**23 February 2021**

TRICARE Encounter Data - Non Institutional

(TED-NI)

for the

MHS Data Repository (MDR)

(Version 1.07.11)

Current Specification

**Revision History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Version** | **Date** | **Originator** | **Para/Tbl/Fig** | **Description of Change** |
| 1.03.00 | 07/21/2009 | J. Huber | * Page 17
 | * TED Indicator
* Fixed sequencing of appendix (appendix E missing)
 |
| 1.04.00 | 02/04/2010 | J. Huber | * Page 12
* Page 18
 | * Added National Provider Identifiers
* Hospital Dept Number
 |
| 1.04.01 | 04/05/2010 | J. Huber |  | * Clarification in the rule for Hospital Department Number; changed "as of October 1, 2009" to "if cycle date is after October 1, 2009
 |
| 1.04.02 | 08/13/2010 | J. Huber | * Internally Derived Fields
 | * Added contractor numbers 04 and 15 to TED Indicator derivation
* Added contractor numbers 04 and 15 to Contract Type derivation
 |
| 1.04.03[[1]](#footnote-1) | 05/11/2011 | M. North for J. HuberJ. Huber | * Appendix G
 | * Replace derivation algorithm for MERHCF flag in Appendix G. Re-calculate MERHCF flag for all TRD-NI datasets, apply retroactively from current FY to FY01.
 |
| * Page 10
 | * Added documentation on source of MDC
 |
| * Page 14
 | * Add field: Accrual Fund Indicator
 |
| * Page 15
 | * DEERS Beneficiary Category, change blank and missing to UNK
 |
| * Page 15
 | * DSPONSVC - change blank to Z
 |
| * Page 15
 | * RACE - change blank to Z
 |
| * Page 15
 | * ETHNIC - change blank to Z
 |
| * Page 16
 | * PARC - change blank to ZZ
 |
| * Page 16
 | * Drop DDS for FY09+
 |
| * Page 21
 | * Add new internally derived field: ACV Group
 |
| * Page 21
 | * Add derived field: Age Group Common
 |
| * Page 21
 | * Add derived field: PPS Product Line
 |
| 1.04.04 | 10/12/2012 | J. Huber | * Table 1
 | * Add Enrollment MEPRS Code and Medical Home Flag.
 |
| 1.05.01 | 2/12/2013 | J. Huber | * Internally Derived Fields
 | * Add contractor numbers 05,08
* Remove Contractor numbers 16,17,18
 |
| 1.05.01 | 2/12/2013 | J. Huber | * Internally Derived Fields
* Appendix N
 | * Add derived field: Number of Evaluative Visits
 |
| 1.05.02 | 4/22/2013 | J. Huber | * Internally Derived Fields
* Appendix N
 | * Clarified derived field: Number of Evaluative Visits
 |
| 1.05.03 | 4/23/2013 | M. North | * Table 1
 | * Increase field sizes for ICD10. Delete source position column for TED.
 |
| 1.05.04 | 6/07/2013 | J. Huber | * Table 1
 | * Added PCM\_ID
* Modified ACV Group algorithm
 |
| 1.05.05 | 11/18/2013 | D. McDonald | * Table 1
 | * Add TRICARE Young Adult Flag
 |
| 1.06.01 | 11/18/2014 | J. Huber | * Table 1
 | * Added POA flags, additional ICD fields, and ICD Edition Number
 |
| 1.07.01 | 5/18/2015 | W. Funk | * Section 1
* Section 2
* Section 5
* Section 6
* Section 7
 | * Included language noting that HCSRs are no longer used and that combined HCSR/TED processing business rules were moved to Appendix X.
* Added ICD version number (which is out of date)
* Moved update section that includes HCSR/TED rules to an appendix and deleted references to only HCSR Processing.
* Moved the merge table that includes both HCSR/TED rules to an appendix and deleted rows that were related to HCSR processing only. Added criteria to CPT lookup.
* Moved old file layout to an appendix. Added input positions, added or modified logic for: work RVU, PE RVU, Malpractice RVU, APC Weight, DEERS Bencat Common, Evaluative Visits, Historical RVU, Enrollment Site MSMA, underwritten region. Altered language on RVU table merge.
 |
| 1.07.02 | 8/25/2015 | W. Funk | * Section VI
* Table 1
 | * Updated merge table
* Updated RVU logic to accommodate global coding
 |
| 1.07.03 | 11/17/2015 | W. Funk | * Section VI
* Table 1
 | * Updated merge table
* Added fields from referral and MTF-MCSC merge
* Moved enrollment MEPRS code and TYA Flag derivations from the internally derived field section to the body of table 1. Deleted medical home flag and renamed enrollment MEPRS Code.
 |
| 1.07.04 | 11/19/2015 | W. Funk | * Section VI
* Table 1
 | * Updated merge table
* Changed the format of APC weight and enrollment site eMSM. Clarified logic related to APCs. Corrected a type.
 |
| 1.07.05 | 12/1/2015 | W. Funk | * Table 1
 | * Removed language about how to match from RVU field.
 |
| 1.07.06 | 1/8/2016 | W. Funk | * Appendix N & O
 | * Added Appendix N and Appendix O
 |
| 1.07.07 | 8/8/2016 | W. Funk | * Table 1
 | * Updated rule for place of service
 |
| 1.07.08 | 9/26/2017 | W. Funk | * Table 2
 | * Added fields related to NDAA 2017 and T2017
 |
| 1.07.09 | 10/4/2017 | W. Funk | * Appendix P
 | * Corrected a typo in the ACV Group derivation
 |
| 1.07.10 | 1/21/2021 | W. Funk | * Appendix N
 | * Updated Appendix K: Merge to MTF Network Referral File
 |
| 1.07.11 | 2/23/2021 | W. Funk |  |  |

# MDR TRICARE Encounter Data — Non-Institutional

1. Source:

The source system is the TMA-Aurora HCSR/TED acceptance system’s Net Master Databases (or copies). Two basic files are sent, each containing accepted or provisionally accepted claims with end dates of care in the fiscal years required. The files are:

* Pure net TED records, from TED ODS Netmaster, or equivalent
* TED Adjustments to HCSRs (ATOH), from HCSR ODS Netmaster or equivalent

Two one-time data files are also provided from the HCSR ODS database, in order to complete each fiscal year’s database. These files include:

* Net HCSRs, from HCSR ODS Netmaster
* A one-time file with the HCSR Key and Amount Paid prior to any TED adjustments

All of these source files are combined to produce fiscal year claims files for the MDR.

HCSRs were discontinued in August 2014. After that, only TED records are used. This processing specification focuses on TED-only data, however Appendix X describes the processing when HCSRS and TEDs were both used.

1. Transmission (Format and Frequency)

Purchased care data files are normally transmitted via secure FTP from TMA-Aurora to the MDR according to ICD 1300-1642-03. Files are sent monthly. Purchased care data records consist of institutional claims[[2]](#footnote-2), non-institutional claims, and provider records. This specification deals solely with non-institutional records.

1. Organization and Batching

There are three types of MDR TED non-institutional files, each containing accepted or provisionally accepted claims. These files include:

* Cancellation and Denial File: Contains all non-institutional TEDs (HCSR cancellations are not retained in this file[[3]](#footnote-3)) with allowed amount less than or equal to 0. The format is the same as the TED non-institutional interface with the MDR. This is a cumulative file, spanning all years of TED data[[4]](#footnote-4).
* Defense Health Program Files (also referred to as the CHAMPUS file): These fiscal year files (sorted into fiscal years based on the end date of care) contain most raw fields from the TED, as well as appended fields described in this document. Records are included in this file if the value of the MERHCF Flag is A, N or U.
* Medicare Eligible Retiree Health Care Fund (MERHCF) Files: These fiscal year files (sorted into fiscal year files based on end date of care of line item) contain most raw fields from the TED, as well as appended fields as described in this document. Records are included in this file if the value of the MERHCF Flag is U or T.
1. Receiving Filters

Only net records (a record is a net non-institutional line item) are provided to the MDR, as described in Section I. Only accepted or provisionally accepted records are provided in the source data. For the initial load, records are included if the end date of care on the net line item is in the fiscal year. Each monthly TED update batch includes line items for records accepted or provisionally accepted by the TMA-Aurora system in the previous month. This should include initial records, adjustments to records previously sent, and cancellations and denials.

1. Update Process

TEDs that are denied or cancelled (records with an allowed amount less than or equal to 0) are separated out and added the master cancellation data file. Then, records from the wrong fiscal year are dropped from the data.

Using the remaining records, the processor identifies records that may potentially have changed fiscal year when the record was updated and the end date of care moved into the next fiscal year. These records are not removed from the data feed, they are just identified and saved to an intermediate data set. This data set contains the TED number and line item number for every record where the begin date is in a fiscal year prior to the fiscal year of the end date of care. This file will be referred to as the previous fiscal year data set later in this document.

Next, the processor appends variables to the incremental data feed. Then it combines incremental and master data sets, interleaving records by TED number, line item number and cycle date. The processor retains only the most recent version of the TED, as identified by TED number and line item number[[5]](#footnote-5). Then the processor uses the previous fiscal year data set to remove from the master data set any records that have moved to a subsequent fiscal year. This is done to ensure that records are not in two fiscal years.

Then the master cancellation data set is used to remove cancelled TEDs from the updated master data set. Additional processing is performed to append more fields to the master TED-NI data set. All of the appended fields are described in the next two sections of this document.

The remaining records are identified as either CHAMPUS or TDEFIC, or in some cases both, and written to the appropriate data set(s). These incremental data sets are then used to update the appropriate master data set. The update processing described in the rest of this section, applies to both the CHAMPUS and TDEFIC data.

1. Field Transformations and Deletions for MDR Core Database

This section of this functional specification describes the data merges that are necessary to append many of the fields in the MDR TED Non-Institutional file.

The table below describes each reference (or data) file being used to append fields to each MDR Non-Institutional record. This table also lists whether or not the merge should be accomplished against the monthly feed (increment) or whether it is necessary to re-merge the corresponding file to each of the MDR Non-Institutional records during each monthly process[[6]](#footnote-6). The basis upon which the MDR non-institutional records should be merged to the reference (or data) files is also described.

| **Merge** | **Merge to** | **Date Matching** | **Additional Matching** |
| --- | --- | --- | --- |
| Reservist GWOT file | Master | Begin date of care from NI line item and dates associated with each reservist benefit type segment. | Sponsor social security number |
| Longitudinal VM File  | Master | Begin Date of Care on TED, with begin and end dates for each changeable demographic segment. | EDI\_PN if available. See VM-6 Specification |
| Master Person Index | Master | None | For records with blank EDI\_PN, match TED records by sponssn, patsex, patdob and grouped member relationship code. See VM-6 Specification |
| Relative Value Unit Table  | Increment | CY of end date of care and CY of MDR Purchased Care RVU Table where setting flag = PC (and setting flag = DC for modifier 54 or 55 only. For modifier 55, the DC weight for 99024 is used.) | Procedure Code + Modifier 1 from NI Line Item with Procedure Code + Modifier from RVU Table. If no match, try procedure code + modifier 2 matched with procedure code and modifier from RVU table. If match still not found, match based on procedure code only. |
| Legacy Relative Value Unit Table | Increment | CY of end date of care and CY of MDR legacy RVU Table | Procedure code from NI Line Item with Procedure Code from RVU table. |
| TED Episode Reference File (Admitting TED Number) | Master | Begin date of care | EDI\_PN |
| APC Weight Table | Master | CY | APC |
| DMISID  | Master | FY of end date of care, FY of MDR DMISID SAS format file. | Application based on enrollment DMISID, DEERS enrollment DMISID and geography related DMISID |
| Omni-CAD | Increment | FY/FM of end date of care, FY/FM of MDR Omni CAD format file | Patient zip code & sponsor service. Also based on provider zip |
| Administrative Tail reference file | Increment | FY of end date of care and FY of MDR administrative tail format file. | Contract type |
| NYU ER Algorithm Diagnosis Grouping File | Master |  | Diagnosis 1 |
| Enrollment MEPRS Code | Master | Begin Date of Care is between the begin and end date of the enrollment MEPRS Code | EDI\_PN |
| NYU ER Algorithm Classification File  | Master |  | Diagnosis Group (from NYU ER Algorithm Diagnosis Grouping file) |
| MTF Network Referral File | Master | N/A | See Appendix I |
| MDR Referral File | Master | N/A | UIN |
| MDR PCM Identity Lookup | Master | End Date of Care is between the start and stop date of the PCM Identifier segment | EDIPN |

Business rules for each of the appended fields are described in the body of the format table in Section VII, or in an Appendix, referenced in that table.

1. File Layout

The MDR TED files are stored as SAS data sets, in separate fiscal year files. There are two primary TED Non-Institutional Datasets per year: the DHP Files and the MERHCF Files, as well as a cancellation / denial file. This table refers to records processed that are purely derived from TEDs (FYxx and later). For the file layout and business rules associated with combined HCSR/TED data, refer to appendix H.

The formats and processing rules for the two MDR non-institutional TED master files are provided in the tables below. Records in the cancellation/denial files remain in the format contained in the feed to the MDR.

**Table 2: File Layout for MDR Non-Institutional Master Files**

| **MDR TED Field** | **SAS Name** | **Format** | **Source Element – TED** | **TED ODS Feed Position** | **Business Rule** |
| --- | --- | --- | --- | --- | --- |
| TED Number | tedno | $24  | 2-015 | 12 | No transformation. |
| 2-020 |
| 2-025 |
| 2-030 |
| 2-035 |
| Line Item Number | linum | $3  | 2-145 |  | No transformation. |
| Process to Completion Date | procdate | yyyymmdd | 2-040 | 13 | Convert to SAS Date  |
|
| Sponsor SSN | sponssn | $9  | 2-050 | 15 | No transformation. |
| Sponsor SSN Type Code | idtype | $1  | 2-051 | 16 | No transformation |
| Service Branch | sponsvc | $1  | 2-055 | 17 | No transformation |
| AGR Service Legal Authority | agrauth | $1  | 2-056 | 18 | No transformation |
| Last Name | lastname | $35  | 2-061 | 19 | No transformation. |
| First Name | frstname | $25  | 20 | No transformation |
| Middle Name | midlname | $25  | 21 | No transformation |
| Cadency | cadency | $10  | 2-064 | 22 | No transformation |
| Patient SSN | patssn | $9  | 2-065 | 23 | No transformation |
| Patient SSN Type Code | pidtype | $1  | 2-066 | 24 | No transformation |
| Date of Birth | patdob | yyyymmdd | 2-070 | 25 | Convert to SAS Date |
| DEERS Patient ID | deersid | $11  | 2-082 | 28 | No transformation |
| Gender | patsex | $1  | 2-085 | 29 | No transformation. |
| Patient Zip Code | patzip | $5  | 2-090 | 30 | No transformation |
| Patient Zip Code + 4 | patzip4 | $4  | 31 | No transformation |
| Override Code 1 – 3 | ovride1 - 3 | $2  | 2-095 to 098 | 32-34 | No transformation |
| Submission Code | subcode | $1  | 2-100 | 35 | No transformation |
| Claim Form Type | clmform | $1  | 2-105 | 36 | No transformation |
| Administrative Clin 1 – 3 | admcln1 - 3 | $6  | 2-108 | 37-39 | Parse into three separate fields. |
| Enrollment DMISID | enrsite | $4  | 2-110 | 40 | No transformation. |
| Total Interest Paid | intpaid | SN9.2 | 2-112 |  | No transformation |
| Reason for Interest | intreas | $2  | 2-113 |  | No transformation |
| ICD Version | icdver | $2  | 2-114 |  | No transformation |
| Principal Diagnosis | dx1 | $7  | 2-115 |  | No transformation |
| Secondary Diagnosis n; n=1 to 24 | dxn | $7  | 2-116 through 2-138 and 2-340 |  | No transformation |
| Principal Diagnosis Present on Admission | poa1 | $1  | 2-115 |  | No transformation |
| Secondary Diagnosis n Present on Admission; n=1 to 24 | poan | $1  | 2-116 through 2-138 and 2-340 |  | No transformation |
| TED Record Correction Indicator | reccrt | $1  | 2-139 |  | No transformation |
| Administrative Claim Count Code 1 - 3 | clmcnt1 - 3 | SN1 | Derived in TED ODS |  | Parse into three separate fields. |
| Total Amount Allowed – Claim Level | t\_allow | SN11.2 | Derived in TED ODS |  | No transformation |
| Total Amount Billed – Claim Level | t\_bill | SN11.2 | Derived in TED ODS |  | No transformation |
| Total Amount Paid – Claim Level | t\_paid | SN11.2 | Derived in TED ODS |  | No transformation |
| Total OHI Paid – Claim Level | t\_ohi | SN11.2 | Derived in TED ODS |  | No transformation |
| Benefit Claim Count Code | benclmct | ZD1 | Derived in TED ODS |  | No transformation |
| Contractor Number | konum | $2  | Derived in TED ODS |  | No transformation.  |
| Cycle Number | cycle | $8  | Derived in TED ODS |  | No transformation. |
| Deductible Flag | dedcflag | $1  | Derived in TED ODS |  | No transformation. |
| Diagnosis Code Edition Number | dxedit | $1  | Derived in TED ODS |  | No transformation. |
| Initial Transmission Date | trnsdate | yyyymmdd | Derived in TED ODS |  | Convert to SAS Date |
| Derived MDC | mdc | $2  | Derived in TED ODS |  |  No transformation |
| Patient Age | patage | 3 | Derived in TED ODS |  |  No transformation |
| Acceptance Date | accptdt | yyyymmdd | Derived in TED ODS |  | Convert to SAS Date |
| TMA Batch/Voucher Processing Date | vouchdt | yyyymmdd | Derived in TED ODS | 539-546 | Convert to SAS Date |
| Begin Date of Care | begdate | yyyymmdd | 2-150 |  | Convert to SAS Date |
| End Date of Care | enddate | yyyymmdd | 2-155 |  | Convert to SAS Date |
| Procedure Code  | cpt | $5  | 2-160 |  | No transformation |
| Procedure Code Modifier 1 - 4 | cptmod1 - 4 | $2  | 2-165 |  | Parse field 2-165 into 4 separate fields of length 2. |
| National Drug Code | ndc | $11  | 2-170 |  | No transformation |
| Number of Services | svcs | SN3 | 2-175 |  | Multiple by -1 if number of services is less than 0, else no transformation |
| Amount Billed (Line Item) | bill | SN9.2 | 2-180 |  | No transformation |
| Amount Allowed (Line Item) | allow | SN9.2 | 2-185 |  | No transformation |
| OHI Paid (Line Item) | ohi | SN9.2 | 2-190 |  | No transformation |
| Type of Other Government Health Insurance | govins | $1  | 2-191 |  | No transformation |
| Begin Reason Code for Other Government Ins | govinbeg | $1  | 2-192 |  | No transformation |
| Amount Applied to Deductible | deduc | SN5.2 | 2-195 |  | No transformation |
| Amount Patient Cost Share  | patcost | SN9.2 | 2-200 |  | No transformation |
| Copayment Factor | copayfac | $1  | 2-201 |  | No transformation |
| Amount Paid (Line Item) | paid | SN9.2 | 2-205 |  | No transformation |
| Adjustment/Denial Reason Code | adjden | $5  | 2-220 |  | No transformation |
| Provider Individual NPI Number | provnpi | $10  | 2-225 |  | No transformation |
| Provider Organizational NP Number | grpnpi | $10  | 2-230 |  | No transformation |
| Provider State/Country Code | provloc | $3  | 2-235 |  | No transformation |
| Provider Tax ID | taxid | $9  | 2-240 |  | No transformation |
| Multiple Provider Suffix | multprov | $4  | 2-245 |  | No transformation |
| Provider Zip | provzip | $5  | 2-250 |  | Parse into two separate fields |
| Provider Zip + 4 | provzip4 | $4  |
| Provider Specialty Code | hipaaspc | $10  | 2-255 |  | No transformation |
| Provider Participation Indicator | provpart | $1  | 2-260 |  | No transformation |
| Provider Network Status Indicator | network | $1  | 2-265 |  | No transformation |
| Physician Referral Number | refnum | $13  | 2-270 |  | No transformation |
| Type of Service 1 – 2 | typsvc1 -2 | $1  | 2-280 |  | Parse into two separate fields |
| Sponsor Status | memcat | $1  | 2-285 |  | No transformation |
| Sponsor Pay Grade | paygrd | $2  | 2-291 |  | No transformation |
| Sponsor Pay Plan | payplan | $5  | 2-292 |  | No transformation |
| Member Relationship Code | memrln | $1  | 2-295 |  | No transformation |
| HCDP  | hcdp | $3  | 2-301 |  | No transformation |
| TED Region | tedreg | $1  | 2-303 |  | No transformation |
| Special Processing Code 1 -4 | sprocd1 -4 | $2  | 2-305 |  | Parse field 2-305 into 4 separate 2 character special processing code fields.  |
| Health Care Delivery Program Special Entitlement Code | hcdpspec | $2  | 2-306 |  | No transformation |
| Care Authorization/NAS Number | authnum | $15  | 2-310 |  | No transformation |
| Care Authorization/NAS Issue Reason | authrsn | $1  | 2-315 |  | No transformation |
| Care Authorization/NAS Exc Reason | authexcp | $2  | 2-320 |  | No transformation |
| Pricing Rate Code | pricert | $2  | 2-325 |  | No transformation |
| Primary Procedure Flag | primepx | $1  | Derived in TED ODS |  | No transformation |
| Provider Specialty Code – Derived | provspec | $2  | Derived in TED ODS |  | No transformation |
| Provisional Acceptance Indcator | provact | $7  | Derived in TED ODS |  | No transformation |
| Ambulatory Payment Classification Code (APC) | apccode | $5  | 2-330 |  | No transformation |
| OPPS Payment Status Indicator Code | oppspsic | $2  | 2-331 |  | No transformation |
| Accrual Fund Eligibility Indicator | accrual\_fund\_ind | $1  | Derived in TED ODS |  | No transformation |
| From Reservist File Merge |
| Reservist Status | res\_stat | $1  | N/A | N/A | Populate with reservist status from MDR Reservist format file, if the begin date of care is between the begin and end dates of the reservist status code. |
| Special Operations Code | soc | $2  | N/A | N/A | Populate with special operations code from MDR Reservist format file, if the begin date of care is between the begin and end dates of the reservist status code. |
| From DEERS LVM Merge |
| DEERS Enrollment DMISID | denrsite | $4  | N/A | N/A | Fill with enrollment DMISID from LVM, if the begin date of care on the claim is between the begin and end date associated with the enrollment site. For FY03 and earlier, fill with enrollment DMISID from longitudinal enrollment file merge. See VM6 Specification, Section G18 and 19 for segment and field positions |
| DEERS Alternate Care Value | acv | $1  | N/A | N/A | Fill with ACV from LVM, if the begin date of care on the claim is between the begin and end date associated with the ACV. For FY03 and earlier, fill with enrollment DMISID from longitudinal enrollment file merge. and end date associated with the ACV. Blank fill for begin dates of care after Jan 1, 2018. See VM6 Specification, Section G18 and 19 for segment and field positions. |
| DEERS Enrolled Health Care Delivery Program Code | dhcdp | $3  | N/A | N/A | Fill with DEERS health care delivery program coverage code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS health care delivery program coverage code. See VM6 Specification, Section G18 and 19 for segment and field positions |
| DEERS Beneficiary Category | bencat | $3  | N/A | N/A | Fill with DEERS beneficiary category from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS beneficiary category. Change blank and Z to UNK. See VM6 Specification, Section G18 and 19 for segment and field positions  |
| DEERS Sponsor Service Aggregate | dsponsvc | $1  | N/A | N/A | Fill with DEERS sponsor service (aggregate) from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS sponsor service (aggregate). Change blank to Z. See VM6 Specification, Section G18 and 19 for segment and field positions |
| DEERS Zip Code | deerszip | $5  | N/A | N/A | Fill with DEERS zip code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS zip code. See VM6 Specification, Section G18 and 19 for segment and field positions |
| DEERS Medical Privilege Code | privcode | $1  | N/A | N/A | Fill with DEERS privilege code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS privilege code. See VM6 Specification, Section G18 and 19 for segment and field positions |
| DEERS Race Code | race | $1  | N/A | N/A | Fill with DEERS Race from LVM. Change blank to Z. Apply retroactively to all TED-NI datasets, working backwards from current FY to FY01.. See VM6 Specification, Section G18 and 19 for segment and field positions |
| DEERS Ethnicity Code | ethnic | $1  | N/A | N/A | Fill with DEERS Ethnicity Code from LVM. Change blank to Z. Apply retroactively to all TED-NI datasets, working backwards from current FY to FY01. See VM6 Specification, Section G18 and 19 for segment and field positions |
| DEERS Dependent Suffix | dds | $2  | N/A | N/A | Fill with DDS from LVM if a match is found, else if no match is found fill DDS from record, else DDS is blank. See VM6 Specification, Section G18 and 19 for segment and field positions |
| TPR Eligibility Flag | tprelg | $1  | N/A | N/A | Fill with TPR Eligibility Code from LVM, if the begin date of care on the claim is between the begin and end date associated with the TPR Eligibility Code. See VM6 Specification, Section G18 and 19 for segment and field positions  |
| Primary Care Manager ID | pcmidlvm | $18  | N/A | N/A | Fill with PCMID from LVM, if the begin date of care on the claim is between the begin and end date associated with the PCM ID. See VM6 Specification, Section G18 and 19 for segment and field positions  |
| TYA Flag | tyaflag | $1 | N/A | N/A | Fill with TYA Flag from LVM4, if the begin date of care on the record is between the begin and end dates associated with the TYA Flag. If no match is found or a match is found but the date window criteria do not apply then set to “0”. See VM6 Specification, Section G18 and 19 for segment and field positions |
| DEERS HCDP – Assigned | hcdp\_assgn | $3 |  |  | If the begin date of care is between the begin and end date of D\_MI\_HCDP\_PLN\_CVG\_CD then fill with D\_MI\_HCDP\_PLN\_CVG\_CD else leave blank; see VM=6 specification, section G18 and 19 for segment and field position.  |
| Eligibility Group | elg\_grp | $2 |  |  | If the begin date or care is between the begin and end date of D\_ELG\_GRP\_CD then fill with D\_ELG\_GRP\_CD else leave blank; see VM=6 specification, section G18 and 19 for segment and field position.  |
| Enrollment Group | enr\_grp | $2 |  |  | If the begin date of careis between the begin and end date of D\_ENR\_GRP\_CD then fill with D\_ENR\_GRP\_CD else leave blank; see VM=6 specification, section G18 and 19 for segment and field position |
| PCM Type Code | pcm\_type | $1 |  |  | If the begin date of care is between the begin and end date of D\_PCM\_TYPE\_CD then fill with D\_PCM\_TYPE\_CD else leave blank; see VM=6 specification, section G18 and 19 for segment and field position.  |
| From MPI Merge |
| EDI\_PN | edi\_pn | $10  | 2-080 | N/A | Fill with position 232 if populated. Otherwise, implement MPI merge. |
| Person Association Reason Code | parc | $2  | N/A | N/A | See MPI specification. Change blank to ZZ.  |
| From RVU Table merge: (limited only to setting flag is PC)  |
| Relative Value Unit - Work | workrvu | 8.2 | N/A | N/A | If the provider specialty code is in the list in Appendix B or (if provider specialty is 99 and APC weight is 0), then set workrvu equal to (the minimum of 99 or the number of services) \* work rvu from RVU weight table.  |
| Relative Value Unit – Practice Expense | pervu | 8.2 | N/A | N/A | If the provider specialty code is in the list in Appendix B or if (provider specialty is 99 and APC weight is 0) then: if the place of service is office (11) or home (12) then set pervu equal to the minimum of 99, or the number of services \* non-facility practice rvu from RVU weight table; otherwise (place of service is not 11 or 12) then set pervu equal to the (minimum of 99 or the number of services) \* facility practice rvu from RVU weight table.  |
| Relative Value Unit - Malpractice | malprvu | 8.2 | N/A | N/A | If the provider specialty code is in the list in Appendix B or if (provider specialty is 99 and APC weight is 0) then set malprvu equal to (the minimum of 99 or the number of services) \* malpractice rvu from RVU weight table. |
| RVU Simple | simprvu | 8.2 | N/A | N/A | Match to RVU table matching calendar year of end date of care. Do not include modifiers in the match criteria. Multiply the minimum of 99 and the number of services by the work RUV. Set to zero of provider specialty code is 99. |
| Historical RVU | histrvu | 8.2 | N/A | N/A | Apply the same logic as in work RVU, except use the prior year’s weight table instead of that which matches the year of care.  |
| Evaluative Visits | evalvisits | 2 | N/A | N/A | FY08 and later. See Appendix N.  |
| From Merge to Admitting TED Number Reference File |
| Admitting TED Number  | admtedno | $24  | N/A | N/A | See Appendix L. |
| Lab Add-On Amount | labadd | 7.2 | N/A | N/A | Currently blank. |
| Rad Add-On Amount | radadd | 8.2 | N/A | N/A |
| Rx Add-On Amount | rxadd | 7.2 | N/A | N/A |
| Other Add-On Amount | othadd | 10.2 | N/A | N/A |
| Merge to APC Weight Table |
| APC Weight | apc\_weight | 10.4  | N/A | N/A | If PSI (oppspsic) is A, B, C, E, F, N, Q , Q1, Q2, Q3, W, Z, TB, or XX, or there is no PSI, then set APC Weight to 0. Else if there is a CPT modifier of 73 or 52, then set APC Weight to the raw APC Weight \* number of services \* 50%. Else if the PSI is not T then if the CPT has a modifier of 50 or if the bilateral flag in the CPT/HCPCS table is 1 or 3, then APC Weight = raw APC weight \* 200% \* number of services, else APC Weight = raw APC weight \* unit of service. Else if the PSI is T: Create an array of all TEDs grouped by TED ICN. Scan all of the APC weights for each of the line items with an APC and select the line item with the highest weight. Weight that line item or any line item with a modifier of 76, 77, 78 or 79 as follows: Else {line item does not have a T PSI}If the modifier is 50 or if the bilateral flag in the CPT/HCPCS table is 1 or 3 then APC weight = raw APC weight \* units of service Else APC weight = raw APC weight \*50%\* units of service. If the CPT modifier is 50 or if the bilateral flag in the CPT/HCPCS table is 1 or 3, then the APC weight = raw APC Weight \* 150% \* units of service Else APC weight = (1 + 50% raw APC weight \* (units of service -1))/units of service  |
| From OMNI CAD Merge |
| Residence Catchment Area | catch | $4  | N/A | N/A | Based on matching FY, FM and patzip; if sponsvc=A then set equal to ACATCH, if sponsvc = F then set equal to FCATCH; if sponsvc in (M, N) then set equal to NCATCH, otherwise set equal to OCATCH. If zip code not found in MDR Omni-CAD, set equal to ‘0999’  |
| Residence PRISM Area | prism | $4  | N/A | N/A | Based on matching FY, FM and patzip; if sponsvc=A then set equal to APRISM, if sponsvc = F then set equal to FPRISM; if sponsvc in (M, N) then set equal to NPRISM, otherwise set equal to OPRISM. If zip code not found in MDR Omni-CAD, set equal to ‘0999’ |
| Residence TPR Flag | tprflag | $1  | N/A | N/A | TPRFLAG, based on matching FY, FM and patzip |
| Provider Catchment Area | pvcatch | $4  | N/A | N/A | Based on matching FY, FM and provzip; set = OCATCH. If provzip not found in MDR Omni-CAD, set equal to ‘0999’ |
| Provider PRISM Area | pvprism | $4  | N/A | N/A | Based on matching FY, FM and provzip; set = OPRISM. If provzip not found in MDR Omni-CAD, set equal to ‘0999’ |
| Provider TPR Flag | pvtpr | $1  | N/A | N/A | TPRFLAG, based on matching FY, FM and provzip |
| Residence Region | resreg | $2  | N/A | N/A | MOD\_REG, based on matching FY, FM and patzip |
| Residence TNEX Region | restnex | $1  | N/A | N/A | HSSCREG, based on matching FY, FM and patzip |
| Beneficiary T3 Region | ben\_t3\_reg | $2 |  |  | T3\_REG, based on matching FY, FM and patzip |
| Beneficiary T2017 Region | ben\_t17\_reg | $2 |  |  | T17\_Reg, based on matching FY, FM and patzip |
| Provider T3 Region | prov\_t3\_reg | $2 |  |  | T3\_REG, based on matching FY, FM and provzip |
| Provider T2017 Region | prov\_t17\_reg | $2 |  |  | T17\_Reg, based on matching FY, FM and provzip |
| From DMISID Index Table Merge |
| Residence Catchment Area Service Branch | catchsvc | $1  | N/A | N/A | UBU\_SVC, based on matching FY and catch |
| Enrollment Region | enrreg | $2  | N/A | N/A | MOD\_REG, based on matching FY and denrsite |
| Enrollment HSSC Region | enrhssc | $1  | N/A | N/A | HSSCREG, based on matching FY and denrsite |
| Enrollment Site Service Branch | enrsvc | $1  | N/A | N/A | UBU\_SVC, based on matching FY and denrsite |
| PPS Enrollment Parent DMIS ID | ppsprnt | $4  | N/A | N/A | PPS\_PAR, based on matching FY and denrsite |
| Enrollment Site EMSM | msma | $3 | N/A | N/A | MSMA, based on matching FY and denrsite |
| Enrollment Site T3 Region | enr\_t3\_reg | $2 |  |  | T3\_REG, based on matching FY, FM and denrsite |
| Enrollment Site T2017 region | enr\_t17\_reg | $2 |  |  | T17\_REG based on matching FY, FM and denrsite |
| Enrollment site of record T3 Region | enr\_of\_rec\_t3\_reg | $2 |  |  | T3\_REG, based on matching FY, FM and enrsite |
| Enrollment site of record T2017 Region | enr\_of\_rec\_t17\_reg | $2 |  |  | T17\_REG, based on matching FY, FM and enrsite |
| Referring MTF T3 Region | ref\_t3\_reg | $2 |  |  | T3\_REG, based on matching FY, FM and ref\_mtf |
| Referring MTF T2017 Region | ref\_t17\_reg | $2 |  |  | T17\_REG, based on matching FY, FM and ref\_mtf |
| From Enrollment MEPRS Code Merge |
| Enrollment MEPRS Code | enr\_meprs\_cd | $4 |  |  | Enrollment MEPRS Code |
| From NYU ER Algorithm Diagnosis Grouping and Classification Tables |
| Non-Emergent ER Flag | er\_nonemerg | N | N/A | N/A | Use NYU algorithm to map all diagnoses to groups, then map to NYU classification file and fill with non-emergent ER Flag weight. |
| Emergent, PC Treatable ER Flag | er\_pc\_treatable | N | N/A | N/A | Use NYU algorithm to map all diagnoses to groups, then map to NYU classification file and fill with emergent PC Treatable ER Flag weight |
| Emergent, Preventable or Avoidable ER Flag | er\_preventable | N | N/A | N/A | Use NYU algorithm to map all diagnoses to groups, then map to NYU classification file and fill with emergent preventable or avoidable ER Flag weight |
| Emergent, Not Preventable or Avoidable ER Flag | er\_not\_preventable | N | N/A | N/A | Use NYU algorithm to map all diagnoses to groups, then map to NYU classification file and fill with Emergent, preventable or avoidable ER flag |
| Unclassified ER Flag | er\_unclass | N | N/A | N/A | Use NYU algorithm to map all diagnoses to groups, then map to NYU classification file and fill with emergent, not preventable or avoidable ER weight. |
| From MTF Network Referral File |
| Referring MTF | ref\_mtf | $4 | N/A | N/A | See Appendix N and Appendix O for matching and derivation logic. |
| CHCS Order Number for Referral | ref\_order\_num | $12 | N/A | N/A | See Appendix N and Appendix O for matching and derivation logic. |
| UIN | uin | $17 | N/A | N/A | See Appendix N and Appendix O for matching and derivation logic. |
| MTF Network Referral Match Flag | mtfref\_flag | $1 | N/A | N/A | See Appendix O for derivation. |
| From MDR Referral File |
| Referring Provider | ref\_provid | $9 | N/A | N/A | See Appendix O for matching and derivation logic. |
| Referring Provider EDIPN | ref\_edipn | $10 | N/A | N/A | See Appendix O for matching and derivation logic. |
| Referring Provider NPI | ref\_npi | $19 | N/A | N/A | See Appendix O for matching and derivation logic. |
| Referral Date | ref\_date | SAS | N/A | N/A | REFDATE |
| Referral Begin Date | ref\_begdate | SAS | N/A | N/A | See Appendix O for matching and derivation logic. |
| Referral End Date | ref\_enddate | SAS | N/A | N/A | See Appendix O for matching and derivation logic. |
| Referring MEPRS Code | ref\_meprscd | $4 | N/A | N/A | See Appendix O for matching and derivation logic. |
| ATC Category | ref\_atc\_cat | $1 | N/A | N/A | See Appendix O for matching and derivation logic. |
| Lookup from PCM Lookup File |
| PCM NPI | pcm\_npi | $10 |  |  | PCM NPI |
| PCM Name | pcm\_name | $40 |  |  | PCM Name |
| Internally Derived Fields |
| Adjustment Reason Derived Code | dadjcd | $2  | N/A | N/A | Apply adjustment reason format[1] file to the adjustment/denial reason code (2-220). If the type of reason code is “B”, then set adjustment reason derived code according to the format. Otherwise, if the type of reason is C and amount allowed by procedure code >0, then set according to the format, otherwise set to blank |
| Denial Reason Derived Code | denrsn | $2  | N/A | N/A | Apply denial reason format6 file to the adjustment/denial reason code (2-220). If the type of reason code is “D”, then set denial reason derived code to the format, else if the type of reason code is “C” and amount allowed by procedure code<=0 then set according to the format, otherwise set to blank. |
| Category of Care | catcare | $2  | N/A | N/A | See Appendix C. |
| TFL Flag (MERHCF) | tflflag | $1  | N/A | N/A | See Appendix G. |
| Fiscal Year of Acceptance Date | fyaccpt | $4  | N/A | N/A | Fiscal year of acceptance date |
| Fiscal Month of Acceptance Date | fmaccpt | $2  | N/A | N/A | Fiscal month of acceptance date |
| Provider Choice | prvchc | $3  | N/A | N/A | If any of the special processing codes (1-4) are “PO” then set = “POS” (prime point of service); otherwise, if enrollment status is “V” then set = “EXT” (extra); otherwise if enrollment status is “T” then set = “STD” (standard), otherwise leave blank.  |
| IBNR Category | ibnrcat | $1  | N/A | N/A | See Appendix H. |
| Fiscal Year | fy | $4  | N/A | N/A | Fiscal year equivalent of calendar month of end date of care |
| Fiscal Month | fm | $2  | N/A | N/A | Fiscal month equivalent of calendar month of end date of care |
| Calendar Year | cy | $4  | N/A | N/A | Calendar year of end date of care |
| Calendar Month | cm | $2  | N/A | N/A | Calendar month of end date of care |
| TED Indicator | tedind | $1  | N/A | N/A | If the last byte of the TED Number is either 0 (zero) or 5, then set the TED Indicator to ‘T’; else if the contractor number is in (02,04,05,08,15,61,62,63,64,65,70,71,99) then set the TED Indicator to ‘A’; else set the TED Indicator to ‘H’.  |
| Program Indicator Code | pic | $1  | N/A | N/A | If the 2nd character of type of service equal ‘M or ‘B’ then pic=’D’, else if any special processing codes (1-4) equal=’PF’ then pic=’H’, else if the 2nd character of type of service equal ‘G’ then pic=’T’, else if 1st character of type of service equal ‘I’ or ‘M’ then pic=’I’ else pic=‘N’ |
| Coverage Category | cvgcat | $1  | N/A | N/A | If any of the special processing codes (up to 4) have the value (“FF”, “FS”, “FG”, “R”, “T”) or enrollment status is ’PS’ then set to “T” (TDEFIC/TFL), else if enrollment status is V then set to “E” (Extra), else if enrollment status is T then set to “S” (Standard), else if enrollment status is “W” or starts with an “S” then set to “A” (Supp Care) else if any of the special processing codes are “PO” then set to “X” (POS), else if enrollment status in (‘U’, “Z”, “WF” “X” “XF”) then set to “P” (Prime), else set to “O” (Other). |
| Monthly Transaction Amount | mnamt | 8 | N/A | N/A | If the claim is an intial claim, set to amount paid. If claim is an adjustment record, set to difference between the amount paid on the adjustment record and the amount paid on the record in the database. |
| Age Group Code | agegrp | $1  | N/A | N/A | If 0 <= patage <= 4 then set to “A”, else if patage<=14 then set to “B”, else if patage<=17 then set to “C”, else if patage<=24 then set to “D”, else if patage<=34 then set to “E”, else if patage<=44 then set to “F”, else if patage<=64 then set to “G”, else if patage not blank or negative set to “H”, else set to “Z” |
| Number of Visits | visits | 2 | N/A | N/A | If the 2nd character of type of service is G, B, or M, set to 0. Otherwise, if the CPT Code is in one of the following ranges: [90000-90580], 90590, [90594-90595], [90599-92871], [92898-94999], [95200-97799], 97810, 97813, [98900-98922], [99150-99152], [99155-99195], [99201-99539], [99551-99601], then set the number of visits to be the minimum of the number of services and 99. Otherwise, if the CPT Code is [95000-95199] then if the type of submission code is C, E, set to 0, otherwise set to 1. For all remaining records, set visits to 0. |
| Hospital Department Number | hospdep | $2  | N/A | N/A | If 2nd character of type of service equal ‘B’ or ‘M’ then hospdep=’20’ else if a match is found for the principal DX in the hospital department table then hospdep= value from the table, else hospdep=‘14’. Blank fill for FY15 and later |
| Amount Patient Pay | patpay | 8 | N/A | N/A | If Provider Participation Indicator=’Y’ or any Special Processing Codes (1-4)=’NE’ then amount patient pay=amount allowed-amount paid, else if any Special Processing Codes (1-4)=’PO’ or enrollment status not equal (‘U’, ‘Z’ ‘BB’ ‘WF’) then do (if (allowed\*115)/100 > amount billed then amount patient pay=amount billed-amount paid, else amount patient pay=((allow\*115)/100)-amount paid), else amount patient pay=amount allowed-amount paid |
| Type of Submission | typesub | $1  | N/A | N/A | See Appendix D. |
| Provisional Acceptance Indicator | provaccp | $1  | N/A | N/A | If positions 476-482 (these are the provisional acceptance indicators) are blank in the TED data feed, then set to 0, otherwise set to 1 |
| Contract Type | contype | $1  | N/A | N/A | If contractor number in (62, 63, 64, 04, 05,08) then contype=’1’ (Tnex), else if contractor number in (03, 06, 07, 11, 25, 26, 60) then contype=’2’ (MCSC) else if contractor number is 61 or 70 then contype is 3 (Trex), else if contractor number is 65 or 71 then contype=’4’ (TDEFIC), else if contractor number is 02 then contype=’5’ (TMOP) else if contractor number is 15 then contype=’7’ (overseas) else contype=’6’ (other).  |
| Tnex Option Period | Op | $1  | N/A | N/A | Assign per Appendix E unless contractor number is 71. If contractor number is 71 and end date of care is between July1, 2008 and June 30, 2009 then set to 1, else if edoc is between July 1, 2009 and June 30 2010 then set to 2. |
| Medicare Pharmacy Indicator | medrx | $1  | N/A | N/A | If the OGP Type Code (govins) is H, I, J or L and the program indicator code is ‘D’ then set to Y. Otherwise set to N. |
| Hybrid Enrollment Site | hybenr | $4  | N/A | N/A | Fill with DEERS Enrollment Site if enrollment HSSC Region is O or Blank, or (if comben=4 and HCDP is not in (401-402, 405-412) and TED flag is not “T”), otherwise, fill with enrollment site. |
| PPS Product Line | ppsprod | $2  | N/A | N/A | See Appendix F. |
| Space A (reliant) Flag  | spacea | $1  | N/A | N/A | For FY04+: If DEERS ACV in (A, B, E, F, H, J, M, or Q) then space A flag is ‘N’. Else space A flag is ‘Y’. Prior to FY04, if enrollment status is (U, Z, BB, W, WA, WF or WO), or comben is ‘4’ then space A flag is ‘N’, else ‘Y’. |
| Underwritten Flag | undflag | $1  | N/A | N/A | Blank fill. See Appendix J for historical derivation. |
| Record Change Flag | chngeflg | $1  | N/A | N/A | Compare record to previous master dataset. If new record or record have been changed then assign change flag to ‘Y’, otherwise ‘N’. |
| Age Group Common | expage | $1  | N/A | N/A | If 0 <= patage <= 4 then set to “A”, else if patage<=14 then set to “B”, else if patage<=17 then set to “C”, else if patage<=24 then set to “D”, else if patage<=34 then set to “E”, else if patage<=44 then set to “F”, else if patage<=64 then set to “G”, else if patage<=69 then set to “H”, else if patage<=74 then set to “I”, else if patage<=79 then set to “J”, else if patage<=84 then set to “K”, else if patage not blank or negative set to “L”, else set to “Z”  |
| PPS Product Line | prodline | $8  | N/A | N/A | See appendix M  |
| Total RVU | totrvu | 8.2 | N/A | N/A | For FY04 and later: Work RVU + Practice Expense RVU. For FY03 and earlier set to blank |
| Number of Encounters | enc | 3 | N/A | N/A | For FY04 and later: If the line item receives work RVU credit (must assign work RVU first), then: If begin date = end date, then set to 1; otherwise the number of encounters is the lesser of the number of services and the number of days between (inclusive) the begin and end date.. For FY03 and later, leave blank |
| HCSR Amount Paid | hcsrpay | 10.2 | N/A | N/A | Set to 0 if TED flag is T. Otherwise, match to HCSR records based on HCSR key. Assign the HCSR payment amount from the reference file to the 1st line item number TED number. This matching need only be done when preparing the original database. The value from the initial assignment can simply be retained for subsequent processing of HCSRs, including ATOH application. |
| Administrative Tail | admtail | 5.2 | N/A | N/A | Currently blank. |
| Raw Beneficiary Category | comben | $1  |   | N/A | If HCDP in (401, 402, 405-412): if patient is a sponsor (memrln=’A’) then set to 2, else set to 3. If HCDP not in (401, 402, 405-412), then set to the common beneficiary category in the data feed. |
| Enrollment Status | enrstat | $2  | 2-300 | N/A | If Raw Enrollment DMISID begins with 69 and enrollment status (@735 in feed) is not “U”, then set to “U”. Otherwise, fill with enrollment status from the data feed.  |
| DEERS Bencat Common | dcomben | $1 | N/A | N/A | If DEERS beneficiary category is ACT or GRD then set to 4, else if DEERS beneficiary category is DA or DGR then set to 1, else if DEERS beneficiary category is RET then set to 2, else set to 3. |
| Place of Service | place | $2 | 2-275 |  | If contractor number in (61, 70,73) then place = ‘01’ else set place = raw value from feed. |
| ACV Group | acvgroup | $2 |  |  | If begin date is >=1/1/2018 then:f enr\_grp is “P” then set to “PR” elseif enr\_grp is “L” then set to “PL” elseif enr\_group=”U” then set to “DP” elseif (bencat common=4 and pcm\_type=N) then “R” elseif pcm\_type=”O” then “R” elseif elg\_grp in (“R” “S”) then “O” else “O”For logic prior to Jan 2018, see appendix P |

1. Refresh Frequency

## Monthly

1. Data Marts
2. M2

 See TED(NI) Extract for the M2.

1. Special Outputs

Periodically, a study should test whether the completion factors are still accurate that are used to estimate missing TEDN based on lag since the end-date-of-care.

**Appendix A: Provider Specialty Codes Receiving Work RVU Credit**

Work Relative Value Units are assigned to each record by matching the MDR Purchased Care RVU Format Table to each non-institutional record based on CPT code and CPT modifier 1 and calculating work RVUs for only specific provider specialty codes. The codes that receive work RVU credit are contained in the table below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Code** | **Description** |  | **Code** | **Description** |
| 01 | General Practice |  | 42 | Nurses (RN) |
| 02 | General Surgery |  | 43 | Nurses (LPN) |
| 03 | Allergy |  | 44 | Occupational Therapy (OTR) |
| 04 | Otology, Laryngology, Rhinology |  | 45 | Speech Pathologist/Speech Therapist |
| 05 | Anesthesiology |  | 47 | Endocrinology |
| 06 | Cardiovascular Disease |  | 48 | Podiatry - Surgical Chiropody |
| 07 | Dermatology |  | 50 | Proctology and Rectal Surgery |
| 08 | Family Practice |  | 57 | Certified Prosthetist - Orthotist |
| 10 | Gastroenterology |  | 62 | Clinical Psychologist (Billing Independently) |
| 11 | Internal Medicine |  | 64 | Audiologists (Billing Independently) |
| 13 | Neurology |  | 65 | Physical Therapist (Independent Practice) |
| 14 | Neurosurgery |  | 69 | Independent Laboratory (Billing Independently) |
| 16 | Obstetrics/Gynecology |  | 70 | Clinic or other group practice |
| 18 | Ophthalmology |  | 80 | Anesthetist |
| 19 | Oral Surgery (Dentists only) |  | 81 | Dietitian (Deleted 10/25/98) |
| 20 | Orthopedic Surgery |  | 82 | Education Specialist |
| 22 | Pathology |  | 83 | Nurse, Private Duty |
| 24 | Plastic Surgery |  | 84 | Physician’s Assistant |
| 25 | Physical Medicine and Rehabilitation |  | 85 | Certified Clinical Social Worker |
| 26 | Psychiatry |  | 86 | Christian Science |
| 28 | Proctology |  | 90 | Nurse Practitioner |
| 29 | Pulmonary Diseases |  | 91 | Clinical Psychiatric Nurse Specialist |
| 30 | Radiology |  | 92 | Certified Nurse Midwife |
| 33 | Thoracic Surgery |  | 93 | Mental Health Counselor |
| 34 | Urology |  | 94 | Certified Marriage and Family Therapist |
| 35 | Chiropractor, licensed |  | 95 | Pastoral Counselor |
| 36 | Nuclear Medicine |  | 96 | Marriage and Family Therapist (Only valid for Connecticut, Massachusetts, New Jersey and New York) (Deleted 10/25/94) |
| 37 | Pediatrics |  | 97 | M.S.W., A.C.S.W. (Deleted 10/25/94) |
| 38 | Geriatrics |  | 98 | Optometrist |
| 39 | Nephrology |  | HH | Home Health Aide/Homemaker |
| 40 | Neonatology |  | ON | Oncologist |

**Appendix B: Category of Care Logic**

The Category of Care is a two digit field. The first character is derived from the table below, with conditions tested in priority order. Brackets indicate inclusive ranges.

| **Priority** | **1st Char** | **Description** | **Procedure Code** | **Patient Age** | **Special Processing Codes 1 - 4** | **Type of Service (2nd position)** |
| --- | --- | --- | --- | --- | --- | --- |
| 1a | A1 | Psychiatric | [90800-90899] | <19 | Any | Any |
| 1b | A | Psychiatric | [90800-90899] | >=19 | Any | Any |
| 2a | B3 | OB | [59400-59799]  | <19 | Any | Any |
| 2b | B2 | OB | [59400-59799] | >=19 | Any | Any |
| 2c | B1 | OB | [59000-59399, 59800-59899] | <19 | Any | Any |
| 2d | B | OB | [59000-59399, 59800-59899] | >=19 | Any | Any |
| 3a | C1 | Gynecological | [56000-58999] | <19 | Any | Any |
| 3b | C | Gynecological | [56000-58999] | >=19 | Any | Any |
| 4a | D1 | Surgical | [10000-69999] OR G0001, G0002, G0051, G0052, G0053, G0104, G0105, G0120, G0121, G0122, G0127, G0159, G0160, G0168, G0169, G0170, G0171, G0183, G0184, G0185, G0186, G0187, G0272, G0289, G0290, G0291, G0297, G0298, G0299, G0300, G0341, G0342, G0343, G0364, M0301 , M0302, Q0081, Q0156, Q0157, S0630, S0800, S0801, S0802, S0803, S0804, S0805, S0806, S0807, S0808, S0809, S0810, S0811, S0812, S2050, S2052, S2053, S2054, S2055, S2060, S2061, S2065, S2070, S2080, S2082, S2085, S2090, S2091, S2095, S2102, S2103, S2109, S2112, S2113, S2115, S2120, S2135, S2140, S2142, S2150, S2152, S2180, S2190, S2202, S2204, S2205, S2206, S2207, S2208, S2209, S2210, S2211, S2213, S2220, S2225, S2230, S2235, S2250, S2260, S2300’, S2340, S2341, S2342, S2350, S2351, S2360, S2361, S2370, S2371, S2400, S2401, S2402, S2403, S2404, S2405, S2409, S2411, S4011, S4015, S4016, S4018, S4020, S4021, S4022, S4025, S4028, S4981, S4989, S8048, S9085, | <19 | Any | Any |
| 4b | D | Surgical | [10000-69999] OR G0001, G0002, G0051, G0052, G0053, G0104, G0105, G0120, G0121, G0122, G0127, G0159, G0160, G0168, G0169, G0170, G0171, G0183, G0184, G0185, G0186, G0187, G0272, G0289, G0290, G0291, G0297, G0298, G0299, G0300, G0341, G0342, G0343, G0364, M0301 , M0302, Q0081, Q0156, Q0157, S0630, S0800, S0801, S0802, S0803, S0804, S0805, S0806, S0807, S0808, S0809, S0810, S0811, S0812, S2050, S2052, S2053, S2054, S2055, S2060, S2061, S2065, S2070, S2080, S2082, S2085, S2090, S2091, S2095, S2102, S2103, S2109, S2112, S2113, S2115, S2120, S2135, S2140, S2142, S2150, S2152, S2180, S2190, S2202, S2204, S2205, S2206, S2207, S2208, S2209, S2210, S2211, S2213, S2220, S2225, S2230, S2235, S2250, S2260, S2300’, S2340, S2341, S2342, S2350, S2351, S2360, S2361, S2370, S2371, S2400, S2401, S2402, S2403, S2404, S2405, S2409, S2411, S4011, S4015, S4016, S4018, S4020, S4021, S4022, S4025, S4028, S4981, S4989, S8048, S9085, | >=19 | Any | Any |
| 5a | H1 | Program for Persons with Disabilities | Any | <19 | PF | Any |
| 5b | H | Program for Persons with Disabilities | Any | >=19 | PF | Any |
| 6a | F1 | Dental | Any | <19 | Any | G |
| 6b | F | Dental | Any | >=19 | Any | G |
| 7a | G1 | Drug | 98800 | <19 | Any | B,M |
| 7b | G | Drug | 98800 | >=19 | Any | B,M |
| 8a | E1 | All Other | Any | <19 | Any | Any |
| 8b | E | All Other | Any | >=19 | Any | Any |

**Appendix C: Type of Submission Code**

The Type of Submission Code is a 1 character field derived from AMOUNT ALLOWED TOTAL, AMOUNT PAID BY OTHER HEALTH INSURANCE, AMOUNT PAID BY GOVERNMENT CONTRACTOR, TOTAL AMOUNT BILLED, DENIAL REASON DERIVED CODE, and SUBMISSION CODE.

**IF**, on the current TED Net Record, AMOUNT ALLOWED (TOTAL, Derived) > 0,

and AMOUNT PAID BY OTHER HEALTH INSURANCE (TOTAL, Derived) > 0

and AMOUNT PAID BY GOVERNMENT CONTRACTOR TOTAL (Derived) < 0 or = 0, then

 The value of TYPE OF SUBMISSION, DERIVED is ‘O’ (100% paid by Other Health insurance)

**ELSE**

**IF**, on the current TED Net Record, AMOUNT ALLOWED (TOTAL, Derived) < or = 0,

and all Line Items contain a value in DENIAL REASON DERIVED CODE,

and the AMOUNT PAID BY OTHER HEALTH INSURANCE (TOTAL,derived) = TOTAL AMOUNT BILLED,

 **then** The value of TYPE OF SUBMISSION, DERIVED is ‘O’ (100% paid by Other Health insurance)

**ELSE**

**IF**, on the current TED Net Record, AMOUNT ALLOWED (TOTAL, Derived) < or = 0

and all Line Items contain a value in DENIAL REASON DERIVED CODE t**hen** The value of TYPE OF SUBMISSION, DERIVED is ‘D’ (Complete

contractor denial initial TED Record submission)

**ELSE**

**IF** TYPE OF SUBMISSION on the current TED Net Record = ‘D’ (Complete contractor denial initial TED Record submission)

and at least one Line Items does not contain a value in DENIAL REASON DERIVED CODE and AMOUNT ALLOWED (TOTAL) (derived) not = 0

and AMOUNT PAID GOVERNMENT CONTRACTOR TOTAL (derived) > 0

 **then** The value of TYPE OF SUBMISSION, DERIVED is ‘I’, (Initial TED Record submission)

**ELSE**

**IF** TYPE OF SUBMISSION on the current TED Net Record = ‘D’ (Complete contractor denial initial TED Record submission)

 **Then**

The value of TYPE OF SUBMISSION, DERIVED is ‘D’ (Complete contractor denial initial TED Record submission)

**ELSE**

**IF** TYPE OF SUBMISSION on current TED Net Record =

‘A’ (Adjustment to TED Record data) or

‘B’ (Adjustment to non-TED Record (HCSR) data or

‘I’ (Initial TED Record submission)

**then** The value of TYPE OF SUBMISSION, DERIVED is ‘I,’ (Initial TED Record submission)

**ELSE**

**IF** TYPE OF SUBMISSION on current TED Net Record = ‘C’ (Complete cancellation of TED Record data) or

‘E’ (Complete cancellation of non-TED Record (HCSR) data

**then** the value of TYPE OF SUBMISSION, DERIVED is ‘C’ (Complete cancellation of TED record data)

**ELSE** The value of TYPE OF SUBMISSION, DERIVED is the value of TYPE OF SUBMISSION on the current Net Record.

**Appendix D: TNex Option Period**

This variable is a 1 character field that represents the TNex option period of the claim. It is derived based on the following fields:

* Contract Type (contype)
* End Date of Care (enddate)
* Residence Region (resreg)

The combinations of values in each of these fields that result in a particular TNex Option Period are presented below.

| **Case** | **Contract Type (contype)** | **Residence Region (resreg)** | **End Date of Care** **(cy, cm)** | **TNex Option Period** **(op)** |
| --- | --- | --- | --- | --- |
| 1 | 1 (TNex) | 11 | Jun 2004 – Mar 2005 | 1 |
| 2 | 2, 5, 9, 10, 12, AK | Jul 2004 – Mar 2005 | 1 |
| 3 | 3, 4 | Aug 2004 – Mar 2005 | 1 |
| 4 | 1 | Sep 2004 – Mar 2005 | 1 |
| 5 | 7,8  | Oct 2004 – Mar 2005 | 1 |
| 6 | 6 | Nov 2004 – Mar 2005 | 1 |
| 7 | Any | Nov 2004 – Mar 2005  | 1 |
| 8 | Any | Apr 2005 – Mar 2006 | 2 |
| 9 | Apr 2006 – Mar 2007 | 3 |
| 10 | Apr 2007 – Mar 2008 | 4 |
| 11 | Apr 2008 – Mar 2009 | 5 |
| 12 | 3 (TRex) | Any | Jun 2004 – May 2005 | 1 |
| 13 | Jun 2005 – May 2006 | 2 |
| 14 | Jun 2006 – May 2007 | 3 |
| 15 | Jun 2007 – May 2008 | 4 |
| 16 | Jun 2008 – May 2009 | 5 |
| 17 | 4 (TDEFIC) | 11 | Apr 2004 – Mar 2005 | 1 |
| 18 | 2, 5 | Jun 2004 – Mar 2005 | 1 |
| 19 | 9, 10, 12, AK | Jul 2004- Mar 2005 | 1 |
| 20 | 3, 4 | Aug 2004 – Mar 2005 | 1 |
| 21 | 1 | Sep 2004 – Mar 2005 | 1 |
| 22 | 7,8  | Oct 2004 – Mar 2005 | 1 |
| 23 | 6 | Nov 2004 – Mar 2005 | 1 |
| 24 | Any | Nov 2004 – Mar 2005 | 1 |
| 25 | Any | Apr 2005 – Mar 2006 | 2 |
| 26 | Apr 2006 – Mar 2007 | 3 |
| 27 | Apr 2007 – Mar 2008 | 4 |
| 28 | Apr 2008 – Mar 2009 | 5 |
| 29 | 5 (TMOP) | Any | Mar 2003 – Feb 2004 | 1 |
| 30 | Mar 2004 – Feb 2005 | 2 |
| 31 | Mar 2005 – Feb 2006 | 3 |
| 32 | Mar 2006 – Feb 2007 | 4 |
| 33 | Mar 2007 – Feb 2008 | 5 |
| 34 | 1(TNex) | Any | Apr 2009 – Mar 2010 | 6 |
| Not in any of the above 1-34 cases | Any | Any | Any | Blank |

**Appendix E: PPS Product Line**

| **PPS Product Line Num** | **PPS Product Line** | **Place of Service** | **Provider Specialty Code** |
| --- | --- | --- | --- |
| 01 | ER | 23 | Any |
| 02 | Mental Health | Not 23 | 62, 85, 26, 94, 93, 91, 95 |
| 03 | Facility | Not 23 | 99 |
| 04 | PC | Not 23 | 01 , 11 , 37 , 08 , 90 , 84 , 70 |
| 05 | IM Sub | Not 23 | 10, 06, 13, 34, 29, 03, 47, 39, 40, 38, ON |
| 06 | Optometry | Not 23 | 98, 18 |
| 07 | Ortho | Not 23 | 20, 65, 48, 25 |
| 08 | Radiology | Not 23 | 30 |
| 09 | ENT | Not 23 | 04 |
| 10 | OB | Not 23 | 16, 92 |
| 11 | Surgery | Not 23 | 02 |
| 12 | Dermatology | Not 23 | 07 |
| 13 | Surg Sub | Not 23 | 24, 14, 33, 28, 50 |
| 14 | Anesthesia | Not 23 | 05, 80 |
| 15 | None | Not 23 | 69, 49, 42, 43, 51, 59, 88, 82, 97, 60, 81, 35, 83, BC |
| 16 | Home | Not 23 | HA, HH |
| 17 | Pathology | Not 23 | 22 |
| 18 | Other | All else | All else |

**Appendix F: Medicare Eligible Retiree Health Care Fund (MERHCF) Flag**

The MERHCF flag has 4 values (A,N,U,T), which are based on accrual fund eligibility and patient age and beneficiary category (common). First the ACCRUAL FUND status is determined, then the patient age or ben cat common is used to assign the MERHCF flag.

If the DEERS Health Care Delivery Program Code (dhcdp) is blank, use the Health Care Delivery Program Code from the TED processing (hcdp).

If the contractor number (konum) is '04','05','08','62', '63' or '64' then ACCRUAL FUND = DHP.

If the enrollment status (enrstat) is 'SR', 'AA' or 'Y' then ACCRUAL FUND = DHP.

If any special processing code (sprocd1-sprocd4) is 'AR', 'DC' or 'DE' then ACCRUAL FUND = DHP.

If the member relationship (memrln) is 'A' or 'Z' and either the enrollment status is 'SN' or any special processing code is 'AN' then ACCRUAL FUND = DHP.

If the member relationship is 'A' and the member category (memcat) is 'A', 'G', 'J', 'N', 'S', 'T', 'V', or 'Y' then ACCRUAL FUND = DHP.

If the health care delivery program code (dhcdp or hcdp) is between '405' and '414' or between '417' and '421' then ACCRUAL FUND = DHP.

If the health care delivery program code is '000', '121' or '122' then ACCRUAL FUND = DHP.

If the other government insurance begin reason code (govinbeg) is 'N' then ACCRUAL FUND = DHP.

If the other government insurance (govins) is not 'A', 'C', 'H', 'I', or 'L' then ACCRUAL FUND = DHP.

If the member category is not 'F', 'H', 'R' or 'W' and the health care delivery program code is not blank, '004', '005', '016', '017', '021', '023', '110', '111', '114', '115', '136', '137', '138', '139', 143', '144', '148', '149', '151' then ACCRUAL FUND = DHP.

If none of the above conditions are true then ACCRUAL FUND = MERHCF.

If ACCRUAL FUND is DHP and the beneficiary category (comben) is 1 or 4 then MERHCF flag is 'A'.

 If ACCRUAL FUND is DHP and the beneficiary category is 2 or 3 then MERHCF flag is 'N'.

If ACCRUAL FUND is MERHCF and patient age (patage) < 65 then MERHCF flag is 'U'.

If ACCRUAL FUND is MERHCF and patient age (patage) => 65 then MERHCF flag is 'T'.

**Appendix G: IBNR Category**

| Category Number | Category | Program Indicator Code | Service Type Code | Enrollment Status |
| --- | --- | --- | --- | --- |
| 1 | Drugs | D | Not I or M | Not Applicable |
| 2 | Non-TFL Inpatient | Any | I or M | Not FE or FS |
| 3 | TFL Inpatient | Any | I or M | FE or FS |
| 4 | Non-TFL Ambulatory | Not D | Not I or M | Not FE or FS |
| 5 | TFL Ambulatory | Not D | Not I or M | FE or FS |

**APPENDIX H – Historical Processing of Combined TED/HCSRs:**

**Table H1: External File Merges:**

| **Merge** | **Merge to** | **Date Matching** | **Additional Matching** |
| --- | --- | --- | --- |
| DEERS Person Demographics file | Increment |  | Match to HCSR or ATOH records based on SPONSSN and DDS (if both fields are no blank), otherwise, merge on PATSSN.Must be done prior to application of LVM4. Critical field. Check match statistics carefully. **Retain EDI\_PN values in subsequent processing.** |
| DEERS Dependent Suffix File[[7]](#footnote-7) | Initial HCSR and ATOH | FY based on end date of care | Match to HCSR or ATOH records by TED Key**. One time** **requirement to add DDS (if empty)**; only needed to build the initial datasets. Must be done prior to application of LVM4 and the DEERS Person Demographics file. **Retain DDS values in subsequent processing.** |
| Longitudinal Enrollment | Master | Fiscal year and calendar month of begin date of care on NI record, with enrollment information from corresponding monthly enrollment segment. | Sponsor social and DDS. **One time requirement for FY03 and earlier only**. Only needed to apply the DEERS ACV and DEERS Enrollment site variables. **Retain values in subsequent processing.** |
| Longitudinal VM4 File  | Master | Begin Date of Care on TED, with begin and end dates for each changeable demographic segment. | EDI\_PN if available. |
| Master Person Index | Master | None | For records with blank EDI\_PN, match TED and ATOH records by sponssn, patsex, patdob and grouped member relationship code. See VM-6 Specification |
| Relative Value Unit Table  | Increment | CY of end date of care and CY of MDR Purchased Care RVU Table. | Procedure Code + Modifier 1 from NI Line Item with Procedure Code + Modifier from RVU Table. |
| Legacy Relative Value Unit Table | Increment | CY of end date of care and CY of MDR legacy RVU Table | Procedure code from NI Line Item with Procedure Code from RVU table. |
| DMISID  | Master | FY of end date of care, FY of MDR DMISID SAS format file. | Application based on enrollment DMISID, DEERS enrollment DMISID and catchment area DMISID |
| Omni-CAD | Increment | FY/FM of end date of care, FY/FM of MDR Omni CAD format file | Patient zip code & sponsor service. Also based on provider zip |
| Administrative Tail reference file | Increment | FY of end date of care and FY of MDR administrative tail format file. | Contract type |
| Reservist GWOT file | Master | Begin date of care from NI line item and dates associated with each reservist benefit type segment. | Sponsor social security number |
| Final HCSR Payment Amount Reference File | Initial HCSR and ATOH | FY of reference file and FY of claim file | TED number. One time requirement for FY05 and earlier. Only used to build the initial database. Retain values during subsequent processing. |
| TED Episode Reference File | Master | Begin date of care | EDI\_PN |

 **Update Process:**

The data in the HCSR feed is first mapped to TED format, and then appended to the corresponding TED feeds[[8]](#footnote-8). When the raw feed of Non-Institutional TED data is processed, two types of records are removed from the feed. First, TEDs that are denied or cancelled (records with an allowed amount less than or equal to 0) are separated out and added the master cancellation data file. Then, ATOH records and records from the wrong fiscal year are dropped from the data.

Using the remaining records, the processor identifies records that may potentially have changed fiscal year when the record was updated and the end date of care moved into the next fiscal year. These records are not removed from the data feed, they are just identified and saved to an intermediate data set. This data set contains the TED number and line item number for every record where the begin date is in a fiscal year prior to the fiscal year of the end date of care. This file will be referred to as the previous fiscal year data set later in this document.

Next, the processor appends variables to the incremental data feed. Then it combines incremental and master data sets, interleaving records by TED number, line item number and cycle date. The processor retains only the most recent version of the TED, as identified by TED number and line item number[[9]](#footnote-9). Then the processor uses the previous fiscal year data set to remove from the master data set any records that have moved to a subsequent fiscal year. This is done to ensure that records are not in two fiscal years.

Then the master cancellation data set is used to remove cancelled TEDs from the updated master data set. Additional processing is performed to append more fields to the master TED-NI data set. All of the appended fields are described in the next two sections of this document.

The remaining records are identified as either CHAMPUS or TDEFIC, or in some cases both, and written to the appropriate data set(s). These incremental data sets are then used to update the appropriate master data set. The update processing described in the rest of this section, applies to both the CHAMPUS and TDEFIC data.

**File Layout and Business Rules:**

**Mapping Tables**

Records that are sent in that originated as HCSRs undergo a mapping process to ensure consistency among data elements, regardless of whether the data originated from a HCSR or a TED. Fields are read in from the HCSR data feeds, and transformed to the TED coding shema according to the tables below.

**Table H-2: Sponsor Pay Plan**

|  |  |
| --- | --- |
| **HCSR Rank** | **Pay Plan** |
| [00-09] | ME |
| [10-15] | MW |
| 19 | MC |
| [20-31] | MO |
| [40-58] | GS |
| 90 | ZZ |
| 95 | ZZ |
| 99 | ZZ |
| Any Other | ZZ |

**Table H-3: Sponsor Pay Grade**

|  |  |  |
| --- | --- | --- |
| **HCSR Rank** | **Pay Plan** | **Pay Grade** |
| [00-09] | ME | HCSR Rank |
| [10-15] | MW | [01-05] (HCSR Rank – 10) |
| 19 | MC | 01 |
| [20-31] | MO | [01-11] (HCSR Rank – 20) |
| [40-58] | GS | [01-18] (HCSR Rank – 40) |
| 00,90,95,99 | Any | 00 |
| All Other | All Other | 00 |

**Table H-4: Branch of Service**

| **HCSR Service** | **HCSR Sponsor Status** | **TED Service** |
| --- | --- | --- |
| A | T | 1 |
| N | T | 2 |
| M | T | 3 |
| F | T | 4 |
| A | Not T | A |
| C | Not T | X |
| E | Not T | H |
| F | Not T | F |
| I | Not T | O |
| M | Not T | M |
| N | Not T | N |
| P | Not T | C |
| All other | Not T | X |

**Table H-5: Sponsor Status**

|  |  |
| --- | --- |
| **Sponsor Status** | **Member Category** |
| B | A |
| I | D |
| K | Z |
| O | D |
| All other | Set to sponsor status |

**Table H-6: Patient Relationship to Sponsor**

| **HCSR Patient Relationship to Sponsor** | TED Member Relationship |
| --- | --- |
| <blank> | A |
| C | C |
| F | G |
| G | G |
| H | H |
| L | F |
| M | F |
| P | F |
| R | I |
| S | B |
| T | H |
| U | F |
| V | C |
| W | E |
| X | Z |
| Y | I |
| Z | Z |

**Table H-7: Submission Code**

| **HCSR Type of Submission** | **TED Type of Submission** |
| --- | --- |
| A | B |
| B | B |
| C | E |
| D | D |
| E | E |
| F | B |
| G | B |
| I | I |
| O | O |
| R | R |

**Table H-8: Special Processing Codes**

|  |
| --- |
|  |
| **HCSR Special Processing Code** | **TED Special Processing Code** |
| @ | 10 |
| # | 11 |
| $ | 12 |
| & | 14 |
| ? | 16 |
| \* | 17 |
| All Other | No change |

**Table H-9: Pricing Rate Code**

|  |  |
| --- | --- |
| **HCSR Type of Submission** | **TED Type of Submission** |
| U | V |
| V | LC |
| All Other | No change |

**Table H-10: HCSR Country Code to TED Country Code (**Used in mapping provider zip, patient zip, provider state/country code.)

| **HCSR State/****Country Code** | **TED State/****Country Code** |  | **HCSR State/****Country Code** | **TED State/****Country Code** |  | **HCSR State/****Country Code** | **TED State/****Country Code** |  | **HCSR State/****Country Code** | **TED State/****Country Code** |  | **HCSR State/****Country Code** | **TED State/****Country Code** |  | **HCSR State/****Country Code** | **TED State/****Country Code** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| AW | ABW |  | KM | COM |  | HT | HTI |  | MS | MSR |  | SO | SOM |  | 09 | CT  |
| AF | AFG |  | CV | CPV |  | HU | HUN |  | MQ | MTQ |  | PM | SPM |  | 10 | DE  |
| AO | AGO |  | CR | CRI |  | ID | IDN |  | MU | MUS |  | ST | STP |  | 11 | DC  |
| AI | AIA |  | CU | CUB |  | IN | IND |  | MW | MWI |  | SR | SUR |  | 12 | FL  |
| AX | ALA |  | CX | CXR |  | IO | IOT |  | MY | MYS |  | SK | SVK |  | 13 | GA  |
| AL | ALB |  | KY | CYM |  | IE | IRL |  | YO | MYT |  | SI | SVN |  | 15 | HI  |
| AD | AND |  | CY | CYP |  | IR | IRN |  | NA | NAM |  | SE | SWE |  | 16 | ID  |
| AN | ANT |  | CZ | CZE |  | IQ | IRQ |  | NC | NCL |  | SZ | SWZ |  | 17 | IL  |
| AE | ARE |  | DE | DEU |  | IS | ISL |  | NE | NER |  | SC | SYC |  | 18 | IN  |
| AR | ARG |  | DJ | DJI |  | IL | ISR |  | NF | NFK |  | SY | SYR |  | 19 | IA  |
| AM | ARM |  | DM | DMA |  | IT | ITA |  | NG | NGA |  | TC | TCA |  | 20 | KS  |
| AS | ASM |  | DK | DNK |  | JM | JAM |  | NI | NIC |  | TD | TCD |  | 21 | KY  |
| AQ | ATA |  | DO | DOM |  | JO | JOR |  | NU | NIU |  | TG | TGO |  | 22 | LA  |
| TF | ATF |  | DZ | DZA |  | JP | JPN |  | NL | NLD |  | TH | THA |  | 23 | ME  |
| AG | ATG |  | EC | ECU |  | KZ | KAZ |  | NO | NOR |  | TJ | TJK |  | 24 | MD  |
| AU | AUS |  | EG | EGY |  | KE | KEN |  | NP | NPL |  | TM | TKM |  | 25 | MA  |
| AT | AUT |  | ER | ERI |  | KG | KGZ |  | NR | NRU |  | TP | TMP |  | 26 | MI  |
| AZ | AZE |  | EH | ESH |  | KH | KHM |  | NZ | NZL |  | TT | TTO |  | 27 | MN  |
| BI | BDI |  | ES | ESP |  | KI | KIR |  | OM | OMN |  | TN | TUN |  | 28 | MS  |
| BE | BEL |  | EE | EST |  | KN | KNA |  | PK | PAK |  | TR | TUR |  | 29 | MO  |
| BJ | BEN |  | ET | ETH |  | KR | KOR |  | PA | PAN |  | TV | TUV |  | 30 | MT  |
| BF | BFA |  | FI | FIN |  | KW | KWT |  | PN | PCN |  | TW | TWN |  | 31 | NE  |
| BD | BGD |  | FJ | FJI |  | LA | LAO |  | PE | PER |  | TZ | TZA |  | 32 | NV  |
| BG | BGR |  | FK | FLK |  | LB | LBN |  | PH | PHL |  | UG | UGA |  | 33 | NH  |
| BH | BHR |  | FR | FRA |  | LR | LBR |  | PW | PLW |  | UA | UKR |  | 34 | NJ  |
| BS | BHS |  | FO | FRO |  | LY | LBY |  | PG | PNG |  | UM | UMI |  | 35 | NM  |
| BA | BIH |  | FM | FSM |  | LC | LCA |  | PL | POL |  | UY | URY |  | 36 | NY  |
| BY | BLR |  | FX | FXX |  | LI | LIE |  | PR | PRI |  | BQ | USA |  | 37 | NC  |
| BZ | BLZ |  | GA | GAB |  | LK | LKA |  | KP | PRK |  | UZ | UZB |  | 38 | ND  |
| BM | BMU |  | GB | GBR |  | LS | LSO |  | PT | PRT |  | VA | VAT |  | 39 | OH  |
| BO | BOL |  | GE | GEO |  | LT | LTU |  | PY | PRY |  | VC | VCT |  | 40 | OK  |
| BR | BRA |  | GH | GHA |  | LU | LUX |  | PF | PYF |  | VE | VEN |  | 41 | OR  |
| BB | BRB |  | GI | GIB |  | LV | LVA |  | QA | QAT |  | VG | VGB |  | 42 | PA  |
| BN | BRN |  | GN | GIN |  | MO | MAC |  | RE | REU |  | VI | VIR |  | 44 | RI  |
| BT | BTN |  | GP | GLP |  | MA | MAR |  | RO | ROM |  | VN | VNM |  | 45 | SC  |
| BV | BVT |  | GM | GMB |  | MC | MCO |  | RS | RUS |  | VU | VUT |  | 46 | SD  |
| BW | BWA |  | GW | GNB |  | MD | MDA |  | RW | RWA |  | WF | WLF |  | 47 | TN  |
| CF | CAF |  | GQ | GNQ |  | MG | MDG |  | SA | SAU |  | WS | WSM |  | 48 | TX  |
| CA | CAN |  | GR | GRC |  | MV | MDV |  | CS | SCG |  | YE | YEM |  | 49 | UT  |
| CC | CCK |  | GD | GRD |  | MX | MEX |  | SD | SDN |  | YU | YUG |  | 50 | VT  |
| CH | CHE |  | GL | GRL |  | MH | MHL |  | SN | SEN |  | ZA | ZAF |  | 51 | VA  |
| CL | CHL |  | GT | GTM |  | MK | MKD |  | SG | SGP |  | ZM | ZMB |  | 53 | WA  |
| CN | CHN |  | GF | GUF |  | ML | MLI |  | GS | SGS |  | ZW | ZWE |  | 54 | WV  |

**Appendix Ha: DEERS Person Demographic File**

Under the TRICARE Next Generation contracts, new demographic data elements were added to the DEERS interface with the fiscal intermediaries, allowing for new content to be available on TED records. This content is added to HCSRS and ATOH records based on a derivation from matching to a DEERS point in time based extract. This process is done on the initial MDR database for each year prior to FY06 as well as monthly ATOH feeds.

The following demographic variables added to HCSR and ATOH records are listed below.[[10]](#footnote-10) Create one DEERS file containing both FY04 and FY05. Prior years will be added at a later time.

To create the DEERS merge files:

1. Read in primary eligible PITE/VM4 records.
2. Create a PITE month date element, indicating the month of the PITE data.
3. For each EDI\_PN, retain the most recent non-blank value (with primary eligibility) for:
	1. Sponsor Social Security Number
	2. Legacy DDS Code
	3. DEERS Patient ID
	4. Sponsor Social Type Code
	5. Patient Social Security Number
	6. Patient Social Type Code
	7. Cadency
4. And (for each EDI\_PN) retain most current Medicare A and Medicare B segments:
	1. Medicare A Begin Reason Code, Effective and Expiration Dates
	2. Medicare B Begin Reason Code, Effective and Expiration Dates
5. And (for each EDI\_PN) retain a monthly history segment of:
	1. AGR Legal Service Authority Code

To match the pre-processed DEERS files to the HCSR data:

1. Sort DEERS file and deduplicate by sponsor social and DEERS dependent suffix where both fields are populated. (If either of these fields is unpopulated, records should be merged to DEERS data based on patient social security number, if available. If unavailable, the DEERS-based values to be added to HCSRs described in this Appendix should be coded as unknown).
2. Sort HCSRs by sponsor social and DDS (or patient social, as noted above).
3. Match to DEERS records. Only retain records that result with a matching HCSR. In other words, delete DEERS only records.
4. For matching records, populate the HCSR demographic data
	1. From the matching DEERS record:
		1. EDI\_PN
		2. Cadency
		3. Patient Social (if empty)
		4. Patient ID Type Code
		5. DEERS ID
		6. Sponsor ID Type Code
	2. Populate AGR Legal Service Authority information by matching the month of the begin date of care to month of DEERS file. If the begin date of care is prior to the earliest month of available AGR Legal Service Authority information, fill with earliest available information for the beneficiary. If no match is found, leave blank.
	3. By deriving the Type of Other Government Health Insurance (GOVINS) and the Begin Reason Code for Other Government Insurance (GOVINBEG) from the most recently reported Medicare information available for the respective FY. In order to derive the GOVINS and the GOVINBEG, the begin date of care should be compared with the effective and expiration dates of Medicare eligibility. Should the care begin outside the window of eligibility, the associated Medicare begin reason code should be considered to be “N”. Do this comparison separately for Medicare A and for Medicare B, and then derive the GOVINS and GOVINBEG segments according to the table below:

| **OGP Type Code** | **OGP Begin Reason Code** | **Medicare A date window contains the begin date of care** | **Medicare B date window contains the begin date of care** | **HCSR Branch of Service** |
| --- | --- | --- | --- | --- |
| A (Medicare A)  | Set to value in Medicare A Begin Reason Code DEERS record. | Yes | No | Any but V |
| B (Medicare B) | Set to value in Medicare B Begin Reason Code DEERS record. | No | Yes | Any but V |
| C (Medicare A and B) | Set to the value contained in the Medicare A begin reason code if not N, otherwise, use the value from the Medicare B begin reason code. | Yes | Yes | Any but V |
| V (CHAMPVA) | Set to V | Any | Any | V |
| N (No Medicare) | Set to W | All Other |

### **APPENDIX I: Underwritten Flag**

(No longer populated) The purpose of Underwritten Flag is to code which region the responsible for the claim. This methodology is verified and approved by the DHA and MCSC. For Regional jurisdiction, Prime beneficiaries (defined by enrollment status) are assigned to each contractor based on enrollment region and enrollment DMIS IDs (for the 69XXs and 79XXs ids). Non-Prime beneficiaries are assigned based on residence region. The new 69XX (managed care contractor) and 79XX (remote) series of enrollment DMIS IDs are being assigned to enrollment region “00”. Thus, those enrollment DMIS IDs must be included with the enrollment regions. There are 4 values in which this variable may contain (N, S, W, blank). A blank value means the record is not underwritten. This flag should only be applied to TED claims (based on TED flag).

Below are rules used to determine the underwritten flag in the non-institutional TED.

1. Pharmacy claims (based on program indicator code=D or procedure code=98800 or provider taxid=43186775) claims are not underwritten
2. Active Duty (based on common beneficiary code=4) claims are not underwritten.
3. USFHP enrollees (based on alternate care value=U) claims are not underwritten.
4. TRICARE Senior Pharmacy, Senior Supplement, Senior Prime, TRICARE for Life (based on enrollment status=PS,TS,BB,FE,FS and special processing codes=FF,FS,FG) claims are not underwritten.
5. Supplemental care (based on enrollment status= SN,SO,SR,ST) claims are not underwritten.
6. TRICARE Reserve Select (based on DHCDP code=401-415 or ACV R) claims are not underwritten.
7. CHCBP (based on enrollment status=AA,Y) claims are not underwritten.
8. Foreign claims (based on provider state/country code) claims are not underwritten.
9. TRICARE Dual Eligibles ages less than 65 (based on special processing codes=R,T,RS) claims are not underwritten.
10. Cancer-clinical trials, utero fetal surgery, CCTP or ICMP (based on special processing codes=CL,CT,CM) claims are not underwritten.
11. TRR (based on ACV of V) are not underwritten
12. TYA (based on DHCDP of 422-432) are not underwritten
13. Tobacco and weight demonstration program claims are not underwritten (based on DHCDP)
14. Autism Demonstration and Autism Tutor Program are not underwritten (any special processing code of AU, PF, AP)
15. Claims that are not underwritten have a blank value.

**Appendix J: Master Person Index Merge for EDI\_PN**

Some Records in the HCSR feeds do not include EDI\_PN. As a result, if TED flag is not equal to ‘T’ or ‘A’ then derive EDI\_PN from DEERS Demographics File by matching on HCSR keys. Otherwise if TED flag is equal to ‘T’ or ‘A’ then no transformation. If no match is found, leave blank. Retain value from initial EDI\_PN merge should the HCSR be adjusted with an ATOH. This is done as a one time requirement to add EDI\_PN and only needed to build the initial HCSR datasets (see Appendix I).

As part of ongoing monthly process, apply MPI merge to master data set (regardless of TED flag). If a record has an EDI\_PN of blank, ‘1111111111’ or ‘9999999999’ then do the following:

1. If EDI\_PN is blank, ‘1111111111’ or ‘9999999999’ then set EDI\_PN to blank.
2. Derive a temporary variable name FMP based on member relationship code, in order.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Member Relationship Code** | **Patient Age** | **Patient Sex** | **Description** | **Temporary FMP** |
| A | Any | Any | Self | 20 |
| C, D, E, L | Any | Any | Child | 01 |
| B, G, H, I, J, K | Any | Any | Spouse | 30 |
| F | Any | Any | Other | 40 |
| Any | <18 | Any | Child | 01 |
| Any | >=18 | F | Spouse | 30 |
| All Other | Any | Any | Self | 20 |

1. For this subset of records, send sponssn, patsex, patdob and temporary FMP variables to MPI merge program. If a match is found in the MPI file, then replace EDI\_PN in master TED-NI file with EDI\_PN from MPI file.

**Appendix K: Apply TED Episode Reference File**

The purpose of the TED Episode Reference file is to allow the linking of institutional and non-institutional claims that are part of an episode of care. Below is logic used to apply TED Episode Reference File to non-institutional claims.

* Apply Admitting TED number to master TED-NI file using corresponding FY Episode Reference Table.
* Do not apply Episode Reference Table to pharmacy claims (PIC=D or CPT=98800).
* Do not apply Episode Reference Table to CPT codes that start with A, C, D, E, P and R.
	+ Apply Episode Reference Table if TED-NI claim is inpatient based on place of service equal 21 (inpatient hospital), 25 (birthing center), 51 (inpatient psychiatric facility), and 61 (comprehensive inpatient rehabilitation facility). If begin date of TED-NI is within episode admit date and end date of episode then populate claim admitting TEDNO with episode admitting TEDNO. If the begin date of TED-NI overlaps between 2 episode segments then populate claim admitting TEDNO with 2nd episode admitting TEDNO.

**Appendix L: PPS Product Line Derivation**

|  |  |  |
| --- | --- | --- |
| **PPS Product Line** | **Place of Service** | **Provider Specialty Code - Derived** |
| ER | 23 | Any |
| MH | Not 23 | 62, 85, 26, 94, 93, 91, 95 |
| FACILITY | Not 23 | 99 |
| PC | Not 23 | 01 , 11 , 37 , 08 , 90 , 84 , 70 |
| IMSUB | Not 23 | 10, 06, 13, 34, 29, 03, 47, 39, 40, 38, ON |
| OPTOM | Not 23 | 98, 18 |
| ORTHO | Not 23 | 20, 65, 48, 25 |
| RAD | Not 23 | 30 |
| ENT | Not 23 | 04 |
| OBGYN | Not 23 | 16, 92, GY |
| SURG | Not 23 | 02 |
| DERM | Not 23 | 07 |
| SURGSUB | Not 23 | 24, 14, 33, 28, 50 |
| ANESTH | Not 23 | 05, 80 |
| NONE | Not 23 | 69, 49, 42, 43, 51, 59, 88, 82, 97, 60, 81, 35, 83, BC, HB |
| HOME | Not 23 | HA, HH |
| PATH | Not 23 | 22 |
| OTHER | All else | All else |

**Appendix M: Calculation of Number of Evaluative Visits**

The number of evaluative visits is a claim-based measure of documented interactions between a patient and a specific provider. To calculate the number of evaluative visits on a claim for a given provider and allocate its value to the line items that compose that provider's contribution to the claim, use the following algorithm.

First, for each line item in a claim that is attributed to a specific provider, calculate a weight for each day in the range defined by the begin date of care and end date of care on the line item. If the procedure code for the line item appears has an associated EVALVISFLG (from CPT Merge) = Y, then the weight is the lesser of either the number of services divided by the number of days in the range or 1. If the procedure code for the line item has an EVALVISFLG of N then the weight is 0.

Second, for each day of care attributed to that provider for that claim, compare the weights for that day from each of the line items. The largest weight is retained and all other weights from that day are

set to 0. In the case of a tie for the largest weight, retain only the value associated with the lowest line number. (Consequently, after this step, only one non-zero weight is possible for any given

day.)

 Third, for each line item attributed to that provider for that claim, sum the remaining weights from each day. Round up any fractional value in the sum and assign the result to the number of evaluative visits for that line item. The maximum number of evaluative visits for any one provider on any one day is 1.The maximum number of evaluative visits for a range of dates is the sum of all Numbers of Service for that range of dates where there is one or more CPT code with EVALVISFLG=Y.

**Appendix N: Merge to MTF Network Referral File**

The MTF Network Referral file contains information on claims resulting from referrals made from within MTFs to providers in the Purchased Care Network. The primary purpose of the file is to link all MTF-to-Network Referrals to their subsequent MDR TED claims data. This appendix describes how to accomplish this linking for TEDNI line item level data.

The data for the MTF to Network Referral table comes from each TRICARE region Managed Care Support Contractors’ (MCSC) own data marts.

Beginning in 2019, TED TCN is coming in on the referral records, and therefore can be used to match to the TEDNO on the claims. For those referrals without a TED TCN, we must look at the MCSC Claim Number.

The formats of the TED TCN and the MCSC claim number in the data marts is different than the format of the TEDNO field in the MDR TED datasets. The TEDNO in the MDR is a $24 character field, whereas the TED TCN and the MCSC Claim Number are $14 character fields. Here is a mock example of how the values of these fields can be linked:

TEDNO: 2015071MI X59JR 3134505

TED TCN: 2015071MIX59JR

MCSC Claim Number: 2015071X59JR

The first four characters of all represent the calendar year of the claim. The 5th through 7th characters represent the calendar day in Julian format. In the example above, “071” would represent March 11th. The 8th and 9th characters represent the state and can be found on both the TED TCN and the TEDNO. It is not on the MCSC Claim Number. The last 5 characters of the TED TCN and the MCSC Claim Number are a unique (within the region) alphanumeric identifier that correspond to the same 5 characters of the TEDNO at positions 11-15. It is important to note that this identifier is not unique across regions, on the same Julian date. Therefore the region needs to be used as part of the match key.

To match the TEDS to the MTF Referral data, first merge by TED TCN if it exists. IF not, then merge by MCSC Claim number. Since TED TCN has the additional 2 characters for the state, we will call this matching field claim15. To match by MCSC Claim number, this will be called claim13. An example of SAS logic to accomplish this is:

From MTF Referral File:

 length claim13 $13. claim15 $15.;

 if ted\_tcn='' then do;

 claim15='';

 claim13=region||substr(mcsc\_claim\_num,1,12);

 end;

 else do;

 claim15=region||ted\_tcn;

 claim13='';

 end;

From the TED claims:

 length claim15 $15 claim13 $13.;

 claim15=tedreg||substr(tedno,1,9)||substr(tedno,11,5);

 claim13=tedreg||substr(tedno,1,7)||substr(tedno,11,5);

For TED-NI data, the merge logic that could be used would look similar to this:

proc sort data=teds;

 by claim15 linum;

proc sort data=ref;

 by claim15 linum;

data match nomatch;

 merge teds(in=a) ref(in=b keep=claim15 linum uin ted\_tcn mcsc\_claim\_num begdate subdmis);

 by claim15 linum;

 if a and b and claim15 ne '' then output match;

 else if a and not b then output nomatch;

proc sort data=nomatch;

 by claim13 linum;

proc sort data=ref;

 by claim13 linum;

data match2;

 merge nomatch(in=a) ref(in=b keep=claim13 linum uin ted\_tcn mcsc\_claim\_num begdate subdmis);

 by claim13 linum;

 if a and b then output match2;

data matched;

 set match match2;

run;

For all matched records, the UIN field is now added to the TEDNI line items.

Beginning in April 2020, Submitting DMIS ID has been added to some of the MTF Referral records. If this field, exists, then this represents the Referring DMISID, otherwise, the first 4 characters of the UIN field represent the DMISID of the Referring MTF (ref\_mtf). The 6th through 17th characters of the UIN represent the CHCS Order Number (ref\_order\_num).

**Appendix O: Merge to MDR Referral File**

The MDR Referral dataset contains many fields describing the MTF-to-Network referrals. Once the UIN has been added to the TEDNI line item records as described in Appendix I, the UIN field can be used to merge to the MDR Referral data directly and the associated fields described in Table 1 can be added. For these line item records that are identified directly through the UIN, the MTF Network Referral Match Flag should be set to ‘U’.

Additionally, there are TEDNI line items associated with an MTF-to-Network referral that can be identified heuristically by checking the begin (ref\_begdate) and end dates (ref\_enddate) of the referral obtained from the MDR Referral dataset. Any TEDNI line items that fall within the date window of a directly identified MTF-to-Network referral, and have the same Provider Individual NPI (provnpi) as any directly identified MTF-to-Network referred lines, can be flagged as associated with that referral as well. For these records, the MTF Network Referral Match Flag should be set to “H”, and all the associated referral fields from the MTF Network Referral File and the MDR Referral Files described in Table 1 can be populated.

Appendix P: ACV Group

For time periods before Jan 1, 2018, ACV is derived as follows:

For FY03 and before:

If ACV = A, D, or E then “PR”

Else if ACV = G or L then “PL”

Else if ACV = U then “DP”

Else if Ben Cat Common = 4 then “R”

Else “O”

For FY04 and after:

If ACV = A, E, H, or J then “PR”

Else if ACV = B or F then “OP”

Else if ACV = G or L then “PL”

Else if ACV = U then “DP”

Else if ACV = R or V then “O”

Else if ACV = M or Q then “R”

Else if Ben Cat Common = 4 then “R”

Else “O”

This is a change in coding schema and it is recognized that not all years may be processed with the new values. The legacy rules are:

For FY03 and before:

If ACV = A, D, or E then “1”

Else if ACV = G or L then “3”

Else if ACV = U then “4”

Else if Ben Cat Common = 4 then “5”

Else “6”

For FY04 and after:

If ACV = A, E, H, or J then “1”

Else if ACV = B or F then “2”

Else if ACV = G or L then “3”

Else if ACV = U then “4”

Else if ACV = R or V then “6”

Else if ACV = M or Q then “5”

Else if Ben Cat Common = 4 then “5”

Else “6”

1. After Accrual Fund Indicator field has been created, BEA Aurora will supply a file with TED Numbers and Accrual Fund Indicators back to when field first appeared in TED (FY 2008). [↑](#footnote-ref-1)
2. A TED or HCSR is not technically a “claim”, rather, these records are reports of line items on claims. However, the term “claim” shall be used in this document for simplicity. [↑](#footnote-ref-2)
3. It is assumed that the MDR HCSR processed data will contain these records, so that mapping to TED format is unnecessary. [↑](#footnote-ref-3)
4. At a future time, it may be required to split the cancellation and denial files, due to size. [↑](#footnote-ref-4)
5. Certain field values are retained from the initial database when updating HCSRs with ATOHs. These fields are identified in the layout table. [↑](#footnote-ref-5)
6. This is a functional requirement, because if reference files are subject to change retroactively, data in the existing MDR database will be incorrect if the changed table is not re-applied to old records. [↑](#footnote-ref-6)
7. The DDS file is a one-time requirement, intended to fill in missing person identifying information available historically in the MDR, but dropped from the HCSR Operational data store. The preparation of this data file is described in an appendix. [↑](#footnote-ref-7)
8. This process will only be required for records in fiscal years FY05 and earlier. [↑](#footnote-ref-8)
9. Certain field values are retained from the initial database when updating HCSRs with ATOHs. These fields are identified in the layout table. [↑](#footnote-ref-9)
10. It is recognized that the values in these fields may change as a result of the ATOH process, but it is unlikely. A review should be conducted after a year or so, to determine whether subsequent adjustments do change the content of any of these data values. If so, a periodic retrofit may be in order. (Of course, considering the volume of ATOH, periodic retrofits may not be in order for long!) [↑](#footnote-ref-10)