# MDR Institutional Claims File

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1. Source:

The MDR Institutional Data File contains both HCSRs and TED derived HCSRs. This format serves as a short term solution until the MDR is modified to receive TEDs, without a derivation into HCSR format.

Data Capture: Managed Care Support Contractor claims processing system

MHS Data Capture: TMA Claims Acceptance Systems

1. Transmission (Format and Frequency)

*Update files* are provided monthly. The files are sent on compatible tapes or via FTP. The fiscal year is identified based on the “end-date-of-care month” and “end-date-of-care year” in the record. [[1]](#footnote-1) All years should be sent, but only processed for the past 4 years and the current year with any new or adjusted HCSRs have been received since the previous month. Fiscal years older than this will be processed on a semi-annual cycle.

1. Receiving Filters

Each monthly data feed of HCSRs and TED-derived HCSRs includes all records accepted or provisionally accepted or changed in the previous month.

1. Update Process

To update the master fiscal year MDR HCSR databases, the feed data are interleaved with the master database. For each line item, only the record with the greatest HCSR Number (largest sort order) is retained. If more than one record shares a HCSR number, the record with the most recent cycle year and month are retained.

The update process must work when an adjustment to a claim changes the fiscal year of the end date (now a likely occurrence with TED records) of care. That is, the record must be removed from the fiscal year file that it was originally placed in (based on the original end date of care) and the most recent version of that record placed in the fiscal year file that appears on the update record (based on the changed end date of care).

1. Field Transformations and Deletions for MDR Core Database

* *Application of Master Person Index to MDR HCSR Files:* The MDR Master Person Index created in VM-4 (AKA PITE) processing, and is used to append missing information about a person’s identity to MDR HCSR Records. The process for appending the person information differs based on whether the record in the MDR HCSR database is TED based, or HCSR based.

For HCSR-based records (TED Flag is blank): The MPI is de-duplicated based on sponsor social security number and DDS. That file is merged to the MDR HCSR/TED file by sponsor social security number and DDS, and the DEERS DoD EDI\_PN from the MPI is appended to the HCSR record in position 76.

For TED-based records (TED Flag is ‘T’): The MPI is de-duplicated based on EDI\_PN and sponsor social security number. That file is merged to the MDR HCSR/TED file by EDI\_PN and sponsor social security number, and the DEERS Legacy DDS from the MPI is appended to the HCSR record in position 186.

* *Application of Reservist Attributes*: The MDR Reservist format files are applied to HCSR records with end dates of care in FY01 or later. Two fields are added to the end of each record in the MDR HCSR-I databases: The Reservist Status Code and the Special Operations Code. These fields are populated with the values from the reservist reference file, if the admission date is between the begin and end date of care of the reservist status code contained in the MDR Reservist Format file.

1. File Layout

The file layout for HCSR data in the MDR varies depending on the year of the data. The table below reflects the file layout for HCSR files for fiscal years 2000 and later. The format for data prior to FY2000 is contained in an appendix

| **CHAMPUS Health Care Service Record (HCSR) - Institutional** | | | | |
| --- | --- | --- | --- | --- |
| **Field Name** | **Type[[2]](#footnote-2)** | **Size** | **Position** | **Comments** |
| Error Count | SN | 3 | 1-3 |  |
| Record Type Code | A | 1 | 4 | Indicates an individual hcsr record by type.  All records in this file will have “1”, indicating an institutional HCSR. |
| *Batch Group* |  |  |  |  |
| Contractor Number | A | 2 | 5-6 | Identification code for the contractor. It is used to identify each contractor submitting health care service records, pricing file records, and provider file records. |
| *Batch Record Data* |  |  |  |  |
| HCSR Contract Number | A | 7 | 7-13 | Unique number assigned to a contract. The first two digits of the contract number followed by the one character alpha procurement code followed by the last four digits of the contract number |
| Record Type Code (Batch) | A | 1 | 14 | Indicates whether this HCSR came in a batch (value is 0) or in a voucher (value is 5) |
|  | | | | |
| *Batch Control Data*  Data uniquely identifies a batch of records. These fields have this meaning only if the Record Type Code (batch) in position 14 is “0” | | | | |
| Batch Create Date | N | 7 | 15-21 | Yyyyddd  Date the contractor first created the batch for transmission to ochampus. This date will not change through the resubmission process. |
| Batch Sequence Number | A | 2 | 22-23 | A sequential number assigned by the contractor to identify the batch sequence of the record category submitted. Once assigned, the sequence number cannot be reused with the same batch date and remains with the batch through resubmission process |
| Batch Resubmit Seq. Number | A | 2 | 24-25 | The number of re-submissions for the batch for other than batch-level error rejections. Incremented by one for each resubmission. |
| *Voucher Control Data*  Data uniquely identifies a voucher. These fields have this meaning only if the Record Type Code (batch) in position 14 is “5” | | | | |
| Voucher Number ID |  |  |  | The base identifier for a group or block of claim payment records from an fi, assigned by the processing fi. |
| Voucher Branch of Service | A | 2 | 15-16 | Voucher number branch of service to assign the branch of service that the medical care is to be billed.  01 – Army  02 – Air Force  03 – Navy/MC  05 – Non-DoD  10 - CHCBP  21 – Active Duty – Army  22 – Active Duty – Air Force  23 – Active Duty – Marine-Corps/Navy  25 – Active Duty – Non DoD (TPR)  26 - Army - National Guard (TPR)  41 - Army (Comp Clin Eval Pgm)  42 - Air Force (Comp Clin Eval Pgm)  43 - Navy/MC (Comp Clin Eval Pgm)  45 - Non DOD (Comp Clin Eval Pgm)  71 - Army-DP, SPL/ Emrgnt, abused, Kitsap  72 - AF-DP, SPL/ Emrgnt, abused, Kitsap  73 - Nv/MC-DP, SPL/ Emrgnt, abused, Kitsap  A1 - Army - Spmtl Hlth pgm - ER  A2 - Air Force - Spmtl Hlth pgm - ER  A3 - Navy/MC - Spmtl Hlth pgm - ER  A5 - Non DOD - Spmtl Hlth pgm - ER  A6 - Army Nat Guard - Spmtl Hlth pgm - ER  B1 - Army (Spmtl Care MTF)  B2 - Air Force (Spmtl Care MTF)  B3 - Navy/MC (Spmtl Care MTF )  B5 - Non DOD (Spmtl Care MTF)  B6 - Army Nat Guard (Spmtl Care MTF)  C1 - Army - Tricare Senior Supplement  C2 - Air Force - Tricare Senior Supplement  C3 - Navy/MC - Tricare Senior Supplement  C5 - Non DOD - Tricare Senior Supplement  D1 - Army - Pharmacy Redesign  D2 - Air Force - Pharmacy Redesign  D3 - Navy/MC - Pharmacy Redesign  D5 - Non DOD - Pharmacy Redesign  E1 - Army - Spmtl Hlth Non-ER  E2 - Air Force - Spmtl Hlth Non-ER  E3 - Navy/MC - Spmtl Hlth Non-ER  E5 - Non DOD - Spmtl Hlth Non-ER  E6 - Army Nat Guard - Spmtl Hlth Non-ER  FA - TSP Dover AFB  FB - TSP Keesler AFB  FC - TSP Brook Army MC  FD - TSP Wilford HMC  FE - TSP FT Sill  FF - TSP Sheppard  FG - TSP Ft Carson  FH - TSP AF Academy  FJ - TSP Naval MC SD  FK - TSP Madigan AMC |
| Voucher Number FY | N | 1 | 17 | Designates fiscal year (y) to which voucher funds are obligated.  0 thru 9 - the units digit of the fiscal year. |
| Voucher Number Seq Number | A | 3 | 18-20 | Uniquely identifies each voucher for a given fi for a given fiscal year. Used by fi's to link their invoicing methodologies to the ochampus voucher processing. Some fi's process a voucher each workday; other FI's with lower claim volumes may only process one or two vouchers per week. |
| Voucher Resubmit Seq Number | N | 2 | 21-22 | The number of times a voucher has been resubmitted to correct edit errors. Initial submission is set to 00. |
| Filler | A | 3 | 23-25 |  |
|  |  |  |  |  |
| HCSR Batch Begin Date | N | 8 | 26-33 | Yyyymmdd |
| HCSR Batch End Date | N | 8 | 34-41 | Yyyymmdd |
| Voucher Notice Date | N | 8 | 42-49 | Yyyymmdd  The date the voucher funding was authorized by ochampus. This date must be earlier than or the same as the fi voucher processing date. |
| Voucher Create Date | N | 8 | 50-57 | Yyyymmdd  Date the contractor first created the voucher for transmission to ochampus |
| Subtype Sort Number | N | 2 | 58-59 |  |
| Record Received Sequence Number | N | 7 | 60-66 |  |
| Record Processed Sequence Number | N | 7 | 67-73 |  |
| **Filler** | **A** | **2** | **74-75** |  |
| **Person ID** | **A** | **10** | **76-85** | **DEERS unique person identifier.** |
| **TED Flag** | **A** | **1** | **86** | **“T” for a TED-derived HCSR, blank otherwise.** |
| HCSR Number |  |  |  | The number consisting of the icn, time and suffix that uniquely identifies a hcsr. |
| HCSR Internal Control Number (ICN) |  |  |  | The unique number assigned by the contractor that reflects the date of receipt of the treatment encounter data and the control sequence for contractor management control purposes. |
| **HCSR No. Layout if TED Flag is “T”** | | | | |
| **HCSR Filing Date** | **N** | **7** | **87-93** | **Yyyyddd**  **The date the filing for payment of health care services rendered was received by the contractor.** |
| **Filing State/Country Code** | **A** | **3** | **94-96** | **Code that indicates the filing state or country where the care was provided.** |
| **HCSR Sequence Number** | **A** | **7** | **97-103** | **Number assigned by the contractor to uniquely identify the individual hcsr. Once assigned, the sequence number cannot be reused with the same filing state, filing date and hcsr suffix combination.** |
| HCSR Time | A | 6 | 104-109 | Unique system time assigned by the fi when issuing an initial hcsr record. |
| HCSR Suffix | A | 1 | 110 | Code to uniquely identify when treatment encounter data is split into groupings for hcsr reporting purposes.  Assigned in alphabetic order  a – no split required  b – first split  c – second split  d-y – etc. |
| **HCSR No. Layout if TED Flag is blank** | | | | |
| **HCSR Filing Date** | **N** | **7** | **87-93** | **Yyyyddd**  **The date the filing for payment of health care services rendered was received by the contractor.** |
| **Filing State/Country Code** | **A** | **2** | **94-95** | **Code that indicates the filing state or country where the care was provided.** |
| **HCSR Sequence Number** | **A** | **5** | **96-100** | **Number assigned by the contractor to uniquely identify the individual hcsr. Once assigned, the sequence number cannot be reused with the same filing state, filing date and hcsr suffix combination.** |
| **HCSR Time** | **A** | **6** | **101-106** | **Unique system time assigned by the fi when issuing an initial hcsr record.** |
| **HCSR Suffix** | **A** | **1** | **107** | **Code to uniquely identify when treatment encounter data is split into groupings for hcsr reporting purposes.**  **Assigned in alphabetic order**  **a – no split required**  **b – first split**  **c – second split**  **d-y – etc.** |
| **Filler** | **A** | **3** | **108-110** |  |
| Program Indicator Code | A | 1 | 111 | Identifies to which champus program the services being reported on the hcsr are related.  Institutional hcsr:  i – institutional  h – program for the handicapped  non-institutional hcsr:  d – drug  h – program for the handicapped  i – institutional (excluding d, h and t)  n – non-institutional (excluding d, h and t)  t – dental (excluding d and h) |
| HCSR Processed to Completion Date | N | 8 | 112-119 | Yyyymmdd  Processed to completion date for the health care service record (hcsr). This date does not change for re-submissions unless previously coded in error. |
| HCSR Adjustment Identified Date | N | 8 | 120-127 | Date the contractor determined an adjustment HCSR was required. This date does not change for re-submissions unless previously coded in error. This date is zero filled on non-adjustment HCSRS. The format is YYYYMMDD. |
| Sponsor SSN | A | 9 | 128-136 | Sponsor social security account number or veterans administration file number.  All numeric - normal claims.  All blanks - nato & security agent claims (extremely rare).  first 3 digits zeroes - deceased sponsor only. |
| Sponsor Pay Grade | A | 2 | 137-138 | Sponsor's pay grade code.  HCSR code definitions:  00 – unknown enlisted  01-09 – enlisted (e1-e9)  10 – unknown warrant officer  11-14 – warrant officer (w1- w4)  19 – academy of navy OCS students  20 – unknown officer  21-31 – officer (01-011)  40 – unknown civil service  41-58 – GS1-GS18  90 – unknown  95 – not applicable (including CHAMPVA)  99 – other |
| Sponsor Branch of Service | A | 1 | 139 | Sponsor's uniformed service branch or organization that creates entitlement to the health care.  Codes for HCSR:  A – Army  E – Public Health Service  F – Air Force  I – NOAA  M – Marines  N – Navy  P – Coast Guard  C – CHAMPVA |
| Patient Category |  |  |  | Category of patient type downloaded from DEERS. If unavailable from DEERS, is reported from healthcare data received by contractor. |
| Sponsor Status | A | 1 | 140 | Code indicating official status of sponsor in regard to a current level of participation in a uniformed branch of service/affiliation. |
| Patient Relationship | A | 1 | 141 | Code that defines the relationship of the patient to sponsor, downloaded from DEERS. |
| Patient Name | A | 27 | 142-168 | Legal name of patient, downloaded from DEERS. (if unavailable from DEERS, the name comes from the health care data submitted to contractor.) The last name is at least two characters, followed by a comma. |
| Patient SSN | A | 9 | 169-177 | Patient social security account number. If unknown, blank fill. |
| Patient DOB | N | 8 | 178-185 | YYYYMMDD  Date 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. |
| **DEERS Dependent Suffix Code** | **A** | **2** | **186-187** | **Code maintained by DEERS that uniquely identifies the patient within the family. If TED flag is blank, this value was received on the HCSR. If TED flag is “T”, this value was derived via a DEERS merge, based on the TED (HCSR) number and a separate TED feed.** |
| Patient Sex | A | 1 | 188 | Sex of patient/beneficiary.  Codes for HCSR:  M – male  F – female |
| Patient Zip/Country Code | A | 9 | 189-197 | US postal zip code or foreign country code for patient's legal residence at the time service was rendered. Must not be the zip code of a post office box. If the code is a two-character foreign country code, it must be left justified. |
| Enrollment Code | A | 2 | 198-199 | Code indicating whether or not the patient is enrolled with the contractor. |
| *NAS ID Number* |  |  |  | Unique number assigned by the MTF when issuing a non-availability statement (NAS). For reporting purposes this is down loaded from the DEERS database. |
| NAS ID Number Prefix | A | 1 | 200 | A one character numeric digit at the beginning of the NAS ID number. For valid and active NAS ID numbers, this is a zero. |
| NAS MTF Code | A | 3 | 201-203 | A unique numeric code assigned to each military treatment facility. |
| NAS Issue Date | A | 4 | 204-207 | A four character Julian date in the format YDDD. This date is contained within the non-availability statement ID number that is issued for treatment outside of a MTF catchment area. |
| NAS Facility Sequence | A | 3 | 208-210 | A facility sequence number assigned in accordance with the implementing instructions of the issuing facility's host service. |
| Reason for Payment Reduction | A | 1 | 211 | Reason payment reduction assessed  A - mental health pre-authorization not obtained  B – adjunctive dental care pre-authorization not obtained  C - procedure/services in TRICARE regions not authorized |
| Major Diagnostic Category Code | A | 2 | 212-213 | A code representing the major diagnostic category for which a nas was issued |
| Derived Major Diagnostic Code | A | 2 | 214-215 | This field is derived from the principle diagnosis code via a black box program. |
| NAS Issue Reason Code | A | 1 | 216 |  |
| Claim Form Type | A | 1 | 217 | The code associated with the primary claim form submitted.  A – DD form 2520 (long)  B – DD form 2520 (short)  C – HCFA form 1500  D – UBF-1  F – UB-92  G – electronic institutional claim submission  H – electronic non-institutional claim submission  I – electronic drug submission  J – other |
| MTF Code Authorized Care | A | 4 | 218-221 | Four digit DMIS code from the catchment area directory identifying the MTF that authorized the care. |
| Number Payment Reduction Days | SN | 3 | 222-224 | Number of payment reduction days/services assessed for institutional records, number of payment reduction days will be reported. |
| Total Amount Billed | SN | 9,2 | 225-233 | Total amount billed for all services. Total amount for which patient/provider has requested reimbursement. |
| Total Amount Allowed | SN | 9,2 | 234-242 | Total amount allowed for all authorized services as determined by the contractor. |
| Amount Paid by OHI | SN | 9,2 | 243-251 | Total amount paid by other health insurance for all services reported on the hcsr. |
| Amount Allowed by OHI | SN | 9,2 | 252-260 | Total amount allowed by other health insurance for all services reported on the hcsr |
| Amount Third Party Liability | SN | 9,2 | 261-269 | Total amount paid by outside party (excluding patient's other health insurance coverage) e.g. Third party liability for services reported. |
| Amount of Payment Reduction | SN | 9,2 | 270-278 | Total amount of payment withheld by the fi /contractor. |
| Patient Coinsurance Amount | SN | 8,2 | 279-286 | The amount of allowed charges that beneficiaries are required to pay under ochampus. |
| Patient Copayment Amount | SN | 8,2 | 287-294 | A predetermined, fixed amount charged by the fi/contractor under champus prime, or other demonstrations, or the fixed amounts under the standard champus program that the beneficiary is liable for paying for covered services. |
| Amount Paid by Govt Contractor | SN | 9,2 | 295-303 | The portion of total amount allowed that was paid by gov’t fi/contractor for the services reported. |
| Reservist Status Code | A | 1 | 304 | See Section V, Application of Reservist Attributes. |
| Special Operations Code | A | 2 | 305-306 | See Section V, Application of Reservist Attributes. |
| Filler | A | 4 | 307-310 | No transformation. |
| Override Code 1 | A | 2 | 311-312 | The first of three codes that 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. |
| Override Code 2 | A | 2 | 313-314 | The second of three codes that 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. |
| Override Code 3 | A | 2 | 315-316 | The third of three codes that 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. |
| Type of Submission Code | A | 1 | 317 | Code indicating the HCSR submission type. |
| NAS Exception Reason Code | A | 2 | 318-319 | Code that indicates reason for the exception to the requirement of a non-availability statement (NAS). |
| Health Care Plan Code | A | 2 | 320-321 | Codes that identify the unique health care plan, that the provider was affiliated with when the care was rendered. |
| ICD Edition ID Number | A | 1 | 322 | Code identifying the edition number of the international classification of diseases used in determining the diagnosis codes on both types of HCSRS. For institutional records only, identifies edition number for determination of operation/non surgical procedures. |
| HCSR Adjust Code | A | 1 | 323 | Code indicating the primary reason for the positive or negative adjustment HCSR. |
| Special Processing Code 1 | A | 2 | 324-325 | First of three codes to indicate that special processing is required for certain care. |
| Special Processing Code 2 | A | 2 | 326-327 | Second of three codes to indicate that special processing is required for certain care. |
| Special Processing Code 3 | A | 2 | 328-329 | Third of three codes to indicate that special processing is required for certain care. |
| Special Rate Code | A | 2 | 330-331 | Code to indicate which special rates apply in calculating patient cost share or government contractor pay amount. |
| Provider Contract Affiliation Code | A | 1 | 332 | Code indicating whether the provider is under contract with the contractor. All codes are irrespective of any partnership agreements.  For provider records:  0 – not applicable1 – contracted  2 – not contracted  3 – contracted/not contracted  4 – active duty GSU |
| Provider State/Country Code | A | 2 | 333-334 | Code for the state or foreign country in which the care was actually received. |
| Provider Tax ID | A | 9 | 335-343 | The IRS taxpayer identification number (TIN) assigned to the institution/provider supplying the care. For institutions, it must be the employer identification number (EIN). For individual providers it must be the EIN or SSN, if available. If not available, the contractor will report the contractor-assigned number. On HCSRS all nines are used for transportation services under program for the handicapped and for the drug program when the services are from a non-participating pharmacy. |
| Multiple Provider Indicator | A | 4 | 344-347 | Identification number that uniquely identifies individual providers using the same taxpayer identification number (tin). Codes are assigned per OCHAMPUS instructions. Must be zero filled if there are no multiple providers within the taxpayer identification number (tin). For clinics, the sub-identifier is assigned with an alpha character in the first position followed by three numeric, sequentially assigned numbers, or 2 alpha in the first two positions followed by 2 numeric sequentially assigned numbers. When the clinic itself is submitted (specialty code=70), the sequential number is either 001or 01. Individual providers within begin with 002 or02 and so on, all having the same characters in the first two positions as the clinic. All other non-institutional providers and institutional providers use numerics in all four characters of the sub-identifier. |
| Provider Care Zip Code | A | 9 | 348-356 | The zip code of the location where the care was provided. Must be a valid zip code or blanks if a foreign country. |
| Provider Participation Indicator | A | 1 | 357 | Indicates whether or not the provider accepted assignment of benefits for services rendered.  N - no  Y – yes |
| Principle Diagnosis Code | A | 6 | 358-363 | The condition code established, after study, to be the major cause for the patient to obtain medical care as coded on the UB-82 or otherwise indicated by the provider. The ICD-ED-NBR element specifies the diagnosis code manual for the code values. |
| Secondary Diagnosis Code 1 | A | 6 | 364-369 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 2 | A | 6 | 370-375 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 3 | A | 6 | 376-381 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 4 | A | 6 | 382-387 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 5 | A | 6 | 388-393 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 6 | A | 6 | 394-399 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 7 | A | 6 | 400-405 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 8 | A | 6 | 406-411 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Region Code Header | A | 2 | 412-413 |  |
| Filler | A | 4 | 414-417 |  |
| Patient Pay Total | SN | 9,2 | 418-426 | 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. |
| MTF Code | A | 3 | 427-429 | The three digit DMIS (defense medical information system) ID code which identifies the military treatment facility or other specific area (BRAC site or non-catchment area) in which the patient residence is located. (Includes only US and Puerto Rico areas – not overseas or non-catchment areas.) |
| MTF Branch of Service | A | 1 | 430 | 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 |
| Bill MTF Code | A | 3 | 431-433 | Code that identifies the medical treatment facility (mtf) which is financially responsible for the cost of care provided. |
| Bill Branch of Service | A | 1 | 434 | The branch of service that is financially responsible for the cost of the care provided. |
| Patient Age | N | 3 | 435-437 | HCSR definition: Age of patient calculated based on earliest begin date of care versus patient's date of birth.  Other systems: Age of patient submitting claim calculated based on cycle date versus patient's date of birth. |
| Cycle Number Year | A | 2 | 438-439 |  |
| Cycle Number Month | A | 2 | 440-441 |  |
| Cycle Sequence Number | N | 2 | 442-443 |  |
| HCSR Accept Date | N | 6 | 444-449 | YYYYMM  Calendar year and month a HCSR was accepted for accounting purposes. |
| Claim Count Code | SN | 1 | 450 | To indicate primary claim group for all claim groups with a common claim number. On the net HCSR database, this code is the sum of all the history records (original, adjustments, and cancellations) for the 'primary' HCSR (and therefore greater than 1). Primary HCSR is the first HCSR in ICN-suffix 'group' to update the database. For non-primary HCSRS, the sum of all history records is always equal to zero.  0 = non-primary claim group  1 or greater = primary claim group |
| Benefit Claim Count Code | SN | 1 | 451 | Claim count that represents the primary care the beneficiary receives exclusive of any supplemental billings, adjustments or cancellations from the provider.  +1 – positive benefit count  -1 – negative benefit count  0 – no benefit count |
| Administrative Claim Count Code | SN | 1 | 452 | Indicates administrative payment record, on the net hcsr database, this is the sum of all history records (original, adjustments, 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 |
| Source Health Care Data | A | 2 | 453-454 | Indicates source of health care data. |
| Net Record Type Code | A | 1 | 455 | After possible multiple submissions have been netted, resultant type of submission of net record. |
| Key Field Change Code | A | 1 | 456 |  |
| Hospital Department Number | A | 2 | 457-458 | The hospital department categorization for a given diagnosis code. |
| Care End Fiscal Year | N | 4 | 459-462 |  |
| Health Services Region Code | A | 2 | 463-464 | A health service region defined by zip codes |
| Beneficiary Category | A | 1 | 465 | Categorization of beneficiaries based on a given sponsor status for cost sharing and reporting purposes. For non-availability statements:  Categorization of beneficiaries based on the sponsor's status and the patient's relationship to that sponsor.  1 – active-dependent  2 – retired-sponsor  3 – retired/deceased-dependent and all other patients  4 – active duty sponsor |
| Filler | A | 4 | 466-469 |  |
| Type of Institution Code | A | 2 | 470-471 | A code indicating type of institution for institutional providers. |
| Admission Date | N | 8 | 472-479 | Date of initial admission to the institution for this episode of care. |
| Bill Classification Code | A | 1 | 480 | A code describing type of billing from the facility.  Valid codes for HCSRS:  1 – inpatient  2 – hospital based hospice |
| Bill Frequency Code | A | 1 | 481 | A code indicating frequency of billing from the hospital.  Valid codes for hcsrs:  1 – admit thru discharge hcsr  2 – interim - initial hcsr  3 – interim - interim hcsr  4 – interim - final claim  5 – admit through transfer hcsr  7 – replacement of prior claim  8 – void/cancel of prior claim |
| Type of Admission Code | A | 1 | 482 | A code indicating the type of the admission.  1 – emergency  2 – urgent  3 – elective  4 – newborn |
| Source of Admission Code | A | 1 | 483 | A code indicating the referral source for the admission. |
| Discharge Status Code | A | 2 | 484-485 | Code indicating patient status as of the end date of care on the HCSR. |
| Begin Date of Care | N | 8 | 486-493 | Earliest date of care reported in the health care data. |
| End Date of Care | N | 8 | 494-501 | Latest date of care reported on the institutional health care data. |
| Number of Births | SN | 1 | 502 | Number of births, both live and stillborn, occurring during delivery. |
| Total Bed Days | SN | 3 | 503-505 | Total number of days of hospital care during the period covered by the HCSR whether or not allowable. |
| Government Authorized Bed Days | SN | 3 | 506-508 | Number of hospital days authorized for services where there was 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 |
| Admission Diagnosis Code | A | 6 | 509-514 | Code identifying diagnosis under which the patient was admitted to the institution. |
| Principle OP-NS Procedure Code | A | 5 | 515-519 | Code identifying principal procedure performed during the period covered by this HCSR as coded on the UB82 form. |
| Secondary OP-NS Procedure Code 1 | A | 5 | 520-524 | Code identifying procedures (other than primary) performed during the period covered by this HCSR as coded on the UB82 form. The proced-cd-method-code element specifies which procedure code manual to refer to for code values. |
| Secondary OP-NS Procedure Code 2 | A | 5 | 525-529 | Code identifying procedures (other than primary) performed during the period covered by this HCSR as coded on the UB82 form. |
| Secondary OP-NS Procedure Code 3 | A | 5 | 530-534 | Code identifying procedures (other than primary) performed during the period covered by this HCSR as coded on the UB82 form. |
| Secondary OP-NS Procedure Code 4 | A | 5 | 535-539 | Code identifying procedures (other than primary) performed during the period covered by this HCSR as coded on the UB82 form. |
| Secondary OP-NS Procedure Code 5 | A | 5 | 540-544 | Code identifying procedures (other than primary) performed during the period covered by this HCSR as coded on the UB82 form. |
| DRG Number | A | 3 | 545-547 | Identifies the diagnosis related group (drg) determined for the episode of care. |
| DRG Grouper Edition | A | 2 | 548-549 | Identifies the edition number of the diagnosis related grouper which is used to determine the drg. |
| DRG Pricer Edition | A | 2 | 550-551 | Identifies the diagnosis related pricer used to determine the drg. |
| Admission Count Code | SN | 1 | 552 | A claim may fall into 1 of 3 admission categories; admission,  Non-admission, or cancellation of an original admission. This field indicates the category of the claim.  +1 – claim is an admission claim  0 – claim is a non-admission claim  -1 – claim is a cancellation of an original admission claim. |
| Category of Care | A | 2 | 553-554 | Major breakouts of data used for reporting care, based on benefit program (dental, drug, PFTH) 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. |
| DRG Derived Code | A | 3 | 555-557 | 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. |
| Care End Date Year | A | 4 | 558-561 |  |
| Care End Date Month | A | 2 | 562-563 |  |
| Relative Weighted Product (RWPs) | SN | 7,4 | 564-570 | DRG CHAMPUS weight adjusted for stay outliers: Only "acute care" HCSRS get RWP calculations. The basic RWP calculation is alike for HCSRS and SIDRS, and is affected by length-of-stay for outliers.  "Transfer" cases get the same RWP calculation in HCSRs as in SIDRs. Interim HCSRs (no discharge date) are always treated as long-stay outliers. The initial one gets the base weight for the DRG, plus or minus the outlier per diem depending on whether it is shorter or longer than the outlier threshold. All non-initial continuation HCSRs are treated as pure outlier stays, receiving 33% of the (DRG mean weight per day) times the length of stay, while not receiving any "base weight" credit. |
| Preventable Admission | A | 1 | 571 | Applies algorithm to identify preventable admissions, coded as:  A = Asthma  B =Bacterial Pneumonia  C = COPD  D = Diabetes  G = Gastroenteritis  H = Congestive Heart Failure  P = Angina Pectoris  U = Urinary Tract Infection / Kidney  T = (Tissue) Cellulitis  0 = Not a preventable admission |
| Filler |  |  | 572-583 |  |
| Revenue Information Occurrence Count | N | 2 | 584-585 | Indicates number of occurrences of revenue codes and related data elements occur on the HCSR record. |
| *Revenue Data* |  |  |  | The following data occurs 0 to 50 times depending on the value of ‘Revenue Info Occurrence Count’ |
| Revenue Code | A | 4 | 586-589 | A code that identifies revenue categories associated with the type of service rendered. Like revenue codes are summarized provided the reason for allowance/denials the same for each. |
| Nbr of Services by Revenue Code | SN | 7 | 590-596 | A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, or renal dialysis treatments, etc. |
| Total Charge by Revenue Code | SN | 9,2 | 597-605 | Amount billed for this revenue code. |
| Denial Reason Code | A | 2 | 606-607 | Justification for denial of detail line item on HCSR by the contractor. |
| Occurrence Count | PN | 2 | 608-609 |  |
| Previous Denial Reason Code | A | 2 | 610-611 | Justification for denial of detail line item on HCSR by the contractor. |

1. Refresh Frequency

## Monthly

1. Data Marts
2. MHS Mart (M2)

See Health Care Service Record (Institutional), Description of Data Feed provided to M2 (HCSR(I) – Current M2.doc)

B. PHOTO

1. Special Outputs

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

**Appendix A:**

**File Layout for Records in HSCR(I) files for the MDR in Fiscal Years 2000 and Earlier[[3]](#footnote-3)**

| **CHAMPUS Health Care Service Record (HCSR) - Institutional** | | | | |
| --- | --- | --- | --- | --- |
| **Field Name** | **Type[[4]](#footnote-4)** | **Size** | **Position** | **Comments** |
| Error Count | SN | 3 | 1-3 |  |
| Record Type Code | A | 1 | 4 | Indicates an individual hcsr record by type.  All records in this file will have “1”, indicating an institutional HCSR. |
| *Batch Group* |  |  |  |  |
| Contractor Number | A | 2 | 5-6 | Identification code for the contractor. It is used to identify each contractor submitting health care service records, pricing file records, and provider file records. |
| *Batch Record Data* |  |  |  |  |
| HCSR Contract Number | A | 7 | 7-13 | Unique number assigned to a contract. The first two digits of the contract number followed by the one character alpha procurement code followed by the last four digits of the contract number |
| Record Type Code (Batch) | A | 1 | 14 | Indicates whether this HCSR came in a batch (value is 0) or in a voucher (value is 5) |
|  | | | | |
| *Batch Control Data*  Data uniquely identifies a batch of records. These fields have this meaning only if the Record Type Code (batch) in position 14 is “0” | | | | |
| Batch Create Date | N | 7 | 15-21 | Yyyyddd  Date the contractor first created the batch for transmission to ochampus. This date will not change through the resubmission process. |
| Batch Sequence Number | A | 2 | 22-23 | A sequential number assigned by the contractor to identify the batch sequence of the record category submitted. Once assigned, the sequence number cannot be reused with the same batch date and remains with the batch through resubmission process |
| Batch Resubmit Seq. Number | A | 2 | 24-25 | The number of re-submissions for the batch for other than batch-level error rejections. Incremented by one for each resubmission. |
| *Voucher Control Data*  Data uniquely identifies a voucher. These fields have this meaning only if the Record Type Code (batch) in position 14 is “5” | | | | |
| Voucher Number ID |  |  |  | The base identifier for a group or block of claim payment records from an fi, assigned by the processing fi. |
| Voucher Branch of Service | A | 2 | 15-16 | Voucher number branch of service to assign the branch of service that the medical care is to be billed.  01 – Army  02 – Air Force  03 – Navy/MC  05 – Non-DoD  10 - CHCBP  21 – Active Duty – Army  22 – Active Duty – Air Force  23 – Active Duty – Marine-Corps/Navy  25 – Active Duty – Non DoD (TPR)  26 - Army - National Guard (TPR)  41 - Army (Comp Clin Eval Pgm)  42 - Air Force (Comp Clin Eval Pgm)  43 - Navy/MC (Comp Clin Eval Pgm)  45 - Non DOD (Comp Clin Eval Pgm)  71 - Army-DP, SPL/ Emrgnt, abused, Kitsap  72 - AF-DP, SPL/ Emrgnt, abused, Kitsap  73 - Nv/MC-DP, SPL/ Emrgnt, abused, Kitsap  A1 - Army - Spmtl Hlth pgm - ER  A2 - Air Force - Spmtl Hlth pgm - ER  A3 - Navy/MC - Spmtl Hlth pgm - ER  A5 - Non DOD - Spmtl Hlth pgm - ER  A6 - Army Nat Guard - Spmtl Hlth pgm - ER  B1 - Army (Spmtl Care MTF)  B2 - Air Force (Spmtl Care MTF)  B3 - Navy/MC (Spmtl Care MTF )  B5 - Non DOD (Spmtl Care MTF)  B6 - Army Nat Guard (Spmtl Care MTF)  C1 - Army - Tricare Senior Supplement  C2 - Air Force - Tricare Senior Supplement  C3 - Navy/MC - Tricare Senior Supplement  C5 - Non DOD - Tricare Senior Supplement  D1 - Army - Pharmacy Redesign  D2 - Air Force - Pharmacy Redesign  D3 - Navy/MC - Pharmacy Redesign  D5 - Non DOD - Pharmacy Redesign  E1 - Army - Spmtl Hlth Non-ER  E2 - Air Force - Spmtl Hlth Non-ER  E3 - Navy/MC - Spmtl Hlth Non-ER  E5 - Non DOD - Spmtl Hlth Non-ER  E6 - Army Nat Guard - Spmtl Hlth Non-ER  FA - TSP Dover AFB  FB - TSP Keesler AFB  FC - TSP Brook Army MC  FD - TSP Wilford HMC  FE - TSP FT Sill  FF - TSP Sheppard  FG - TSP Ft Carson  FH - TSP AF Academy  FJ - TSP Naval MC SD  FK - TSP Madigan AMC |
| Voucher Number FY | N | 1 | 17 | Designates fiscal year (y) to which voucher funds are obligated.  0 thru 9 - the units digit of the fiscal year. |
| Voucher Number Seq Number | A | 3 | 18-20 | Uniquely identifies each voucher for a given fi for a given fiscal year. Used by fi's to link their invoicing methodologies to the ochampus voucher processing. Some fi's process a voucher each workday; other FI's with lower claim volumes may only process one or two vouchers per week. |
| Voucher Resubmit Seq Number | N | 2 | 21-22 | The number of times a voucher has been resubmitted to correct edit errors. Initial submission is set to 00. |
| Filler | A | 3 | 23-25 |  |
|  |  |  |  |  |
| HCSR Batch Begin Date | N | 8 | 26-33 | Yyyymmdd |
| HCSR Batch End Date | N | 8 | 34-41 | Yyyymmdd |
| Voucher Notice Date | N | 8 | 42-49 | Yyyymmdd  The date the voucher funding was authorized by ochampus. This date must be earlier than or the same as the fi voucher processing date. |
| Voucher Create Date | N | 8 | 50-57 | Yyyymmdd  Date the contractor first created the voucher for transmission to ochampus |
| Subtype Sort Number | N | 2 | 58-59 |  |
| Record Received Sequence Number | N | 7 | 60-66 |  |
| Record Processed Sequence Number | N | 7 | 67-73 |  |
| Filler | A | 16 | 74-89 |  |
| HCSR Number |  |  |  | The number consisting of the icn, time and suffix that uniquely identifies a hcsr. |
| HCSR Internal Control Number (ICN) |  |  |  | The unique number assigned by the contractor that reflects the date of receipt of the treatment encounter data and the control sequence for contractor management control purposes. |
| HCSR Filing Date | N | 7 | 90-96 | Yyyyddd  The date the filing for payment of health care services rendered was received by the contractor. |
| Filing State/Country Code | A | 2 | 97-98 | Code that indicates the filing state or country where the care was provided. |
| HCSR Sequence Number | A | 5 | 99-103 | Number assigned by the contractor to uniquely identify the individual hcsr. Once assigned, the sequence number cannot be reused with the same filing state, filing date and hcsr suffix combination. |
| HCSR Time | A | 6 | 104-109 | Unique system time assigned by the fi when issuing an initial hcsr record. |
| HCSR Suffix | A | 1 | 110 | Code to uniquely identify when treatment encounter data is split into groupings for hcsr reporting purposes.  Assigned in alphabetic order  a – no split required  b – first split  c – second split  d-y – etc. |
| Program Indicator Code | A | 1 | 111 | Identifies to which champus program the services being reported on the hcsr are related.  Institutional hcsr:  i – institutional  h – program for the handicapped  non-institutional hcsr:  d – drug  h – program for the handicapped  i – institutional (excluding d, h and t)  n – non-institutional (excluding d, h and t)  t – dental (excluding d and h) |
| HCSR Processed to Completion Date | N | 8 | 112-119 | Yyyymmdd  Processed to completion date for the health care service record (hcsr). This date does not change for re-submissions unless previously coded in error. |
| HCSR Adjustment Identified Date | N | 8 | 120-127 | Date the contractor determined an adjustment HCSR was required. This date does not change for re-submissions unless previously coded in error. This date is zero filled on non-adjustment HCSRS. The format is YYYYMMDD. |
| Sponsor SSN | A | 9 | 128-136 | Sponsor social security account number or veterans administration file number.  All numeric - normal claims.  All blanks - nato & security agent claims (extremely rare).  first 3 digits zeroes - deceased sponsor only. |
| Sponsor Pay Grade | A | 2 | 137-138 | Sponsor's pay grade code.  HCSR code definitions:  00 – unknown enlisted  01-09 – enlisted (e1-e9)  10 – unknown warrant officer  11-14 – warrant officer (w1- w4)  19 – academy of navy OCS students  20 – unknown officer  21-31 – officer (01-011)  40 – unknown civil service  41-58 – GS1-GS18  90 – unknown  95 – not applicable (including CHAMPVA)  99 – other |
| Sponsor Branch of Service | A | 1 | 139 | Sponsor's uniformed service branch or organization that creates entitlement to the health care.  Codes for HCSR:  A – Army  E – Public Health Service  F – Air Force  I – NOAA  M – Marines  N – Navy  P – Coast Guard  C – CHAMPVA |
| Patient Category |  |  |  | Category of patient type downloaded from DEERS. If unavailable from DEERS, is reported from healthcare data received by contractor. |
| Sponsor Status | A | 1 | 140 | Code indicating official status of sponsor in regard to a current level of participation in a uniformed branch of service/affiliation. |
| Patient Relationship | A | 1 | 141 | Code that defines the relationship of the patient to sponsor, downloaded from DEERS. |
| Patient Name | A | 27 | 142-168 | Legal name of patient, downloaded from DEERS. (if unavailable from DEERS, the name comes from the health care data submitted to contractor.) The last name is at least two characters, followed by a comma. |
| Patient SSN | A | 9 | 169-177 | Patient social security account number. If unknown, blank fill. |
| Patient DOB | N | 8 | 178-185 | YYYYMMDD  Date 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. |
| DEERS Dependent Suffix Code | A | 2 | 186-187 | Code maintained by DEERS that uniquely identifies the patient within the family. |
| Patient Sex | A | 1 | 188 | Sex of patient/beneficiary.  Codes for HCSR:  M – male  F – female |
| Patient Zip/Country Code | A | 9 | 189-197 | US postal zip code or foreign country code for patient's legal residence at the time service was rendered. Must not be the zip code of a post office box. If the code is a two-character foreign country code, it must be left justified. |
| Enrollment Code | A | 2 | 198-199 | Code indicating whether or not the patient is enrolled with the contractor. |
| *NAS ID Number* |  |  |  | Unique number assigned by the MTF when issuing a non-availability statement (NAS). For reporting purposes this is down loaded from the DEERS database. |
| NAS ID Number Prefix | A | 1 | 200 | A one character numeric digit at the beginning of the NAS ID number. For valid and active NAS ID numbers, this is a zero. |
| NAS MTF Code | A | 3 | 201-203 | A unique numeric code assigned to each military treatment facility. |
| NAS Issue Date | A | 4 | 204-207 | A four character Julian date in the format YDDD. This date is contained within the non-availability statement ID number that is issued for treatment outside of a MTF catchment area. |
| NAS Facility Sequence | A | 3 | 208-210 | A facility sequence number assigned in accordance with the implementing instructions of the issuing facility's host service. |
| Reason for Payment Reduction | A | 1 | 211 | Reason payment reduction assessed  A - mental health pre-authorization not obtained  B – adjunctive dental care pre-authorization not obtained  C - procedure/services in TRICARE regions not authorized |
| Major Diagnostic Category Code | A | 2 | 212-213 | A code representing the major diagnostic category for which a nas was issued |
| Derived Major Diagnostic Code | A | 2 | 214-215 | This field is derived from the principle diagnosis code via a black box program. |
| NAS Issue Reason Code | A | 1 | 216 |  |
| Claim Form Type | A | 1 | 217 | The code associated with the primary claim form submitted.  A – DD form 2520 (long)  B – DD form 2520 (short)  C – HCFA form 1500  D – UBF-1  F – UB-92  G – electronic institutional claim submission  H – electronic non-institutional claim submission  I – electronic drug submission  J – other |
| MTF Code Authorized Care | A | 4 | 218-221 | Four digit DMIS code from the catchment area directory identifying the MTF that authorized the care. |
| Number Payment Reduction Days | SN | 3 | 222-224 | Number of payment reduction days/services assessed for institutional records, number of payment reduction days will be reported. |
| Total Amount Billed | SN | 9,2 | 225-233 | Total amount billed for all services. Total amount for which patient/provider has requested reimbursement. |
| Total Amount Allowed | SN | 9,2 | 234-242 | Total amount allowed for all authorized services as determined by the contractor. |
| Amount Paid by OHI | SN | 9,2 | 243-251 | Total amount paid by other health insurance for all services reported on the hcsr. |
| Amount Allowed by OHI | SN | 9,2 | 252-260 | Total amount allowed by other health insurance for all services reported on the hcsr |
| Amount Third Party Liability | SN | 9,2 | 261-269 | Total amount paid by outside party (excluding patient's other health insurance coverage) e.g. Third party liability for services reported. |
| Amount of Payment Reduction | SN | 9,2 | 270-278 | Total amount of payment withheld by the fi /contractor. |
| Patient Coinsurance Amount | SN | 8,2 | 279-286 | The amount of allowed charges that beneficiaries are required to pay under ochampus. |
| Patient Copayment Amount | SN | 8,2 | 287-294 | A predetermined, fixed amount charged by the fi/contractor under champus prime, or other demonstrations, or the fixed amounts under the standard champus program that the beneficiary is liable for paying for covered services. |
| Amount Paid by Govt Contractor | SN | 9,2 | 295-303 | The portion of total amount allowed that was paid by gov’t fi/contractor for the services reported. |
| Filler | A | 7 | 304-310 |  |
| Override Code 1 | A | 2 | 311-312 | The first of three codes that 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. |
| Override Code 2 | A | 2 | 313-314 | The second of three codes that 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. |
| Override Code 3 | A | 2 | 315-316 | The third of three codes that 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. |
| Type of Submission Code | A | 1 | 317 | Code indicating the HCSR submission type. |
| NAS Exception Reason Code | A | 2 | 318-319 | Code that indicates reason for the exception to the requirement of a non-availability statement (NAS). |
| Health Care Plan Code | A | 2 | 320-321 | Codes that identify the unique health care plan, that the provider was affiliated with when the care was rendered. |
| ICD Edition ID Number | A | 1 | 322 | Code identifying the edition number of the international classification of diseases used in determining the diagnosis codes on both types of HCSRS. For institutional records only, identifies edition number for determination of operation/non surgical procedures. |
| HCSR Adjust Code | A | 1 | 323 | Code indicating the primary reason for the positive or negative adjustment HCSR. |
| Special Processing Code 1 | A | 2 | 324-325 | First of three codes to indicate that special processing is required for certain care. |
| Special Processing Code 2 | A | 2 | 326-327 | Second of three codes to indicate that special processing is required for certain care. |
| Special Processing Code 3 | A | 2 | 328-329 | Third of three codes to indicate that special processing is required for certain care. |
| Special Rate Code | A | 2 | 330-331 | Code to indicate which special rates apply in calculating patient cost share or government contractor pay amount. |
| Provider Contract Affiliation Code | A | 1 | 332 | Code indicating whether the provider is under contract with the contractor. All codes are irrespective of any partnership agreements.  For provider records:  0 – not applicable1 – contracted  2 – not contracted  3 – contracted/not contracted  4 – active duty GSU |
| Provider State/Country Code | A | 2 | 333-334 | Code for the state or foreign country in which the care was actually received. |
| Provider Tax ID | A | 9 | 335-343 | The IRS taxpayer identification number (TIN) assigned to the institution/provider supplying the care. For institutions, it must be the employer identification number (EIN). For individual providers it must be the EIN or SSN, if available. If not available, the contractor will report the contractor-assigned number. On HCSRS all nines are used for transportation services under program for the handicapped and for the drug program when the services are from a non-participating pharmacy. |
| Multiple Provider Indicator | A | 4 | 344-347 | Identification number that uniquely identifies individual providers using the same taxpayer identification number (tin). Codes are assigned per OCHAMPUS instructions. Must be zero filled if there are no multiple providers within the taxpayer identification number (tin). For clinics, the sub-identifier is assigned with an alpha character in the first position followed by three numeric, sequentially assigned numbers, or 2 alpha in the first two positions followed by 2 numeric sequentially assigned numbers. When the clinic itself is submitted (specialty code=70), the sequential number is either 001or 01. Individual providers within begin with 002 or02 and so on, all having the same characters in the first two positions as the clinic. All other non-institutional providers and institutional providers use numerics in all four characters of the sub-identifier. |
| Provider Care Zip Code | A | 9 | 348-356 | The zip code of the location where the care was provided. Must be a valid zip code or blanks if a foreign country. |
| Provider Participation Indicator | A | 1 | 357 | Indicates whether or not the provider accepted assignment of benefits for services rendered.  N - no  Y – yes |
| Principle Diagnosis Code | A | 6 | 358-363 | The condition code established, after study, to be the major cause for the patient to obtain medical care as coded on the UB-82 or otherwise indicated by the provider. The ICD-ED-NBR element specifies the diagnosis code manual for the code values. |
| Secondary Diagnosis Code 1 | A | 6 | 364-369 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 2 | A | 6 | 370-375 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 3 | A | 6 | 376-381 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 4 | A | 6 | 382-387 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 5 | A | 6 | 388-393 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 6 | A | 6 | 394-399 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 7 | A | 6 | 400-405 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 8 | A | 6 | 406-411 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Region Code Header | A | 2 | 412-413 |  |
| Filler | A | 4 | 414-417 |  |
| Patient Pay Total | SN | 9,2 | 418-426 | 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. |
| MTF Code | A | 3 | 427-429 | The three digit DMIS (defense medical information system) ID code which identifies the military treatment facility or other specific area (BRAC site or non-catchment area) in which the patient residence is located. (Includes only US and Puerto Rico areas – not overseas or non-catchment areas.) |
| MTF Branch of Service | A | 1 | 430 | 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 |
| Bill MTF Code | A | 3 | 431-433 | Code that identifies the medical treatment facility (mtf) which is financially responsible for the cost of care provided. |
| Bill Branch of Service | A | 1 | 434 | The branch of service that is financially responsible for the cost of the care provided. |
| Patient Age | N | 3 | 435-437 | HCSR definition: Age of patient calculated based on earliest begin date of care versus patient's date of birth.  Other systems: Age of patient submitting claim calculated based on cycle date versus patient's date of birth. |
| Cycle Number Year | A | 2 | 438-439 |  |
| Cycle Number Month | A | 2 | 440-441 |  |
| Cycle Sequence Number | N | 2 | 442-443 |  |
| HCSR Accept Date | N | 6 | 444-449 | YYYYMM  Calendar year and month a HCSR was accepted for accounting purposes. |
| Claim Count Code | SN | 1 | 450 | To indicate primary claim group for all claim groups with a common claim number. On the net HCSR database, this code is the sum of all the history records (original, adjustments, and cancellations) for the 'primary' HCSR (and therefore greater than 1). Primary HCSR is the first HCSR in ICN-suffix 'group' to update the database. For non-primary HCSRS, the sum of all history records is always equal to zero.  0 = non-primary claim group  1 or greater = primary claim group |
| Benefit Claim Count Code | SN | 1 | 451 | Claim count that represents the primary care the beneficiary receives exclusive of any supplemental billings, adjustments or cancellations from the provider.  +1 – positive benefit count  -1 – negative benefit count  0 – no benefit count |
| Administrative Claim Count Code | SN | 1 | 452 | Indicates administrative payment record, on the net hcsr database, this is the sum of all history records (original, adjustments, 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 |
| Source Health Care Data | A | 2 | 453-454 | Indicates source of health care data. |
| Net Record Type Code | A | 1 | 455 | After possible multiple submissions have been netted, resultant type of submission of net record. |
| Key Field Change Code | A | 1 | 456 |  |
| Hospital Department Number | A | 2 | 457-458 | The hospital department categorization for a given diagnosis code. |
| Care End Fiscal Year | N | 4 | 459-462 |  |
| Health Services Region Code | A | 2 | 463-464 | A health service region defined by zip codes |
| Beneficiary Category | A | 1 | 465 | Categorization of beneficiaries based on a given sponsor status for cost sharing and reporting purposes. For non-availability statements:  Categorization of beneficiaries based on the sponsor's status and the patient's relationship to that sponsor.  1 – active-dependent  2 – retired-sponsor  3 – retired/deceased-dependent and all other patients  4 – active duty sponsor |
| Filler | A | 4 | 466-469 |  |
| Type of Institution Code | A | 2 | 470-471 | A code indicating type of institution for institutional providers. |
| Admission Date | N | 8 | 472-479 | Date of initial admission to the institution for this episode of care. |
| Bill Classification Code | A | 1 | 480 | A code describing type of billing from the facility.  Valid codes for HCSRS:  1 – inpatient  2 – hospital based hospice |
| Bill Frequency Code | A | 1 | 481 | A code indicating frequency of billing from the hospital.  Valid codes for hcsrs:  1 – admit thru discharge hcsr  2 – interim - initial hcsr  3 – interim - interim hcsr  4 – interim - final claim  5 – admit through transfer hcsr  7 – replacement of prior claim  8 – void/cancel of prior claim |
| Type of Admission Code | A | 1 | 482 | A code indicating the type of the admission.  1 – emergency  2 – urgent  3 – elective  4 – newborn |
| Source of Admission Code | A | 1 | 483 | A code indicating the referral source for the admission. |
| Discharge Status Code | A | 2 | 484-485 | Code indicating patient status as of the end date of care on the HCSR. |
| Begin Date of Care | N | 8 | 486-493 | Earliest date of care reported in the health care data. |
| End Date of Care | N | 8 | 494-501 | Latest date of care reported on the institutional health care data. |
| Number of Births | SN | 1 | 502 | Number of births, both live and stillborn, occurring during delivery. |
| Total Bed Days | SN | 3 | 503-505 | Total number of days of hospital care during the period covered by the HCSR whether or not allowable. |
| Government Authorized Bed Days | SN | 3 | 506-508 | Number of hospital days authorized for services where there was 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 |
| Admission Diagnosis Code | A | 6 | 509-514 | Code identifying diagnosis under which the patient was admitted to the institution. |
| Principle OP-NS Procedure Code | A | 5 | 515-519 | Code identifying principal procedure performed during the period covered by this HCSR as coded on the UB82 form. |
| Secondary OP-NS Procedure Code 1 | A | 5 | 520-524 | Code identifying procedures (other than primary) performed during the period covered by this HCSR as coded on the UB82 form. The proced-cd-method-code element specifies which procedure code manual to refer to for code values. |
| Secondary OP-NS Procedure Code 2 | A | 5 | 525-529 | Code identifying procedures (other than primary) performed during the period covered by this HCSR as coded on the UB82 form. |
| Secondary OP-NS Procedure Code 3 | A | 5 | 530-534 | Code identifying procedures (other than primary) performed during the period covered by this HCSR as coded on the UB82 form. |
| Secondary OP-NS Procedure Code 4 | A | 5 | 535-539 | Code identifying procedures (other than primary) performed during the period covered by this HCSR as coded on the UB82 form. |
| Secondary OP-NS Procedure Code 5 | A | 5 | 540-544 | Code identifying procedures (other than primary) performed during the period covered by this HCSR as coded on the UB82 form. |
| DRG Number | A | 3 | 545-547 | Identifies the diagnosis related group (drg) determined for the episode of care. |
| DRG Grouper Edition | A | 2 | 548-549 | Identifies the edition number of the diagnosis related grouper which is used to determine the drg. |
| DRG Pricer Edition | A | 2 | 550-551 | Identifies the diagnosis related pricer used to determine the drg. |
| Admission Count Code | SN | 1 | 552 | A claim may fall into 1 of 3 admission categories; admission,  Non-admission, or cancellation of an original admission. This field indicates the category of the claim.  +1 – claim is an admission claim  0 – claim is a non-admission claim  -1 – claim is a cancellation of an original admission claim. |
| Category of Care | A | 2 | 553-554 | Major breakouts of data used for reporting care, based on benefit program (dental, drug, PFTH) 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. |
| DRG Derived Code | A | 3 | 555-557 | 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. |
| Care End Date Year | A | 4 | 558-561 |  |
| Care End Date Month | A | 2 | 562-563 |  |
| Relative Weighted Product (RWPs) | SN | 7,4 | 564-570 | DRG CHAMPUS weight adjusted for stay outliers: Only "acute care" HCSRS get RWP calculations. The basic RWP calculation is alike for HCSRS and SIDRS, and is affected by length-of-stay for outliers.  "Transfer" cases get the same RWP calculation in HCSRs as in SIDRs. Interim HCSRs (no discharge date) are always treated as long-stay outliers. The initial one gets the base weight for the DRG, plus or minus the outlier per diem depending on whether it is shorter or longer than the outlier threshold. All non-initial continuation HCSRs are treated as pure outlier stays, receiving 33% of the (DRG mean weight per day) times the length of stay, while not receiving any "base weight" credit. |
| Preventable Admission | A | 1 | 571 | Applies algorithm to identify preventable admissions, coded as:  A = Asthma  B =Bacterial Pneumonia  C = COPD  D = Diabetes  G = Gastroenteritis  H = Congestive Heart Failure  P = Angina Pectoris  U = Urinary Tract Infection / Kidney  T = (Tissue) Cellulitis  0 = Not a preventable admission |
| Filler |  |  | 572-583 |  |
| Revenue Information Occurrence Count | N | 2 | 584-585 | Indicates number of occurrences of revenue codes and related data elements occur on the HCSR record. |
| *Revenue Data* |  |  |  | The following data occurs 0 to 50 times depending on the value of ‘Revenue Info Occurrence Count’ |
| Revenue Code | A | 4 | 586-589 | A code that identifies revenue categories associated with the type of service rendered. Like revenue codes are summarized provided the reason for allowance/denials the same for each. |
| Nbr of Services by Revenue Code | SN | 7 | 590-596 | A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, or renal dialysis treatments, etc. |
| Total Charge by Revenue Code | SN | 9,2 | 597-605 | Amount billed for this revenue code. |
| Denial Reason Code | A | 2 | 606-607 | Justification for denial of detail line item on HCSR by the contractor. |
| Occurrence Count | PN | 2 | 608-609 |  |
| Previous Denial Reason Code | A | 2 | 610-611 | Justification for denial of detail line item on HCSR by the contractor. |

**Appendix B: Layout of HCSR-I for Fiscal Years 1999 and Previous[[5]](#footnote-5)**

| **CHAMPUS Health Care Service Record (HCSR) - Institutional** | | | | |
| --- | --- | --- | --- | --- |
| **Field Name** | **Type** | **Size** | **Position** | **Comments** |
| Error Count | SN | 3 | 1-3 |  |
| Record Type Code | A | 1 | 4 | Indicates an individual hcsr record by type.  All records in this file will have “1”, indicating an institutional HCSR. |
| *Batch Group* |  |  |  |  |
| Contractor Number | A | 2 | 5-6 | Identification code for the contractor. It is used to identify each contractor submitting health care service records, pricing file records, and provider file records. |
| *Batch Record Data* |  |  |  |  |
| HCSR Contract Number | A | 7 | 7-13 | Unique number assigned to a contract. The first two digits of the contract number followed by the one character alpha procurement code followed by the last four digits of the contract number |
| Record Type Code (Batch) | A | 1 | 14 | Indicates whether this HCSR came in a batch (value is 0) or in a voucher (value is 5) |
|  | | | | |
| *Batch Control Data*  Data uniquely identifies a batch of records. These fields have this meaning only if the Record Type Code (batch) in position 14 is “0” | | | | |
| Batch Create Date | N | 7 | 15-21 | Yyyyddd  Date the contractor first created the batch for transmission to ochampus. This date will not change through the resubmission process. |
| Batch Sequence Number | A | 2 | 22-23 | A sequential number assigned by the contractor to identify the batch sequence of the record category submitted. Once assigned, the sequence number cannot be reused with the same batch date and remains with the batch through resubmission process |
| Batch Resubmit Seq. Number | A | 2 | 24-25 | The number of re-submissions for the batch for other than batch-level error rejections. Incremented by one for each resubmission. |
| *Voucher Control Data*  Data uniquely identifies a voucher. These fields have this meaning only if the Record Type Code (batch) in position 14 is “5” | | | | |
| Voucher Number ID |  |  |  | The base identifier for a group or block of claim payment records from an fi, assigned by the processing fi. |
| Voucher Branch of Service | A | 2 | 15-16 | Voucher number branch of service to assign the branch of service that the medical care is to be billed.  01 – Army  02 – Air Force  03 – Navy/MC  05 – Non-DoD  10 - CHCBP  21 – Active Duty – Army  22 – Active Duty – Air Force  23 – Active Duty – Marine-Corps/Navy  25 – Active Duty – Non DoD (TPR)  26 - Army - National Guard (TPR)  41 - Army (Comp Clin Eval Pgm)  42 - Air Force (Comp Clin Eval Pgm)  43 - Navy/MC (Comp Clin Eval Pgm)  45 - Non DOD (Comp Clin Eval Pgm)  71 - Army-DP, SPL/ Emrgnt, abused, Kitsap  72 - AF-DP, SPL/ Emrgnt, abused, Kitsap  73 - Nv/MC-DP, SPL/ Emrgnt, abused, Kitsap  A1 - Army - Spmtl Hlth pgm - ER  A2 - Air Force - Spmtl Hlth pgm - ER  A3 - Navy/MC - Spmtl Hlth pgm - ER  A5 - Non DOD - Spmtl Hlth pgm - ER  A6 - Army Nat Guard - Spmtl Hlth pgm - ER  B1 - Army (Spmtl Care MTF)  B2 - Air Force (Spmtl Care MTF)  B3 - Navy/MC (Spmtl Care MTF )  B5 - Non DOD (Spmtl Care MTF)  B6 - Army Nat Guard (Spmtl Care MTF)  C1 - Army - Tricare Senior Supplement  C2 - Air Force - Tricare Senior Supplement  C3 - Navy/MC - Tricare Senior Supplement  C5 - Non DOD - Tricare Senior Supplement  D1 - Army - Pharmacy Redesign  D2 - Air Force - Pharmacy Redesign  D3 - Navy/MC - Pharmacy Redesign  D5 - Non DOD - Pharmacy Redesign  E1 - Army - Spmtl Hlth Non-ER  E2 - Air Force - Spmtl Hlth Non-ER  E3 - Navy/MC - Spmtl Hlth Non-ER  E5 - Non DOD - Spmtl Hlth Non-ER  E6 - Army Nat Guard - Spmtl Hlth Non-ER  FA - TSP Dover AFB  FB - TSP Keesler AFB  FC - TSP Brook Army MC  FD - TSP Wilford HMC  FE - TSP FT Sill  FF - TSP Sheppard  FG - TSP Ft Carson  FH - TSP AF Academy  FJ - TSP Naval MC SD  FK - TSP Madigan AMC |
| Voucher Number FY | N | 1 | 17 | Designates fiscal year (y) to which voucher funds are obligated.  0 thru 9 - the units digit of the fiscal year. |
| Voucher Number Seq Number | A | 3 | 18-20 | Uniquely identifies each voucher for a given fi for a given fiscal year. Used by fi's to link their invoicing methodologies to the ochampus voucher processing. Some fi's process a voucher each workday; other FI's with lower claim volumes may only process one or two vouchers per week. |
| Voucher Resubmit Seq Number | N | 2 | 21-22 | The number of times a voucher has been resubmitted to correct edit errors. Initial submission is set to 00. |
| Filler | A | 3 | 23-25 |  |
|  |  |  |  |  |
| HCSR Batch Begin Date | N | 8 | 26-33 | Yyyymmdd |
| HCSR Batch End Date | N | 8 | 34-41 | Yyyymmdd |
| Voucher Notice Date | N | 8 | 42-49 | Yyyymmdd  The date the voucher funding was authorized by ochampus. This date must be earlier than or the same as the fi voucher processing date. |
| Voucher Create Date | N | 8 | 50-57 | Yyyymmdd  Date the contractor first created the voucher for transmission to ochampus |
| Subtype Sort Number | N | 2 | 58-59 |  |
| Record Received Sequence Number | N | 7 | 60-66 |  |
| Record Processed Sequence Number | N | 7 | 67-73 |  |
| Filler | A | 16 | 74-89 |  |
| HCSR Number |  |  |  | The number consisting of the icn, time and suffix that uniquely identifies a hcsr. |
| HCSR Internal Control Number (ICN) |  |  |  | The unique number assigned by the contractor that reflects the date of receipt of the treatment encounter data and the control sequence for contractor management control purposes. |
| HCSR Filing Date | N | 7 | 87-93 | Yyyyddd  The date the filing for payment of health care services rendered was received by the contractor. |
| Filing State/Country Code | A | 2 | 94-95 | Code that indicates the filing state or country where the care was provided. |
| HCSR Sequence Number | A | 5 | 96-100 | Number assigned by the contractor to uniquely identify the individual hcsr. Once assigned, the sequence number cannot be reused with the same filing state, filing date and hcsr suffix combination. |
| HCSR Time | A | 6 | 101-106 | Unique system time assigned by the fi when issuing an initial hcsr record. |
| HCSR Suffix | A | 1 | 107 | Code to uniquely identify when treatment encounter data is split into groupings for hcsr reporting purposes.  Assigned in alphabetic order  a – no split required  b – first split  c – second split  d-y – etc. |
| Program Indicator Code | A | 1 | 111 | Identifies to which champus program the services being reported on the hcsr are related.  Institutional hcsr:  i – institutional  h – program for the handicapped  non-institutional hcsr:  d – drug  h – program for the handicapped  i – institutional (excluding d, h and t)  n – non-institutional (excluding d, h and t)  t – dental (excluding d and h) |
| HCSR Processed to Completion Date | N | 8 | 112-119 | Yyyymmdd  Processed to completion date for the health care service record (hcsr). This date does not change for re-submissions unless previously coded in error. |
| HCSR Adjustment Identified Date | N | 8 | 120-127 | Date the contractor determined an adjustment HCSR was required. This date does not change for re-submissions unless previously coded in error. This date is zero filled on non-adjustment HCSRS. The format is YYYYMMDD. |
| Sponsor SSN | A | 9 | 128-136 | Sponsor social security account number or veterans administration file number.  All numeric - normal claims.  All blanks - nato & security agent claims (extremely rare).  first 3 digits zeroes - deceased sponsor only. |
| Sponsor Pay Grade | A | 2 | 137-138 | Sponsor's pay grade code.  HCSR code definitions:  00 – unknown enlisted  01-09 – enlisted (e1-e9)  10 – unknown warrant officer  11-14 – warrant officer (w1- w4)  19 – academy of navy OCS students  20 – unknown officer  21-31 – officer (01-011)  40 – unknown civil service  41-58 – GS1-GS18  90 – unknown  95 – not applicable (including CHAMPVA)  99 – other |
| Sponsor Branch of Service | A | 1 | 139 | Sponsor's uniformed service branch or organization that creates entitlement to the health care.  Codes for HCSR:  A – Army  E – Public Health Service  F – Air Force  I – NOAA  M – Marines  N – Navy  P – Coast Guard  C – CHAMPVA |
| Patient Category |  |  |  | Category of patient type downloaded from DEERS. If unavailable from DEERS, is reported from healthcare data received by contractor. |
| Sponsor Status | A | 1 | 140 | Code indicating official status of sponsor in regard to a current level of participation in a uniformed branch of service/affiliation. |
| Patient Relationship | A | 1 | 141 | Code that defines the relationship of the patient to sponsor, downloaded from DEERS. |
| Patient Name | A | 27 | 142-168 | Legal name of patient, downloaded from DEERS. (if unavailable from DEERS, the name comes from the health care data submitted to contractor.) The last name is at least two characters, followed by a comma. |
| Patient SSN | A | 9 | 169-177 | Patient social security account number. If unknown, blank fill. |
| Patient DOB | N | 8 | 178-185 | YYYYMMDD  Date 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. |
| DEERS Dependent Suffix Code | A | 2 | 186-187 | Code maintained by DEERS that uniquely identifies the patient within the family. |
| Patient Sex | A | 1 | 188 | Sex of patient/beneficiary.  Codes for HCSR:  M – male  F – female |
| Patient Zip/Country Code | A | 9 | 189-197 | US postal zip code or foreign country code for patient's legal residence at the time service was rendered. Must not be the zip code of a post office box. If the code is a two-character foreign country code, it must be left justified. |
| Enrollment Code | A | 2 | 198-199 | Code indicating whether or not the patient is enrolled with the contractor. |
| *NAS ID Number* |  |  |  | Unique number assigned by the MTF when issuing a non-availability statement (NAS). For reporting purposes this is down loaded from the DEERS database. |
| NAS ID Number Prefix | A | 1 | 200 | A one character numeric digit at the beginning of the NAS ID number. For valid and active NAS ID numbers, this is a zero. |
| NAS MTF Code | A | 3 | 201-203 | A unique numeric code assigned to each military treatment facility. |
| NAS Issue Date | A | 4 | 204-207 | A four character Julian date in the format YDDD. This date is contained within the non-availability statement ID number that is issued for treatment outside of a MTF catchment area. |
| NAS Facility Sequence | A | 3 | 208-210 | A facility sequence number assigned in accordance with the implementing instructions of the issuing facility's host service. |
| Reason for Payment Reduction | A | 1 | 211 | Reason payment reduction assessed  A - mental health pre-authorization not obtained  B – adjunctive dental care pre-authorization not obtained  C - procedure/services in TRICARE regions not authorized |
| Major Diagnostic Category Code | A | 2 | 212-213 | A code representing the major diagnostic category for which a nas was issued |
| Derived Major Diagnostic Code | A | 2 | 214-215 | This field is derived from the principle diagnosis code via a black box program. |
| NAS Issue Reason Code | A | 1 | 216 |  |
| Claim Form Type | A | 1 | 217 | The code associated with the primary claim form submitted.  A – DD form 2520 (long)  B – DD form 2520 (short)  C – HCFA form 1500  D – UBF-1  F – UB-92  G – electronic institutional claim submission  H – electronic non-institutional claim submission  I – electronic drug submission  J – other |
| MTF Code Authorized Care | A | 4 | 218-221 | Four digit DMIS code from the catchment area directory identifying the MTF that authorized the care. |
| Number Payment Reduction Days | SN | 3 | 222-224 | Number of payment reduction days/services assessed for institutional records, number of payment reduction days will be reported. |
| Total Amount Billed | SN | 9,2 | 225-233 | Total amount billed for all services. Total amount for which patient/provider has requested reimbursement. |
| Total Amount Allowed | SN | 9,2 | 234-242 | Total amount allowed for all authorized services as determined by the contractor. |
| Amount Paid by OHI | SN | 9,2 | 243-251 | Total amount paid by other health insurance for all services reported on the hcsr. |
| Amount Allowed by OHI | SN | 9,2 | 252-260 | Total amount allowed by other health insurance for all services reported on the hcsr |
| Amount Third Party Liability | SN | 9,2 | 261-269 | Total amount paid by outside party (excluding patient's other health insurance coverage) e.g. Third party liability for services reported. |
| Amount of Payment Reduction | SN | 9,2 | 270-278 | Total amount of payment withheld by the fi /contractor. |
| Patient Coinsurance Amount | SN | 8,2 | 279-286 | The amount of allowed charges that beneficiaries are required to pay under ochampus. |
| Patient Copayment Amount | SN | 8,2 | 287-294 | A predetermined, fixed amount charged by the fi/contractor under champus prime, or other demonstrations, or the fixed amounts under the standard champus program that the beneficiary is liable for paying for covered services. |
| Amount Paid by Govt Contractor | SN | 9,2 | 295-303 | The portion of total amount allowed that was paid by gov’t fi/contractor for the services reported. |
| Filler | A | 7 | 304-310 |  |
| Override Code 1 | A | 2 | 311-312 | The first of three codes that 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. |
| Override Code 2 | A | 2 | 313-314 | The second of three codes that 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. |
| Override Code 3 | A | 2 | 315-316 | The third of three codes that 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. |
| Type of Submission Code | A | 1 | 317 | Code indicating the HCSR submission type. |
| NAS Exception Reason Code | A | 2 | 318-319 | Code that indicates reason for the exception to the requirement of a non-availability statement (NAS). |
| Health Care Plan Code | A | 2 | 320-321 | Codes that identify the unique health care plan, that the provider was affiliated with when the care was rendered. |
| ICD Edition ID Number | A | 1 | 322 | Code identifying the edition number of the international classification of diseases used in determining the diagnosis codes on both types of HCSRS. For institutional records only, identifies edition number for determination of operation/non surgical procedures. |
| HCSR Adjust Code | A | 1 | 323 | Code indicating the primary reason for the positive or negative adjustment HCSR. |
| Special Processing Code 1 | A | 2 | 324-325 | First of three codes to indicate that special processing is required for certain care. |
| Special Processing Code 2 | A | 2 | 326-327 | Second of three codes to indicate that special processing is required for certain care. |
| Special Processing Code 3 | A | 2 | 328-329 | Third of three codes to indicate that special processing is required for certain care. |
| Special Rate Code | A | 2 | 330-331 | Code to indicate which special rates apply in calculating patient cost share or government contractor pay amount. |
| Provider Contract Affiliation Code | A | 1 | 332 | Code indicating whether the provider is under contract with the contractor. All codes are irrespective of any partnership agreements.  For provider records:  0 – not applicable1 – contracted  2 – not contracted  3 – contracted/not contracted  4 – active duty GSU |
| Provider State/Country Code | A | 2 | 333-334 | Code for the state or foreign country in which the care was actually received. |
| Provider Tax ID | A | 9 | 335-343 | The IRS taxpayer identification number (TIN) assigned to the institution/provider supplying the care. For institutions, it must be the employer identification number (EIN). For individual providers it must be the EIN or SSN, if available. If not available, the contractor will report the contractor-assigned number. On HCSRS all nines are used for transportation services under program for the handicapped and for the drug program when the services are from a non-participating pharmacy. |
| Multiple Provider Indicator | A | 4 | 344-347 | Identification number that uniquely identifies individual providers using the same taxpayer identification number (tin). Codes are assigned per OCHAMPUS instructions. Must be zero filled if there are no multiple providers within the taxpayer identification number (tin). For clinics, the sub-identifier is assigned with an alpha character in the first position followed by three numeric, sequentially assigned numbers, or 2 alpha in the first two positions followed by 2 numeric sequentially assigned numbers. When the clinic itself is submitted (specialty code=70), the sequential number is either 001or 01. Individual providers within begin with 002 or02 and so on, all having the same characters in the first two positions as the clinic. All other non-institutional providers and institutional providers use numerics in all four characters of the sub-identifier. |
| Provider Care Zip Code | A | 9 | 348-356 | The zip code of the location where the care was provided. Must be a valid zip code or blanks if a foreign country. |
| Provider Participation Indicator | A | 1 | 357 | Indicates whether or not the provider accepted assignment of benefits for services rendered.  N - no  Y – yes |
| Principle Diagnosis Code | A | 6 | 358-363 | The condition code established, after study, to be the major cause for the patient to obtain medical care as coded on the UB-82 or otherwise indicated by the provider. The ICD-ED-NBR element specifies the diagnosis code manual for the code values. |
| Secondary Diagnosis Code 1 | A | 6 | 364-369 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 2 | A | 6 | 370-375 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 3 | A | 6 | 376-381 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 4 | A | 6 | 382-387 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 5 | A | 6 | 388-393 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 6 | A | 6 | 394-399 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 7 | A | 6 | 400-405 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Diagnosis Code 8 | A | 6 | 406-411 | Code describing additional diagnosis of conditions that co-exist at the time of admission or during the treatment encounter. |
| Region Code Header | A | 2 | 412-413 |  |
| Filler | A | 4 | 414-417 |  |
| Patient Pay Total | SN | 9,2 | 418-426 | 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. |
| MTF Code | A | 3 | 427-429 | The three digit DMIS (defense medical information system) ID code which identifies the military treatment facility or other specific area (BRAC site or non-catchment area) in which the patient residence is located. (Includes only US and Puerto Rico areas – not overseas or non-catchment areas.) |
| MTF Branch of Service | A | 1 | 430 | 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 |
| Bill MTF Code | A | 3 | 431-433 | Code that identifies the medical treatment facility (mtf) which is financially responsible for the cost of care provided. |
| Bill Branch of Service | A | 1 | 434 | The branch of service that is financially responsible for the cost of the care provided. |
| Patient Age | N | 3 | 435-437 | HCSR definition: Age of patient calculated based on earliest begin date of care versus patient's date of birth.  Other systems: Age of patient submitting claim calculated based on cycle date versus patient's date of birth. |
| Cycle Number Year | A | 2 | 438-439 |  |
| Cycle Number Month | A | 2 | 440-441 |  |
| Cycle Sequence Number | N | 2 | 442-443 |  |
| HCSR Accept Date | N | 6 | 444-449 | YYYYMM  Calendar year and month a HCSR was accepted for accounting purposes. |
| Claim Count Code | SN | 1 | 450 | To indicate primary claim group for all claim groups with a common claim number. On the net HCSR database, this code is the sum of all the history records (original, adjustments, and cancellations) for the 'primary' HCSR (and therefore greater than 1). Primary HCSR is the first HCSR in ICN-suffix 'group' to update the database. For non-primary HCSRS, the sum of all history records is always equal to zero.  0 = non-primary claim group  1 or greater = primary claim group |
| Benefit Claim Count Code | SN | 1 | 451 | Claim count that represents the primary care the beneficiary receives exclusive of any supplemental billings, adjustments or cancellations from the provider.  +1 – positive benefit count  -1 – negative benefit count  0 – no benefit count |
| Administrative Claim Count Code | SN | 1 | 452 | Indicates administrative payment record, on the net hcsr database, this is the sum of all history records (original, adjustments, 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 |
| Source Health Care Data | A | 2 | 453-454 | Indicates source of health care data. |
| Net Record Type Code | A | 1 | 455 | After possible multiple submissions have been netted, resultant type of submission of net record. |
| Key Field Change Code | A | 1 | 456 |  |
| Hospital Department Number | A | 2 | 457-458 | The hospital department categorization for a given diagnosis code. |
| Care End Fiscal Year | N | 4 | 459-462 |  |
| Health Services Region Code | A | 2 | 463-464 | A health service region defined by zip codes |
| Beneficiary Category | A | 1 | 465 | Categorization of beneficiaries based on a given sponsor status for cost sharing and reporting purposes. For non-availability statements:  Categorization of beneficiaries based on the sponsor's status and the patient's relationship to that sponsor.  1 – active-dependent  2 – retired-sponsor  3 – retired/deceased-dependent and all other patients  4 – active duty sponsor |
| Filler | A | 4 | 466-469 |  |
| Type of Institution Code | A | 2 | 470-471 | A code indicating type of institution for institutional providers. |
| Admission Date | N | 8 | 472-479 | Date of initial admission to the institution for this episode of care. |
| Bill Classification Code | A | 1 | 480 | A code describing type of billing from the facility.  Valid codes for HCSRS:  1 – inpatient  2 – hospital based hospice |
| Bill Frequency Code | A | 1 | 481 | A code indicating frequency of billing from the hospital.  Valid codes for hcsrs:  1 – admit thru discharge hcsr  2 – interim - initial hcsr  3 – interim - interim hcsr  4 – interim - final claim  5 – admit through transfer hcsr  7 – replacement of prior claim  8 – void/cancel of prior claim |
| Type of Admission Code | A | 1 | 482 | A code indicating the type of the admission.  1 – emergency  2 – urgent  3 – elective  4 – newborn |
| Source of Admission Code | A | 1 | 483 | A code indicating the referral source for the admission. |
| Discharge Status Code | A | 2 | 484-485 | Code indicating patient status as of the end date of care on the HCSR. |
| Begin Date of Care | N | 8 | 486-493 | Earliest date of care reported in the health care data. |
| End Date of Care | N | 8 | 494-501 | Latest date of care reported on the institutional health care data. |
| Number of Births | SN | 1 | 502 | Number of births, both live and stillborn, occurring during delivery. |
| Total Bed Days | SN | 3 | 503-505 | Total number of days of hospital care during the period covered by the HCSR whether or not allowable. |
| Government Authorized Bed Days | SN | 3 | 506-508 | Number of hospital days authorized for services where there was 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 |
| Admission Diagnosis Code | A | 6 | 509-514 | Code identifying diagnosis under which the patient was admitted to the institution. |
| Principle OP-NS Procedure Code | A | 5 | 515-519 | Code identifying principal procedure performed during the period covered by this HCSR as coded on the UB82 form. |
| Secondary OP-NS Procedure Code 1 | A | 5 | 520-524 | Code identifying procedures (other than primary) performed during the period covered by this HCSR as coded on the UB82 form. The proced-cd-method-code element specifies which procedure code manual to refer to for code values. |
| Secondary OP-NS Procedure Code 2 | A | 5 | 525-529 | Code identifying procedures (other than primary) performed during the period covered by this HCSR as coded on the UB82 form. |
| Secondary OP-NS Procedure Code 3 | A | 5 | 530-534 | Code identifying procedures (other than primary) performed during the period covered by this HCSR as coded on the UB82 form. |
| Secondary OP-NS Procedure Code 4 | A | 5 | 535-539 | Code identifying procedures (other than primary) performed during the period covered by this HCSR as coded on the UB82 form. |
| Secondary OP-NS Procedure Code 5 | A | 5 | 540-544 | Code identifying procedures (other than primary) performed during the period covered by this HCSR as coded on the UB82 form. |
| DRG Number | A | 3 | 545-547 | Identifies the diagnosis related group (drg) determined for the episode of care. |
| DRG Grouper Edition | A | 2 | 548-549 | Identifies the edition number of the diagnosis related grouper which is used to determine the drg. |
| DRG Pricer Edition | A | 2 | 550-551 | Identifies the diagnosis related pricer used to determine the drg. |
| Admission Count Code | SN | 1 | 552 | A claim may fall into 1 of 3 admission categories; admission,  Non-admission, or cancellation of an original admission. This field indicates the category of the claim.  +1 – claim is an admission claim  0 – claim is a non-admission claim  -1 – claim is a cancellation of an original admission claim. |
| Category of Care | A | 2 | 553-554 | Major breakouts of data used for reporting care, based on benefit program (dental, drug, PFTH) 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. |
| DRG Derived Code | A | 3 | 555-557 | 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. |
| Care End Date Year | A | 4 | 558-561 |  |
| Care End Date Month | A | 2 | 562-563 |  |
| Relative Weighted Product (RWPs) | SN | 7,4 | 564-570 | DRG CHAMPUS weight adjusted for stay outliers: Only "acute care" HCSRS get RWP calculations. The basic RWP calculation is alike for HCSRS and SIDRS, and is affected by length-of-stay for outliers.  "Transfer" cases get the same RWP calculation in HCSRs as in SIDRs. Interim HCSRs (no discharge date) are always treated as long-stay outliers. The initial one gets the base weight for the DRG, plus or minus the outlier per diem depending on whether it is shorter or longer than the outlier threshold. All non-initial continuation HCSRs are treated as pure outlier stays, receiving 33% of the (DRG mean weight per day) times the length of stay, while not receiving any "base weight" credit. |
| Preventable Admission | A | 1 | 571 | Applies algorithm to identify preventable admissions, coded as:  A = Asthma  B =Bacterial Pneumonia  C = COPD  D = Diabetes  G = Gastroenteritis  H = Congestive Heart Failure  P = Angina Pectoris  U = Urinary Tract Infection / Kidney  T = (Tissue) Cellulitis  0 = Not a preventable admission |
| Filler |  |  | 572-583 |  |
| Revenue Information Occurrence Count | N | 2 | 584-585 | Indicates number of occurrences of revenue codes and related data elements occur on the HCSR record. |
| *Revenue Data* |  |  |  | The following data occurs 0 to 50 times depending on the value of ‘Revenue Info Occurrence Count’ |
| Revenue Code | A | 4 | 586-589 | A code that identifies revenue categories associated with the type of service rendered. Like revenue codes are summarized provided the reason for allowance/denials the same for each. |
| Nbr of Services by Revenue Code | SN | 7 | 590-596 | A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, or renal dialysis treatments, etc. |
| Total Charge by Revenue Code | SN | 9,2 | 597-605 | Amount billed for this revenue code. |
| Denial Reason Code | A | 2 | 606-607 | Justification for denial of detail line item on HCSR by the contractor. |
| Occurrence Count | PN | 2 | 608-609 |  |
| Previous Denial Reason Code | A | 2 | 610-611 | Justification for denial of detail line item on HCSR by the contractor. |

1. . [↑](#footnote-ref-1)
2. See appendix for an explanation of the SN (signed numeric) format. [↑](#footnote-ref-2)
3. The position of the HCSR Number is different for fiscal years 2000 and later, compared with fiscal years 1999 and previous. [↑](#footnote-ref-3)
4. See appendix for an explanation of the SN (signed numeric) format. [↑](#footnote-ref-4)
5. The position of the HCSR Number is different for fiscal years 1999 and previous, compared with fiscal years 2000 and later. [↑](#footnote-ref-5)