pediatrics	100000000	Individuals or Groups (of Individuals)
2080A0000X	Adolescent Medicine	100000000	Individuals or Groups (of Individuals)
2080C0008X	Child Abuse Pediatrics	100000000	Individuals or Groups (of Individuals)
2080I0007X	Clinical & Laboratory Immunology	100000000	Individuals or Groups (of Individuals)
2080P0006X	Developmental – Behavioral Pediatrics	100000000	Individuals or Groups (of Individuals)
2080H0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
2080T0002X	Medical Toxicology	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2080N0001X	Neonatal-Perinatal Medicine	100000000	Individuals or Groups (of Individuals)
2080P0008X	Neurodevelopmental Disabilities	100000000	Individuals or Groups (of Individuals)
2080P0201X	Pediatric Allergy/Immunology	100000000	Individuals or Groups (of Individuals)
2080P0202X	Pediatric Cardiology	100000000	Individuals or Groups (of Individuals)
2080P0203X	Pediatric Critical Care Medicine	100000000	Individuals or Groups (of Individuals)
2080P0204X	Pediatric Emergency Medicine	100000000	Individuals or Groups (of Individuals)
2080P0205X	Pediatric Endocrinology	100000000	Individuals or Groups (of Individuals)
2080P0206X	Pediatric Gastroenterology	100000000	Individuals or Groups (of Individuals)
2080P0207X	Pediatric Hematology-Oncology	100000000	Individuals or Groups (of Individuals)
2080P0208X	Pediatric Infectious Diseases	100000000	Individuals or Groups (of Individuals)
2080P0210X	Pediatric Nephrology	100000000	Individuals or Groups (of Individuals)
2080P0214X	Pediatric Pulmonology	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2080P0216X	Pediatric Rheumatology	100000000	Individuals or Groups (of Individuals)
2080T0004X	Pediatric Transplant Hepatology	100000000	Individuals or Groups (of Individuals)
2080S0012X	Sleep Medicine	100000000	Individuals or Groups (of Individuals)
2080S0010X	Sports Medicine	100000000	Individuals or Groups (of Individuals)
202K00000X	Phlebology	100000000	Individuals or Groups (of Individuals)
208100000X	Physical Medicine & Rehabilitation	100000000	Individuals or Groups (of Individuals)
2081H0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
2081N0008X	Neuromuscular Medicine	100000000	Individuals or Groups (of Individuals)
2081P2900X	Pain Medicine	100000000	Individuals or Groups (of Individuals)
2081P0010X	Pediatric Rehabilitation Medicine	100000000	Individuals or Groups (of Individuals)
2081P0004X	Spinal Cord Injury Medicine	100000000	Individuals or Groups (of Individuals)
2081S0010X	Sports Medicine	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
208200000X	Plastic Surgery	100000000	Individuals or Groups (of Individuals)
2082S0099X	Plastic Surgery Within the Head and Neck	100000000	Individuals or Groups (of Individuals)
2082S0105X	Surgery of the Hand	100000000	Individuals or Groups (of Individuals)
2083A0100X	Aerospace Medicine	100000000	Individuals or Groups (of Individuals)
2083T0002X	Medical Toxicology	100000000	Individuals or Groups (of Individuals)
2083X0100X	Occupational Medicine	100000000	Individuals or Groups (of Individuals)
2083P0500X	Preventive Medicine/Occupational Environmental Medicine	100000000	Individuals or Groups (of Individuals)
2083P0901X	Public Health & General Preventive Medicine	100000000	Individuals or Groups (of Individuals)
2083S0010X	Sports Medicine	100000000	Individuals or Groups (of Individuals)
2083P0011X	Undersea and Hyperbaric Medicine	100000000	Individuals or Groups (of Individuals)
2084A0401X	Addiction Medicine	100000000	Individuals or Groups (of Individuals)
2084P0802X	Addiction Psychiatry	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2084B0002X	Bariatric Medicine	100000000	Individuals or Groups (of Individuals)
2084B0040X	Behavioral Neurology & Neuropsychiatry	100000000	Individuals or Groups (of Individuals)
2084P0804X	Child & Adolescent Psychiatry	100000000	Individuals or Groups (of Individuals)
2084N0600X	Clinical Neurophysiology	100000000	Individuals or Groups (of Individuals)
2084D0003X	Diagnostic Neuroimaging	100000000	Individuals or Groups (of Individuals)
2084F0202X	Forensic Psychiatry	100000000	Individuals or Groups (of Individuals)
2084P0805X	Geriatric Psychiatry	100000000	Individuals or Groups (of Individuals)
2084H0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
2084P0005X	Neurodevelopmental Disabilities	100000000	Individuals or Groups (of Individuals)
2084N0400X	Neurology	100000000	Individuals or Groups (of Individuals)
2084N0402X	Neurology with Special Qualifications in Child Neurology	100000000	Individuals or Groups (of Individuals)
2084N0008X	Neuromuscular Medicine	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2084P2900X	Pain Medicine	100000000	Individuals or Groups (of Individuals)
2084P0800X	Psychiatry	100000000	Individuals or Groups (of Individuals)
2084P0015X	Psychosomatic Medicine	100000000	Individuals or Groups (of Individuals)
2084S0012X	Sleep Medicine	100000000	Individuals or Groups (of Individuals)
2084S0010X	Sports Medicine	100000000	Individuals or Groups (of Individuals)
2084V0102X	Vascular Neurology	100000000	Individuals or Groups (of Individuals)
208VP0014X	Interventional Pain Medicine	100000000	Individuals or Groups (of Individuals)
208VP0000X	Pain Medicine	100000000	Individuals or Groups (of Individuals)
2085B0100X	Body Imaging	100000000	Individuals or Groups (of Individuals)
2085D0003X	Diagnostic Neuroimaging	100000000	Individuals or Groups (of Individuals)
2085R0202X	Diagnostic Radiology	100000000	Individuals or Groups (of Individuals)
2085U0001X	Diagnostic Ultrasound	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2085H0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
2085N0700X	Neuroradiology	100000000	Individuals or Groups (of Individuals)
2085N0904X	Nuclear Radiology	100000000	Individuals or Groups (of Individuals)
2085P0229X	Pediatric Radiology	100000000	Individuals or Groups (of Individuals)
2085R0001X	Radiation Oncology	100000000	Individuals or Groups (of Individuals)
2085R0205X	Radiological Physics	100000000	Individuals or Groups (of Individuals)
2085R0203X	Therapeutic Radiology	100000000	Individuals or Groups (of Individuals)
2085R0204X	Vascular & Interventional Radiology	100000000	Individuals or Groups (of Individuals)
208600000X	Surgery	100000000	Individuals or Groups (of Individuals)
2086H0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
2086S0120X	Pediatric Surgery	100000000	Individuals or Groups (of Individuals)
2086S0122X	Plastic and Reconstructive Surgery	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2086S0105X	Surgery of the Hand	100000000	Individuals or Groups (of Individuals)
2086S0102X	Surgical Critical Care	100000000	Individuals or Groups (of Individuals)
2086X0206X	Surgical Oncology	100000000	Individuals or Groups (of Individuals)
2086S0127X	Trauma Surgery	100000000	Individuals or Groups (of Individuals)
2086S0129X	Vascular Surgery	100000000	Individuals or Groups (of Individuals)
208G00000X	Thoracic Surgery (Cardiothoracic Vascular Surgery)	100000000	Individuals or Groups (of Individuals)
204F00000X	Transplant Surgery	100000000	Individuals or Groups (of Individuals)
208800000X	Urology	100000000	Individuals or Groups (of Individuals)
2088F0040X	Female Pelvic Medicine and Reconstructive Surgery	100000000	Individuals or Groups (of Individuals)
2088P0231X	Pediatric Urology	100000000	Individuals or Groups (of Individuals)
103K00000X	Behavioral Analyst	100000000	Individuals or Groups (of Individuals)
103G00000X	Clinical Neuropsychologist	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
103GC0700X	Clinical	100000000	Individuals or Groups (of Individuals)
101Y00000X	Counselor	100000000	Individuals or Groups (of Individuals)
101YA0400X	Addiction (Substance Use Disorder)	100000000	Individuals or Groups (of Individuals)
101YM0800X	Mental Health	100000000	Individuals or Groups (of Individuals)
101YP1600X	Pastoral	100000000	Individuals or Groups (of Individuals)
101YP2500X	Professional	100000000	Individuals or Groups (of Individuals)
101YS0200X	School	100000000	Individuals or Groups (of Individuals)
106H00000X	Marriage & Family Therapist	100000000	Individuals or Groups (of Individuals)
102X00000X	Poetry Therapist	100000000	Individuals or Groups (of Individuals)
102L00000X	Psychoanalyst	100000000	Individuals or Groups (of Individuals)
103T00000X	Psychologist	100000000	Individuals or Groups (of Individuals)
103TA0400X	Addiction (Substance Use Disorder)	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
103TA0700X	Adult Development & Aging	100000000	Individuals or Groups (of Individuals)
103TC0700X	Clinical	100000000	Individuals or Groups (of Individuals)
103TC2200X	Clinical Child & Adolescent	100000000	Individuals or Groups (of Individuals)
103TB0200X	Cognitive & Behavioral	100000000	Individuals or Groups (of Individuals)
103TC1900X	Counseling	100000000	Individuals or Groups (of Individuals)
103TE1000X	Educational	100000000	Individuals or Groups (of Individuals)
103TE1100X	Exercise & Sports	100000000	Individuals or Groups (of Individuals)
103TF0000X	Family	100000000	Individuals or Groups (of Individuals)
103TF0200X	Forensic	100000000	Individuals or Groups (of Individuals)
103TP2701X	Group Psychotherapy	100000000	Individuals or Groups (of Individuals)
103TH0004X	Health	100000000	Individuals or Groups (of Individuals)
103TH0100X	Health Service	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
103TM1700X	Men & Masculinity	100000000	Individuals or Groups (of Individuals)
103TM1800X	Mental Retardation & Developmental Disabilities	100000000	Individuals or Groups (of Individuals)
103TP0016X	Prescribing (Medical)	100000000	Individuals or Groups (of Individuals)
103TP0814X	Psychoanalysis	100000000	Individuals or Groups (of Individuals)
103TP2700X	Psychotherapy	100000000	Individuals or Groups (of Individuals)
103TR0400X	Rehabilitation	100000000	Individuals or Groups (of Individuals)
103TS0200X	School	100000000	Individuals or Groups (of Individuals)
103TW0100X	Women	100000000	Individuals or Groups (of Individuals)
104100000X	Social Worker	100000000	Individuals or Groups (of Individuals)
1041C0700X	Clinical	100000000	Individuals or Groups (of Individuals)
1041S0200X	School	100000000	Individuals or Groups (of Individuals)
111N00000X	Chiropractor	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
111NI0013X	Independent Medical Examiner	100000000	Individuals or Groups (of Individuals)
111NI0900X	Internist	100000000	Individuals or Groups (of Individuals)
111NN0400X	Neurology	100000000	Individuals or Groups (of Individuals)
111NN1001X	Nutrition	100000000	Individuals or Groups (of Individuals)
111NX0100X	Occupational Health	100000000	Individuals or Groups (of Individuals)
111NX0800X	Orthopedic	100000000	Individuals or Groups (of Individuals)
111NP0017X	Pediatric Chiropractor	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
111NR0200X	Radiology	100000000	Individuals or Groups (of Individuals)
111NR0400X	Rehabilitation	100000000	Individuals or Groups (of Individuals)
111NS0005X	Sports Physician	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
111NT0100X	Thermography	100000000	Individuals or Groups (of Individuals)
125K00000X	Advanced Practice Dental Therapist	100000000	Individuals or Groups (of Individuals)
126800000X	Dental Assistant	100000000	Individuals or Groups (of Individuals)
124Q00000X	Dental Hygienist	100000000	Individuals or Groups (of Individuals)
126900000X	Dental Laboratory Technician	100000000	Individuals or Groups (of Individuals)
125J00000X	Dental Therapist	100000000	Individuals or Groups (of Individuals)
122300000X	Dentist	100000000	Individuals or Groups (of Individuals)
1223D0001X	Dental Public Health	100000000	Individuals or Groups (of Individuals)
1223D0004X	Dentist Anesthesiologist	100000000	Individuals or Groups (of Individuals)
1223E0200X	Endodontics	100000000	Individuals or Groups (of Individuals)
1223G0001X	General Practice	100000000	Individuals or Groups (of Individuals)
1223P0106X	Oral and Maxillofacial Pathology	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
1223X0008X	Oral and Maxillofacial Radiology	100000000	Individuals or Groups (of Individuals)
1223S0112X	Oral and Maxillofacial Surgery	100000000	Individuals or Groups (of Individuals)
1223X0400X	Orthodontics and Dentofacial Orthopedics	100000000	Individuals or Groups (of Individuals)
1223P0221X	Pediatric Dentistry	100000000	Individuals or Groups (of Individuals)
1223P0300X	Periodontics	100000000	Individuals or Groups (of Individuals)
1223P0700X	Prosthodontics	100000000	Individuals or Groups (of Individuals)
122400000X	Denturist	100000000	Individuals or Groups (of Individuals)
132700000X	Dietary Manager	100000000	Individuals or Groups (of Individuals)
136A00000X	Dietetic Technician, Registered	100000000	Individuals or Groups (of Individuals)
133V00000X	Dietitian, Registered	100000000	Individuals or Groups (of Individuals)
133VN1006X	Nutrition, Metabolic	100000000	Individuals or Groups (of Individuals)
133VN1004X	Nutrition, Pediatric	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
133VN1005X	Nutrition, Renal	100000000	Individuals or Groups (of Individuals)
133N00000X	Nutritionist	100000000	Individuals or Groups (of Individuals)
133NN1002X	Nutrition, Education	100000000	Individuals or Groups (of Individuals)
146N00000X	Emergency Medical Technician, Basic	100000000	Individuals or Groups (of Individuals)
146M00000X	Emergency Medical Technician, Intermediate	100000000	Individuals or Groups (of Individuals)
146L00000X	Emergency Medical Technician, Paramedic	100000000	Individuals or Groups (of Individuals)
146D00000X	Personal Emergency Response Attendant	100000000	Individuals or Groups (of Individuals)
152W00000X	Optometrist	100000000	Individuals or Groups (of Individuals)
152WC0802X	Corneal and Contact Management	100000000	Individuals or Groups (of Individuals)
152WL0500X	Low Vision Rehabilitation	100000000	Individuals or Groups (of Individuals)
152WX0102X	Occupational Vision	100000000	Individuals or Groups (of Individuals)
152WP0200X	Pediatrics	100000000	Individuals or Groups (of Individuals)

~~Provider Taxonomy Code~~	~~Provider Taxonomy Description~~	~~Provider Facility Type Code~~	~~Provider Facility Type Description~~
~~152WS0006X~~	~~Sports Vision~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~152WV0400X~~	~~Vision Therapy~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~156F00000X~~	~~Technician/Technologist~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~156FC0800X~~	~~Contact Lens~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~156FC0801X~~	~~Contact Lens Fitter~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~156FX1700X~~	~~Ocularist~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~156FX1100X~~	~~Ophthalmic~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~156FX1101X~~	~~Ophthalmic Assistant~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~156FX1800X~~	~~Optician~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~156FX1201X~~	~~Optometric Assistant~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~156FX1202X~~	~~Optometric Technician~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~156FX1900X~~	~~Orthoptist~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
164W00000X	Licensed Practical Nurse	100000000	Individuals or Groups (of Individuals)
167G00000X	Licensed Psychiatric Technician	100000000	Individuals or Groups (of Individuals)
164X00000X	Licensed Vocational Nurse	100000000	Individuals or Groups (of Individuals)
163W00000X	Registered Nurse	100000000	Individuals or Groups (of Individuals)
163WA0400X	Addiction (Substance Use Disorder)	100000000	Individuals or Groups (of Individuals)
163WA2000X	Administrator	100000000	Individuals or Groups (of Individuals)
163WP2201X	Ambulatory Care	100000000	Individuals or Groups (of Individuals)
163WC3500X	Cardiac Rehabilitation	100000000	Individuals or Groups (of Individuals)
163WC0400X	Case Management	100000000	Individuals or Groups (of Individuals)
163WC1400X	College Health	100000000	Individuals or Groups (of Individuals)
163WC1500X	Community Health	100000000	Individuals or Groups (of Individuals)
163WC2100X	Continence Care	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
163WC1600X	Continuing Education/Staff Development	100000000	Individuals or Groups (of Individuals)
163WC0200X	Critical Care Medicine	100000000	Individuals or Groups (of Individuals)
163WD0400X	Diabetes Educator	100000000	Individuals or Groups (of Individuals)
163WD1100X	Dialysis, Peritoneal	100000000	Individuals or Groups (of Individuals)
163WE0003X	Emergency	100000000	Individuals or Groups (of Individuals)
163WE0900X	Enterostomal Therapy	100000000	Individuals or Groups (of Individuals)
163WF0300X	Flight	100000000	Individuals or Groups (of Individuals)
163WG0100X	Gastroenterology	100000000	Individuals or Groups (of Individuals)
163WG0000X	General Practice	100000000	Individuals or Groups (of Individuals)
163WG0600X	Gerontology	100000000	Individuals or Groups (of Individuals)
163WH0500X	Hemodialysis	100000000	Individuals or Groups (of Individuals)
163WH0200X	Home Health	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
163WH1000X	Hospice	100000000	Individuals or Groups (of Individuals)
163WI0600X	Infection Control	100000000	Individuals or Groups (of Individuals)
163WI0500X	Infusion Therapy	100000000	Individuals or Groups (of Individuals)
163WL0100X	Lactation Consultant	100000000	Individuals or Groups (of Individuals)
163WM0102X	Maternal Newborn	100000000	Individuals or Groups (of Individuals)
163WM0705X	Medical-Surgical	100000000	Individuals or Groups (of Individuals)
163WN0002X	Neonatal Intensive Care	100000000	Individuals or Groups (of Individuals)
163WN0003X	Neonatal, Low-Risk	100000000	Individuals or Groups (of Individuals)
163WN0300X	Nephrology	100000000	Individuals or Groups (of Individuals)
163WN0800X	Neuroscience	100000000	Individuals or Groups (of Individuals)
163WM1400X	Nurse Massage Therapist (NMT)	100000000	Individuals or Groups (of Individuals)
163WN1003X	Nutrition Support	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
163WX0002X	Obstetric, High-Risk	100000000	Individuals or Groups (of Individuals)
163WX0003X	Obstetric, Inpatient	100000000	Individuals or Groups (of Individuals)
163WX0106X	Occupational Health	100000000	Individuals or Groups (of Individuals)
163WX0200X	Oncology	100000000	Individuals or Groups (of Individuals)
163WX1100X	Ophthalmic	100000000	Individuals or Groups (of Individuals)
163WX0800X	Orthopedic	100000000	Individuals or Groups (of Individuals)
163WX1500X	Ostomy Care	100000000	Individuals or Groups (of Individuals)
163WX0601X	Otorhinolaryngology & Head-Neck	100000000	Individuals or Groups (of Individuals)
163WP0000X	Pain Management	100000000	Individuals or Groups (of Individuals)
163WP0218X	Pediatric Oncology	100000000	Individuals or Groups (of Individuals)
163WP0200X	Pediatrics	100000000	Individuals or Groups (of Individuals)
163WP1700X	Perinatal	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
163WS0121X	Plastic Surgery	100000000	Individuals or Groups (of Individuals)
163WP0808X	Psychiatric/Mental Health	100000000	Individuals or Groups (of Individuals)
163WP0809X	Psychiatric/Mental Health, Adult	100000000	Individuals or Groups (of Individuals)
163WP0807X	Psychiatric/Mental Health, Child & Adolescent	100000000	Individuals or Groups (of Individuals)
163WR0006X	Registered Nurse First Assistant	100000000	Individuals or Groups (of Individuals)
163WR0400X	Rehabilitation	100000000	Individuals or Groups (of Individuals)
163WR1000X	Reproductive Endocrinology/Infertility	100000000	Individuals or Groups (of Individuals)
163WS0200X	School	100000000	Individuals or Groups (of Individuals)
163WU0100X	Urology	100000000	Individuals or Groups (of Individuals)
163WW0101X	Women's Health Care, Ambulatory	100000000	Individuals or Groups (of Individuals)
163WW0000X	Wound Care	100000000	Individuals or Groups (of Individuals)
372600000X	Adult Companion	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
372500000X	Chore Provider	100000000	Individuals or Groups (of Individuals)
373H00000X	Day Training/Habilitation Specialist	100000000	Individuals or Groups (of Individuals)
374J00000X	Doula	100000000	Individuals or Groups (of Individuals)
374U00000X	Home Health Aide	100000000	Individuals or Groups (of Individuals)
376J00000X	Homemaker	100000000	Individuals or Groups (of Individuals)
376K00000X	Nurse's Aide	100000000	Individuals or Groups (of Individuals)
376G00000X	Nursing Home Administrator	100000000	Individuals or Groups (of Individuals)
374T00000X	Religious Nonmedical Nursing Personnel	100000000	Individuals or Groups (of Individuals)
374K00000X	Religious Nonmedical Practitioner	100000000	Individuals or Groups (of Individuals)
374700000X	Technician	100000000	Individuals or Groups (of Individuals)
3747A0650X	Attendant Care Provider	100000000	Individuals or Groups (of Individuals)
3747P1801X	Personal Care Attendant	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
171100000X	Acupuncturist	100000000	Individuals or Groups (of Individuals)
171M00000X	Case Manager/Care Coordinator	100000000	Individuals or Groups (of Individuals)
174V00000X	Clinical Ethicist	100000000	Individuals or Groups (of Individuals)
172V00000X	Community Health Worker	100000000	Individuals or Groups (of Individuals)
171W00000X	Contractor	100000000	Individuals or Groups (of Individuals)
171WH0202X	Home Modifications	100000000	Individuals or Groups (of Individuals)
171WV0202X	Vehicle Modifications	100000000	Individuals or Groups (of Individuals)
172A00000X	Driver	100000000	Individuals or Groups (of Individuals)
176P00000X	Funeral Director	100000000	Individuals or Groups (of Individuals)
170300000X	Genetic Counselor, MS	100000000	Individuals or Groups (of Individuals)
174H00000X	Health Educator	100000000	Individuals or Groups (of Individuals)
175L00000X	Homeopath	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
171R00000X	Interpreter	100000000	Individuals or Groups (of Individuals)
174N00000X	Lactation Consultant, Non-RN	100000000	Individuals or Groups (of Individuals)
173000000X	Legal Medicine	100000000	Individuals or Groups (of Individuals)
172M00000X	Mechanotherapist	100000000	Individuals or Groups (of Individuals)
170100000X	Medical Genetics, Ph.D. Medical Genetics	100000000	Individuals or Groups (of Individuals)
176B00000X	Midwife	100000000	Individuals or Groups (of Individuals)
175M00000X	Midwife, Lay	100000000	Individuals or Groups (of Individuals)
171000000X	Military Health Care Provider	100000000	Individuals or Groups (of Individuals)
1710I1002X	Independent Duty Corpsman	100000000	Individuals or Groups (of Individuals)
1710I1003X	Independent Duty Medical Technicians	100000000	Individuals or Groups (of Individuals)
172P00000X	Naprapath	100000000	Individuals or Groups (of Individuals)
175F00000X	Naturopath	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
173C00000X	Reflexologist	100000000	Individuals or Groups (of Individuals)
173F00000X	Sleep Specialist, PhD	100000000	Individuals or Groups (of Individuals)
174400000X	Specialist	100000000	Individuals or Groups (of Individuals)
1744G0900X	Graphics Designer	100000000	Individuals or Groups (of Individuals)
1744P3200X	Prosthetics Case Management	100000000	Individuals or Groups (of Individuals)
1744R1103X	Research Data Abstracter/Coder	100000000	Individuals or Groups (of Individuals)
1744R1102X	Research Study	100000000	Individuals or Groups (of Individuals)
174M00000X	Veterinarian	100000000	Individuals or Groups (of Individuals)
174MM1900X	Medical Research	100000000	Individuals or Groups (of Individuals)
183500000X	Pharmacist	100000000	Individuals or Groups (of Individuals)
1835G0000X	General Practice	100000000	Individuals or Groups (of Individuals)
1835G0303X	Geriatric	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
1835N0905X	Nuclear	100000000	Individuals or Groups (of Individuals)
1835N1003X	Nutrition Support	100000000	Individuals or Groups (of Individuals)
1835X0200X	Oncology	100000000	Individuals or Groups (of Individuals)
1835P0018X	Pharmacist Clinician (PhC)/ Clinical Pharmacy Specialist	100000000	Individuals or Groups (of Individuals)
1835P1200X	Pharmacotherapy	100000000	Individuals or Groups (of Individuals)
1835P1300X	Psychiatric	100000000	Individuals or Groups (of Individuals)
183700000X	Pharmacy Technician	100000000	Individuals or Groups (of Individuals)
367A00000X	Advanced Practice Midwife	100000000	Individuals or Groups (of Individuals)
367H00000X	Anesthesiologist Assistant	100000000	Individuals or Groups (of Individuals)
364S00000X	Clinical Nurse Specialist	100000000	Individuals or Groups (of Individuals)
364SA2100X	Acute Care	100000000	Individuals or Groups (of Individuals)
364SA2200X	Adult Health	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
364SC2300X	Chronic Care	100000000	Individuals or Groups (of Individuals)
364SC1501X	Community Health/Public Health	100000000	Individuals or Groups (of Individuals)
364SC0200X	Critical Care Medicine	100000000	Individuals or Groups (of Individuals)
364SE0003X	Emergency	100000000	Individuals or Groups (of Individuals)
364SE1400X	Ethics	100000000	Individuals or Groups (of Individuals)
364SF0001X	Family Health	100000000	Individuals or Groups (of Individuals)
364SG0600X	Gerontology	100000000	Individuals or Groups (of Individuals)
364SH1100X	Holistic	100000000	Individuals or Groups (of Individuals)
364SH0200X	Home Health	100000000	Individuals or Groups (of Individuals)
364SI0800X	Informatics	100000000	Individuals or Groups (of Individuals)
364SL0600X	Long-Term Care	100000000	Individuals or Groups (of Individuals)
364SM0705X	Medical-Surgical	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
364SN0000X	Neonatal	100000000	Individuals or Groups (of Individuals)
364SN0800X	Neuroscience	100000000	Individuals or Groups (of Individuals)
364SX0106X	Occupational Health	100000000	Individuals or Groups (of Individuals)
364SX0200X	Oncology	100000000	Individuals or Groups (of Individuals)
364SX0204X	Oncology, Pediatrics	100000000	Individuals or Groups (of Individuals)
364SP0200X	Pediatrics	100000000	Individuals or Groups (of Individuals)
364SP1700X	Perinatal	100000000	Individuals or Groups (of Individuals)
364SP2800X	Perioperative	100000000	Individuals or Groups (of Individuals)
364SP0808X	Psychiatric/Mental Health	100000000	Individuals or Groups (of Individuals)
364SP0809X	Psychiatric/Mental Health, Adult	100000000	Individuals or Groups (of Individuals)
364SP0807X	Psychiatric/Mental Health, Child & Adolescent	100000000	Individuals or Groups (of Individuals)
364SP0810X	Psychiatric/Mental Health, Child & Family	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
364SP0811X	Psychiatric/Mental Health, Chronically Ill	100000000	Individuals or Groups (of Individuals)
364SP0812X	Psychiatric/Mental Health, Community	100000000	Individuals or Groups (of Individuals)
364SP0813X	Psychiatric/Mental Health, Geropsychiatric	100000000	Individuals or Groups (of Individuals)
364SR0400X	Rehabilitation	100000000	Individuals or Groups (of Individuals)
364SS0200X	School	100000000	Individuals or Groups (of Individuals)
364ST0500X	Transplantation	100000000	Individuals or Groups (of Individuals)
364SW0102X	Women's Health	100000000	Individuals or Groups (of Individuals)
367500000X	Nurse Anesthetist, Certified Registered	100000000	Individuals or Groups (of Individuals)
363L00000X	Nurse Practitioner	100000000	Individuals or Groups (of Individuals)
363LA2100X	Acute Care	100000000	Individuals or Groups (of Individuals)
363LA2200X	Adult Health	100000000	Individuals or Groups (of Individuals)
363LC1500X	Community Health	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
363LC0200X	Critical Care Medicine	100000000	Individuals or Groups (of Individuals)
363LF0000X	Family	100000000	Individuals or Groups (of Individuals)
363LG0600X	Gerontology	100000000	Individuals or Groups (of Individuals)
363LN0000X	Neonatal	100000000	Individuals or Groups (of Individuals)
363LN0005X	Neonatal, Critical Care	100000000	Individuals or Groups (of Individuals)
363LX0001X	Obstetrics & Gynecology	100000000	Individuals or Groups (of Individuals)
363LX0106X	Occupational Health	100000000	Individuals or Groups (of Individuals)
363LP0200X	Pediatrics	100000000	Individuals or Groups (of Individuals)
363LP0222X	Pediatrics, Critical Care	100000000	Individuals or Groups (of Individuals)
363LP1700X	Perinatal	100000000	Individuals or Groups (of Individuals)
363LP2300X	Primary Care	100000000	Individuals or Groups (of Individuals)
363LP0808X	Psychiatric/Mental Health	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
363LS0200X	School	100000000	Individuals or Groups (of Individuals)
363LW0102X	Women's Health	100000000	Individuals or Groups (of Individuals)
363A00000X	Physician Assistant	100000000	Individuals or Groups (of Individuals)
363AM0700X	Medical	100000000	Individuals or Groups (of Individuals)
363AS0400X	Surgical	100000000	Individuals or Groups (of Individuals)
211D00000X	Assistant, Podiatric	100000000	Individuals or Groups (of Individuals)
213E00000X	Podiatrist	100000000	Individuals or Groups (of Individuals)
213ES0103X	Foot & Ankle Surgery	100000000	Individuals or Groups (of Individuals)
213ES0131X	Foot Surgery	100000000	Individuals or Groups (of Individuals)
213EG0000X	General Practice	100000000	Individuals or Groups (of Individuals)
213EP1101X	Primary Podiatric Medicine	100000000	Individuals or Groups (of Individuals)
213EP0504X	Public Medicine	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
213ER0200X	Radiology	100000000	Individuals or Groups (of Individuals)
213ES0000X	Sports Medicine	100000000	Individuals or Groups (of Individuals)
229N00000X	Anaplastologist	100000000	Individuals or Groups (of Individuals)
221700000X	Art Therapist	100000000	Individuals or Groups (of Individuals)
224Y00000X	Clinical Exercise Physiologist	100000000	Individuals or Groups (of Individuals)
225600000X	Dance Therapist	100000000	Individuals or Groups (of Individuals)
222Q00000X	Developmental Therapist	100000000	Individuals or Groups (of Individuals)
226300000X	Kinesiotherapist	100000000	Individuals or Groups (of Individuals)
225700000X	Massage Therapist	100000000	Individuals or Groups (of Individuals)
224900000X	Mastectomy Fitter	100000000	Individuals or Groups (of Individuals)
225A00000X	Music Therapist	100000000	Individuals or Groups (of Individuals)
225X00000X	Occupational Therapist	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
225XR0403X	Driving and Community Mobility	100000000	Individuals or Groups (of Individuals)
225XE0001X	Environmental Modification	100000000	Individuals or Groups (of Individuals)
225XE1200X	Ergonomics	100000000	Individuals or Groups (of Individuals)
225XF0002X	Feeding, Eating & Swallowing	100000000	Individuals or Groups (of Individuals)
225XG0600X	Gerontology	100000000	Individuals or Groups (of Individuals)
225XH1200X	Hand	100000000	Individuals or Groups (of Individuals)
225XH1300X	Human Factors	100000000	Individuals or Groups (of Individuals)
225XL0004X	Low Vision	100000000	Individuals or Groups (of Individuals)
225XM0800X	Mental Health	100000000	Individuals or Groups (of Individuals)
225XN1300X	Neurorehabilitation	100000000	Individuals or Groups (of Individuals)
225XP0200X	Pediatrics	100000000	Individuals or Groups (of Individuals)
225XP0019X	Physical Rehabilitation	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
224Z00000X	Occupational Therapy Assistant	100000000	Individuals or Groups (of Individuals)
224ZR0403X	Driving and Community Mobility	100000000	Individuals or Groups (of Individuals)
224ZE0001X	Environmental Modification	100000000	Individuals or Groups (of Individuals)
224ZF0002X	Feeding, Eating & Swallowing	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
224ZL0004X	Low Vision	100000000	Individuals or Groups (of Individuals)
225000000X	Orthotic Fitter	100000000	Individuals or Groups (of Individuals)
222Z00000X	Orthotist	100000000	Individuals or Groups (of Individuals)
224L00000X	Pedorthist	100000000	Individuals or Groups (of Individuals)
225100000X	Physical Therapist	100000000	Individuals or Groups (of Individuals)
2251C2600X	Cardiopulmonary	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2251E1300X	Electrophysiology, Clinical	100000000	Individuals or Groups (of Individuals)
2251E1200X	Ergonomics	100000000	Individuals or Groups (of Individuals)
2251G0304X	Geriatrics	100000000	Individuals or Groups (of Individuals)
2251H1200X	Hand	100000000	Individuals or Groups (of Individuals)
2251H1300X	Human Factors	100000000	Individuals or Groups (of Individuals)
2251N0400X	Neurology	100000000	Individuals or Groups (of Individuals)
2251X0800X	Orthopedic	100000000	Individuals or Groups (of Individuals)
2251P0200X	Pediatrics	100000000	Individuals or Groups (of Individuals)
2251S0007X	Sports	100000000	Individuals or Groups (of Individuals)
225200000X	Physical Therapy Assistant	100000000	Individuals or Groups (of Individuals)
224P00000X	Prosthetist	100000000	Individuals or Groups (of Individuals)
225B00000X	Pulmonary Function Technologist	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
225800000X	Recreation Therapist	100000000	Individuals or Groups (of Individuals)
225C00000X	Rehabilitation Counselor	100000000	Individuals or Groups (of Individuals)
225CA2400X	Assistive Technology Practitioner	100000000	Individuals or Groups (of Individuals)
225CA2500X	Assistive Technology Supplier	100000000	Individuals or Groups (of Individuals)
225CX0006X	Orientation and Mobility Training Provider	100000000	Individuals or Groups (of Individuals)
225400000X	Rehabilitation Practitioner	100000000	Individuals or Groups (of Individuals)
227800000X	Respiratory Therapist, Certified	100000000	Individuals or Groups (of Individuals)
2278C0205X	Critical Care	100000000	Individuals or Groups (of Individuals)
2278E1000X	Educational	100000000	Individuals or Groups (of Individuals)
2278E0002X	Emergency Care	100000000	Individuals or Groups (of Individuals)
2278G1100X	General Care	100000000	Individuals or Groups (of Individuals)
2278G0305X	Geriatric Care	100000000	Individuals or Groups (of Individuals)

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~~Provider Taxonomy Code~~	~~Provider Taxonomy Description~~	~~Provider Facility Type Code~~	~~Provider Facility Type Description~~
~~2278H0200X~~	~~Home Health~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~2278P3900X~~	~~Neonatal/Pediatrics~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~2278P3800X~~	~~Palliative/Hospice~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~2278P4000X~~	~~Patient Transport~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~2278P1004X~~	~~Pulmonary Diagnostics~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~2278P1006X~~	~~Pulmonary Function Technologist~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~2278P1005X~~	~~Pulmonary Rehabilitation~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~2278S1500X~~	~~SNF/Subacute Care~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~227900000X~~	~~Respiratory Therapist, Registered~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~2279C0205X~~	~~Critical Care~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~2279E1000X~~	~~Educational~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~
~~2279E0002X~~	~~Emergency Care~~	~~100000000~~	~~Individuals or Groups (of Individuals)~~

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2279G1100X	General Care	100000000	Individuals or Groups (of Individuals)
2279G0305X	Geriatric Care	100000000	Individuals or Groups (of Individuals)
2279H0200X	Home Health	100000000	Individuals or Groups (of Individuals)
2279P3900X	Neonatal/Pediatrics	100000000	Individuals or Groups (of Individuals)
2279P3800X	Palliative/Hospice	100000000	Individuals or Groups (of Individuals)
2279P4000X	Patient Transport	100000000	Individuals or Groups (of Individuals)
2279P1004X	Pulmonary Diagnostics	100000000	Individuals or Groups (of Individuals)
2279P1006X	Pulmonary Function Technologist	100000000	Individuals or Groups (of Individuals)
2279P1005X	Pulmonary Rehabilitation	100000000	Individuals or Groups (of Individuals)
2279S1500X	SNF/Subacute Care	100000000	Individuals or Groups (of Individuals)
225500000X	Specialist/Technologist	100000000	Individuals or Groups (of Individuals)
2255A2300X	Athletic Trainer	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2255R0406X	Rehabilitation, Blind	100000000	Individuals or Groups (of Individuals)
231H00000X	Audiologist	100000000	Individuals or Groups (of Individuals)
231HA2400X	Assistive Technology Practitioner	100000000	Individuals or Groups (of Individuals)
231HA2500X	Assistive Technology Supplier	100000000	Individuals or Groups (of Individuals)
237600000X	Audiologist-Hearing Aid Fitter	100000000	Individuals or Groups (of Individuals)
237700000X	Hearing Instrument Specialist	100000000	Individuals or Groups (of Individuals)
235500000X	Specialist/Technologist	100000000	Individuals or Groups (of Individuals)
2355A2700X	Audiology Assistant	100000000	Individuals or Groups (of Individuals)
2355S0801X	Speech-Language Assistant	100000000	Individuals or Groups (of Individuals)
235Z00000X	Speech-Language Pathologist	100000000	Individuals or Groups (of Individuals)
390200000X	Student in an Organized Health Care Education/Training Program	100000000	Individuals or Groups (of Individuals)
242T00000X	Perfusionist	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
247100000X	Radiologic Technologist	100000000	Individuals or Groups (of Individuals)
2471B0102X	Bone Densitometry	100000000	Individuals or Groups (of Individuals)
2471C1106X	Cardiac-Interventional Technology	100000000	Individuals or Groups (of Individuals)
2471C1101X	Cardiovascular-Interventional Technology	100000000	Individuals or Groups (of Individuals)
2471C3401X	Computed Tomography	100000000	Individuals or Groups (of Individuals)
2471M1202X	Magnetic Resonance Imaging	100000000	Individuals or Groups (of Individuals)
2471M2300X	Mammography	100000000	Individuals or Groups (of Individuals)
2471N0900X	Nuclear Medicine Technology	100000000	Individuals or Groups (of Individuals)
2471Q0001X	Quality Management	100000000	Individuals or Groups (of Individuals)
2471R0002X	Radiation Therapy	100000000	Individuals or Groups (of Individuals)
2471C3402X	Radiography	100000000	Individuals or Groups (of Individuals)
2471S1302X	Sonography	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2471V0105X	Vascular Sonography	100000000	Individuals or Groups (of Individuals)
2471V0106X	Vascular-Interventional Technology	100000000	Individuals or Groups (of Individuals)
243U00000X	Radiology Practitioner Assistant	100000000	Individuals or Groups (of Individuals)
246X00000X	Specialist/Technologist Cardiovascular	100000000	Individuals or Groups (of Individuals)
246XC2901X	Cardiovascular Invasive Specialist	100000000	Individuals or Groups (of Individuals)
246XS1301X	Sonography	100000000	Individuals or Groups (of Individuals)
246XC2903X	Vascular Specialist	100000000	Individuals or Groups (of Individuals)
246Y00000X	Specialist/Technologist, Health Information	100000000	Individuals or Groups (of Individuals)
246YC3301X	Coding Specialist, Hospital Based	100000000	Individuals or Groups (of Individuals)
246YC3302X	Coding Specialist, Physician Office Based	100000000	Individuals or Groups (of Individuals)
246YR1600X	Registered Record Administrator	100000000	Individuals or Groups (of Individuals)
246Z00000X	Specialist/Technologist, Other	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
246ZA2600X	Art, Medical	100000000	Individuals or Groups (of Individuals)
246ZB0500X	Biochemist	100000000	Individuals or Groups (of Individuals)
246ZB0301X	Biomedical Engineering	100000000	Individuals or Groups (of Individuals)
246ZB0302X	Biomedical Photographer	100000000	Individuals or Groups (of Individuals)
246ZB0600X	Biostatistician	100000000	Individuals or Groups (of Individuals)
246ZC0007X	Certified First Assistant	100000000	Individuals or Groups (of Individuals)
246ZE0500X	EEG	100000000	Individuals or Groups (of Individuals)
246ZE0600X	Electroneurodiagnostic	100000000	Individuals or Groups (of Individuals)
246ZG1000X	Geneticist, Medical (PhD)	100000000	Individuals or Groups (of Individuals)
246ZG0701X	Graphics Methods	100000000	Individuals or Groups (of Individuals)
246ZI1000X	Illustration, Medical	100000000	Individuals or Groups (of Individuals)
246ZN0300X	Nephrology	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
246ZS0400X	Surgical	100000000	Individuals or Groups (of Individuals)
246Q00000X	Specialist/Technologist, Pathology	100000000	Individuals or Groups (of Individuals)
246QB0000X	Blood Banking	100000000	Individuals or Groups (of Individuals)
246QC1000X	Chemistry	100000000	Individuals or Groups (of Individuals)
246QC2700X	Cytotechnology	100000000	Individuals or Groups (of Individuals)
246QH0401X	Hemapheresis Practitioner	100000000	Individuals or Groups (of Individuals)
246QH0000X	Hematology	100000000	Individuals or Groups (of Individuals)
246QH0600X	Histology	100000000	Individuals or Groups (of Individuals)
246QI0000X	Immunology	100000000	Individuals or Groups (of Individuals)
246QL0900X	Laboratory Management	100000000	Individuals or Groups (of Individuals)
246QL0901X	Laboratory Management, Diplomate	100000000	Individuals or Groups (of Individuals)
246QM0706X	Medical Technologist	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
246QM0900X	Microbiology	100000000	Individuals or Groups (of Individuals)
246W00000X	Technician, Cardiology	100000000	Individuals or Groups (of Individuals)
247000000X	Technician, Health Information	100000000	Individuals or Groups (of Individuals)
2470A2800X	Assistant Record Technician	100000000	Individuals or Groups (of Individuals)
247200000X	Technician, Other	100000000	Individuals or Groups (of Individuals)
2472B0301X	Biomedical Engineering	100000000	Individuals or Groups (of Individuals)
2472D0500X	Darkroom	100000000	Individuals or Groups (of Individuals)
2472E0500X	EEG	100000000	Individuals or Groups (of Individuals)
2472R0900X	Renal Dialysis	100000000	Individuals or Groups (of Individuals)
2472V0600X	Veterinary	100000000	Individuals or Groups (of Individuals)
246R00000X	Technician, Pathology	100000000	Individuals or Groups (of Individuals)
247ZC0005X	Clinical Laboratory Director, Non-physician	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
246RH0600X	Histology	100000000	Individuals or Groups (of Individuals)
246RM2200X	Medical Laboratory	100000000	Individuals or Groups (of Individuals)
246RP1900X	Phlebotomy	100000000	Individuals or Groups (of Individuals)
251300000X	Local Education Agency (LEA)	250000000	Non-Individual - Agencies
251B00000X	Case Management	250000000	Non-Individual - Agencies
251S00000X	Community/Behavioral Health	250000000	Non-Individual - Agencies
251C00000X	Day Training, Developmentally Disabled Services	250000000	Non-Individual - Agencies
252Y00000X	Early Intervention Provider Agency	250000000	Non-Individual - Agencies
253J00000X	Foster Care Agency	250000000	Non-Individual - Agencies
251E00000X	Home Health	250000000	Non-Individual - Agencies
251F00000X	Home Infusion	250000000	Non-Individual - Agencies
251G00000X	Hospice Care, Community Based	250000000	Non-Individual - Agencies
253Z00000X	In Home Supportive Care	250000000	Non-Individual - Agencies
251J00000X	Nursing Care	250000000	Non-Individual - Agencies
251T00000X	Program of All-Inclusive Care for the Elderly (PACE) Provider Organization	250000000	Non-Individual - Agencies
251K00000X	Public Health or Welfare	250000000	Non-Individual - Agencies
251X00000X	Supports Brokerage	250000000	Non-Individual - Agencies

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
251V00000X	Voluntary or Charitable	250000000	Non-Individual - Agencies
261Q00000X	Clinic/Center	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM0855X	Adolescent and Children Mental Health	260000000	Non-Individual - Ambulatory Health Care Facilities
261QA0600X	Adult Day Care	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM0850X	Adult Mental Health	260000000	Non-Individual - Ambulatory Health Care Facilities
261QA0005X	Ambulatory Family Planning Facility	260000000	Non-Individual - Ambulatory Health Care Facilities
261QA0006X	Ambulatory Fertility Facility	260000000	Non-Individual - Ambulatory Health Care Facilities
261QA1903X	Ambulatory Surgical	260000000	Non-Individual - Ambulatory Health Care Facilities
261QA0900X	Amputee	260000000	Non-Individual - Ambulatory Health Care Facilities
261QA3000X	Augmentative Communication	260000000	Non-Individual - Ambulatory Health Care Facilities
261QB0400X	Birthing	260000000	Non-Individual - Ambulatory Health Care Facilities
261QC1500X	Community Health	260000000	Non-Individual - Ambulatory Health Care Facilities
261QC1800X	Corporate Health	260000000	Non-Individual - Ambulatory Health Care Facilities

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
261QC0050X	Critical Access Hospital	260000000	Non-Individual - Ambulatory Health Care Facilities
261QD0000X	Dental	260000000	Non-Individual - Ambulatory Health Care Facilities
261QD1600X	Developmental Disabilities	260000000	Non-Individual - Ambulatory Health Care Facilities
261QE0002X	Emergency Care	260000000	Non-Individual - Ambulatory Health Care Facilities
261QE0800X	Endoscopy	260000000	Non-Individual - Ambulatory Health Care Facilities
261QE0700X	End-Stage Renal Disease () Treatment	260000000	Non-Individual - Ambulatory Health Care Facilities
261QF0050X	Family Planning, Non-Surgical	260000000	Non-Individual - Ambulatory Health Care Facilities
261QF0400X	Federally Qualified Health Center (FQHC)	260000000	Non-Individual - Ambulatory Health Care Facilities
261QG0250X	Genetics	260000000	Non-Individual - Ambulatory Health Care Facilities
261QH0100X	Health Service	260000000	Non-Individual - Ambulatory Health Care Facilities
261QH0700X	Hearing and Speech	260000000	Non-Individual - Ambulatory Health Care Facilities
261QI0500X	Infusion Therapy	260000000	Non-Individual - Ambulatory Health Care Facilities

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
261QL0400X	Lithotripsy	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM1200X	Magnetic Resonance Imaging (MRI)	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM2500X	Medical Specialty	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM3000X	Medically Fragile Infants and Children Day Care	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM0801X	Mental Health (Including Community Mental Health Center)	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM2800X	Methadone	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM1000X	Migrant Health	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM1103X	Military Ambulatory Procedure Visits Operational (Transportable)	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM1101X	Military and U.S. Coast Guard Ambulatory Procedure	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM1102X	Military Outpatient Operational (Transportable) Component	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM1100X	Military/U.S. Coast Guard Outpatient	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM1300X	Multi-Specialty	260000000	Non-Individual - Ambulatory Health Care Facilities

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
261QX0100X	Occupational Medicine	260000000	Non-Individual - Ambulatory Health Care Facilities
261QX0200X	Oncology	260000000	Non-Individual - Ambulatory Health Care Facilities
261QX0203X	Oncology, Radiation	260000000	Non-Individual - Ambulatory Health Care Facilities
261QS0132X	Ophthalmologic Surgery	260000000	Non-Individual - Ambulatory Health Care Facilities
261QS0112X	Oral and Maxillofacial Surgery	260000000	Non-Individual - Ambulatory Health Care Facilities
261QP3300X	Pain	260000000	Non-Individual - Ambulatory Health Care Facilities
261QP2000X	Physical Therapy	260000000	Non-Individual - Ambulatory Health Care Facilities
261QP1100X	Podiatric	260000000	Non-Individual - Ambulatory Health Care Facilities
261QP2300X	Primary Care	260000000	Non-Individual - Ambulatory Health Care Facilities
261QP2400X	Prison Health	260000000	Non-Individual - Ambulatory Health Care Facilities
261QP0904X	Public Health, Federal	260000000	Non-Individual - Ambulatory Health Care Facilities
261QP0905X	Public Health, State or Local	260000000	Non-Individual - Ambulatory Health Care Facilities

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
261QR0200X	Radiology	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR0206X	Radiology, Mammography	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR0208X	Radiology, Mobile	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR0207X	Radiology, Mobile Mammography	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR0800X	Recovery Care	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR0400X	Rehabilitation	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR0404X	Rehabilitation, Cardiac Facilities	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR0401X	Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR0405X	Rehabilitation, Substance Use Disorder	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR1100X	Research	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR1300X	Rural Health	260000000	Non-Individual - Ambulatory Health Care Facilities
261QS1200X	Sleep Disorder Diagnostic	260000000	Non-Individual - Ambulatory Health Care Facilities

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
261QS1000X	Student Health	260000000	Non-Individual - Ambulatory Health Care Facilities
261QU0200X	Urgent Care	260000000	Non-Individual - Ambulatory Health Care Facilities
261QV0200X	VA	260000000	Non-Individual - Ambulatory Health Care Facilities
273100000X	Epilepsy Unit	270000000	Non-Individual - Hospital Units
275N00000X	Medicare Defined Swing Bed Unit	270000000	Non-Individual - Hospital Units
273R00000X	Psychiatric Unit	270000000	Non-Individual - Hospital Units
273Y00000X	Rehabilitation Unit	270000000	Non-Individual - Hospital Units
276400000X	Rehabilitation, Substance Use Disorder Unit	270000000	Non-Individual - Hospital Units
287300000X	Christian Science Sanitorium	280000000	Non-Individual - Hospitals
281P00000X	Chronic Disease Hospital	280000000	Non-Individual - Hospitals
281PC2000X	Children	280000000	Non-Individual - Hospitals
282N00000X	General Acute Care Hospital	280000000	Non-Individual - Hospitals
282NC2000X	Children	280000000	Non-Individual - Hospitals
282NC0060X	Critical Access	280000000	Non-Individual - Hospitals
282NR1301X	Rural	280000000	Non-Individual - Hospitals
282NW0100X	Women	280000000	Non-Individual - Hospitals
282E00000X	Long Term Care Hospital	280000000	Non-Individual - Hospitals

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
286500000X	Military Hospital	280000000	Non-Individual - Hospitals
2865C1500X	Community Health	280000000	Non-Individual - Hospitals
2865M2000X	Military General Acute Care Hospital	280000000	Non-Individual - Hospitals
2865X1600X	Military General Acute Care Hospital. Operational (Transportable)	280000000	Non-Individual - Hospitals
283Q00000X	Psychiatric Hospital	280000000	Non-Individual - Hospitals
283X00000X	Rehabilitation Hospital	280000000	Non-Individual - Hospitals
283XC2000X	Children	280000000	Non-Individual - Hospitals
282J00000X	Religious Nonmedical Health Care Institution	280000000	Non-Individual - Hospitals
284300000X	Special Hospital	280000000	Non-Individual - Hospitals
291U00000X	Clinical Medical Laboratory	290000000	Non-Individual - Laboratories
292200000X	Dental Laboratory	290000000	Non-Individual - Laboratories
291900000X	Military Clinical Medical Laboratory	290000000	Non-Individual - Laboratories
293D00000X	Physiological Laboratory	290000000	Non-Individual - Laboratories
302F00000X	Exclusive Provider Organization	300000000	Non-Individual - Managed Care Organizations
302R00000X	Health Maintenance Organization	300000000	Non-Individual - Managed Care Organizations
305S00000X	Point of Service	300000000	Non-Individual - Managed Care Organizations

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
305R00000X	Preferred Provider Organization	300000000	Non-Individual - Managed Care Organizations
311500000X	Alzheimer Center (Dementia Center)	310000000	Non-Individual - Nursing & Custodial Care Facilities
310400000X	Assisted Living Facility	310000000	Non-Individual - Nursing & Custodial Care Facilities
3104A0630X	Assisted Living, Behavioral Disturbances	310000000	Non-Individual - Nursing & Custodial Care Facilities
3104A0625X	Assisted Living, Mental Illness	310000000	Non-Individual - Nursing & Custodial Care Facilities
317400000X	Christian Science Facility	310000000	Non-Individual - Nursing & Custodial Care Facilities
311Z00000X	Custodial Care Facility	310000000	Non-Individual - Nursing & Custodial Care Facilities
311ZA0620X	Adult Care Home	310000000	Non-Individual - Nursing & Custodial Care Facilities
315D00000X	Hospice, Inpatient	310000000	Non-Individual - Nursing & Custodial Care Facilities
310500000X	Intermediate Care Facility, Mental Illness	310000000	Non-Individual - Nursing & Custodial Care Facilities
315P00000X	Intermediate Care Facility, Mentally Retarded	310000000	Non-Individual - Nursing & Custodial Care Facilities
313M00000X	Nursing Facility/Intermediate Care Facility	310000000	Non-Individual - Nursing & Custodial Care Facilities

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
314000000X	Skilled Nursing Facility	310000000	Non-Individual - Nursing & Custodial Care Facilities
3140N1450X	Nursing Care, Pediatric	310000000	Non-Individual - Nursing & Custodial Care Facilities
177F00000X	Lodging	170000000	Non-Individual - Other Service Providers
174200000X	Meals	170000000	Non-Individual - Other Service Providers
320800000X	Community Based Residential Treatment Facility, Mental Illness	320000000	Non-Individual - Residential Treatment Facilities
320900000X	Community Based Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities	320000000	Non-Individual - Residential Treatment Facilities
323P00000X	Psychiatric Residential Treatment Facility	320000000	Non-Individual - Residential Treatment Facilities
322D00000X	Residential Treatment Facility, Emotionally Disturbed Children	320000000	Non-Individual - Residential Treatment Facilities
320600000X	Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities	320000000	Non-Individual - Residential Treatment Facilities
320700000X	Residential Treatment Facility, Physical Disabilities	320000000	Non-Individual - Residential Treatment Facilities
324500000X	Substance Abuse Rehabilitation Facility	320000000	Non-Individual - Residential Treatment Facilities
3245S0500X	Substance Abuse Treatment, Children	320000000	Non-Individual - Residential Treatment Facilities

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
385H00000X	Respite Care	380000000	Non-Individual - Respite Care Facility
385HR2050X	Respite Care Camp	380000000	Non-Individual - Respite Care Facility
385HR2055X	Respite Care, Mental Illness, Child	380000000	Non-Individual - Respite Care Facility
385HR2060X	Respite Care, Mental Retardation and/or Developmental Disabilities	380000000	Non-Individual - Respite Care Facility
385HR2065X	Respite Care, Physical Disabilities, Child	380000000	Non-Individual - Respite Care Facility
331L00000X	Blood Bank	330000000	Non-Individual - Suppliers
332100000X	Department of Veterans Affairs (VA) Pharmacy	330000000	Non-Individual - Suppliers
332B00000X	Durable Medical Equipment & Medical Supplies	330000000	Non-Individual - Suppliers
332BC3200X	Customized Equipment	330000000	Non-Individual - Suppliers
332BD1200X	Dialysis Equipment & Supplies	330000000	Non-Individual - Suppliers
332BN1400X	Nursing Facility Supplies	330000000	Non-Individual - Suppliers
332BX2000X	Oxygen Equipment & Supplies	330000000	Non-Individual - Suppliers
332BP3500X	Parenteral & Enteral Nutrition	330000000	Non-Individual - Suppliers
333300000X	Emergency Response System Companies	330000000	Non-Individual - Suppliers
332G00000X	Eye Bank	330000000	Non-Individual - Suppliers
332H00000X	Eyewear Supplier (Equipment, not the service)	330000000	Non-Individual - Suppliers

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
332S00000X	Hearing Aid Equipment	330000000	Non-Individual - Suppliers
332U00000X	Home Delivered Meals	330000000	Non-Individual - Suppliers
332800000X	Indian Health Service/Tribal/Urban Indian Health (I/T/U) Pharmacy	330000000	Non-Individual - Suppliers
335G00000X	Medical Foods Supplier	330000000	Non-Individual - Suppliers
332000000X	Military/U.S. Coast Guard Pharmacy	330000000	Non-Individual - Suppliers
332900000X	Non-Pharmacy Dispensing Site	330000000	Non-Individual - Suppliers
335U00000X	Organ Procurement Organization	330000000	Non-Individual - Suppliers
333600000X	Pharmacy	330000000	Non-Individual - Suppliers
3336C0002X	Clinic Pharmacy	330000000	Non-Individual - Suppliers
3336C0003X	Community/Retail Pharmacy	330000000	Non-Individual - Suppliers
3336C0004X	Compounding Pharmacy	330000000	Non-Individual - Suppliers
3336H0001X	Home Infusion Therapy Pharmacy	330000000	Non-Individual - Suppliers
3336I0012X	Institutional Pharmacy	330000000	Non-Individual - Suppliers
3336L0003X	Long Term Care Pharmacy	330000000	Non-Individual - Suppliers
3336M0002X	Mail Order Pharmacy	330000000	Non-Individual - Suppliers
3336M0003X	Managed Care Organization Pharmacy	330000000	Non-Individual - Suppliers
3336N0007X	Nuclear Pharmacy	330000000	Non-Individual - Suppliers
3336S0011X	Specialty Pharmacy	330000000	Non-Individual - Suppliers

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
335V00000X	Portable X-Ray Supplier	330000000	Non-Individual - Suppliers
335E00000X	Prosthetic/Orthotic Supplier	330000000	Non-Individual - Suppliers
344800000X	Air Carrier	340000000	Non-Individual - Transportation Services
341600000X	Ambulance	340000000	Non-Individual - Transportation Services
3416A0800X	Air Transport	340000000	Non-Individual - Transportation Services
3416L0300X	Land Transport	340000000	Non-Individual - Transportation Services
3416S0300X	Water Transport	340000000	Non-Individual - Transportation Services
347B00000X	Bus	340000000	Non-Individual - Transportation Services
341800000X	Military/U.S. Coast Guard Transport	340000000	Non-Individual - Transportation Services
3418M1120X	Military or U.S. Coast Guard Ambulance, Air Transport	340000000	Non-Individual - Transportation Services
3418M1110X	Military or U.S. Coast Guard Ambulance, Ground Transport	340000000	Non-Individual - Transportation Services
3418M1130X	Military or U.S. Coast Guard Ambulance, Water Transport	340000000	Non-Individual - Transportation Services
343900000X	Non-emergency Medical Transport (VAN)	340000000	Non-Individual - Transportation Services

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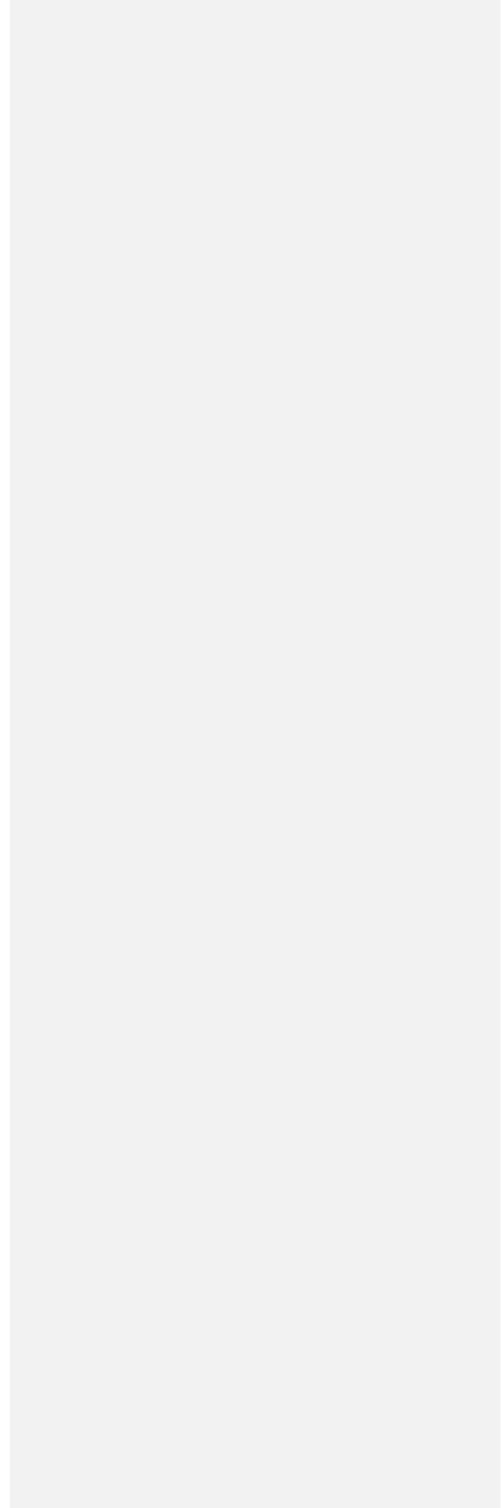
Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
347C00000X	Private Vehicle	340000000	Non-Individual - Transportation Services
343800000X	Secured Medical Transport (VAN)	340000000	Non-Individual - Transportation Services
344600000X	Taxi	340000000	Non-Individual - Transportation Services
347D00000X	Train	340000000	Non-Individual - Transportation Services
347E00000X	Transportation Broker	340000000	Non-Individual - Transportation Services

~~Appendix M~~



Appendix N: Coding Specific Data Elements for Claim Files

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

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

For professional claims:

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

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

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

For financial transactions[9]*:*

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

[9] *CMS Guidance – Reporting Financial Transactions in T-MSIS – 2014-04-23*

Appendix N

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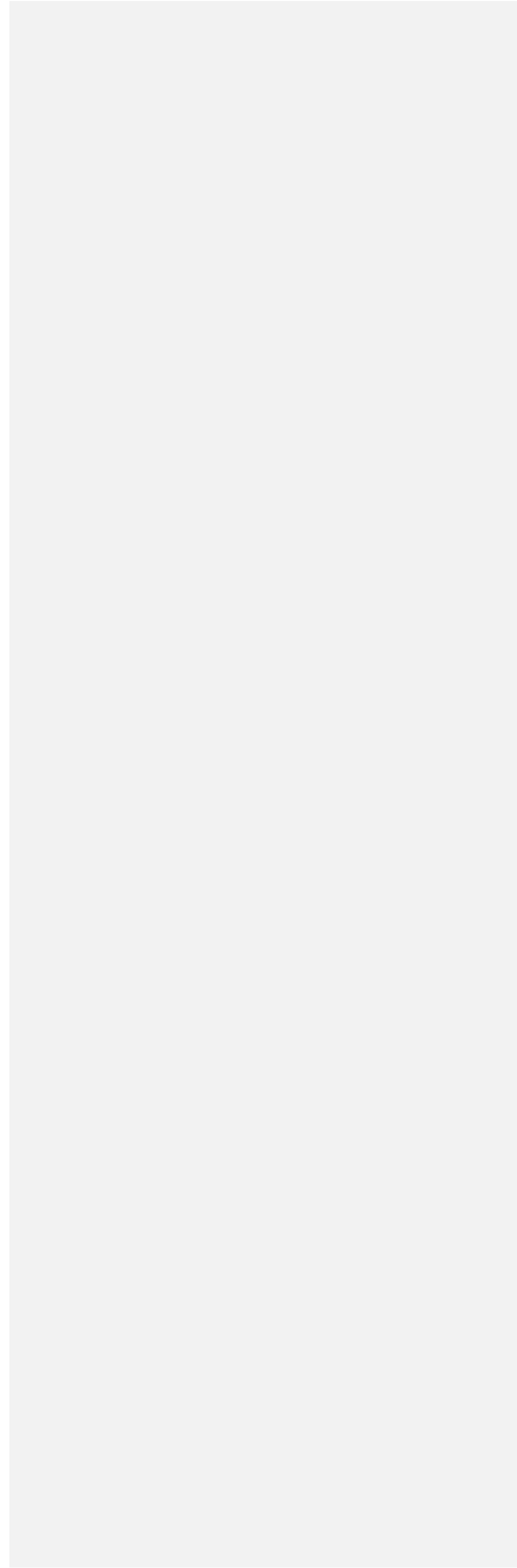

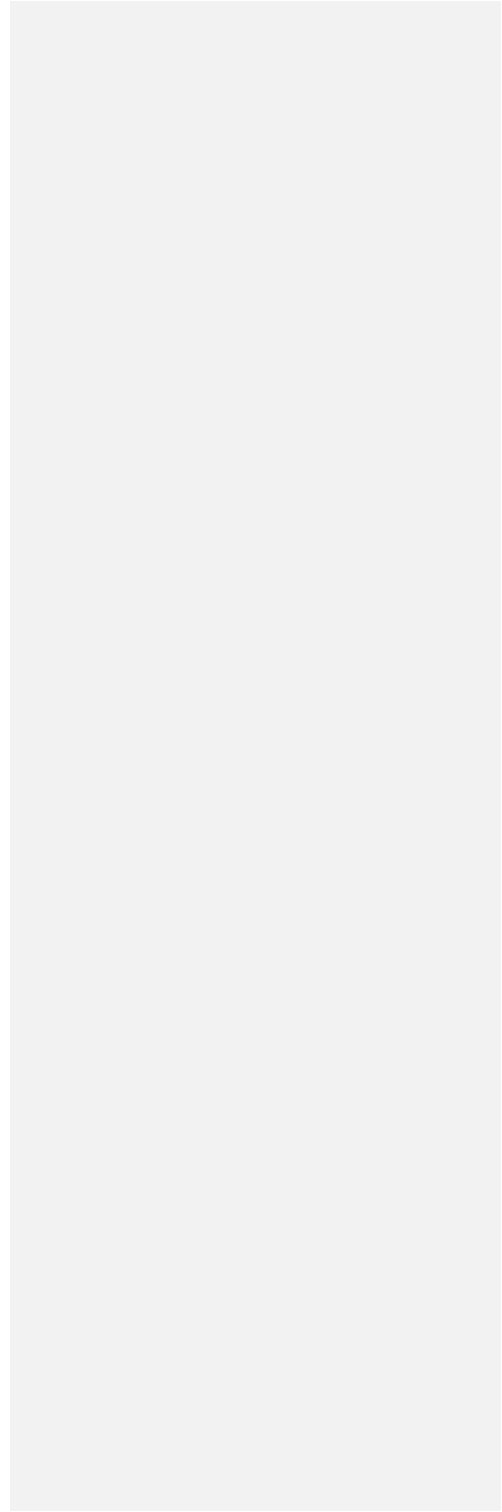

~~Appendix O~~

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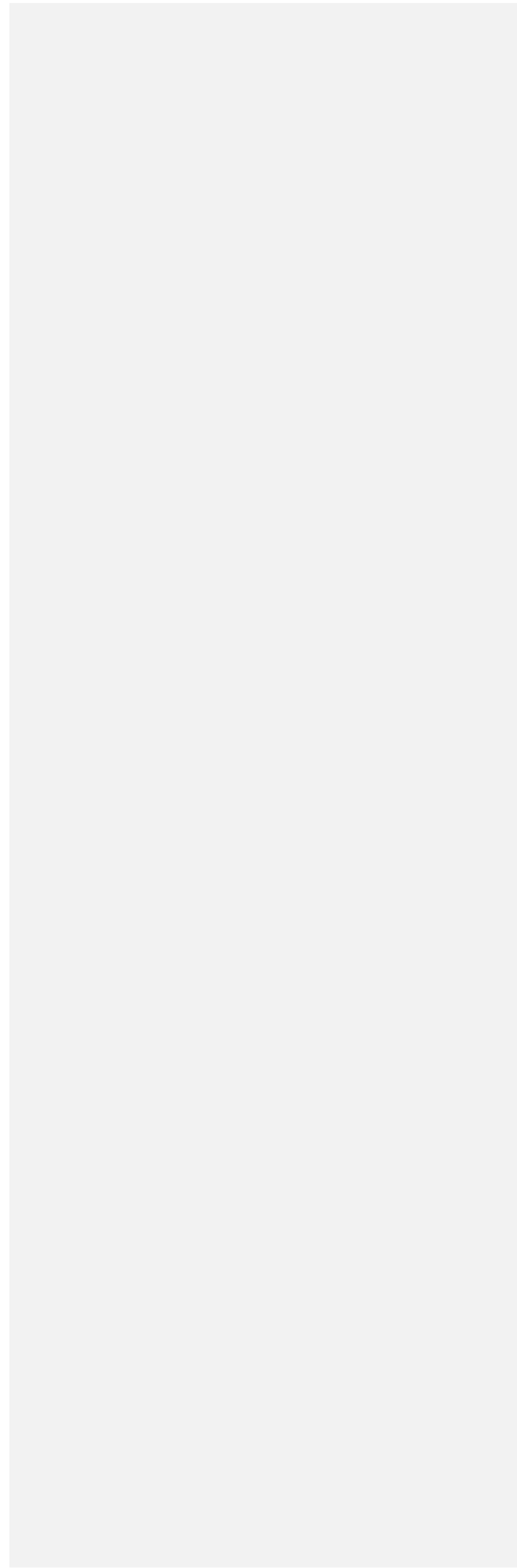

Appendix P: CMS Guidance Library

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

Brief Issue Description

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

Background Discussion

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

What claim transactions should be submitted to T-MSIS?

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

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

Table 1: Finalized Claim Status Categories

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

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

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

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

Table 2: Scenarios for When to Submit Claims

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

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

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

Table 3: Adjustment Indicator Codes and Their Uses

Code	Description of Use
0	Original Claim/Encounter/Payment – Indicates that this is the first (and, when applicable, only) fully adjudicated transaction in a claim family (one or more claims with the related ICN-ORIG and/or ICN-ADJ and typically the same MSIS ID and provider ID(s) also).

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

Are gross adjustments considered claims/encounters?

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

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 43 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 43: 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 54 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 54: ICN-ORIG/ICN-ADJ Relationships Under the Daisy-Chain ICN Approach

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

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

The primary purpose of void transactions (ADJUSTMENT-IND = 1) is to nullify a claim/encounter from T-MSIS when the state does not wish to replace it with an adjusted claim/encounter record. -These records must have

the same claim key data element values as the claim/encounter being voided. -Dollar and quantity fields should be set to zero. -The ADJUDICATION-DATE on these records should be set to the date that the state voided the claim. ~~Table 6 illustrates how the ICN-ORIG and ICN-ADJ values on the members of a claim family are populated when the state wishes to void a claim.~~

~~*Table 6*~~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 ~~7~~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 ~~7~~6: ICN-ORIG/ICN-ADJ – Keeping the Claim Family Intact When the “*Void/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

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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 of the incoming transactions;.
2. If the ADJUSTMENT-IND values of both incoming transactions are the same (but not '5' or '6'), then T-MSIS will reject both incoming transactions;.
3. If the ADJUSTMENT-IND values of both incoming transactions are some combination of '5' and '6' and if there is no active existing transaction in the T-MSIS DB, then T-MSIS will insert both incoming transactions into the T-MSIS DB (note, since neither transaction supersedes the other, the order in which they are inserted does not matter);).
4. If the ADJUSTMENT-IND values of both incoming transactions are some combination of '5' and '6' and if there is an active existing transaction in the T-MSIS DB with an ADJUSTMENT-IND value of '5' or '6', then T-MSIS will insert both incoming transactions into the T-MSIS DB (note, since neither transaction supersedes the other, the order in which they are inserted does not matter);).

5. If the ADJUSTMENT-IND values of both incoming transactions is a '5' or '6' and if there is an active existing transaction in the T-MSIS DB with an ADJUSTMENT-IND value of '0', '1', or '4', then T-MSIS will reject both the incoming transactions;.
6. If the ADJUSTMENT-IND value of one incoming transaction is a '5' or '6' and the ADJUSTMENT-IND of the other transaction is '0', '1', or '4' and if there is an active existing transaction in the T-MSIS DB with an ADJUSTMENT-IND value of '5' or '6', then T-MSIS will insert the incoming transaction with ADJUDICATION-IND of '5' or '6' and reject the incoming transaction with ADJUSTMENT-IND value '0', '1', or '4';.
7. If the ADJUSTMENT-IND value of one incoming transaction is a '5' or '6' and the ADJUSTMENT-IND of the other transaction is '0', '1', or '4' and there is an active existing transaction in the T-MSIS DB with an ADJUSTMENT-IND value of '0', '1', or '4', then T-MSIS will reject the incoming transaction with ADJUSTMENT-IND value '5' or '6' and evaluate the remaining incoming transaction as follows:
   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 of the transactions.

CMS Guidance

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

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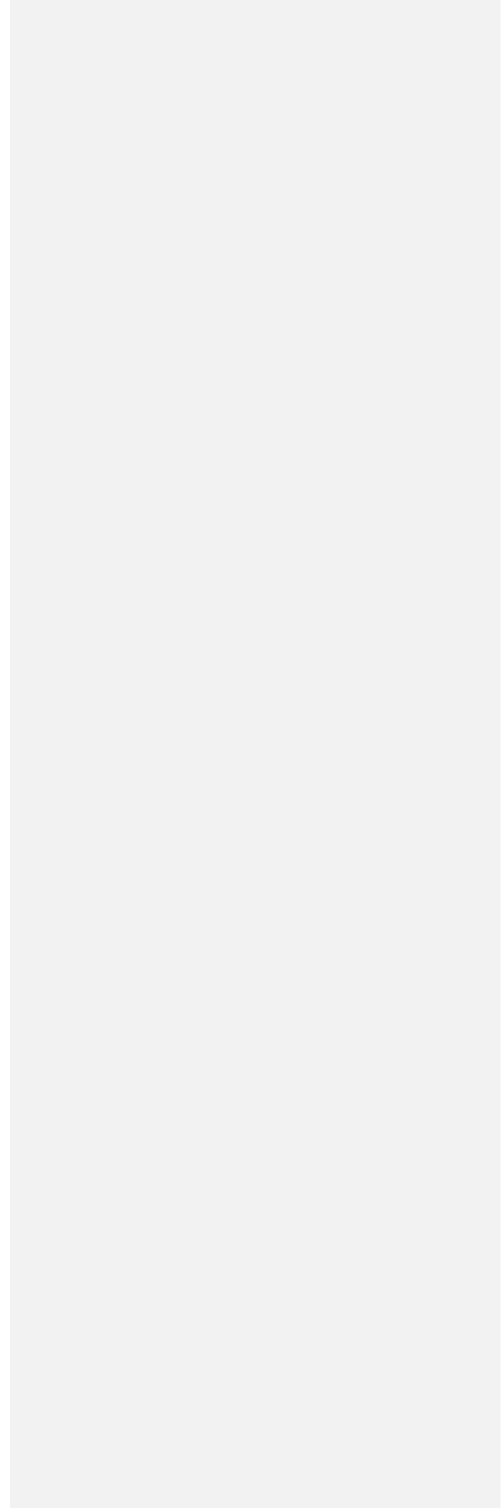

Appendix P.02: Reporting Financial Transactions in T-MSIS

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

Brief Issue Description:

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

Background Discussion

Definition of a financial transaction:

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

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

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

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

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

At Enrollee Level (col. 1-4)				**For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**					
Cap Pymt	**Drug Rebate**	**Cost Stlmnt**	**Spplmntl Pymt**	**Cap Pymt**	**Drug Rebate**	**Cost Stlmnt**	**Spplmntl Pymt**	**DSH Pymt**	**Other Pymt**
CLAIMOT	CLAIMOT CLAIMRX	CLAIMIP CLAIMLT CLAIMOT CLAIMRX	CLAIMIP CLAIMLT CLAIMOT CLAIMRX	CLAIMOT	CLAIMOT CLAIMRX	CLAIMIP CLAIMLT CLAIMOT CLAIMRX	CLAIMIP CLAIMLT CLAIMOT CLAIMRX	CLAIMIP CLAIMOT	CLAIMIP CLAIMLT CLAIMOT CLAIMRX

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

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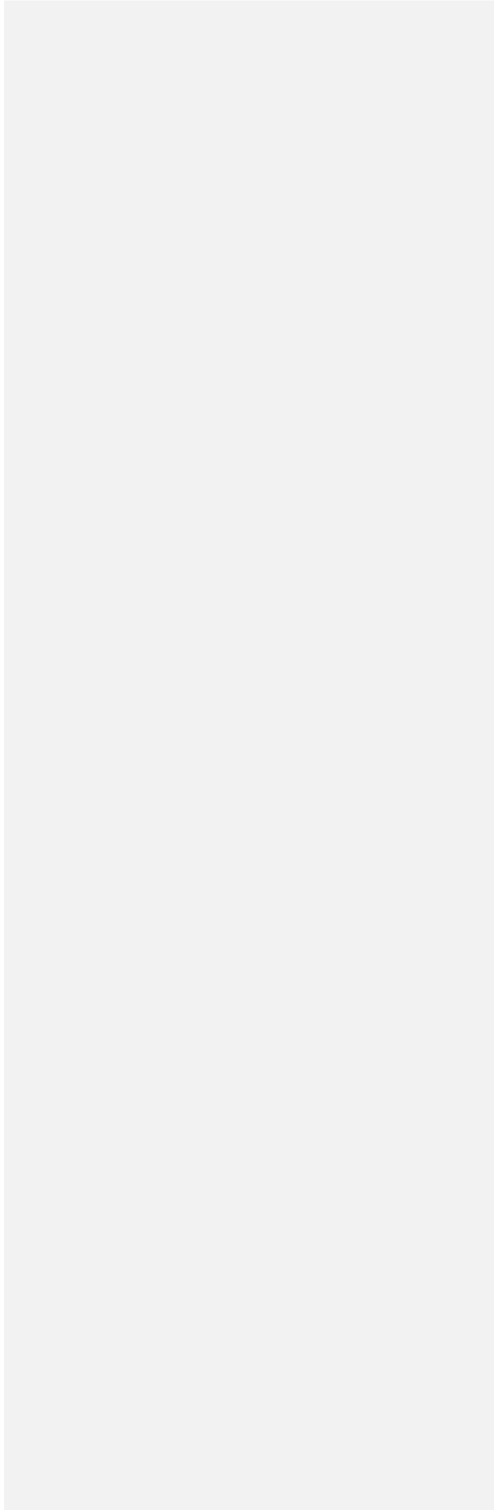

CMS Guidance

When and how to populate data elements for financial transactions:

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

CLAIM-HEADER-RECORD data elements

a. RECORD-ID
b. SUBMITTING-STATE
c. RECORD-NUMBER
d. MSIS-IDENTIFICATION-NUM – Populate with beneficiary's MSIS ID for any beneficiary-specific financial transactions. Otherwise first character of MSIS-IDENTIFICATION-NUM must be "&" to indicate that any characters that might follow do not represent an individual beneficiary's identifier.
e. ICN-ORIG – See the document entitled CMS Guidance: T-MSIS Adjustment Claim Records-Populating ICN-ORG and ICN-ADJ Fields posted on 2/18/2014 to the T-MSIS State Support.
f. ICN-ADJ – See the document entitled CMS Guidance: T-MSIS Adjustment Claim Records-Populating ICN-ORG and ICN-ADJ Fields posted on 2/18/2014 to the T-MSIS State Support
g. ADJUDICATION-DATE – Date the transaction's approval and payment processes were completed.
h. CHECK-EFF-DATE – Populate with the date that Medicaid funds were disbursed. (Note: Even though the TOT-MEDICAID-PAID-AMT field may be set to zero in some circumstances, Medicaid funds were disbursed – and are captured in the SERVICE-TRACKING-PAYMENT-AMT data element.)
i. ADMISSION-DATE – Populate with the first day of the time period covered by this financial transaction (CLAIMIP and CLAIMLT).
j. DISCHARGE-DATE – Populate with the last day of the time period covered by this financial transaction (CLAIMIP and CLAIMLT).
k. BEGINNING-DATE-OF-SERVICE – Populate with the first day of the time period covered by this financial transaction (CLAIMOT).
l. ENDING-DATE-OF-SERVICE – Populate with the last day of the time period covered by this financial transaction (CLAIMOT).
m. DATE-PRESCRIBED – Populate with the first day of the time period covered by this financial transaction (CLAIMRX).
n. PRESCRIPTION-FILL-DATE – Populate with the last day of the time period covered by this financial transaction (CLAIMRX).
o. WAIVER-TYPE – Populate if applicable and available
p. WAIVER-ID – Populate if applicable and available
q. PLAN-ID-NUMBER – Populate with the managed care plan ID for capitation payments made to managed care plans. 8-fill, leave Leave blank or space-fill if transaction does not involve a manage care plan.

r. BILLING-PROV-NPI-NUM – Populate with the provider or entity that the financial transaction was addressed to. 8-fill, leave blank or space-fill if transaction involves a manage care plan.
s. TOT-MEDICAID-PAID-AMT – If TYPE-OF-CLAIM is 4, D, or X, then set to zero – service tracking payment amount will be populated instead. Otherwise populate with the amount paid to the provider or health plan.
t. SERVICE-TRACKING-PAYMENT-AMT – If TYPE-OF-CLAIM is 4, D, or X, then populate this with the amount paid, otherwise 0-fill.
u. TYPE-OF-CLAIM – valid values appropriate for each type of financial transaction are shown in Table 255. (The descriptions of the TYPE-OF-CLAIM values are shown in Table 354. The values appropriate for financial transactions are highlighted in yellow.)

Valid Values

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

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

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

Table 3 – Descriptions of TYPE-OF-CLAIM values

Claim Type (col. 1-3)

Medicaid or Medicaid Expansion	Separate CHIP (Title XXI)	Other	Description	Purpose
1	A	U	Fee-For-Service Claim	Used to report services billed & payments made for specific services rendered to a specific enrollee by a specific provider during a specific period of time. Payment is made only for services actually rendered.
2	B	V	Capitation Payment	Used to report periodic payments made in return for a contractual commitment by the recipient to provide a specified set of services to a specified set of enrollees for a specified period of time. The volume of services actually provided to any given individual is not a factor in the amount of the capitation payment.
3	C	W	Encounter Record	Used to report services provided under a capitated payment arrangement. This includes billing records submitted by providers to non-state entities (e.g., MCOs, health plans) for which the State has no financial liability, since the risk entity has already received a capitated payment from the State.

Medicaid or Medicaid Expansion	Separate CHIP (Title XXI)	Other	Description	Purpose
4	D	X	Service Tracking Claim	Use to report payments made for services rendered to enrollees when the services are not billed and paid at the single enrollee/provider/visit level of detail.
5	E	Y	Supplemental Payment	Used to identify payments that are above a capitation fee or for a sum above a negotiated rate, such as an FQHC additional reimbursement.

v. SOURCE-LOCATION– valid values appropriate for each type of financial transaction are shown in Table 457.

Table 4 – Descriptions of SOURCE-LOCATION values

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

w. SERVICE-TRACKING-TYPE – The appropriate values for financial transactions are shown in Table 5. (The descriptions of the SERVICE-TRACKING-TYPE values are shown in Table 658.)

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

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

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

Table 6 – Descriptions of SERVICE-TRACKING-TYPE values

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

x. FUNDING-CODE – The appropriate values for financial transactions are shown in Table 7. (The descriptions of the FUNDING-CODE values are shown in Table 860.)

Table 7 – FUNDING-CODE values for financial transactions

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

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

Table 8 – Descriptions of FUNDING-CODE values

Code	Description
A	Medicaid Agency
B	CHIP Agency
C	Mental Health Service Agency
D	Education Agency
E	Child and Family Services Agency
F	County
G	City

Code	Description
H	Providers
I	Other

CLAIM-LINE-RECORD data elements

a. SUBMITTING-STATE
b. RECORD-NUMBER
c. MSIS-IDENTIFICATION-NUM
d. ICN-ORIG
e. ICN-ADJ
f. LINE-NUM-ORIG
g. LINE-NUM-ADJ
h. ADJUDICATION-DATE – Date the line-level transaction's approval and payment processes were completed
REVENUE-CODE – 8leave blank or space-fill,
i. PROCEDURE-CODE – leave blank or space-fill
j. PROCEDURE-CODE – 8-fill, leave blank or space-fill
k. NATIONAL-DRUG-CODE – 8-fill, leave blank or space-fill
l. MEDICAID-PAID-AMT – Because there is no data element on the claim line record segment specifically designated to capture service tracking payment amounts at the claim line level, states should populate MEDICAID-PAID-AMT with the amount of Medicaid funds disbursed. For service tracking claims, the sum of the claim line MEDICAID-PAID-AMT values on a claim's claim line record segments should equal the amount reported in the SERVICE-TRACKING-PAYMENT-AMT data element on the claim's claim header record segment.
m. TYPE-OF-SERVICE – The appropriate values for financial transactions are shown in Table 962.

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

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

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

Table 62-TYPE-OF-SERVICE values for financial transactions

n. CMS-64-CATEGORY-FOR-FEDERAL-REIMBURSEMENT – The appropriate values for financial transactions are shown in Table 1063.

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

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

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

Table 63-CMS-64-CATEGORY-FOR-FEDERAL-REIMBURSEMENT values for financial transactions

o. XIX-MBESCBES-CATEGORY-OF-SERVICE – The appropriate values for financial transactions are shown in Table 1164.

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

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

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

Table 64-XIX-MBESCBES-CATEGORY-OF-SERVICE values for financial transactions

p. XXI-MBESCBES-CATEGORY-OF-SERVICE – The appropriate values for financial transactions are shown in Table 1265.

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

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

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

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

Brief Issue Description

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

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

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

CMS Guidance: Building Non-Claim Records

Methods for Submitting non-claim files to T-MSIS

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

Full-File Refresh Method

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

Changed-Segment-Only Method

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

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

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

1. T-MSIS makes no changes to segment effective and end dates of its own volition.
2. If the state does not set segment effective- and end-dates appropriately, unintended overlapping segments with ambiguous data will occur.
3. It is the state's responsibility to tell T-MSIS the revised segment end date on existing segments whenever values on the segment change.
4. Every instance of a segment has a primary key that uniquely identifies it. ***To do anything to an existing segment***, the primary key field values (***which includes the segment effective date***) on the incoming segment MUST MATCH the primary key field values of the existing segment in T-MSIS. The primary key of each segment is listed in the "Rec Segment Keys & Constraints" tab of the *T-MSIS Data Dictionary*. (See Appendix A: Examples of Non-Claim File Segment and/or Record Modification Scenarios for more information on using primary keys.)
5. Record segments that are not applicable to a state or to a particular entity (i.e., an eligible person, provider, managed care entity, or TPL instance) do not need to be submitted.

Amount of Historical Data That Must Be Submitted

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

Appendix P.04

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

Brief Issue Description

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

Background Discussion

Definitions

Simple Qualifier Field – is a data element that contains a code (a.k.a. "flag") that defines/qualifies the coding schema used when populating a set of corresponding data elements. This is necessary because there are several different schemas that a state could use and it needs to be clear which of the schemas is actually used. Examples of "simple qualifier fields" are the DIAGNOSIS-CODE-FLAG-1 through -12 on the CLAIM-HEADER-RECORD-IP record segment (CIP00002). The valid value set for these fields is:

1 ICD-9
2 ICD-10
3 Other

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

Complex Qualifier Field – is a data element that not only defines/qualifies the contents of its corresponding data elements (similar to a "simple qualifier field"), but also represents a situation where the state needs to create a record segment for each valid value that applies to the record's subject.
An example of a "complex qualifier field is LICENSE-TYPE on the PROV-LICENSING-INFO record segment (PRV00004). The valid value set for this field is:

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

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

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

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

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

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

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

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

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

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

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

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

Data Element Use	***Data Element***	***Physician License***	***ABMS Board Certification***	***AOA Board Certification***	***DEA Number***
Tie segments to parent segment	RECORD-ID	PRV00004	PRV00004	PRV00004	PRV00004
Tie segments to parent segment	SUBMITTING-STATE	24	24	24	24

Tie segments to parent segment	RECORD-NUMBER	4506	4507	4508	4509
Tie segments to parent segment	SUBMITTING-STATE-PROV-ID	P0123	P0123	P0123	P0123
Tie segments to parent segment	PROV-LOCATION-ID	0	0	0	0

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

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

CMS Guidance

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

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

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

Appendix P.05

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

Appendix P.05

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; MANAGEDDATE; MANAGED-CARE-SERVICE-AREA-END-DATE

Appendix P.05

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~~	~~NATIONAL-HEALTH-CARE-ENTITY-ID-INFO (MCR00008)~~	~~NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE~~	~~1 - Controlling Health Plan (CHP) ID; 2 - Subhealth Plan (SHP) ID; 3 - Other Entity Identifier (OEID)~~	~~NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008~~	~~STATE-PLAN-ID-NUM; NATIONAL-HEALTH-CARE-ENTITY-ID; NATIONAL-HEALTH-CARE-ENTITY-NAME; NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-EFF-DATE; NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-END-DATE~~
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

Appendix P.05

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-LICENSING-INFO (PRV00004)	LICENSE-TYPE	1 - State, county, or municipality professional or business license; 2 -DEA license; 3-Professional society accreditation; 4 - CLIA accreditation; 5-Other	PROV-LICENSING-INFO-PRV00004	LICENSE-OR-ACCREDITATION-NUMBER; LICENSE-ISSUING-ENTITY-ID; PROV-LICENSE-EFF-DATE; PROV-LICENSE-END-DATE
PROVIDER	PROV-IDENTIFIERS (PRV00005)	PROV-IDENTIFIER-TYPE	1 - State-specific Medicaid Provider ID; 2 – NPI; 3 - Medicare ID; 4 - NCPDP ID; 5 - Federal Tax ID; 6 - State Tax ID; 7 – SSN; 8 – Other; 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)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

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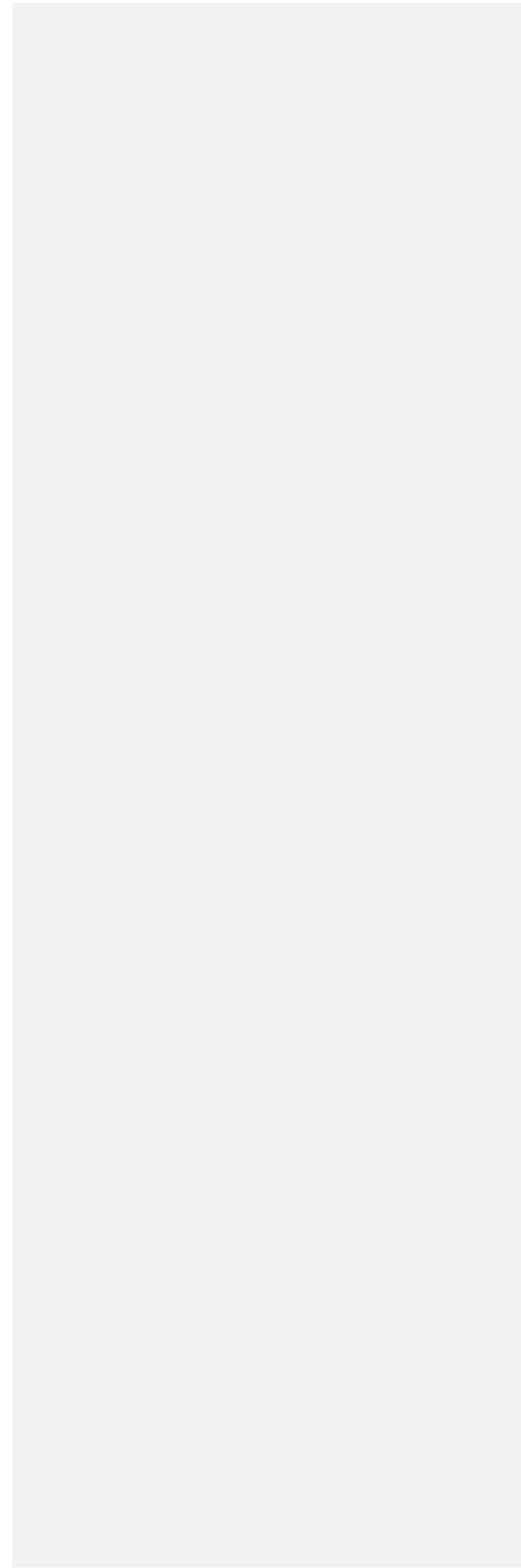
File Name	"Complex Qualifier Field" Information: Record Segment	"Complex Qualifier Field" Information: Data Element Name	"Complex Qualifier Field" Information: Valid Value and Description	Corresponding Data Elements To Be Populated: Record Segment	Corresponding Data Elements To Be Populated: Data Element Name
TPL	TPL-ENTITY-CONTACT-INFORMATION (TPL00006)	TPL-ENTITY-ADDR-TYPE	06 - TPL-Entity Corporate Location; 07 - TPL-Entity Mailing; 08 - TPL-Entity Satellite Location; 09 - TPL-Entity Billing; 10 - TPL-Entity Correspondence; 11 - TPL-Other	TPL-ENTITY-CONTACT-INFORMATION-TPL00006	INSURANCE-CARRIER-ADDR-LN1; INSURANCE-CARRIER-ADDR-LN2; INSURANCE-CARRIER-ADDR-LN3; INSURANCE-CARRIER-CITY; INSURANCE-CARRIER-STATE; INSURANCE-CARRIER-ZIP-CODE; INSURANCE-CARRIER-PHONE-NUM; INSURANCE-CARRIER-NAIC-CODE; INSURANCE-CARRIER-NAME; NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE; NATIONAL-HEALTH-CARE-ENTITY-ID; NATIONAL-HEALTH-CARE-ENTITY-NAME; TPL-ENTITY-CONTACT-INFO-EFF-DATE; TPL-ENTITY-CONTACT-INFO-END-DATE

~~Appendix P.06~~



Appendix P.07: Finding Provider Roles on StandardTD 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
- Under supervision of provider

Provider role information needed for the T-MSIS claim files can be extracted from the standard X-12 transactions. The five tables in the "CMS Guidance" section of this document provide T-MSIS-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~~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.~~

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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-HEADER-RECORD-IP-CIP00002	5010 A2 837-I Institutional Claim	NM109	Referring Provider Identifier	2310F or 2420D	The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. N/A
Referring	REFERRING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-IP-CIP00002	N/A	N/A	N/A	N/A	The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier.
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.
Servicing (Rendering)	SERVICING-PROV-TAXONOMY	CLAIM-LINE-RECORD-IP-CIP00003	N/A	N/A	N/A	N/A	N/A

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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
Under-Direction-of -	UNDER-DIRECTION-OF-PROV-NPI	CLAIM-HEADER-RECORD-IP-CIP00002	N/A	N/A	N/A	N/A	N/A
Under-Direction-of	UNDER-DIRECTION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-IP-CIP00002	N/A	N/A	N/A	N/A	N/A
Under-Supervision-of -	UNDER-SUPERVISION-OF-PROV-NPI	CLAIM-HEADER-RECORD-IP-CIP00002	N/A	N/A	N/A	N/A	N/A
Under-Supervision-of	UNDER-SUPERVISION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-IP-CIP00002	N/A	N/A	N/A	N/A	N/A

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

Provider Role	LT-T-MSIS Data Element	LT-T-MSIS Record Segment	X-12 Transaction	X-12 Element Identifier	X-12 Description	X-12 Loop	Conditional Rules
Admitting (Attending)	ADMITTING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-LT-CLT00002	5010 A2 837-I Institutional Claim	NM109	Attending Provider Identifier	2310A	N/AThe identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier.

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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-TAXONOMY	CLAIM-HEADER-RECORD-LT-CLT00002	5010 A2 837-I Institutional Claim	PRV03	Provider Taxonomy Code	2310A	N/AThe identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier.
Billing	BILLING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-LT-CLT00002	5010 A2 837-I Institutional Claim	NM109	Billing Provider Identifier	2010AA	N/AThe identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier.
Billing	BILLING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-LT-CLT00002	5010 A2 837-I Institutional Claim	PRV03	Provider Taxonomy Code	2000A	N/AThe identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier.

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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
Referring	REFERRING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-LT-CLT00002	5010 A2 837-I Institutional Claim	NM109	Referring Provider Identifier	2310F or 2420D	N/AThe identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier.
Referring	REFERRING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-LT-CLT00002	N/A	N/A	N/A	N/A	The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier.
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.

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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
~~Servicing (Rendering)~~	~~SERVICING-PROV-TAXONOMY~~	~~CLAIM-LINE-RECORD-LT-CLT00003~~	~~N/A~~	~~N/A~~	~~N/A~~	~~N/A~~	~~The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier.~~
~~Under-Direction-of~~	~~UNDER-DIRECTION-OF-PROV-NPI~~	~~CLAIM-HEADER-RECORD-LT-CLT00002~~	~~N/A~~	~~N/A~~	~~N/A~~	~~N/A~~	~~The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier.~~
~~Under-Direction-of~~	~~UNDER-DIRECTION-OF-PROV-TAXONOMY~~	~~CLAIM-HEADER-RECORD-LT-CLT00002~~	~~N/A~~	~~N/A~~	~~N/A~~	~~N/A~~	~~The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier.~~

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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
~~Under-Supervision-of~~	~~UNDER-SUPERVISION-OF-PROV-NPI~~	~~CLAIM-HEADER-RECORD-LT-CLT00002~~	~~N/A~~	~~N/A~~	~~N/A~~	~~N/A~~	~~The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier.~~
~~Under-Supervision-of~~	~~UNDER-SUPERVISION-OF-PROV-TAXONOMY~~	~~CLAIM-HEADER-RECORD-LT-CLT00002~~	~~N/A~~	~~N/A~~	~~N/A~~	~~N/A~~	~~The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier.~~

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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/AThe identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier.
Billing	BILLING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	5010 A2 837-I Institutional Claim	PRV03	Provider Taxonomy Code	2000A	N/AThe identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier.

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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
Referring	REFERRING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-OT-COT00002	5010 A2 837-I Institutional Claim	NM109	Referring Provider Identifier	2310F or 2420D	The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier. N/A
Referring	REFERRING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier.
Referring	REFERRING-PROV-NPI-NUM	CLAIM-LINE-RECORD-OT-COT00003	5010 A2 837-I Institutional Claim	NM109	Referring Provider Identifier	2420D	N/A

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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
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.
Service (Rendering)	SERVICING-PROV-TAXONOMY	CLAIM-LINE-RECORD-OT-COT00003	N/A	N/A	N/A	N/A	The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier.

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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
Under-Direction-of	UNDER-DIRECTION-OF-PROV-NPI	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier.
Under-Direction-of	UNDER-DIRECTION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier.
Under-Supervision-of	UNDER-SUPERVISION-OF-PROV-NPI	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier.

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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
Under-Supervision-of	UNDER-SUPERVISION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier.

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

Provider Role	OT (professional)-T-MSIS Data Element	OT (professional)-T-MSIS Record Segment	X-12 Transaction	X-12 Element Identifier	X-12 Description	X-12 Loop	Conditional Rules
Billing	BILLING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-P Professional Claim	NM109	Billing Provider Identifier	2010AA	N/AThe identifier in the 837p loop 2310A could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420F at the line level of the 837p. If there is a different identifier in 837p loop 2420F then the identifier from 2420F should be reported as the referring provider identifier.
Billing	BILLING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-P Professional Claim	PRV03	Provider Taxonomy Code	2000A	N/AThe identifier in the 837p loop 2310A could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420F at the line level of the 837p. If there is a different identifier in 837p loop 2420F then the identifier from 2420F should be reported as the referring provider identifier.

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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
Referring	REFERRING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-P Professional Claim	NM109	Referring Provider Identifier	2310A or 2420F	N/AThe identifier in the 837p loop 2310A could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420F at the line level of the 837p. If there is a different identifier in 837p loop 2420F then the identifier from 2420F should be reported as the referring provider identifier.
Referring	REFERRING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	The identifier in the 837p loop 2310A could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420F at the line level of the 837p. If there is a different identifier in 837p loop 2420F then the identifier from 2420F should be reported as the referring provider identifier.
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.

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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
~~Under-Direction-of~~	~~UNDER-DIRECTION-OF-PROV-NPI~~	~~CLAIM-HEADER-RECORD-OT-COT00002~~	~~N/A~~	~~N/A~~	~~N/A~~	~~N/A~~	~~The identifier in the 837p loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420D at the line level of the 837p. If there is a different identifier in loop 2420D then the identifier from loop 2420D should be reported as the under-supervision-of provider identifier.~~

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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
Under-Direction-of	UNDER-DIRECTION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	The identifier in the 837p loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420D at the line level of the 837p. If there is a different identifier in loop 2420D then the identifier from loop 2420D should be reported as the under-supervision-of provider identifier.
Under-Supervision-of	UNDER-SUPERVISION-OF-PROV-NPI	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-P Professional Claim	NM109	Supervising Provider Identifier	2310D or 2420D	The identifier in the 837p loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420D at the line level of the 837p. If there is a different identifier in loop 2420D then the identifier from loop 2420D should be reported as the under-supervision-of provider identifier.
Under-Supervision-of	UNDER-SUPERVISION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	The identifier in the 837p loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420D at the line level of the 837p. If there is a different identifier in loop 2420D then the identifier from loop 2420D should be reported as the under-supervision-of provider identifier.

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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/AThe identifier in 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420A at the line level of the 837d. If there is a different identifier in 837d) loop 2420A then the identifier from 2420A should be reported as the servicing/rendering provider identifier.
Billing	BILLING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-D Dental Claim	PRV03	Provider Taxonomy Code	2000A	N/AThe identifier in 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420A at the line level of the 837d. If there is a different identifier in 837d) loop 2420A then the identifier from 2420A should be reported as the servicing/rendering provider identifier.
Referring	REFERRING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-D Dental Claim	NM109	Referring Provider Identifier	2310A	N/AThe identifier in 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420A at the line level of the 837d. If there is a different identifier in 837d) loop 2420A then the identifier from 2420A should be reported as the servicing/rendering provider identifier.
Referring	REFERRING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	N/AThe 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.

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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
Servicing (Rendering)	SERVICING-PROV-NPI-NUM	CLAIM-LINE-RECORD-OT-COT00003	5010 A1 837-D Dental Claim	NM109	Rendering Provider Identifier	2310B or 2420A	The identifier in 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420A at the line level of the 837d. If there is a different identifier in 837d) loop 2420A then the identifier from 2420A should be reported as the servicing/rendering provider identifier.
Servicing (Rendering)	SERVICING-PROV-TAXONOMY	CLAIM-LINE-RECORD-OT-COT00003	5010 A1 837-D Dental Claim	PRV03	Provider Taxonomy Code	2310B or 2420A	The taxonomy in the 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different taxonomy in 2420A at the line level of the 837p. If there is a different taxonomy in 837p loop 2420A then the taxonomy from 2420A should be reported as the servicing/rendering provider taxonomy.
~~Under-Direction-of~~	~~UNDER-DIRECTION-OF-PROV-NPI~~	~~CLAIM-HEADER-RECORD-OT-COT00002~~	~~N/A~~	~~N/A~~	~~N/A~~	~~N/A~~	~~The taxonomy in the 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different taxonomy in 2420A at the line level of the 837p. If there is a different taxonomy in 837p loop 2420A then the taxonomy from 2420A should be reported as the servicing/rendering provider taxonomy.~~
~~Under-Direction-of~~	~~UNDER-DIRECTION-OF-PROV-TAXONOMY~~	~~CLAIM-HEADER-RECORD-OT-COT00002~~	~~N/A~~	~~N/A~~	~~N/A~~	~~N/A~~	~~The taxonomy in the 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different taxonomy in 2420A at the line level of the 837p. If there is a different taxonomy in 837p loop 2420A then the taxonomy from 2420A should be reported as the servicing/rendering provider taxonomy.~~

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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
Under-Supervision-of	UNDER-SUPERVISION-OF-PROV-NPI	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-D Dental Claim	NM109	Supervising Provider Identifier	2310E or 2420C	The identifier in the 837d loop 2310E could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420C at the line level of the 837d. If there is a different identifier in loop 2420C then the identifier from loop 2420C should be reported as the under-supervision-of provider identifier.
Under-Supervision-of	UNDER-SUPERVISION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	The identifier in the 837d loop 2310E could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420C at the line level of the 837d. If there is a different identifier in loop 2420C then the identifier from loop 2420C should be reported as the under-supervision-of provider identifier.

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

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

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

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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

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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

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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

Appendix Q

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