Assigning TAF Records to a Federally Assigned Service Category (FASC)

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Summary

The federally assigned service category (FASC) variable provides users with an alternative method to identify and select records across states' T-MSIS Analytic Files.

All header-level records in the IP, LT, OT, and RX files have been assigned to 21 distinct service categories. The first four categories are for non-claims-based financial transactions, including capitation payments to managed care plans and other non-claims-based payments to hospitals and other providers. The remaining 17 categories include specific services that states tend to report inconsistently (e.g., stays in intermediate care facilities), services with distinct providers (e.g., dental services), and categories that are frequently excluded from certain types of analyses (e.g., transportation and laboratory services are frequently excluded from analyses that use diagnosis codes).

This variable was not designed for benchmarking to external data sources such as the CMS-64.

Background

Although the inpatient (IP), long-term care (LT), other services (OT), and pharmacy (RX) files in T-MSIS as referred to as "national Medicaid claims files," the files contain a much wider variety of record types. T-MSIS files and the corresponding research files, T-MSIS Analytic Files (TAF), also contain the following non-claims-based record types: Medicaid managed care capitation payments, Medicare and private plan premiums, Disproportionate Share Hospital (DSH) payments, drug rebates, and supplemental wrap-around payments for clinic services. Given the wide range of records in TAF, identifying and selecting the correct TAF records is essential for users to accurately produce reliable and replicable results. States add selected classification variables to their T-MSIS submissions that could be used to identify relevant records, such as file type, claim type, and state assigned type of service. However, states are known to use different methods and criteria for assigning those data elements, especially the state assigned type of service. Using these state-added data elements to select TAF records may result in users pulling a slightly different, non-comparable set of records from each state for their analysis.

The federally assigned service category (FASC) variable provides TAF users with an alternative method to identify and select records across states' TAF files. All header records in

the IP, LT, OT, and RX claims files were assigned a federally assigned service category using the consistent and well-documented methodology presented in this brief. The federally assigned service category includes 21 distinct types of records and services (Table 1). This data element is assigned to header records using a method that relies, to the largest extent possible, on data elements that providers code directly on the claims, rather than information that the states add to the records before submitting to T-MSIS. This approach maximizes the consistency in the classification of service use records across states.

The first set of categories are for non-claims-based financial transactions. The second set of categories are split between claims submitted on institutional and non-institutional claim forms. Each of those two groups are then split into specific service categories that include services that states tend to report inconsistently (e.g., stays in intermediate care facilities), services with distinct providers (e.g., dental services), and categories that are frequently excluded from analyses (e.g., transportation and laboratory services are frequently excluded from analyses that use diagnosis codes). The last category is for prescription drugs. The federally assigned service category variable was not designed for specific analyses or benchmarking to external data sources such as the CMS-64.

Table 1. Federally assigned service category (FASC) values

Claim type group	Federally assigned service category (FASC)
Non-claim financial transactions	• Managed care capitation payments • Other per member per month (PMPM) payments • Disproportionate share hospital (DSH) claims • Other financial transaction
Service use (submitted on an institutional claim form)	• Inpatient hospital • Nursing facility • Intermediate care stay • All other overnight facility claims • Hospice • Outpatient facility • Clinic • All other outpatient institutional claims
Service use (submitted on a non-institutional claim form)	• Radiology • Laboratory • Home health • Transportation services • Dental • Home and community-based services (HCBS) not otherwise specified • Durable medical equipment and supplies (DMES) • Physician and all other professional claims
Service use (prescription drug)	• Prescription drug

Note: The first digit of the federally assigned service category documents the claim type group (1 = non-claim financial transaction, 2 = service use, institutional, 3 = service use, non-institutional, 4 = service use, RX). See Appendix A for the full list of valid values.

Managed care capitation payments include comprehensive managed care (CMC) and prepaid health plan (PHP). Other PMPM payments include pulmonary and critical care medicine (PCCM), premium assistance payments, and other monthly beneficiary payments. More details about the methodology for non-claim financial transactions is available in the topic "Expenditure Benchmarking" in the DQ Atlas at www.medicaid.gov/dq-atlas.

Methodology

All header-level records in the IP, LT, OT, and RX files have been assigned to 21 distinct service categories. Appendix A lists each service category, claim type group, valid value, and definition. At a high level, the algorithm for assigning records to a single service category performs the following steps in order:

1. **Identify and classify non-claim financial transactions.** The TAF should include all state expenditures to provide or cover care for Medicaid beneficiaries. Some types of records, such as capitation payments and service tracking claims, do not represent individual services provided to specific people but rather represent financial transactions initiated by Medicaid or the Children's Health Insurance Program (CHIP) without a claim being submitted by a provider. We refer to these records as non-claim financial transactions.

   Most non-claim financial records are identified using the claim type code. Capitation payments and service tracking claims are always considered non-claim financial transactions, unless other unexpected information on the record (such as beneficiary identifier, diagnosis code, and procedure code on service tracking claims) suggest the state made an error in assigning the claim type code. A third claim type code, supplemental payment records, are sometimes classified as non-claim financial transactions or service use records. Supplemental payment records should represent payments for a specific service made in addition to a capitation payment or negotiated rate. However, states vary in their use of this claim type code. Some states use it to report financial transactions and other states use it to report claims that include service use information.

2. **Identify service use records submitted on institutional versus non-institutional claim type forms.** The type of claim form used to submit a claim—institutional or non-institutional—provides valuable insights on which data elements should be reliably filled out on a claim. For example, institutional claims have some data elements not available on other forms, including type of bill and revenue code. We used the pattern of populated and missing data elements on records in the IP, LT, and OT files to classify every service use record as submitted on an institutional or non-institutional claim form (Table 2).

Table 2. Criteria for classifying service use records as institutional versus non-institutional

Claim type	Claim form(s)	Identification criteria
Institutional	Institutional: UB-04 or 837I format	A claim must meet at least one of the following criteria: • At least one line with a valid revenue code • A valid type of bill code and a missing or invalid place of service code

Claim type	Claim form(s)	Identification criteria
Non-institutional	Professional: CMS-1500 or 837P Dental: ADA dental claim form or 837D Non-standard forms for non-medical services (e.g., personal care or home health)	A claim must meet at least one of the following criteria: • Valid place of service code on the header record and a missing or invalid revenue code on all line records • Missing or invalid place of service code on the header record, a missing or invalid type of bill code on the header record, and missing or invalid revenue code plus a valid procedure code on all line records

3. **Map service use records to service categories using header- and line-level information.** Within the institutional and non-institutional claim type groups, we used the following approaches to identify specific services:

   Institutional claims. The most consistent way to classify claims submitted on institutional claim forms by facility type is by type of bill and revenue code. When these data elements—especially revenue code—were not specific enough to differentiate between facility type, we used provider information drawn from the National Plan and Provider Enumeration System (NPPES) to classify the claim into a service category. NPPES is a national system designed to assign unique identifiers to health care providers and health plans that apply for the National Provider Identifier (NPI). When providers register for an NPI, they select a primary taxonomy. The list of provider taxonomies is very detailed and comprehensive, with less inter-state variation in provider classification compared with the information states report in the T-MSIS provider file.

   Non-institutional medical claims. Claims submitted on non-institutional forms should have a procedure code reported on all claim lines. This data element, which contains either a Healthcare Common Procedural Coding System (HCPCS)[1] code or a Current Procedural Terminology (CPT) code, is specific and highly reliable because it forms the basis for payment for most non-institutional claims. Because there are thousands of valid procedure code values that are updated every year, we rely on the Agency for Healthcare Research and Quality's Clinical Classification Software (CCS) to classify non-institutional claims into service categories. We grouped these claims into broad categories and defined some specific service categories that analytic users frequently exclude from analyses that require reliable diagnosis code information, including transportation, laboratory, radiology, and durable medical equipment and supplies (DMES).

   Non-institutional claims submitted on dental forms. The American Dental Association (ADA) maintains its own procedure code set, called the Current Dental Terminology. The

[1] Healthcare Common Procedure Coding System (HCPCS) is a national, standardized code system for medical provider use to report the services provided on claims to Medicare and other health insurance. HCPCS Level I consists of the CPT code set and is used to submit medical claims to payers for procedures and services performed by physicians, nonphysician practitioners, hospitals, laboratories, and outpatient facilities. HCPCS Level II is the national procedure code set for healthcare practitioners, providers, and medical equipment suppliers when filing health plan claims for medical devices, supplies, medications, transportation services, and other items and services.

most reliable method for capturing dental claims is to align with this code set, which generally has procedure codes starting with the letter "D."

Special non-institutional claims. Home health and other home and community-based services (HCBS; including personal care) are important services in Medicaid because of its role in providing coverage to beneficiaries who have disabilities and low income. However, states vary in how providers are instructed to bill for these services, resulting in uneven identification when using procedure code alone. We tested alternative specifications for identifying these services in the 2019 TAF data and found the most reliable method is to examine procedure codes, revenue codes, and type of bill, supplemented by state assigned classification variables for certain HCBS services.

4. **Assign each header claim to a federally assigned service category.** As a final step, each header record is assigned to one federally assigned service category. When service use records meet the criteria for more than one category (e.g., a claim for laboratory services provided and billed by an outpatient hospital), we impose an assignment hierarchy (detailed in Appendix A). The assignment of this variable at the header level allows users to identify comparable records more easily and consistently across states for inclusion or exclusion in their analyses.

Examples of how to use the federally assigned service category (FASC) variable

Table 3 provides several examples of how to use the federally assigned service category variable to identify and select records for an analysis.

Table 3. Examples of how to use the federally assigned service category (FASC) variable

Research aim	FASC methodology step	Approach justification
1. Determine total amount that state Medicaid and CHIP agencies spent on managed care payments	Select all records the FASC variable identifies as a managed care capitation payment (FASC = 14, Managed care capitation payments)	The FASC variable offers users a more accurate and consistent identification method for managed care payments, compared to other methods such as claim type code. States vary in how they code the claim type code. Some states submit Medicaid managed care capitation payments with the claim type code of service tracking claims instead of capitation payments. On the other hand, the FASC variable applies a consistent identification methodology across states.
2. Identify the number of dental providers who served Medicaid and CHIP beneficiaries through the fee-for-service (FFS) system	Select all records the FASC variable identifies as a dental service (FASC = 35, Dental) and then further filter to those records with a claim type code of 1 or A (FFS claims)	The FASC variable allows user to easily identify and select the subset of dental claims based on the ADA's procedure code set. After selecting the correct set of records, the user can filter using additional variables such as claim type code to identify just FFS or just managed care encounter records. The number of unique provider identifiers on these filtered records would identify the number of dental providers in the FFS system.

Research aim	FASC methodology step	Approach justification
3. Count the number of beneficiaries who received services for bipolar disorder during the calendar year	Exclude non-claim financial transactions (FASC = 11-14) and service use categories that have unreliable diagnosis information, including laboratory, radiology, and transportation services (FASC = 31-32, 34).	The FASC variable can help users exclude non-relevant claims from their query, even if there is not a specific category tailored to that research aim. In this case, the exclusion of non-claim financial transactions and service use categories that have unreliable diagnosis information (laboratory, radiology, transportation) will reduce the analysis file size and make it easier to examine and interpret results for the remaining claims. After excluding non-relevant records, the user will need to examine additional variables to identify the number of beneficiaries who received services for bipolar disorder during the calendar year, including diagnosis code information.

Appendix A: Definition for federally assigned service category (FASC) value

Table A.1 lists the federally assigned service categories, claim type group, valid value, and definition for each category. All code value sets are listed in Appendix B.

Table A.1 Definition for federally assigned service category value

FASC (hierarchy ranking)	Claim type group[a] (first digit)	Valid value	TAF file(s)	Category definition
1. Managed care capitation payments (CMC, PHP)	Non-claim financial transaction (1)	11	OT, IP, LT, RX	Managed care capitation payments for CMC capitation payments and PHP capitation payments include OT records that meet all of the following criteria: • A claim type code on the header indicating that the record was a capitation payment, service tracking claim, or supplemental payments (CLM_TYPE_CD=2, B, V, 4, D, X, 5, E, Y), and • At least one line with a TOS code for capitated payment to health maintenance organizations (HMOs), health insurance organization (HIOs), or Program of All-inclusive Care for the Elderly (PACE) plans (TOS_CD=119) or capitated payment to prepaid health plans (TOS_CD=122), and • None of the lines have a type of service (TOS) code indicating DSH payment, drug rebate, or electronic health record (EHR) payment (SRVC_TRKNG_TYPE_CD=1, or TOS_CD=123, 131, 135).
2. Other PMPM payments (PCCM, premium assistance payments, other monthly beneficiary payments)	Non-claim financial transaction (1)	12	OT	PMPM payments for PCCM flat fees and premium assistance payments to private plans include OT records that meet all of the following criteria: • A claim type code on the header indicating that the record was a capitation payment, service tracking claims, or supplemental payments (CLM_TYPE_CD=2, B, V, 4, D, X, 5, E, Y), and at least one line with a TOS code for primary care case management (TOS_CD=120), premium payment for private insurance (TOS_CD=121), PMPM payments for home health services, Medicare premiums, or other PMPM payments (TOS_CD=138-144). • None of the lines have a TOS code indicating DSH payment, drug rebate, or EHR payment (SRVC_TRKNG_TYPE_CD=1, or TOS_CD=123, 131, 135).
3. DSH claims	Non-claim financial transaction (1)	13	IP, LT, OT	DSH claims include IP, LT, or OT records that meet any of the following criteria: • Service tracking and supplemental claims (CLM_TYPE_CD=4, D, X, 5, Y, or E) with a service tracking type code that indicates a DSH payment (SRVC_TRKNG_TYPE_CD=2) • Service tracking or supplemental claims (CLM_TYPE_CD=4, D, X, 5, Y, E) with a TOS code that indicates a DSH payment (TOS_CD=123 on any associated line record) • Medicaid service tracking or supplemental claims (CLM_TYPE_CD=4, X, 5, or Y) with a CMS-64 form category of service that indicates an inpatient hospital DSH or mental health facility DSH (XIX_SRVC_CTGRY_CD=001B or 002B on any associated line record) • IP FFS claims (CLM_TYPE_CD=1) and DSH payments are non-zero and non-null (MDCD_DSH_PD_AMT non-zero and non-null) and with a CMS-64 form category of service that indicates an inpatient hospital DSH or mental health facility DSH (XIX_SRVC_CTGRY_CD=001B or 002B on any associated line record)

Table A.1 (*continued*)

FASC (hierarchy ranking)	Claim type group[a] (first digit)	Valid value	TAF file(s)	Category definition
4. Other financial transactions	Non-claim financial transaction (1)	14	IP, LT, OT, RX	Other financial transactions include remaining lump sum payments reported as service tracking claims, supplemental payments that are financial transactions, and claims that were missing a claim type but had suggestive evidence that they were a financial transaction based on the state assigned TOS code. It includes records that meet any of the following criteria: • All service tracking claims (CLM_TYPE_CD=4, D, X) that do not meet the criteria for managed care capitation payments, other PMPM payments, or DSH claims • All supplemental payments (CLM_TYPE_CD= 5, E, Y) that do not meet the criteria for managed care capitation payments, other PMPM payments, or DSH claims and also meet any of the following criteria: – OT, IP, LT, and RX records where the beneficiary state assigned identification numbers (MSIS_IDENT_NUM) are null, missing, or start with "&," or is 8-filled, 9-filled, or 0-filled – IP and LT records where bill type (BILL_TYPE_CD) and diagnosis code (DGNS_1_CD) are null – OT records where the revenue code (REV_CD), procedure code (PRCDR_CD), and HCPCS rate (HCPCS_RATE) are null values on all lines – RX records where the National Drug Code (NDC_CD) is null on all lines • Records with a null claim type code and at least one line where the TOS code indicates capitated payments to HMOs, HIOs, or PACE plans (TOS_CD=119), capitated payments for primary care case management (TOS_CD=120), premium payments for private health insurance (TOS_CD=121), or capitated payments to prepaid health plans (TOS_CD = 122)
5. Inpatient hospital	Service use, institutional (2)	21	IP, LT	Inpatient hospital acute-care stays include records in the IP or LT file that meet any of the following criteria: • A bill type code for a hospital facility with an inpatient bill classification (BILL_TYPE_CD = 011x or 012x, where "x" is any digit) • A bill type code for a religious nonmedical hospital with an inpatient bill classification (BILL_TYPE_CD = 041x or 042x, where "x" is any digit) • The billing provider NPI (BLG_PRVDR_NPI_NUM) that is associated with an NPPES taxonomy value for the provider is for a (1) general acute-care hospital, (2) military hospital, (3) religious nonmedical health care institution, or (4) special hospital (inpatient hospital code set) *Note: The Social Security Act permits certain small, rural hospitals to enter into a swing bed agreement to use its beds, as needed, to provide either acute or skilled nursing facility care. We included swing beds in the nursing facility category (valid value = 22) because it aligns with Medicare claims classification.*

Table A.1 (*continued*)

FASC (hierarchy ranking)	Claim type group[a] (first digit)	Valid value	TAF file(s)	Category definition
6. Nursing facility	Service use, institutional (2)	22	LT, IP	Nursing facility claims include claims that meet any of the following criteria: • Records in the IP or LT file with a bill type code for a skilled nursing faculty (BILL_TYPE_CD = 021x-029x, where "x" is any digit) • Records in the IP or LT file with a bill type code for swing bed stays in an acute-care hospital (BILL_TYPE_CD = 018x, where "x" is any digit). • Records in the LT file with a billing provider NPI (BLG_PRVDR_NPI_NUM) that is associated with the NPPES taxonomy value for a skilled nursing facility, nursing facility – intermediate care facility, Medicare-defined swing bed unit, or Alzheimer's center (nursing facility code set) *Note: The Social Security Act permits certain small, rural hospitals to enter into a swing bed agreement to use its beds, as needed, to provide either acute or skilled nursing facility care. We included swing beds in the nursing facility category because it aligns with Medicare claims classification.*
7. Intermediate care	Service use, institutional (2)	23	IP, LT	Intermediate care claims include records that meet any of the following criteria: • Records in the IP or LT file with a bill type code for an intermediate care facility (BILL_TYPE_CD = 065x or 066x, where "x" is any digit) • Records in the LT file with a billing provider NPI (BLG_PRVDR_NPI_NUM) that is associated with the NPPES taxonomy value for intermediate care facility--intellectually disabled or intermediate care facility--mental illness (NPPES provider taxonomy = 315P00000X or 310500000X)

Table A.1 (*continued*)

FASC (hierarchy ranking)	Claim type group[a] (first digit)	Valid value	TAF file(s)	Category definition
8. All other overnight facilities	Service use, institutional (2)	24	LT, IP	All other overnight and residential facility claims include respite care facilities, residential facilities, residential treatment facilities, and other types of specialty hospitals, such as psychiatric hospitals and rehabilitation hospitals. This includes records that meet any of the following criteria: • LT or IP records with a bill type code for a residential facility (BILL_TYPE_CD = 086x, where "x" is any digit) • LT records with a billing provider NPI (BLG_PRVDR_NPI_NUM) that is associated with any of the following NPPES taxonomy values (all other overnight facilities code set): – Residential treatment facilities (including for those with intellectual/developmental disabilities, mental illness, emotionally disturbed children, or physical disabilities) – Psychiatric residential treatment facilities – Substance abuse rehab facilities – Chronic disease hospitals – Long-term care hospitals – Psychiatric hospitals (or psychiatric units in hospitals) – Rehabilitation hospitals (or rehab units in hospitals) – Assisted living facilities – Custodial care facilities (including adult care homes)
9. Hospice	Service use, institutional (2)	25	OT, IP, LT	Hospice claims include records in the IP, LT, or OT files that meet any of the following criteria: • A bill type code for hospice (BILL_TYPE_CD = 081x or 082x, where "x" is any digit) • A revenue code on any line that indicates hospice (REV_CD values of 0115, 0125, 0135, 0145, or 0650-0659)
10. Radiology	Service use, non-institutional (3)	31	OT	Radiology services includes claims solely for radiology services, such as computed tomography (CT) scans, routine chest x-rays, mammography, or magnetic resonance imaging (MRI). OT records are classified in this category if either of the following criteria are met • All lines associated with the header record contain a procedure code (PRCDR_CD or HCPCS_RATE) in the CCS range for radiology (radiology code set), or • At least one line associated with the header record contains a procedure code (PRCDR_CD or HCPCS_RATE) in the CCS range for radiology (radiology code set) and all other lines contain a null value in the procedure code fields

Table A.1 (*continued*)

FASC (hierarchy ranking)	Claim type group[a] (first digit)	Valid value	TAF file(s)	Category definition
11. Laboratory	Service use, non-institutional (3)	32	OT	Laboratory services include claims solely for laboratory services, such as arterial blood gases, microscopic examination, laboratory (chemistry and hematology), and pathology. OT records are classified in this category if either of the following criteria: • All lines associated with the header record contain a procedure code (PRCDR_CD or HCPCS_RATE) in the CCS range for laboratory (laboratory code set), or • At least one line associated with the header record contains a procedure code (PRCDR_CD or HCPCS_RATE) in the CCS range for laboratory (laboratory code set) and all other lines contain a null value in the procedure code fields
12. Home health	Service use, non-institutional (3)	33	OT, LT, IP	Records in the IP, LT, or OT file were classified as home health if they meet any of the following criteria: • A bill type code for home health (BILL_TYPE_CD = 032x, 033x, or 034x, where "x" is any digit) • All lines have a revenue code for home health (REV_CD = 0023, 056x-059X) • All lines have a procedure code (PRCDR_CD or HCPCS_RATE) that indicates a home health service (home health_proc code set) *Note: Mixed claims that bundle home health and non-home health services would not be classified in this category. Those claims are most likely to be classified as "HCBS not otherwise specified."*
13. Transportation services	Service use, non-institutional (3)	34	OT	Records in the OT file where any line has procedure code (PRCDR_CD or HCPCS_RATE) in the CCS range for transportation (CCS category value = 239).
14. Dental	Service use, non-institutional (3)	35	OT	The ADA maintains its own procedure code set, called the Current Dental Terminology, all of which start with the letter "D." This category includes OT records with any line that has a procedure code (PROC_CD or HCPCS_RATE) that is 5 characters long and starts with the letter "D."
15. Outpatient facility	Service use, institutional (2)	26	OT, LT, IP	Outpatient facilities includes records in the OT, IP, or LT file that meet either of the following criteria: • A bill type code for outpatient hospital (BILL_TYPE_CD = 013x or 014x, where "x" is any digit), or • A bill type code for an ambulatory surgery center, freestanding birthing center, critical access hospital, or other special facility (BILL_TYPE_CD = 083x, 084x, 085x, or 089x, where "x" is any digit).
16. Clinic	Service use, institutional (2)	27	OT, IP, LT	Clinic services includes records in the OT, IP, or LT files that meet either of the following criteria: • A bill type code for a clinic (BILL_TYPE_CD = 071x-079x, where "x" is any digit), or • A revenue code on any line that indicates clinic services (REV_CD = 0510 through 0529).

Table A.1 (*continued*)

FASC (hierarchy ranking)	Claim type group[a] (first digit)	Valid value	TAF file(s)	Category definition
17. HCBS not otherwise specified	Service use, non-institutional (3)	36	OT	HCBS not otherwise specified includes home-based waiver services, personal care, respite care, adult daycare, homemaker services, chore services, and home-delivered meals. Because of the assignment hierarchy, this category may also include claims where some of the line-level services are home health. Records in the OT file are included in this category if they meet any of the following criteria: • Any line has a revenue code for respite care (066x) or adult daycare (310x) • Any line has a HCBS procedure code (HCBS procedure code set) • Any line has a procedure code for waiver services (T2025) and a place of service of home (SRVC_PLC_CD=12) • Any line has a benefit type code for personal care services (BNFT_TYPE_CD=045) • Any line has a HCBS taxonomy code (HCBS_TXNMY) equal to one of the values in the code set (code set HCBS taxonomy code set) *Note: States often use state-specific procedure codes for HCBS because these services are covered by Medicaid but rarely covered by private insurance or Medicare. No external mapping of state-specific codes exists. Instead of relying on procedure codes alone, this category also uses data elements representing state assigned classifications.*
18. Prescription drug	Service use, RX (4)	41	RX	All prescription drugs or DMES billed using the National Council for Prescription Drug Programs (NCPDP) claim format (used by pharmacies) should be reported in the RX file. Physician- or hospital-administered drugs billed on a medical claim form are generally captured in the OT file, and are not captured in this category. This category includes records in the RX file that meet any of the following criteria: • Any lines that have a validly formatted National Drug Code (that is 10 or 11 characters long and all the characters are digits) • All lines associated with the header have missing or invalidly formatted National Drug Code, and none of the lines have a TOS code for medical equipment/prosthetic devices (TOS_CD = 036) or home health services-medical supplies, equipment, and appliances suitable for use in the home (TOS_CD = 018) • Header records in the RX file with no associated lines *Note: This category does not include any RX records that appear to be DMES based on state assigned TOS code. It also does not include drugs administered and billed by medical providers because these records are often for vaccines, drugs administered as part of dialysis, or drugs administered in an emergency department setting (such as saline solution) that most users would not want to group with other prescription drug fills for analytic purposes.*

Table A.1 (*continued*)

FASC (hierarchy ranking)	Claim type group[a] (first digit)	Valid value	TAF file(s)	Category definition
19. Durable medical equipment and supplies	Service use, non-institutional (3)	37	OT, RX	This category includes claims for visual aids and other optical supplies, hearing devices and audiology supplies, and other DMES. Records were classified in this category if they met either of the following criteria: • Records in the OT file with a procedure code (PRCDR_CD or HCPCS_RATE) in the CCS range for visual aids and other optical supplies, hearing devices and audiology supplies, or DMES (CCS category values = 241-243) • Records in the RX file that meet all of the following criteria: – At least one line that has state assigned TOS code for medical equipment/prosthetic devices (TOS_CD=036) or home health services – medical supplies, equipment, and appliances suitable for use in the home (TOS_CD=018) – All lines have missing or invalidly formatted National Drug Code
20. All other outpatient facility/ institutional claims	Service use, institutional (2)	28	OT	This category includes all claims/encounters that were classified as being submitted on an institutional claim form but do not meet the criteria for any of the categories above.
21. Physician and all other professional claims	Service use, non-institutional (3)	38	OT	This category includes all claims/encounters that were classified as being submitted on a non-institutional claim form but do not meet the criteria for any of the categories above. This category includes physician services across all settings of care, as well as professional claims from non-physician professionals such as physical therapists, occupational therapists, psychologists, nurse midwives, and other mid-level providers. *Note: Although the range of services and providers is broad, these claims should all be related to medical care and, as a result, should have reliable diagnosis code information.*

[a] The first digit of the federally assigned service category documents the claim type group (1 = non-claim financial transaction, 2 = service use, institutional, 3 = service use, non-institutional, 4 = service use, RX).

Appendix B: Code sets

Code set name	Code set values
Inpatient hospital	NPPES provider taxonomy: 282N00000X General Acute Care Hospital; 282NC2000X General Acute Care Hospital – Children; 282NC0060X General Acute Care Hospital - Critical Access; 282NR1301X General Acute Care Hospital – Rural; 282NW0100X General Acute Care Hospital – Women; 286500000X Military Hospital; 2865M2000X Military Hospital - General Acute Care; 2865X1600X Military Hospital - General Acute Care, Transportable; 282J00000X Religious Nonmedical Health Care Institution; 284300000X Special Hospital; 273100000X Epilepsy unit
Nursing facility	NPPES provider taxonomy: 311500000X Alzheimer Center (Dementia Center); 313M00000X Nursing Facility/Intermediate Care Facility; 314000000X Skilled Nursing Facility; 3140N1450X Skilled Nursing Facility – Pediatric; 275N00000X Medicare Defined Swing Bed Unit
All other overnight facilities	NPPES provider taxonomy: 385H00000X Respite Care; 385HR2050X Respite Care – Camp; 385HR2055X Respite Care - Mental Illness, Child; 385HR2060X Respite Care - Child Intellectual and/or Developmental Disabilities Respite Care; 385HR2065X Respite Care - Child Physical Disabilities; 320900000X Community Based Residential Treatment Facility, Intellectual and/or Developmental Disabilities; 320800000X Community Based Residential Treatment Facility, Mental Illness; 323P00000X Psychiatric Residential Treatment Facility; 322D00000X Residential Treatment Facility, Emotionally Disturbed Children; 320600000X Residential Treatment Facility, Intellectual and/or Developmental Disabilities; 320700000X Residential Treatment Facility, Physical Disabilities; 324500000X Substance Abuse Rehabilitation Facility; 3245S0500X Substance Abuse Rehabilitation Facility – Children; 281P00000X Chronic Disease Hospital; 281PC2000X Chronic Disease Hospital – Children; 282E00000X Long Term Care Hospital; 283Q00000X Psychiatric Hospital; 283X00000X Rehabilitation Hospital; 283XC2000X Rehabilitation Hospital – Children; 273R00000X Psychiatric Unit; 273Y00000X Rehabilitation Unit; 276400000X Rehabilitation, Substance Use Disorder Unit; 310400000X Assisted Living Facility; 3104A0625X Assisted Living Facility - mental illness; 3104A0630X Assisted Living Facility - behavioral disturbances; 311Z00000X Custodial Care Facility; 311ZA0620X Custodial Care Facility - Adult Care Home
Home health procedure codes	CPT codes: 99503; 99504; 99505; 99506; 99507; 99509; 99511; 99512; 99600; 99601; 99602; G0068; G0069; G0070; G0088; G0089; G0090; G0151; G0152; G0153; G0154; G0155; G0156; G0157; G0158; G0159; G0160; G0161; G0162; G0163; G0164; G0299; G0300; G0490; G0493; G0494; G0495; G0496; S5108; S5109; S5110; S5111; S5115; S5116; S5180; S5181; S5522; S5523; S9097; S9098; S9122; S9123; S9124; S9127; S9128; S9129; S9131; S9474; T1000; T1001; T1002; T1003; T1004; T1021; T1022; T1030; T1031; T1502; T1503
HCBS procedure codes	CPT codes: T1019; T1020; S5125; S5126; T0005; T1028; S5100; S5101; S5102; S5105; S5120; S5121; S5130; S5131; S5135; S5136; S5150; S5151; S5170
HCBS taxonomy	HCBS taxonomy codes: 04050 Adult Day Health; 04060 Adult Day Services (Social Model); 06010 Home Delivered Meals; 07010 Rent and Food Expenses for Live-In Caregiver; 08030 Personal Care; 08040 Companion; 08050 Homemaker; 08060 Chore; 09012 Respite, In-Home
Radiology	CCS category values: 177-180 CT scans; 181 Myelogram; 182 Mammography; 183 Routine chest x-ray; 184 Intraoperative cholangiogram; 185-186 Gastrointestinal xray; 187 Intravenous pyelogram; 189 Contrast aortagram; 190 Contrast arteriogram of femoral and lower extremity arteries; 191 Arterio- or venogram (not heart and head); 192-197 Diagnostic ultrasound; 198 MRI; 207-210 Radioisotope scans; 226 Other diagnostic radiology and related techniques
Laboratory	CCS category values: 205 Arterial blood gases; 206 Microscopic examination; 233 Laboratory – chemistry and hematology, 234 Pathology; 235 Other laboratory

Appendix C: Revision History

Table C.1. Revisions to methodology brief

Date of revision	Description of revision
August 2024	• Updated language in Table A1 to clarify the logic for the following categories: Radiology, Laboratory, Home health, Outpatient facility

Lauren Hula[1], Allison Barrett[1], Ellen Singer[1], and Arvin Javadi[1]. "Assigning TAF Records to a Federally Assigned Service Category (FASC)." TAF DQ Brief #5241. Baltimore, MD: CMS, 2021.

Reviewers: Jessie Parker[2]; Kimberly Proctor[2]; Jeffrey Galecki[2]; Ali Fokar[2]

[1]Mathematica, [2]Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, Data and Systems Group, Division of Business and Data Analytics

Correspondence should be addressed to DataConnectSupport@cms.hhs.gov