**SDD Interface Control Document**

**Draft Version: Re-Baseline**

**ICD Describing the Data Exchange of**

**TED-I Data from DHA Decision Support Division to MDR**

Data Set: **TED-I**

Source System: **DHA Decision Support Division**

Receiving System: **MDR**

Document Number: **ICD 1300-1641-01**

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*Prepared by:*

The MDR Team for DHA Decision Support Division, part of the DHA Special Staff department, as well as the Solution Delivery Division Program Executive Office

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**Final Approval**

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| Mod 3 | Jul 28, 2006 | Delete “End Date of Care” data element. Correct signed numeric Data Type. | A-3, A-11-13, A-22, A-25-27, A-29, A-31, A-32-33 |  |
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# : Scope

This document describes the interface that provides the TRICARE Encounter Data (TED) Institutional purchased care medical records to the Military Health System (MHS) Data Repository (MDR).

## System Overview

DHA Decision Support Division personnel create the TED Institutional data extract for the MDR by querying the TRICARE Encounter Data (TED) system. The TRICARE Encounter Data (TED) and MDR systems are both managed by the Solution Delivery Division (SDD) Program Executive Office (PEO).

The TED system captures clinical, administrative, and financial data for outpatient, inpatient, ancillary and other care from the Managed Care Support Contractors (MCSCs) who manage the TRICARE purchased care programs. The TED system captures and stores the following types of information:

* Patient demographic information
* Attending provider, other providers and institution of care
* Claim information
* Care Authorization (CA) / Non Availability Statement (NAS) information
* Patient diagnosis
* Patient treatment

The MDR serves as the core repository for MHS clinical, administrative, beneficiary population, enrollment, costing and workload data. The MDR collects, catalogues and organizes data files from a multitude of systems and processes, normalizes, and publishes this information to MHS decision-makers.

## Reference Documents

* EIDS Program Office, CEIS Operational Requirements Document (ORD), Falls Church, VHA, December 1997.
* TMA, *TRICARE Systems Manual 7950.1-M*, Falls Church, VA, 1 Aug 2002.

## Operational Agreement

This ICD provides the technical specification for the data exchange between the Defense Health Agency (DHA) Decision Support Division and the Military Health System (MHS) Data Repository (MDR) for the TED Institutional (TED-I) dataset. Modifications to the ICD will be made by the SDD Program Executive Office as required, and a copy of the revised ICD will be sent to the DHA Decision Support Division.

Appendix A delineates the TED-I data elements that will be sent from DHA Decision Support to the MDR. Should problems occur with the interface, MDR Data Processing Operations personnel will immediately contact DHA Decision Support personnel.

# : Interface Specification

## Identification of Interface

This ICD addresses the following data exchange from DHA Decision Support to the MDR:

* TRICARE Encounter Data Institutional (TED-I) records.

This ICD will be changed *only* if the interface changes from the interface specified herein.

## Precedence and Criticality of Requirements

Clinical and claims data from the MCSCs that is reliable is necessary for the MHS to make knowledge-based decisions. MDR provides this information to MHS decision-makers. A minimum of monthly updates are required for effective performance of the business. An inability to obtain this data for a period of 2 months or greater could have adverse consequences to the business.

## Communications Methods

The TED-I data is extracted from the TED ODS by DHA Decision Support Division personnel on a monthly basis and made available on the SAS Computing Environment (SCE). Once available, DHA Decision Support personnel notify SDD Data Processing Operations via email of file availability. SDD Data Processing Operations personnel connect to the SCE from the MDR via SFTP to access the data and make it available in the MDR. The SFTP feature of Open SSH utilizes a FIPS 140-2 certified cryptographic module of OpenSSL.

The TED-I dataset(s) file naming convention is: net\_inst\_common\_yyyymm.txt.gz and net\_inst\_line\_yyyymm.txt.gz where ‘yyyymm’ is the four digit year and two digit month representing the data contained in the file. For example, the data received in September 2013 arrived with the following filename: net\_inst\_common\_201308.txt.gz and net\_inst\_line\_201308.txt.gz because it contains data through August 2013. For verification of file completeness, a record count of the dataset(s) is provided in the email notification from DHA Decision Support.

## Performance Requirements

The data needs to be provided to SDD on a monthly basis.

## Security and Integrity

The data exchanged in this interface does contain protected patient level identifiable information. The raw data is part of a database that contains sensitive data, and it is protected in accordance with the C2-level protection standards mandated for all "Sensitive Unclassified Systems" by the requirements of DoD Directive 5200.28. These standards help ensure compliance with the following Federal laws:

* Privacy Act of 1974
* U.S. Code, Title 10, Section 1102, Medical Quality Assurance Records
* U.S. Code, Title 10, Section 1030, Fraud and Related Activity in Connection with Computers
* Computer Security Act of 1987
* Health Insurance Portability and Accountability Act (HIPAA)

The production components of TED, MDR, and the SCE operate within the Defense Enterprise Computing Center Detachment, Oklahoma City (DECCD, Oklahoma City) environment. There is no transfer of TED-I data outside the DECCD, Oklahoma City enclave, as part of this interface. Because these systems are contained within the same enclave, access to create and transfer the files among systems adheres to the same connection and password requirements as a regular user.

Users connect to the DECCD, Oklahoma City enclave networks via a Virtual Private Network (VPN), the DISA Out-Of-Band (OOB) VPN or via the DHA VPN, which requires PKI authentication. Once connected to the enclave networks, DHA Decision Support Division personnel and SDD Data Processing Operations personnel will connect to the SDD servers and be authenticated using an AIX username and password. The AIX password for these user accounts will expire every 55 days and meet the following security requirements:

* A minimum 15 character password containing 2 uppercase letters, 2 lowercase letters, 2 numbers, and 2 special characters.

### Data Integrity and Quality

Validation checks related to such items as record counts, file formats, source stamps, and date-time stamps will be performed on the data transferred from the SCE to the MDR. When errors are discovered in the data exchange, the DHA Decision Support Division will be notified immediately by SDD Data Processing Operations personnel. If there are systemic problems, appropriate SDD and DHA Decision Support Division counterparts will be engaged to work issues.

# 

File Format

SDD receives the TRICARE Encounter Data (TED) Institutional (TED-I) dataset(s) on a monthly basis from DHA Decision Support. For SDD application purposes, this data is processed and stored in the MDR. Extracts are provided for user applications such as the MHS MART (M2) as well as to agencies outside the DHA.

Record Layout

Table A-1 describes the TED-I records. Table A-2 describes the Revenue Line Item record. A monthly dataset to MDR will consist of a number of TED-I records and Revenue Line Item records. The records are variable length and separated by a carriage return (CR) character.

All fields are variable length and delimited by the pipe ("|") character. The lengths given are the maximum field lengths. Numeric fields will contain decimal points and leading negative signs where applicable. Unless otherwise specified, blank and missing values are indicated by consecutive delimiters.

File Operational Context

Institutional TEDs are generated for claims associated with the hospital services provided during inpatient hospital admissions, as well as some home health care and home hospice services, whereas, Non-Institutional TEDs are generated for all other claims, including claims for inpatient professional services provided to inpatients.

As claims are updated through transactions between DHA and MCSCs, changes will be reflected in TEDs sent to the MDR. The updated records contain the same TED Record Indicator. Amount fields are the most common fields that change during TED updates. TEDs sent to the MDR provide a total-to-date view of financial transactions at a particular point in time for a particular encounter.

The data shown in Table A-1 are examples of data values for many of the data elements. Since TED-I record content is modified periodically to add, delete, or change data values, users of this document should refer to the TRICARE Systems Manual for the most current and definitive information about data values associated with each data element. The TRICARE Systems Manual is available for review at: http://manuals.tricare.osd.mil/DisplayManual.aspx?SeriesId=T3TSM.

**Table A-1 TED-I Data Feed Record Data Elements**

| **Field Number** | **Field Name**  **(logical name)** | **Field Length** | **Data Type** | **Data Units** | **Value Range** | **Functional Description** |
| --- | --- | --- | --- | --- | --- | --- |
|  | Header Type Indicator | 1 | A-Numeric | NA | 0, 5, 6, 9 | Code to indicate whether the record is a batch header or voucher header, and whether a voucher contains admin rate eligible records. Coded as follows:  0 Batch header (used on all provider and pricing batches, and for institutional/non- institutional financially underwritten non-admin claim rate TED records)  5 Voucher header (used only for institutional/ non- institutional non-financially underwritten non-admin claim rate eligible TED records)  6 Voucher header (used only for institutional/non- institutional non-financially underwritten admin claim rate eligible TED records)  9 Batch header (institutional/non-institutional financially underwritten admin claim rate eligible TED records) |
|  | Contract Number | 13 | A-Numeric | NA | None | The unique 13-character contract number assigned to a contract. |
|  | Batch/Voucher Identifier | 1 | A-Numeric | NA | 3, 5 | Identifies the type of records submitted in the batch/voucher. Coded as follows:  3 Provider (Batch Only)  5 Institutional/Non-Institutional (Batch/Voucher) |
|  | Batch/Voucher ASAP Account Number | 8 | A-Numeric | NA | TMA assigned | Used to identify the ASAP Account Number the voucher will be drawn from. |
|  | Batch/Voucher Date | 7 | Numeric | NA | None | Date the contractor first created the batch/voucher for transmission to TMA. This date will not change through the resubmission process. Format YYYYDDD, where YYYY = Calendar Year and DDD = Julian Date. |
|  | Batch/Voucher Sequence Number | 2 | A-Numeric | NA | None | A sequential number assigned by the contractor to identify the batch/voucher. Once assigned, the number remains with the batch/voucher through resubmission process if applicable. |
|  | Batch/Voucher Resubmission Number | 2 | A-Numeric | NA | None | Identifies the number of resubmissions for the batch/voucher. |
|  | Total Number of Records | 7 | A-Numeric | NA | None | Total number of records submitted in the batch or voucher, exclusive of the header and trailer records. |
|  | Total Amount Paid | 14 | A-Numeric | NA | None | The total benefit dollars paid by the contractor and the interest paid for the TED records contained in either the batch or the voucher. |
|  | Fund Accounting | 12 | Numeric | NA | None | Contains the total Government drug cost dollars dispensed by the contractor. |
|  | Record Type Indicator | 1 | A-Numeric | NA | 1, 2, 3 | Code to indicate the type of record. Coded as follows  1 institutional record  2 non-institutional record  3 provider record |
|  | TED Record Indicator | 24 | A-Numeric | NA | None | Concatenation of the following fields:  Filing Date (length 7) - date the claim was received by the contractor (YYYYDDD)  Filing State/Country Code (length 3) - code that indicates the state or country where the care was provided  Sequence Number (length 7) - unique code assigned by the contractor within the filing date and state/country code.  Time Stamp (length 6) - system time assigned by the claims processor (MMSSHH (minutes, seconds, hundredths))  Adjustment Key (length 1) - for adjustment to a HCSR record, contains the HCSR Suffix. For TED records, contains the indicator for the type of financial record, coded as follows:  0 Batch  5 Voucher |
|  | Date Record Processed to Completion | 8 | A-Numeric | NA | None | Date the contractor processed the claim/treatment encounter data to completion. (Yyyymmdd) |
|  | Date Adjustment Identified | 8 | A-Numeric | NA | None | Date the contractor determined an adjustment TED record was required, not applicable to provisional error correction adjustment (YYYYMMDD). |
|  | Person Identifier (Sponsor) | 9 | A-Numeric | NA | None | The identifier that represents the sponsor. This attribute will usually contain the sponsor’s SSN. |
|  | Person Identifier Type Code (Sponsor) | 1 | A-Numeric | NA | D, F, P, R, S | The code that represents a specific kind of person identifier. Coded as follows:  D Special 9-digit code created for individuals (i.e. babies) who do not have or have not provided an SSN when the record is added to DEERS  F Special 9-digit created for foreign military and nationals. Known as a Foreign Identifier Number (FIN)  I TIN  P Special 9-digit code created for U.S. military personnel before switch to SSNs  R Special 9-digit code created for a DoD contractor who refused to give his or her SSN to RAPIDS  S SSN  Z Not applicable |
|  | Pay Grade Code (Sponsor) | 2 | A-Numeric | NA | OO-ZZ, 00-11 | The code that represents the level of pay (The combination of pay plan code and pay grade code represents the sponsor’s pay category). Coded as follows:  00 Unknown  OO-ZZ Civil service  01 Cadet  01-05 Warrant Officer  01-09 Enlisted  01-11 Officer |
|  | Pay Plan Code (Sponsor) | 5 | A-Numeric | N/A | Codes are located in the TRICARE Systems Manual | The code that represents the type of pay category (The combination of pay plan code and pay grade code represents the sponsor’s pay category). Code values are defined in the TRICARE Systems Manual. |
|  | Service Branch Classification Code (Sponsor) | 1 | A-Numeric | NA | A, C, D, F, H, M, N, O, X, 1, 2, 3, 4 | The code that represents the branch classification of Service with which the sponsor is affiliated.  A Army  C Coast Guard  D Office of Secretary of Defense  F Air Force  H Commissioned Corps of the Public Health Service  M Marine Corps  N Navy  O Commissioned Corps of the National Oceanographic and Atmospheric Administration (NOAA)  X Not applicable  Z Not provided from DEERS  1 Foreign Army  2 Foreign Navy  3 Foreign Marine Corps  4 Foreign Air Force |
|  | AGR Service Legal Authority Code | 1 | A-Numeric | N/A | A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, X, Z | The code that represents the source of the legal authority for Active Guard and Reserve (AGR) service. Code values are defined in the *TRICARE Systems Manual*. |
|  | Health Care Coverage Member Category Code | 1 | A-Numeric | NA | 1, A – W, Y, Z | The member category code during Health Care Coverage period. Coded as follows:  1 Transitional compensation not eligible for retirement  A Active duty  B Presidential appointee  C DoD civil service employee  D Disabled American veteran  E DoD contract employee  F Former member  G National Guard member  H Medal of Honor recipient  I Other Government agency employee  J Academy student  K Non-Appropriated Fund DoD employee  L Lighthouse service  M Non-government agency personnel  N National Guard member  O Other Government contract employee  P Transitional Assistance Management Program (TAMP) member  Q Reserve retiree not eligible for retired pay  R Retired military eligible for retired pay  S Reserve member (mobilized or AD for 31 days or more)  T Foreign military member  U Foreign national employee  V Reserve member (not AD for 30 days)  W DoD beneficiary, person receiving DoD benefits based on  prior association, condition or authorization, e.g., a former  spouse  Y Service affiliates (including ROTC and Merchant Marines)  Z Unknown |
|  | Health Care Coverage Member Relationship Code | 1 | A-Numeric | NA | A – L, Z | The member relationship for the Health Care Coverage period. Coded as follows:  A Self  B Spouse  C Child or stepchild  D Pre-adoptive child  E Ward (court ordered)  F Dependent parent, dependent stepparent, dependent parent-in-law, or dependent step-parent-in-law  G Surviving spouse  H Former spouse (20/20/20)  I Former spouse (20/20/15)  J Former spouse (10/20/10)  K Former spouse (transitional assistance (composite))  L Foster child  Z Unknown |
|  | Person Last Name (Patient) | 35 | A-Numeric | NA | None | Last name of the patient. |
|  | Person First Name (Patient) | 25 | A-Numeric | NA | None | First name of the patient. |
|  | Person Middle Name (Patient) | 25 | A-Numeric | NA | None | Middle name of the patient. |
|  | Person Cadency Name (Patient) | 10 | A-Numeric | NA | None | The cadency name (i.e., Sr, Jr, III, etc.) of the patient. |
|  | Person Identifier (Patient) | 9 | A-Numeric | NA | None | The identifier that represents the patient. This attribute will usually contain the patient’s SSN. |
|  | Person Identifier Type Code (Patient) | 1 | A-Numeric | NA | D, F, I, P, R, S, Z | The code that represents a specific kind of person identifier. Coded as follows:  D Special 9-digit code created for individuals (i.e. babies) who do not have or have not provided an SSN when the record is added to DEERS  F Special 9-digit created for foreign military and nationals. Known as a Foreign Identifier Number (FIN)  I TIN  P Special 9-digit code created for U.S.military personnel before switch to SSNs  R Special 9-digit code created for a DoD contractor who refused to give his or her SSN to RAPIDS  S SSN  Z Not applicable |
|  | Person Birth Calendar Date (Patient) | 8 | Numeric | NA | None | The date when the patient was born. If patient is on DEERS, date is downloaded. If not on DEERS, date is reported from health care data received by contractor (YYYYMMDD). |
|  | Patient Identifier (DoD) | 10 | A-Numeric | NA | None | The identifier associated with a particular patient. It is used to represent a patient within a Department of Defense Electronic Data Interchange. It is the EDIPN. |
|  | DEERS Identifier (Patient) | 11 | A-Numeric | NA | None | A DEERS identifier created from the combination of the DEERS assigned 9-digit DEERS Family Identifier and 2-digit DEERS Beneficiary Identifier. |
|  | Person Sex (Patient) | 1 | A-Numeric | NA | F, M, Z | Code defining sex of the patient. Coded as follows:  F Female  M Male  Z Unknown |
|  | Patient ZIP Code | 5 | A-Numeric | NA | None | First five digits of the U.S. Postal Zip Code or the foreign country code for the patient’s legal residence at the time service was rendered. |
|  | Patient ZIP Code 4 | 4 | A-Numeric | NA | None | Digits 6 thru 9 of the patient ZIP code. |
|  | Enrollment/ Health Plan Code | 2 | A-Numeric | NA | AA, BB, FE, FS, PS, SN, SO, SR, ST, SU, T, TS, U, V, W, WA, WF, WO, X, XF, Y, Z | Code indicating whether the patient is enrolled with the contractor (Prime) or not (non-Prime), or the care was received under the Standard TRICARE Program, or a special care program. Coded as follows:  AA CHCBP Extra  BB TRICARE Senior Prime  FE TRICARE For Life (TFL) – Extra  FS TFL – Standard  PS TRICARE Senior Pharmacy (TSP)  SN Supplemental Health Care Program (SHCP) – Non MTF Referred  SO SHCP – Non TRICARE Eligible  SR SHCP – Referred Care  ST SHCP – Claims for TRICARE eligible  SU SHCP – Referral Designation  T TRICARE Standard Program  TS TRICARE Senior Supplement (TSS)  U TRICARE Prime, Civilian PCM  V TRICARE Extra  W TRICARE Prime Remote (TPR) - Active Duty Claims USA  WA TPR – Foreign ADSM  WF TPR for enrolled Active Duty Family Member (ADFM) residing with a TPR eligible Active Duty Service Member (ADSM)  WO TPR Foreign (ADSM & family)  X Foreign ADSM  XF Foreign ADFM  Y Continued Health Care Benefit Program (CHCBP) Standard  Z TRICARE Prime, MTF/PCM |
|  | Health Care Delivery Program Plan Coverage Code | 3 | A-Numeric | NA | Code values are found in the TRICARE Systems Manual. | The code that represents the plan coverage a family member or sponsor has within a health care delivery program type. Code values are defined in the TRICARE Systems Manual. |
|  | Region Indicator | 2 | A-Numeric | NA | Blank, NC, OC, SC, WC | The region of the Managed Care Support Contractor (MCSC) responsible for the care provided. Coded as follows:  Blank Blank  NC North contract  OC Overseas contract  SC South contract  WC West contract |
|  | PCM Location DMIS-ID | 4 | A-Numeric | NA | None | The 4-digit code that indicates the DMIS ID code of the Primary Care Manager (PCM). Identifies and distinguishes MTF/Clinic enrollments from network enrollments. |
|  | Amount Billed (Total) | 11 | Numeric | NA | None | Total amount billed for all services on the TED record. |
|  | Amount Allowed (Total) | 11 | Numeric | NA | None | Total amount allowed for all authorized services on the TED record. |
|  | Amount Paid By Other Health Insurance | 11 | Numeric | NA | None | Total amount paid by other health insurance, including TPL, for all services reported. |
|  | Other Government Program Type Code | 1 | A-Numeric | NA | A, B, C, H, I, J, L, N, V | The code that represents what type of other government program the person has. Coded as follows:  A Medicare Part A  B Medicare Part B  C Medicare Part A & B  H Medicare Part D  I Medicare Part A & D  J Medicare Part B & D  L Medicare Part A, B, & D  N No Medicare  V CHAMPVA |
|  | Other Government Program Begin Reason Code | 1 | A-Numeric | NA | A, B, D, E, F, G, N, P, R, V, W | The code that indicates the reason that the person’s period of eligibility for a non-DoD Other Government Program began. Coded as follows:  A Eligible for Medicare. Eligibility began after age 65 (person did not have enough quarters of Social Security contributions to qualify at age 65).  B Enrollment in Medicare Part B; over or under age 65.  D Eligible for Medicare under age 65 because of disability.  E Eligible for Medicare at age 65.  F Eligibility for Medicare defaulted at age 65; verification not  received from Center for Medicare and Medicaid Services  (CMS). Applies to Medicare Part A only.  G Enrollment in Medicare Part B declined by beneficiary.  N Not eligible for Medicare. At age 65 this indicates eligibility could not begin because person did not have enough quarters of Social Security contributions to qualify.  P Eligible for Medicare at or after age 65 because of purchase.  R Eligible for Medicare under age 65 because of end-stage renal disease.  V Eligible for CHAMPVA  W Not applicable |
|  | Amount Patient Cost-Share | 11 | Numeric | NA | None | The total amount of money the beneficiary is responsible for paying in connection with the covered services, other than any disallowed amounts. |
|  | Health Care Coverage Copayment Factor Code | 1 | A-Numeric | NA | A, B, C, W, Z | The code used to identify for each insured in managed care the category of copayment and deductible they must pay based on external forces for a particular health care coverage period. Actual rates depend on Health Care Delivery Program Plan Coverage Code. Coded as follows:  A Active duty E4 and below rate  B Active duty E5 and above rate  C Retiree rate  W Unknown copayment factor  Z Not applicable |
|  | Amount Paid by Government Contractor (Total) | 11 | Numeric | NA | None | The portion of total amount allowed that was paid by government contractor for all services reported on the TED record. |
|  | Amount Interest Payment | 11 | Numeric | NA | None | Used by the contractor to report/record any dollar amounts associated with the delivery of health care that could not otherwise be reported in existing TED records fields. |
|  | Reason for Interest Payment | 2 | A-Numeric | NA | A, B, C, D, E | Used to determine the fiscal responsibility for the interest payment based on the following hierarchy:  A Claims pended at government direction that the government has specifically directed the contractor to hold for an extended period  B Claims requiring government intervention  C Claims requiring development for potential third party liability  D Claims requiring an action/interface with another prime contractor  E Claims retained by the contractor that do not fall  into one of the above categories |
| 49-51. | Override Code 1  Override Code 2  Override Code 3 | 2  (3 times) | A-Numeric | NA | 11-15, A, B, C, D, E, F, G, H, I, J, K, M, N, P, Q, R, S, U, V, Y, Z, H1, H2, NC, NS | Three occurrences of two-position codes which indicate that certain questionable data has been identified and approved by the contractor and that normal editing and processing rules should be bypassed for this record. Code values are defined in the TRICARE Systems Manual. |
|  | Type of Submission | 1 | A-Numeric | NA | A, B, C, D, E, I, O, R | Code indicating the TED submission type. Coded as follows:  A Adjustment to TED record data  B Adjustment to non-TED record (HCSR) data  C Complete cancellation to TED record data  D Complete denial initial TED record submission  E Complete cancellation of non-TED (HCSR) data  I Initial TED record submission  O Zero payment TED due to 100% OHI  R Resubmission of an initial TED record that was rejected due to errors |
|  | CA/NAS Number | 15 | A-Numeric | NA | None | The unique number assigned by the MTF when issuing the Care Authorization (CA) or Non Availability Statement (NAS).  NAS requirement eliminated for dates of care on or after 28 Mar 2013. |
|  | CA/NAS Reason for Issuance | 1 | A-Numeric | NA | 1,2,3,4,5,6 | Indicates why the care was not or cannot be provided by a MTF. Coded as follows:  1 Facility not available  2 Professional capability not available  3 Medically inappropriate  4 Facility temporarily not available  5 Professional capability temporarily not available  6 Facility or professional capability permanently not available  NAS requirement eliminated for dates of care on or after 28 Mar 2013. |
|  | CA/NAS Exception Reason | 2 | A-Numeric | NA | B, C, K, L, M, Q, S, 1, 2, 3, 5, 6, 7, 9 | Code that describes the reason for bypassing the requirement of a CA/NAS. Coding:  B Former spouse w/ pre-existing condition  C Good faith payment  K CHCBP  L Hospice  M Abused family member  Q Active duty claims  S Home Health Agency (HHA)  1 Other primary insurance plan  2 Emergency medical treatment  3 Inpatient in college infirmary  5 Residential treatment center  6 Partnerships  7 Specialized Treatment Facility (STF)  9 TRICARE demonstration projects  NAS requirement eliminated for dates of care on or after 28 Mar 2013. |
| 56-59. | Special Processing Code 1  Special Processing Code 2  Special Processing Code 3  Special Processing Code 4 | 2  (4 times) | A-Numeric | NA | 0, 1, 3-7, 10-12, 14, 16, 17, 49, 50, A, E, Q, R, S, T, U, V, W, X, Y, Z, AB-AG, AN, AR, AS, AU, BA, BD, CA, CE, CL, CM, CP, CT, DC, DE, DF, EU, FF, FG, FS, GF, GU, KO, LD, L2, MH, MM, MN, MS, NE, PD, PF, PH, PO, PS, PV, RB, RI, RS, SC, SE, SM, SN, SP, SS, ST, WR | Four occurrences of two alphanumeric characters that indicate special processing is required. Codes values are defined in the TRICARE Systems Manual. |
|  | Health Care Delivery Program Special Entitlement Code | 2 | A-Numeric | NA | 00, 01, 02, 03, 04, 05, 06, 07, 30, 31 | Code used to identify for each insured in managed care any special category that they may have been given for copayment and deductible for a particular health care coverage period. Coded as follows:  00 Not applicable  01 Bosnian Special entitlement  02 Noble Eagle Special entitlement  03 Enduring Freedom  04 TA 60 Benefits After Special Operation  05 TA 120 Benefits After Special Operation  06 Kosovo Special Entitlement  07 Iraqi Freedom Participation Special Entitlement  30 TSP Exception – Grandfathered  31 TSP Exception – Direct Care over 65  Members with Medicare A & B but no TFL |
|  | Pricing Rate Code | 2 | A-Numeric | NA | Blank, D, H, I, J, K, L, P, U, V, CA, CR, DD | Code to indicate the contractor’s pricing methodology used in determining the amount allowed for the service(s) / supplies. Coded as follows:  BLANK No special rate  D Discount rate agreement  H TRICARE / CHAMPUS DRG, short stay outlier  I TRICARE DRG, cost outlier  J TRICARE DRG, no outlier  K Hospital-specific psychiatric per diem  L Region-specific psychiatric per diem  P Per diem rate agreement  U Supplemental health care program claim or active duty member TPR claim paid outside normal limits  V Medicare reimbursement rate  CA Critical Access Hospital (CAH) Reimbursement  CR Cost-to-Charge Ratio (CCR)  DD Discounted DRG |
|  | Provider State or Country Code | 3 | A-Numeric | NA | Codes are located in the TRICARE Systems Manual | Code assigned to identify the state or foreign country in which the care was received. Codes defined in TRICARE Systems Manual. |
|  | Provider Taxpayer Number | 9 | A-Numeric | NA | None | The employer identification number (EIN). |
|  | Provider Sub-Identifier | 4 | A-Numeric | NA | None | Identification number that uniquely identifies multiple providers using the same taxpayer identification number (TIN). |
|  | Provider Individual NPI Number (reserved) | 10 | A-Numeric | NA | None | Reserved for future use. |
|  | Provider Group NPI Number | 10 | A-Numeric | NA | None | Standard unique health identifier for organizational providers. Populated as of January 1, 2009. |
|  | Provider Zip Code | 5 | A-Numeric | NA | None | The first five digits of the zip code or the three-character foreign country code of the location where the care was provided. |
|  | Provider ZIP Code 4 | 4 | A-Numeric | NA | None | Digits 6 thru 9 of the provider ZIP code. |
|  | Provider Participation Indicator | 1 | A-Numeric | NA | N,Y | Indicates whether or not the provider accepted assignment of benefits for services rendered.  N no  Y yes |
|  | Provider Network Status Indicator | 1 | A-Numeric | NA | 1, 2 | Indicates whether or not the provider is a network or non-network provider.  1 Network provider  2 Non-network provider |
|  | Type of Institution | 2 | A-Numeric | NA | Codes are located in the TRICARE Systems Manual | A code describing the type of institution for institutional providers. Codes defined in TRICARE Systems Manual. |
|  | Claim Form Type/EMC Indicator | 1 | A-Numeric | NA | B,C, F, G, H,I,J | The code associated with the primary claim form submitted.  B DD form 2642  C HCFA form 1500  F UB-92  G electronic institutional claim submission  H electronic non-institutional claim submission  I electronic drug claim submission  J other |
|  | Frequency Code | 1 | A-Numeric | NA | 1, 2, 3, 4, 7, 8, 9 | A code that describes the frequency of billing from the institution. Valid codes for TEDs:  1 admit thru discharge TED record  2 interim - initial TED record  3 interim - interim TED record  4 interim - final TED record  7 replacement of prior claim  8 void/cancel of prior claim  9 Final claim for Home Health Agency (HHA) episode |
|  | Type of Admission | 1 | A-Numeric | NA | 1, 2, 3, 4, 5 | A code indicating the type of this admission.  1 Emergency  2 Urgent  3 Elective  4 Newborn  5 Trauma Center |
|  | Source of Admission | 1 | A-Numeric | NA | 1-9, A, B, C, D, E, F | A code indicating admission referral source. Coded as follows:  1 Physician referral (Discontinued 10/01/2007  1 Non-Health Care Facility Point of Origin  (Effective 10/01/2007)  2 Clinic referral  3 HMO referral  4 Transfer from a hospital (Different Facility)  (Discontinued10/01/2007)  5 Transfer from a Skilled Nursing Facility (SNF) or  Intermediate Care Facility (ICF)  6 Transfer from another health care facility  7 Emergency Room (Discontinued 7/01/2010)  8 Court/law enforcement  9 Information not available  A Transfer from Critical Access Hospital (CAH)  (Discontinued 10/01/2007)  B Transfer from another HHA (Discontinued 7/01/2010)  C Readmission to the same HHA (Discontinued 7/01/2010)  D Transfer from Hospital Inpatient in same  Facility resulting in separate claim  E Transfer from Ambulatory Surgery Center (Effective  10/01/2007)  F Transfer from Hospice (Effective 10/01/2007)  1 For newborn, normal delivery  2 For newborn, premature delivery  3 For newborn, sick baby  4 For newborn, extramural baby  5 For newborn, born in this hospital  6 For newborn, born outside this hospital |
|  | Admission Date | 8 | Numeric | NA | None | Date of the patient was first admitted to the institution for this episode. Format: YYYYMMDD. |
|  | Patient Status | 2 | A-Numeric | NA | 01, 02, 03, 04, 05, 06, 07, 08, 20, 21, 30, 40, 41, 42, 43, 50, 51, 61, 62, 63, 64, 65, 66, 69, 70, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95 | Code indicating patient status as of the end date of care on the TED record. Code meanings are found in the TRICARE Systems Manual |
|  | Begin Date of Care | 8 | A-Numeric | NA | None | Earliest date of care reported on this TED record (YYYYMMDD). |
|  | End Date of Care | 8 | A-Numeric | NA | None | Latest date of care reported on this TED record (YYYYMMDD). |
| 80-82. | Administrative CLIN 1  Administrative CLIN 2  Administrative CLIN 3 | 6  (3 times) | A-Numeric | NA | None | Three occurrences of the six-position Contract Line Item Number for which an administrative fee is requested.  To be reported on contracts awarded prior to 08/2007 only. |
|  | Covered Days | 3 | Numeric | NA | None | Number of hospital days where there was any allowance by the contractor. The day of admission is counted as a hospital day. The day of discharge is not counted as a hospital day. |
|  | DRG Number | 3 | A-Numeric | NA | None | Identifies the diagnosis related group (drg) determined for this care. |
|  | HIPPS Code | 5 | A-Numeric | NA | Codes are located in the TRICARE Systems Manual | Health Insurance Prospective Payment System (HIPPS) rate codes identify specific patient characteristics (or case mix) on which TRICARE SNF and HHA payment determinations are made. Code values are defined in the TRICARE Systems Manual. |
|  | Admission Diagnosis | 7 | A-Numeric | NA | None | Code identifying diagnosis under which the patient was admitted to the institution. Decimal point not included. |
|  | Principal Treatment Diagnosis | 7 | A-Numeric | NA | None | The condition established, after study, to be the major cause for the patient to obtain medical care as coded on the claim form or otherwise indicated by the provider. Decimal point not included. |
|  | Secondary Treatment Diagnosis-1 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point not included. |
|  | Secondary Treatment Diagnosis-2 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point not included. |
|  | Secondary Treatment Diagnosis-3 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point not included. |
|  | Secondary Treatment Diagnosis-4 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point not included. |
|  | Secondary Treatment Diagnosis-5 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point not included. |
|  | Secondary Treatment Diagnosis-6 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point not included. |
|  | Secondary Treatment Diagnosis-7 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point not included. |
|  | Secondary Treatment Diagnosis-8 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point not included. |
|  | Secondary Treatment Diagnosis-9 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point not included. |
|  | Secondary Treatment Diagnosis-10 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point not included. |
|  | Secondary Treatment Diagnosis-11 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point not included. |
|  | Principal Operation/Non-Surgical Procedure Code | 7 | A-Numeric | NA | None | The code that identifies the principal procedure performed during the period covered by this TED record as coded on the UB-92. |
|  | Secondary Operation/Non-Surgical Procedure Code-1 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-2 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-3 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-4 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-5 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-6 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-7 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-8 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-9 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-10 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-11 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | TED Record Correction Indicator | 1 | A-Numeric | NA | 1, 2, 3 | Indicates the type of adjustment:  1 Correction to provisional error  2 Non-provisional correction/adjustment  3 Both provisional and non-provisional |
|  | Total Occurrence/Line Item Count | 3 | A-Numeric | NA | 001-450 | The number of sets of revenue codes and related data elements that occur on the record. |
| 113-115. | Administrative Claim Count Code - 1  Administrative Claim Count Code - 2  Administrative Claim Count Code - 3 | 1  (3 times) | Numeric | NA | 0-9 | Three codes one position elements indicating status of administrative payment record processing. On the net TED database, this is the sum of all history records (original, adjustments, and cancellations). If multiple adjustments/ cancellations are processed, the code could be greater than one. Only one cancellation is permitted.  1 or greater – positive administrative payment  0 – no administrative payment |
|  | Admission Count Code | 1 | Numeric | NA | 0, 1 | 0 claim is a non-admission claim  1 claim is an admission claim |
|  | Total Patient Pay | 13 | Numeric | NA | None | If provider participation indicator = 'Y' (yes), total patient pay = amount allowed-amount paid by contractor. If provider participation indicator = 'N' (no), total patient pay = amount billed-amount paid by contractor. |
|  | Beneficiary Category | 1 | A-Numeric | NA | 1, 2, 3, 4 | Categorization of beneficiaries based on a given sponsor status for cost sharing and reporting purposes. For non-availability statements, categorization of beneficiaries is based on the sponsor's status and the patient's relationship to that sponsor. Coded as follows:  1 – active-dependent  2 – retired-sponsor  3 – retired/deceased-dependent and all other patients  4 – active duty sponsor |
|  | Benefit Claim Count Code | 1 | Numeric | NA | 0, 1 | Code indicating whether a claim has been cancelled. Coded as follows:  0 claim has been cancelled  1 claim has not been cancelled |
|  | Care End Fiscal Year | 4 | Numeric | NA | None | The fiscal year that the delivery of care was completed. |
|  | Category of Care | 2 | A-Numeric | NA | None | Major breakouts of data used for reporting care, based on benefit program (dental, drug, ECHO) or treatment diagnosis, revenue and procedure codes. Secondary breakouts of data used for reporting care, based on patient age, and subset of diagnosis and procedure codes. |
|  | Contractor Number | 2 | A-Numeric | NA | None | Identification code for the contractor. It is used to identify each contractor submitting health care service records and provider file records. |
|  | Cycle Number | 8 | Numeric | NA | None | Derived processing cycle Format: YyyymmNN where NN equals a sequential number within the month. |
|  | Diagnosis Edition Identifier | 1 | A-Numeric | NA | None | Identifies the edition number of the diagnosis related grouper which is used to determine the DRG. |
|  | DRG Derived Code | 3 | A-Numeric | NA | None | The DRG code derived by OCHAMPUS returned by the grouper software package. Elements used principal and secondary diagnosis, procedure codes, discharge status, sex, birth date, admission date, and discharge date. |
|  | Health Services Region Code (TNEX) | 2 | A-Numeric | NA | None | The TNEX health service region defined by contractor responsibility for managed care support contractors or by zip codes for the TDEFIC and pharmacy contracts. |
|  | Health Services Region Code (Non-TNEX) | 2 | A-Numeric | NA | None | The Non-TNEX health service region defined by zip codes |
|  | Hospital Department Number | 2 | A-Numeric | NA | None | Obsolete - blank filled. |
|  | Initial Transmission Date | 8 | Numeric | NA | None | The derived date when the claim was initially transmitted to TMA. Format: Yyyymmdd. |
|  | Inpatient Outpatient Indicator | 1 | A-Numeric | NA | I, O | An indicator of whether the patient was treated as an inpatient or outpatient. Coded as follows:  I Inpatient  O Outpatient |
|  | MDC | 2 | A-Numeric | NA | None | The derived Medical Diagnostic Category (MDC). |
|  | MTF Branch of Service | 1 | A-Numeric | NA | 1-6 | Identifies the branch of service responsible for the military treatment facility/area.  1 Army  2 Navy  3 Air Force  4 Coast Guard  5 Public Health Service  6 State Non-Catchment Area |
|  | MTF/Non-Catchment Code | 4 | A-Numeric | NA | None | Four digit DMIS code from the catchment area directory identifying the catchment or non-catchment area of residence. |
|  | Number of Births | 1 | Numeric | NA | None | Number of births, both live and stillborn, occurring during delivery. |
|  | Patient Age | 3 | Numeric | NA | None | Age of patient calculated based on earliest begin date of care versus patient's date of birth. |
|  | Provisional Acceptance Common Indicator | 7 | A-Numeric | NA | None | Seven occurrences of a one character code indicating an error group for relational errors occurring in the common portion of the record. |
|  | Provisional Acceptance Correction Date -1 | 8 | Numeric | NA | None | The date of the correction to the provisional acceptance of the claim record. Format YYYYMMDD. |
|  | Provisional Acceptance Correction Date -2 | 8 | Numeric | NA | None | The date of the correction to the provisional acceptance of the claim record. Format YYYYMMDD. |
|  | Provisional Acceptance Correction Date -3 | 8 | Numeric | NA | None | The date of the correction to the provisional acceptance of the claim record. Format YYYYMMDD. |
|  | Provisional Acceptance Date - 1 | 8 | Numeric | NA | None | The date of the provisional acceptance of the claim record. Format YYYYMMDD. |
|  | Provisional Acceptance Date – 2 | 8 | Numeric | NA | None | The date of the provisional acceptance of the claim record. Format YYYYMMDD. |
|  | Provisional Acceptance Date – 3 | 8 | Numeric | NA | None | The date of the provisional acceptance of the claim record. Format YYYYMMDD. |
|  | TED Acceptance Date | 8 | Numeric | NA | None | The date the record was first accepted into TED. Format YYYYMMDD. |
|  | TMA Batch/Voucher Processing Date | 8 | Numeric | NA | None | The derived date that TMA processed the claim. Format: YYYYMMDD. |
|  | Total Bed Days | 3 | Numeric | NA | None | Total number of days of hospital care during the period covered by the TED/HCSR whether or not allowable. |
|  | Type of Submission, Derived | 1 | A-Numeric | NA | A, B, C, D, E, I, O, R | Code indicating the derived TED submission type. Coded as follows:  A Adjustment to TED record data  B Adjustment to non-TED record (HCSR) data  C Complete cancellation to TED record data  D Complete denial initial TED record submission  E Complete cancellation of non-TED (HCSR) data  I Initial TED record submission  O Zero payment TED due to 100% OHI  R Resubmission of an initial TED record that was rejected due to errors |
|  | Accrual Fund Eligibility Indicator | 1 | A-Numeric | NA | E, I | Code indicating accrual fund eligibility. Coded as follows:  E = Eligible for Accrual Fund  I = Ineligible for Accrual Fund |
|  | Secondary Treatment Diagnosis-12 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-13 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-14 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-15 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-16 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-17 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-18 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-19 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-20 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-21 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-22 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-23 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-24 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Operation/Non-Surgical Procedure Code-12 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-13 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-14 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-15 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-16 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-17 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-18 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-19 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-20 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-21 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-22 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-23 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Secondary Operation/Non-Surgical Procedure Code-24 | 7 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
|  | Present on Admission - Principal Dx | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 1 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 2 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 3 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 4 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 5 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 6 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 7 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 8 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 9 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 10 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 11 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 12 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 13 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 14 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 15 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 16 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 17 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 18 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 19 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 20 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 21 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 22 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 23 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 24 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | ICD Version | 1 | A-Numeric | NA | 9,0 | 9 denotes ICD-9 diagnosis codes, 0 denotes ICD-10 diagnosis codes used for all diagnoses |

*Notes:*

*1. This record is pipe ("|") delimited.*

**Table A-2 TED-I Line Item File Data Elements**

| **Field Number** | **Field Name**  **(logical name)** | **Field Length** | **Data Type** | **Data Units** | **Value Range** | **Functional Description** |
| --- | --- | --- | --- | --- | --- | --- |
|  | TED Record Indicator | 24 | A-Numeric | NA | None | Concatenation of the following fields:  Filing Date (length 7) - date the claim was received by the contractor (YYYYDDD)  Filing State/Country Code (length 3) - code that indicates the state or country where the care was provided  Sequence Number (length 7) - unique code assigned by the contractor to identify an individual claim within the filing date and state/country code.  Time Stamp (length 6) - system time assigned by the claims processor (MMSSHH (minutes, seconds, hundredths))  Adjustment Key (length 1) - for adjustment to a HCSR record, contains the HCSR Suffix. For TED records, contains the indicator for the type of financial record, coded as follows:  0 Batch  5 Voucher |
|  | Cycle Number | 8 | Numeric | NA | None | Derived processing cycle. Format: YyyymmNN where NN equals a sequential number within the month. |
|  | End Date of Care | 8 | A-Numeric | NA | None | Latest date of care reported on this TED record (YYYYMMDD). |
|  | Occurrence/Line Item Number | 3 | A-Numeric | NA | 001-450 | The unique number for each utilization/revenue data occurrence within the TED record. Line item must be assigned in sequential ascending order. |
|  | Revenue Code | 4 | A-Numeric | NA | UB-92 revenue codes | Code which identifies revenue categories associated with the type of service rendered. Like revenue codes should be summarized to one occurrence for reporting on the TED record. |
|  | Units of Service By Revenue Code | 10 | Numeric | NA | None | The number of services rendered or number of days, by revenue category. |
|  | Total Charge by Revenue Code | 11 | Numeric | NA | None | Amount billed for this revenue code. |
|  | Adjustment/ Denial Reason Code | 5 | A-Numeric | NA | Codes are located in the *TRICARE Systems Manual* | The code describing the reason for the payment denial/adjustment of the line item. Codes defined in *TRICARE Systems Manual.* |
|  | Adjustment Reason Derived Code | 2 | A-Numeric | NA | None | Obsolete - blank filled. |
|  | Denial Reason Derived Code | 2 | A-Numeric | NA | None | Obsolete - blank filled. |
|  | Provisional Acceptance Line Item Indicator | 7 | A-Numeric | NA | None | Seven occurrences of a 1 character code indicating the category of the errors which caused a line item to be provisionally accepted. |

*Notes:*

*1. This record is pipe ("|") delimited*



| **Acronym** | **Name** |
| --- | --- |
| **AD** | Active Duty |
| **ADFM** | Active Duty Family Member |
| **ADSM** | Active Duty Service Member |
| **AGR** | Active Guard and Reserve |
| **ASAP** | Automated Standard Application for Payments |
| **CA** | Consultation Appointment |
| **CAH** | Critical Access Hospital |
| **CCB** | Configuration Management Board |
| **CEIS** | Corporate Executive Information System |
| **CHAMPVA** | Civilian Health and Medical Program for the Department of Veterans Affairs |
| **CHCBP** | Continued Health Care Benefit Program |
| **DCN** | Document Change Notice |
| **DECC** | Defense Enterprise Computing Center |
| **DEERS** | Defense Enrollment Eligibility Reporting System |
| **DMIS** | Defense Medical Information System |
| **DMDC** | Defense Manpower Data Center |
| **DoD** | Department of Defense |
| **DRG** | Diagnosis Related Group |
| **EIDS** | Executive Information/Decision Support |
| **EIN** | Employer Identification Number |
| **EMC** | Electronic Media Claims |
| **FI** | Financial Intermediary |
| **FIN** | Foreign Identifier Number |
| **HCFA 1500** | Health Care Financing Administration Professional Fee Billing Claim |
| **HCPCS** | Healthcare Common Procedure Coding System |
| **HCSR** | Health Care Service Record |
| **HCSR-I** | HCSR Institutional |
| **HHA** | Home Health Agency |
| **HIPAA** | Health Insurance Portability and Accountability Act |
| **HIPPS** | Health Insurance Prospective Payment System |
| **HMO** | Health Maintenance Organization |
| **ICD** | Interface Control Document |
| **ICD-9** | International Classification of Diseases (9th revision) |
| **ICD-10** | International Classification of Diseases (10th revision) |
| **ICF** | Intermediate Care Facility |
| **ICN** | Internal Control Number |
| **M2** | MHS MART |
| **MCSC** | Managed Care Support Contractor |
| **MDC** | Medical Diagnostic Category |
| **MDR** | MHS Data Repository |
| **MHS** | Military Health System |
| **MTF** | Medical Treatment Facility |
| **NAS** | Non Availability Statement |
| **NATO** | North Atlantic Treaty Organization |
| **NOAA** | National Oceanographic and Atmospheric Administration |
| **NPI** | National Provider Identifier |
| **OCHAMPUS** | Office of Civilian Health and Medical Program of the Uniformed Services |
| **ODS** | Operational Data Store |
| **OHI** | Other Health Insurance |
| **OP** | Outpatient |
| **ORD** | Operational Requirements Document |
| **PCDW** | Purchased Care Data Warehouse |
| **PCM** | Primary Care Manager |
| **RAPIDS** | Real-Time Automated Personnel Identification System |
| **SDD** | Solution Delivery Division |
| **SHCP** | Supplemental Health Care Program |
| **SNF** | Skilled Nursing Facility |
| **SSN** | Social Security Number |
| **STF** | Specialized Treatment Facility |
| **TAMP** | Transitional Assistance Management Program |
| **TED** | TRICARE Encounter Data |
| **TED-I** | TED Institutional |
| **TFL** | TRICARE For Life |
| **TIN** | Taxpayer Identification Number |
| **TMA** | TRICARE Management Activity |
| **TMA-A** | TMA Aurora |
| **TNEX** | TRICARE Next Generation Contract |
| **TPL** | Third Party Liability |
| **TPR** | TRICARE Prime Remote |
| **TSP** | TRICARE Senior Prime |
| **TSS** | TRICARE Senior Supplement |
| **UB04** | Uniform Billing Claim Form |