**21 July 2014**

HIPAA 837 Professional File Processing Specification for the

Central Billing Event Repository (CBER)

(Version 1.00.04)

Future Specification

**Revision History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Version** | **Date**  | **Para/Tbl/Fig** | **Originator** | **Description of Change** |
| 1.00.00 | 2/19/14 | * Whole Document
 | W.Funk | * Initial version
 |
| 1.00.01 | 5/27/14 | * Section V
* Section VI
* Table 4
* Table 5
 | W. Funk | * Modified receiving filters
* Clarified the update process
* Edited multiple fields for naming convention, field length and/or derivation
* Edited business rules, field lengths
 |
| 1.00.02 | 6/3/2014 | * Table 2
* Table 3
* Section V
 | W. Funk | * Changed the inclusion criteria for MSA to exclude Coast Guard
* Deleted CMAC table merge
* Modified the receiving filters. Excluded CMAC table criteria and instead utilize a new field in the CPT table.
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| 1.00.03 | 6/25/2014 | * Section IV
* Section V
* Table 3
* Table 4
* Table 5
* Section XI
 | W. Funk | * Clarified that source data comes from the MDR
* Removed reference to CMAC Rate table; incorporated the Charge Available Flag from the CPT/HCPCS Table;
* Changed merge order for MPI
* Deleted APC flag, changed logic for place of service
* Changed length of geographic location of injury and prior authorization; altered logic for a date/time qualifier
* Changed output frequency to TBD
 |
| 1.00.04 (on hold) | 7/8/2014 | * Section IV
* Table 4
* Section IX
* Table 5
 | W. Funk | * Identified final storage location.
* Added anesthesia base units
* Clarified language surrounding when th send records to the services.
* Changed field numbering on service extract.
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**CBER 837 Professional (837P)**

1. Background:

The Central Billing Event Repository (CBER) project is intended to create data files that the Services can use to bill for care provided in military treatment facilities, under the following programs: Third Party Collections (TPC), Medical Affirmative Claims (MAC), and Medical Services Accounts (MSA). This processing specification describes the file that is used for billing for professional services. This data file uses MHS data sources and a series of reference files to ensure that records conform as closely as possible to HIPAA standards.

1. Source:

There are two primary sources for the CBER 837P file: The MDR Comprehensive Ambulatory Professional Encounter Record (CAPER) and the MDR CADRE Basic File.

1. Transmission (Format and Frequency):

Since the primary data sources are MDR files, and CBER processing will occur in the MDR environment, no transmission is necessary. The CBER 837P is processed weekly.

1. Organization and Batching

Source Data: Source data are already in the MDR. The 837 Professional data will be prepared from the MDR CAPER Basic, MDR CAPER Enhanced and MDR CADRE.

CBER processing will occur on a weekly basis. Records will be batched and made available for processing each *pick-a-day DHSS*. The initial batch will contain the first week of feed data. Thereafter, batches will include all feeds that have been sent since the previous batching. Unprintable characters should be removed from data prior to submission for processing.

Output Products: The CBER 837P processor produces the files described in table 1. The preparation of the SAS file is described in subsequent sections of this document. The text file is described in Section XII.

**Table 1: CBER 837P Processor Output Products**

|  |  |  |
| --- | --- | --- |
| **MDR File** | **File Naming Convention** | **Member Name** |
| CBER 837P SAS | TBD | TBD |
| CBER 837P Text | TBD | TBD |

Files will be stored in the mdr/restricted/cber path. Archival of files is also required, so that corresponding “apub” and other files (i.e., log, aprod, etc) are also loaded into the MDR according to routine operating procedures.

1. Receiving Filters

Potentially billable records are defined based on patient characteristics, in combination with the type of care and other administrative data recorded on an MDR record.

Table 2 describes rules related to patient characteristics that will qualify as billable (when additional criteria noted below are also applicable).

**Table 2: Rules Related to Patient Characteristics for Generating a CBER 837 Billing Record:**

| **Criteria** | **Rule** |
| --- | --- |
| **TPC**: Patient has Other Health Insurance | There is a match for this patient in the MDR OHI file (any policy that is active) (based on person ID, first, and if no match, based on patient SSN) and the date of care is between the begin and end dates of the OHI or the OHI Flag is “Y”.  |
| **MSA**: Patient has a Billable Patient Category Code | Patient category is billable based on MDR patcat table. This is determined by the presence of anything other than blank or “NC” in the outpatient individual or outpatient agency columns if the MEPRS code begins with B, D or F, or the presence of anything other than blank or “NC” in the inpatient individual or inpatient agency columns if the MEPRS code begins with an A. Records for NOAA and Public Health Service are also included based on DEERS Sponsor Service. All Coast Guard records (based on patcat or branch of service) are deleted (this Coast Guard exclusion should be programmed as a parameter to ensure that a change in decision can be reacted to quickly). |
| **MAC**: The care indicated is the result of an accident[[1]](#footnote-1) | Care indicated is within the window [180 days prior to most recent encounter date where injury flag is Yes, Date where injury flag is Yes + 2 years] as determined by the MDR Injury Reference File, which tracks injury information as reported in direct care data.  |

If a record appears with no National Provider ID (indicating the healthcare professional who provided care), exclude the record.

Also, records with a branch of service code of B, G, R, 1, 3, 5 and 6 are deleted

Delete records with CPT 99024.

Records that meet the above criteria are further filtered to ensure that the care represented on the MDR CAPER or Ancillary Record represents a valid professional service and is billed on the proper form. This is done by merging to the CPT/HCPCS reference table and the HIPAA Taxonomy table ~~and the CMAC rate table~~ as described in Section VI.

 Keep records where the charge available flag from the CPT/HCPCS table is Y. After that, keep records that meet any of the following conditions:

CAPER:

* the restricted taxonomy billing flag on the HIPAA Taxonomy Table (i.e. no restrictions) is “N” or
* if restricted taxonomy billing flag is “Y” and the CPT/HCPCS has a value of “Y” for the restricted CPT billing flag (NURSE\_BILL) or

Delete records where MEPRS1 Code = A and inpatient billing exclusion flag (BILLEXLC\_IP) is “N” (from match to the CPT/HCPCS table).

CADRE:

* Records should be held for 7 calendar days to see if both a professional (modifier 26) and technical (modifier TC) component to arrive. If for a given CHCS Host, Accession Number, Order ID and CPT Code there is only a professional component keep the record. Furthermore, match to the CPT/HCPCS table and if the value of the default claim form (DFLTCLM) is “P” then keep.
* ~~Delete records where there is no matching rate for the CPT/Modifier in the CMAC rate table.~~

Additionally, the MDR 837-P processor must compare records with the same CHCS Host, Accession Number, Order ID and CPT Code.

* If two records show up with the same CHCS Host, accession number and CPT code and one has a modifier 32 or 00 and the other a modifier 90, exclude the record with the modifier 32 or 00.

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1. Update Process

The MDR CBER files will be updated on a weekly basis.

Each row of the 837P file represents a record that meets the CBER criteria from data derived from either an MDR CADRE file or a CAPER file. The CAPER file is the result of a transformation of each qualifying CAPER from an encounter based record into line item record(s). That is, each CAPER-based record represents a billable provider linked to a billable procedure. Provider/procedure linkages are established using the direct provider/procedure linkers on the CAPER. Also, a provider/procedure link is assumed for the appointment provider and the 1st E&M code when there is only one provider listed on a record. Records retained according the criteria outlined in Section V. During the transformation of the CAPER to a billable record, a ‘procedure number’ and ‘provider number’ element are assigned to keep track of the order of the providers and procedures. These provider/procedure numbers should retain the order in which they are in the CAPER (though not necessarily the same ordinality). The details about how to accomplish this transformation are contained in Appendix A. The derivation used in processing from the CADRE file is described in Appendix C. Also, table 4 describes how the results of these transformed files are incorporated into the CBER 837P file.

When updating the master database, records are netted by retaining the most recently received record for any given record key. For CAPER, the key is the CHCS Host, Appointment ID Number, Provider Number and Procedure Number. For CADRE records, the record key is the CHCS Host, Accession Number, Order ID, CPT and CPT Modifier.

1. Field Transformations and Deletions for CBER Core Database

There are several merges required to prepare the CBER 837P File. An asterisk after the merge file name indicates that existing MDR processing utilities should be used.

**Table 3: External Reference File Merges**

| **Merge** | **Date Matching** | **Additional Matching** |
| --- | --- | --- |
| MDR Address File |  | Match based on EDIPN first. If no match, use patient SSN |
| MDR NPPES (Merge 1) | Deactivation Date has not passed. | Provider NPI where entity type code is individual. |
| MDR NPPES (Merge 2) | Deactivation Date has not passed. | Match Supervising Provider NPI to NPI where entity type code is individual. |
| MDR DMISID Index Table | Fiscal Year of DMISID Table and Fiscal Year of CAPER/Ancillary Record | DMISID for first match, Parent DMISID for second match. |
| MDR Injury Reference File | Encounter date between start and stop date of injury information. | EDIPN first, then Patient SSN. |
| MDR HIPAA Taxonomy File |  | Provider Taxonomy  |
| MDR SIDR |  | MTF and PRN |
| Patient category code table |  | Patient Category Code and Patient Subcategory Code.  |
| CPT/HCPCS reference table | Calendar year | For CAPER : CPT. For CADRE : CPT and Modifier where setting flag is « PC ». |
| CAPER Cancellation File |  | CHCS Host and Appointment IEN |
| MDR OHI File | Encounter date is between the begin and end dates of the OHI. | EDIPN first, and if no match, then patient SSN. |
| MPI  | N/A | See MPI Specification. |
| ~~CMAC Rate Table~~ | ~~CY~~ | ~~CPT/HCPCS Code and Modifier~~ |
| ASC Group Table | Encounter date between effective and termination date. If termination date is blank, consider the ASC Group to not have been terminated yet. | CPT |

Business rules for each of the appended fields that result from the merges above, are described in the body of the table in Section VIII, or in an appendix, referenced in that table.

1. Record Layout and Content

The CBER 837P file is processed weekly. Table 4 describes the content of the CBER 837P SAS File.

**Table 4: CBER 837P Data Structure and Business Rules**

| **Data Element** | **SAS Name** | **Format** | **CAPER Restructured File****(Appendix A)** | **Merged CADRE File (appendix C)** | **Business Rule** |
| --- | --- | --- | --- | --- | --- |
| CHCS Host | HOST\_DMISID | $4  | HOST\_DMISID | HOST\_DMISID | No transformation |
| Treatment DMISID | DMISID | $4  | DMISID | DMISID | No transformation. |
| Appointment ID Number | APPTIDNO | $10 | APPTIDNO | N/A | No transformation. |
| Record ID | RECORD\_ID | $41  | APPTIDNO | MDRKEY | If data source is “C” then RECORD\_ID is “C|CHCS Host | appointment ID Number | provider number | procedure number”, else RECORD\_ID is defined as follows: If the record came from laboratory, set the RECORD\_ID to a concatenation of 'L', CHCS Host, Accession Number, and Record Number. If it came from radiology, set the RECORD\_ID to a concatenation of 'R', CHCS Host, Accession Number, Order ID, Procedure Code, and Procedure Code Modifier  |
| Ordering Appointment Number | ORD\_APPTIEN | $14  | N/A | APPNO | CAPER: Leave blank. For CADRE, no transformation. |
| Ordering DMIS ID | ORD\_MTF | $4  | N/A | ORD\_DMISID | CAPER: Leave blank. For CADRE, no transformation |
| Ordering MEPRS Code | ORD\_MEPRSCD | $4 | N/A | ORD\_MEPRSCD | No transformation. |
| CCE Status | CCESTAT | $1 | CCESTAT | N/A | No transformation. |
| Patient EDIPN | EDI\_PN | $10  | PATUNQ | EDIPN | No transformation.  |
| Patient SSN | PATSSN | $9  | PATSSN | PATSSN | No transformation.  |
| Patient DOB | PATDOB | CCYYMMDD | PATDOB | PATDOB | For CAPER: Format at CCYYMMDD.  |
| Patient Gender | PATSEX | $1  | PATSEX | SEX | For both CAPER and Ancillary: If not “M” or “F” then set to “U” else no transformation.  |
| Patient Category Code (3) | PATCAT | $3  | PATCAT | PATCAT | No transformation. |
| Patient Subcategory Code | PATCAT\_SUBCAT | $1  | PATCAT2 | PATCAT2 | No transformation |
| Other Health Insurance – Local | OHI | $1  | OHI | OHI | No transformation.  |
| Medical Insurance Billable | INSBILL | $1  | INSBILL | N/A | No transformation. |
| Patient Hospital Status | HOSPSTAT | $1  | HOSPSTAT | N/A | For CAPER: No transformation.  |
| Encounter Date | ENCDATE | CCYYMMDD | ENCDATE | ENCDATE | Format as CCYYMMDD. |
| Inpatient Appointment | INPAPPT | $1  | INPAPPT | N/A | No transformation.  |
| Inpatient Record ID | MTF\_PRN | $12  | MTF\_PRN | MTF\_PRN | If source is “C” then no transformation else MTF\_PRN = ORDERING DMISID | substring(PRN,5,7). |
| MEPRS Code | MEPRSCD | $4  | MEPRSCD | N/A | For CAPER: No transformation. For MDR Ancillary, leave blank. |
| Ambulatory Surgery | AMBSURG | $1  | AMBSURG | N/A | For CAPER: No transformation. For MDR Ancillary, leave blank.  |
| Injury Related Flag | INJREL | $1  | INJREL | N/A | For CAPER: No transformation.  |
| Date of Injury | INJDATE | CCYYMMDD | INJDATE | N/A | For CAPER: No transformation.  |
| Injury Related Cause 1- 3 | INJCODEn | $2  | INJCODEn | N/A | For CAPER: No transformation.  |
| Injury Geographic Location | INJGEOGLOC | $5  | INJGEOGLOC | N/A | For CAPER: No transformation.  |
| Injury Place of Accident | INJPOA | $54  | INJPOA | N/A | For CAPER: No transformation.  |
| Injury Place of Employment | INJPOE | $54  | INJPOE | N/A | For CAPER: No transformation.  |
| Provider Number | PROVNUM | 3 | PROVNUM | N/A | If the record originates from the ancillary file, set to 1, else set to the provider number from which this line item originates. |
| Procedure Number | PROCNUM | 3 | PROCNUM | N/A | If the record originates from the ancillary file, set to 1, else set to the procedure number from which this line item originates. |
| Diagnosis 1 – Diagnosis 10 | DX1 – DX10 | $7  | DX1 – DX10 | N/A | For CAPER records: Fill each diagnosis code variable if the diagnosis code pointer indicates that the reported diagnosis codes related to the procedure for this line item. (Renumber so that diagnoses appear in continuous positions). For MDR Ancillary, link to CAPER based on by CHCS Host and Appointment ID = Related Record ID, ~~where appointment match flag = “LIN”~~ and retrieve diagnosis codes from the CAPER. |
| Provider NPI | PROVNPI | $10  | PROVNPI | CPNPI | If source is “C” fill with the NPI for provider (provnum), else leave blank.  |
| Provider NPI Type | NPITYPE | $1  | PROVNPITYPE | CPNPI\_TYP | Set to ‘1’ |
| Provider EDIPN | PROVEDIPN | $10  | PROVEDIPN | CPEDIPN | For CAPER: Fill with the EDIPN for provider (provnum).  |
| Provider Taxonomy | HIPAATAX | $11  | PROVHIPAA | CPHIPAA | For CAPER: Fill with the Provider Taxonomy for provider (provnum).  |
| Procedure Code | PROC | $5  | PROC | CPT | For CAPER: Fill with the procedure code of procedure (procnum). For ancillary: fill with CPT. |
| Proc Code Modifier 1 – 3 | MOD1 – MOD3 | $2  | CPTMODx | CPTMOD | For CAPER: Fill with the modifiers for procedure code (procnum). For ancillary, fill with CPTMOD. If the value of CPTMOD is TC, then set to 32. |
| Units of Service | UOS | 3 | CPTUNITS | COUNT | If source is “C”, fill with the Unit of Service of procedure code (procnum), else fill with COUNT from MDR Ancillary.  |
| APC Weight | APC\_WT | 9.4 | APC\_WT | N/A | If source is “C” fill with APC Weight, else leave blank. |
| APC | APC | $5  | APC | N/A | If source is “C”, fill with APC, else leave blank. |
| Supervising Provider | SUPNPI | $10  | SUPNPI | N/A | If CAPER: Fill with the NPI of the Supervising Provider, if any of the provider roles associated with this procedure indicate a supervisory provider. If Ancillary, leave blank. |
| CLIA Number | CLIA | $15  | N/A | CLIA | No transformation. |
| Sponsor Service | SPONSVC | $1  | SPONSVC | SPONSVC | No transformation. |
| Beneficiary Category | BENCAT | $3  | BENCATX | BENCAT | No transformation. |
| Ancillary Record Type | ANC\_RECTYPE | $1 | N/A | ANC\_RECTYPE | No transformation |
| File Date | FILE\_DT | CCYYMMDD | FILEDATE | FILEDATE | Reformat as CCYYMMDD as necessary. |
| **From MDR Address file (if not match found, leave blank)**  |
| Patient Last Name | LASTNAME | $27  | N/A | N/A | If C\_UPDT >= D\_UPDT then C\_NAME2, else D\_NAME2. |
| Patient First Name | FIRSTNAME | $20  | N/A | N/A | If C\_UPDT >=D\_UPDT, then C\_NAME1, else D\_NAME2. |
| Patient Suffix | SUFFIX | $4  | N/A | N/A | Set to D\_CADENCY |
| Patient Address Line 1 | ADDR1 | $40  | N/A | N/A | If C\_UPDT >=D\_UPDT, then C\_ADDR1, else D\_ADDR1 |
| Patient Address Line 2 | ADDR2 | $40  | N/A | N/A | If C\_UPDT >=D\_UPDT, then C\_ADDR2, else D\_ADDR2 |
| Patient City | CITY | $20  | N/A | N/A | If C\_UPDT >=D\_UPDT, then C\_CITY, else D\_CITY |
| Patient State | STATE | $2  | N/A | N/A | If C\_UPDT >=D\_UPDT, then C\_STATE, else D\_STATE.  |
| Patient Country Code | COUNTRY | $2  | N/A | N/A | Set to D\_CNTRY |
| Patient Zip Code | PATZIP | $9  | N/A | N/A | If C\_UPDT >=D\_UPDT, then C\_ZIP, else concatenate D\_ZIP | DZIP4. |
| **From CPT/HCPCS Table Merge** |
| Work RVU | WORKRVU | 7.4 | N/A | N/A | WORKPC \* UOS |
| Practice Expense RVU | PERVU | 7.4 | N/A | N/A | For CAPER: If APC is populated then then set to PEEXPFAPC \* UOS (from CAPER BASIC), else set to the PEXPNFPC \* UOS (from CAPER BASIC). For CADRE: Set to PEEXPFAPC \*UOS. |
| Bilateral Flag | BILATERAL | $1  | N/A  | N/A | BILATERAL |
| Medicare Payment Status Indicator | RVU\_PSI | $1  | N/A | N/A  | MEDSTAT |
| Multiple Procedure Flag | MULT\_PROC | $1  | N/A  | N/A | MULTPROC |
| CPT Restricted Billing Flag | RESTRICT \_CPT | $1  | N/A | N/A | NURSE\_BILL |
| ASC\_Group | ASC\_GROUP | $2  | N/A | N/A | If place of service is 24 set to ASC, else leave blank |
| Anesthesia Related Flag | ANESTHESIA | $1 | N/A | N/A | ANESTHESIA |
| Anesthesia Base Units | ANESTHESIA\_BASE | TBD | N/A | N/A | BASE\_UNITS. Format of field should match what is on CPT Table.  |
| **From NPPES Merge 1** |
| Provider Last Name | PROVLAST | $35  | N/A | N/A | Set to LASTNAME |
| Provider First Name | PROVFIRST | $20  | N/A | N/A | Set to FIRSTNAME |
| Provider Middle Name | PROVMID | $20  | N/A | N/A | Set to MIDNAME |
| Provider Suffix | PROVSFX | $4  | N/A | N/A | Set to SUFFIX |
| **From NPPES Merge 2** |
| Supervising Provider Last Name | SUPLAST | $35  | N/A | N/A | For CAPER: Set to LASTNAME. For Ancillary: Leave blank. |
| Supervising Provider Middle Name | SUPMID | $20  | N/A | N/A | For CAPER: Set to MIDNAME. For Ancillary: Leave blank. |
| Supervising Provider First Name | SUPFIRST | $20  | N/A | N/A | For CAPER: Set to FIRSTNAME. For Ancillary: Leave blank. |
| Supervising Provider Suffix | SUPSFX | $4  | N/A | N/A | For CAPER: Set to SUFFIX. For Ancillary: Leave blank. |
| **From DMISID Table** |
| Parent DMISID | PARENT | $4  | N/A | N/A | Set to UBU\_PAR |
| Submitter Name | SUB\_NAME | $30  | N/A | N/A | If MTF NPI is populated, then set to DMISID Name, else set to the Name associated with the parent DMISID. |
| Submitter/Billing HIPAA Taxonomy | SUB\_TAX | $10  | N/A | N/A | If MTF NPI is populated then set to MTF Type 2 Taxonomy, else set to parent Type 2 Taxonomy. |
| Submitter/Billing NPI | SUB\_NPI | $10  | N/A | N/A | If MTF NPI is populated then set to NPI, else set to Parent NPI. |
| Billing Provider Name | BILL\_NAME | $35  | N/A | N/A | Set to INSTALNM |
| CMAC Locality Code | LOCALITY | $3  | N/A | N/A | Set to LOCALITY  |
| Work GPCI | GPCI\_WORK | 5.3 | N/A | N/A | Set to GPCI\_WORK  |
| PE GPCI | GPCI\_PE | 5.3 | N/A | N/A | Set to GPCI\_PE  |
| CBER IP Start Date | IP\_START | SAS Date | N/A | N/A | No transformation.  |
| CBER IP Stop Date | IP\_STOP | SAS Date | N/A | N/A | No transformation.  |
| VA MSA Carrier ID | VA\_CARRIER | $9  | N/A | N/A | No transformation |
| MTF Service | SERVICE | $1  | N/A | N/A | Set to UBU\_SVC |
| **~~From MDR Injury Reference File~~** |
| ~~Injury Related Record Flag~~ | ~~INJ\_REL~~ | ~~$1~~  | ~~N/A~~ | ~~N/A~~ | ~~Set to 1 if the record is added to the 837P file because it meets the criteria for injury reporting in table 2, else set to 0.~~ |
| **~~From SIDR Merge~~** |
| Admission Date | ADMDATE | CCYYMMDD | N/A | N/A | Set to ADMDATE, formatted as CCYYMMDD. |
| Discharge Date | DISPDATE | CCYYMMDD | N/A | N/A | Set to DISPDATE, formatted as CCYYMMDD.  |
| **CAPER Cancellation File** |
| CAPER Record Cancel Date | CAPER\_CANCEL | CCYYMMDD | N/A | N/A | If record source is “C” then set to the cancellation date by matching to the CAPER Cancellation file by CHCS Host and Appointment IEN. If there is no match in the CAPER Cancellation file, leave blank. |
| **HIPAA Taxonomy** |
| Provider Restricted Billing Flag | RESTRICT\_TAX | $1  | N/A | N/A | No transformation. (HCPRESTRICT)  |
| Provider CMAC Category | CMAC\_CLASS | $1  | N/A | N/A | No transformation**.**  (HCPREIMB) |
| **ASC Table** |
| ASC Group | ASC | $2 | N/A | N/A | Payment Group |
| **Internally Derived Fields** |
| ~~APC Flag~~ | ~~APC\_FLAG~~ | ~~$1~~  | ~~N/A~~ | ~~N/A~~ | ~~For CAPER: Set to 1 if any of the following criteria are met: (1) MEPRS code = BIA; (2) 4~~~~th~~ ~~digit of the MEPRS code is 5; (3) MTF is 0124 and the 4~~~~th~~ ~~digit of the MEPRS code is 6; (4) source is “A”. For Ancillary: Set to 0.~~ |
| Claim Frequency Code | CLAIM\_FREQ | $1  | N/A | N/A | Set to "1" if the record has never been updated. Set to 6 if this is an update record, set to 8 is cancelled |
| ~~Original Record Source~~ | ~~SOURCE~~ | ~~$1~~  | ~~N/A~~ | ~~N/A~~ | ~~If the source of the record is a CAPER, set to C, else A.~~ |
| Initial CBER Processing Date | INITDATE | CCYYMMDD | N/A | N/A | Date this record was first processed into the CBER 837P file. |
| Record Source | SOURCE | $1  | N/A | N/A | Set to “C” if record source is CAPER, else set to “A”. |
| ~~Last CBER Update Date~~ | ~~UPDT\_DT~~ | ~~CCYYMMDD~~ | ~~N/A~~ | ~~N/A~~ | ~~Date this record was last updated in the CBER 837P file.~~ |
| Fiscal Year | FY | $4  | N/A | N/A | Derive from encounter date. |
| Fiscal Month | FM | $2  | N/A | N/A | Derive from encounter date. |
| Calendar Year | CY | $4  | N/A | N/A | Derive from encounter date. |
| Calendar Month | CM | $2  | N/A | N/A | Derive from encounter date. |
| Number of Line Items | LI | 3 | N/A | N/A | Set to 1 |
| MSA Flag | MSA | $1  | N/A | N/A | Set to 1 if this record meets the criteria for MSA billing from Section V, else set to 0. |
| MAC Flag | MAC | $1  | N/A | N/A | Set to 1 if this record meets the criteria for MAC billing from Section V, else set to 0. |
| TPC Flag | TPC | $1  | N/A | N/A | Set to 1 if this record meets the criteria for TPC billing from Section V, else set to 0. |
| Implementation Version Guide | VERSION | $10  | N/A | N/A | Element: 1705 (ST03). Set to ‘005010X222’ |
| Place of Service | PLACE | $2  | N/A | N/A | If CAPER: If MEPRS code = BIA then place = 23, else if CBER IP Start Date < Service Date < CBER IP End Date and APC is populated then place = 22, else if ((Service Date is not between CBER IP Start Date and CBER IP End Date or CBER IP Dates are blank) and APC is populated then place = 24, else if MEPRS1 Code = A then place = 21 else place = 11. If CADRE: Set to 21 if ordering MEPRS code is “A”, else link to order (based on associated appointment IEN and CHCS Host) and if APC is populated on the ordering record and CBER IP Start Date < Service Date < CBER IP End Date then set to 22, else set to 49. |
| Diagnosis Type Code | DX\_TYPE | $3  | N/A | N/A | Set to “BF” for care that begins prior to <parameter> (set currently to Oct 1, 2015) else set to “ABF” |
| ~~Record Cancellation Date~~ | ~~REC\_CANCEL~~ | ~~YYYYMMDD~~ | ~~N/A~~ | ~~N/A~~ | ~~Set to the earliest of the CAPER or Ancillary record status.~~ |
| MSA Key | MSA\_KEY | $9  | N/A | N/A | If patcat is K61 (with subcategories 1-9 or A-D) then set to VA\_CARRIER, else Appendix B.  |
| Death Flag | DEATH | $1  | N/A | N/A | Set to 1 if the disposition status indicates a death, else set to 0. |
| Death Date | DTH\_DT | YYYYMMDD | N/A | N/A | Set to the encounter date associated with the record that indicates a death. |
| ~~Anesthesia Procedure Flag~~ | ~~ANESTHESIA~~ | ~~$1~~  | ~~N/A~~ | ~~N/A~~ | ~~Set to 1 if the procedure code is in the range 00100-01999 (excluding codes ending with “F” or “T”), else if procedure code in (99100 99116 99135 99140) then set to 1 else set to 0.~~ |
| Change Date | CHG\_DT | CCYYMMDD | N/A | N/A | Match this batch of CBER data to the previous batch based on record type and record key. If any of the values on an existing record changed from the last batch to this one, fill the change date on the new record with the processing date. |
| Change Flag | CHG\_FLAG | $1  | N/A | N/A | Match this batch of CBER data to the previous batch based on record type and record key. If any of the values on an existing record changed from the last batch to this one, fill the change flag on the new record with “U”, else fill with N. |
| Anesthesia Related Procedure Flag | ANESTHESIA\_REL | $1 | N/A | N/A | If anesthesia is 1, fill with first listed non-anesthesia, non E&M with a matching CHCS Host and APPT ID No. Else leave blank. |

1. Refresh Frequency

Weekly

1. Quality Review Requirements

In order to ensure processing is done correctly, several basic quality review requirements are presented in this section.

1. Basic Data Flow Process Check: A spreadsheet should be maintained that tracks record counts associated with each data step used in processing. Record counts from the raw monthly feeds should be recorded and checked, with particular attention paid to the first step, where the file is transformed into a line item file.
2. Record counts should be maintained for each type of inclusion (section 5) and compared to previous processing cycles for consistency.
3. File Size: Record counts should increase as the files are updated for each fiscal year.
4. Proc contents should be reviewed and compared against specifications to ensure conformance.
5. Each month the values observed in certain fields should be checked to see if new or modified values are introduced. Fields that should be checked include raw fields used by the processor to derive other fields, and raw fields used to control the flow of processing.
6. Routine feed and file management procedures should be followed for the MDR 837-P processor.
7. Data Marts
8. Special Outputs

An output file is provided to the Services TBD. Records are in this file if the event is deemed potentially billable. This can occur because the patient has other health insurance, is covered under the MSA Program, or has had an accident or injury that is potentially billable. Note that all records of care occurring within 180 days prior to or two years after an accident are provided. Many of these records will not be billable (e.g. unrelated to an accident), however it is left to the billing entity to make that determination.

The layout for this non-institutional file is provided below. The file is “^” delimited. The initial provision of this file will include all records meeting the criteria outlined in Section V (Receiving Filters). Thereafter, only new, changed or cancelled records are transmitted. New records are those with CBER code of “N”. For changed records, identified with CBER code = “U”, the Services will have already received an initial version of the record with the same Record ID as the changed one. The change on the record may require a modification to a bill that has already been sent. The Change Flag variable on the Service extract will be set to represent the last time that an extract was provided to the Services. It is extremely important that the Services apply updates in the order they are received.

Table 5: Service Feed Layout

| **Domain** | **Loop** | **Segment** | **Element #** | **Element** | **Output Position** | **Format** | **Rule** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Biller | 1000A | Submitter Name | 1 | Entity Identification Code | 1 | $2  | Set to "41" |
| Biller | 1000A | Submitter Name | 2 | Entity Type Qualifier | 2 | $1  | Set to "2" |
| Biller | 1000A | Submitter Name | 3 | Submitter Name Last or Organization | 3 | $30  | SUB\_NAME (MTF Name from DMISID Table) |
| Biller | blank

|  |
| --- |
| 1000A |

 | Submitter Name | 9 | Submitter Identifier | 4 | $10  | SUB\_NPI (MTF NPI) |
| Biller | 1000A | Submitter EDI Contact Information | 1 | Contact Function Code | 5 | $2  | Set to "IC" |
| Biller | 2000A | Billing Provider Specialty Information | 1 | Provider Code | 6 | $2  | Set to "BI" |
| Biller | 2000A | Billing Provider Specialty Information | 2 | Reference Identification Qualifier | 7 | $3  | Set to "PXC" |
| Biller | 2000A | Billing Provider Specialty Information | 3 | Provider Taxonomy Code | 8 | $10  | SUB\_TAX |
| Biller | 2010AA | Billing Provider Name | 1 | Entity Identifier Code | 9 | $2  | Set to "85" |
| Biller | 2010AA | Billing Provider Name | 2 | Entity Type Qualifier | 10 | $1  | Set to "1" |
| Biller | 2010AA | Billing Provider Name | 3 | Billing Provider Last or Organization Name | 11 | $28  | PROVLAST |
| Biller | 2010AA | Billing Provider Name | 4 | Billing Provider First Name | 12 | $28  | PROVFIRST |
| Biller | 2010AA | Billing Provider Name | 5 | Billing Provider Middle Name or Initial | 13 | $20  | PROVMID |
| Biller | 2010AA | Billing Provider Name | 6 | Name Prefix | 14 | N/A |  N/A |
| Biller | 2010AA | Billing Provider Name | 7 | Billing Provider Name Suffix | 15 | $4  | PROVSFX |
| Biller | 2010AA | Billing Provider Name | 8 | Identification Code Qualifier | 16 | $2  | Set to "XX" |
| Biller | 2010AA | Billing Provider Name | 9 | Billing Provider Identifier  | 17 | $10  | PROVNPI |
| Patient Name | 2010CA | Patient Name | 1 | Entity Identification Code | 18 | $2  | Set to "QC" |
| Patient Name | 2010CA | Patient Name | 2 | Entity Type Qualifier | 19 | $1  | Set to "1" |
| Patient Name | 2010CA | Patient Name | 3 | Patient Last Name  | 20 | $27  | LASTNAME |
| Patient Name | 2010CA | Patient Name | 4 | Patient First Name | 21 | $20  | FIRSTNAME |
| Patient Name | 2010CA | Patient Name | 5 | Patient Middle Name or Initial | 22 | N/A | N/A |
| Patient Name | 2010CA | Patient Name | 6 | Name Prefix | 23 | N/A | N/A |
| Patient Name | 2010CA | Patient Name | 7 | Patient Name Suffix | 24 | $4  | SUFFIX |
| Patient Name | 2010CA | Patient Name - Address | 1 | Patient Address Line | 25 | $40  | ADDR1 |
| Patient Name | 2010CA | Patient Name - Address | 2 | Patient Address Line | 26 | $40  | ADDR2 |
| Patient Name | 2010CA | Patient Name - Address | 1 | Patient City Name | 27 | $20  | CITY |
| Patient Name | 2010CA | Patient Name - Address | 2 | Patient State Code | 28 | $2  | STATE |
| Patient Name | 2010CA | Patient Name - Address | 3 | Patient Postal Zone or ZIP Code | 29 | $5  | PATZIP |
| Patient Name | 2010CA | Patient Name - Address | 4 | Patient Country Code | 30 | $2  | COUNTRY |
| Patient Name | 2010CA | Patient Name - Address | 5 | Location Qualifier | 31 | N/A | N/A |
| Patient Name | 2010CA | Patient Name - Address | 6 | Location Identifier | 32 | N/A | N/A |
| Patient Name | 2010CA | Patient Name - Address | 7 | Country Subdivision Code | 33 | N/A | N/A |
| Patient Name | 2010CA | Patient Name - Demographics | 1 | Date Time Period Format Qualifier | 34 | $2  | Set to "D8" |
| Patient Name | 2010CA | Patient Name - Demographics | 2 | Patient Birth Date | 35 | CCYYMMDD | PATDOB |
| Patient Name | 2010CA | Patient Name - Demographics | 3 | Patient Gender Code | 36 | $1  | PATSEX |
| Claim | 2300 | Claim Information | 2 | Total Claim Charge Amount | 37 | N/A | Leave Blank |
| Claim | 2300 | Claim Information | 5-01 | Place of Service | 38 | $2  | PLACE |
| Claim | 2300 | Claim Information | 5-02 | Facility Qualifier Code | 39 | $1  | Set to "B" |
| Claim | 2300 | Claim Information | 5-03 | Claim Frequency Code | 40 | $1  | CLAIM\_FREQ |
| Claim | 2300 | Claim Information | 6 | Provider or Supplier Signature Indicator | 41 | $1  | Set to "Y" |
| Claim | 2300 | Claim Information | 7 | Assignment or Plan Participation Code | 42 | $1  | Set to "A" |
| Claim | 2300 | Claim Information | 8 | Benefits Assignment Certification Indicator | 43 | $1  | Set to "Y" |
| Claim | 2300 | Claim Information | 9 | Release of Information code | 44 | $1  | Set to "Y" |
| Claim | 2300 | Claim Information | 10 | Patient Signature Source Code | 45 | N/A | N/A |
| Claim | 2300 | Claim Information | 11-01 | Related-Causes Code | 46 | $2  | INJCODE1 |
| Claim | 2300 | Claim Information | 11-02 | Related-Causes Code | 47 | $2  | INJCODE2 |
| Claim | 2300 | Claim Information | 11-03 | Related-Causes Code | 48 | $2  | INJCODE3 |
| Claim | 2300 | Claim Information | 11-04 | Auto Accident State or Province Code | 49 | $5  | INJGEOGLOC |
| ~~Claim~~ | ~~2300~~ | ~~Claim Information~~ | ~~11-05~~ | ~~Country Code~~ | ~~50~~ | ~~$2~~  | ~~INJGEOGLOC~~ |
| Claim | 2300 | Claim Information | 12 | Special Program Indicator | 50 | N/A | Leave Blank |
| Claim | 2300 | Claim Information - Date Accident | 1 | Date/Time Qualifier | 51 | $3  | If injury related cause code is "AA" then set to "439" |
| Claim | 2300 | Claim Information - Date Accident | 2 | Date Time Period Qualifier | 52 | $2  | If injury related cause code is "AA" then set to "D8" |
| Claim | 2300 | Claim Information - Date Accident | 3 | Accident Date | 53 | CCYYMMDD | If injury related cause code is "AA" then set to INJDATE |
| Claim | 2300 | Claim Information - Date Admission | 1 | Date Time Qualifier | 54 | $3  | If MEPRS Code = A, set to "435" else leave blank |
| Claim | 2300 | Claim Information - Date Admission | 2 | Date Time Period Qualifier | 55 | $1  | If MEPRS Code = A, set to "D8" else leave blank |
| Claim | 2300 | Claim Information - Date Admission | 3 | Related Hospitalization Admission Date | 56 | CCYYMMDD | ADMDATE |
| Claim | 2300 | Claim Information - Date of Discharge | 1 | Date Time Qualifier | 57 | $3  | If MEPRS Code = A, set to "096" |
| Claim | 2300 | Claim Information - Date Discharge | 2 | Date Time Period Qualifier | 58 | $1  | If MEPRS Code = A, set to "D8" |
| Claim | 2300 | Claim Information - Date Discharge | 3 | Related Hospitalization Discharge Date | 59 | CCYYMMDD | DISPDATE |
| Claim | 2300 | Claim Information - Service Authorization Exc Code | 1 | Reference Identiification Qualifier  | 60 | $2  | Set to "4N" |
| Claim | 2300 | Claim Information - Service Authorization Exc Code | 2 | Service Authorization Exception Code | 61 | $1  | Set to "3" |
| Claim | 2300 | Claim Information - Prior Authorization | 1 | Reference Identification Qualifier | 62 | $2  | Set to "G1" |
| Claim | 2300 | Claim Information - Prior Authorization | 2 | Prior Authorization | 63 | $50 | Says "Send Prior Authorization number, from Feed?" |
| Claim | 2300 | Claim Information - CLIA | 1 | Reference Identification Qualifier | 64 | $2  | Set to "X4" |
| Claim | 2300 | Claim Information - CLIA | 2 | Clinical Laboratory Improvement Amendment # | 65 | $15  | CLIA |
| Claim | 2300 | Claim Information - Medical Record Number | 1 | Reference Identification Qualifier | 66 | $2  | Set to "EA" |
| Claim | 2300 | Claim Information - Medical Record Number | 2 | Medical Record Number | 67 | $15  | MTF\_PRN |
| Claim | 2300 | Claim Information - Diagnosis Codes | 1-01 | Diagnosis Type Code | 68 | $3  | DX\_TYPE |
| Claim | 2300 | Claim Information - Diagnosis Codes | 1-02 | Diagnosis Code | 69 | $70  | DX1-DX10; concatenated. |
| Claim | 2300 | Claim Information - Anesthesia Related Proc | 1-01 | Code List Qualifier Code | 70 | $2  | Set to "BP" |
| Claim | 2300 | Claim Information - Anesthesia Related Proc | 1-02 | Anesthesia Related Surgical Procedure | 71 | $5  | ANESTHESIA\_REL |
| Provider | 2310B | Rendering Provider Name | 1 | Entity Identifier Code | 72 | $2  | Set to "82" |
| Provider | 2310B | Rendering Provider Name | 2 | Entity Type Qualifier | 73 | $1  | Set to "1" |
| Provider | 2310B | Rendering Provider Name | 3 | Rendering Provider Last or Organization Name | 74 | N/A | PROVLAST (already in the output from billing provider segment) |
| Provider | 2310B | Rendering Provider Name | 4 | Rendering Provider First Name | 75 | N/A | PROVFIRST |
| Provider | 2310B | Rendering Provider Name | 5 | Rendering Provider Middle Name or Initial | 76 | N/A | PROVMID |
| Provider | 2310B | Rendering Provider Name | 6 | Name Prefix | 77 | N/A |   |
| Provider | 2310B | Rendering Provider Name | 7 | Rendering Provider Name Suffix | 78 | N/A | PROVSFX |
| Provider | 2310B | Rendering Provider Name | 8 | Identification code Qualifier | 79 | $2  | Set to "XX" |
| Provider | 2310B | Rendering Provider Name | 9 | Rendering Provider Identifier | 80 | $10  | PROVNPI |
| Provider | 2310B | Rendering Provider Name - Provider Specialty | 1 | Provider Code | 81 | $2  | Set to "PE" |
| Provider | 2310B | Rendering Provider Name - Provider Specialty | 2 | Reference Identification Qualifier | 82 | $3  | Set to "PXC" |
| Provider | 2310B | Rendering Provider Name - Provider Specialty | 3 | Provider Taxonomy Code | 83 | $10  | PROVHIPAA |
| Provider | 2310D | Supervising Provider Name | 1 | Entity Identifier Code | 84 | $2  | Set to "DQ" |
| Provider | 2310D | Supervising Provider Name | 2 | Entity Type Qualifier | 85 |  $1 | Set to "1" |
| Provider | 2310D | Supervising Provider Name | 3 | Supervising Provider Last Name | 86 |  $35 | SUPLAST |
| Provider | 2310D | Supervising Provider Name | 4 | Supervising Provider First Name | 87 |  $20 | SUPFIRST |
| Provider | 2310D | Supervising Provider Name | 5 | Supervising Provider Middle Name or Initial | 88 | $20  | SUPMID |
| Provider | 2310D | Supervising Provider Name | 7 | Supervising Provider Name Suffix | 89 | $5  | SUPSFX |
| Provider | 2310D | Supervising Provider Name | 8 | Identification Code Qualifier | 90 |  $2 | Set to "XX" |
| Provider | 2310D | Supervising Provider Name | 9 | Supervising Provider Identifier | 91 |  $10 | SUPNPI |
| Procedure | 2400 | Service Line Number | 1-01 | Product or Service ID Qualifier | 92 |  $2 | Set to "HC" |
| Procedure | 2400 | Service Line Number | 1-02 | Procedure Code | 93 |  $5 | PROC |
| Procedure | 2400 | Service Line Number | 1-03 | Procedure Code - Modifier 1 | 94 | $2  | PROCMOD1 |
| Procedure | 2400 | Service Line Number | 1-04 | Procedure Code - Modifier 2 | 95 |  $2 | PROCMOD2 |
| Procedure | 2400 | Service Line Number | 1-05 | Procedure Code - Modifier 3 | 96 |  $2 | PROCMOD3 |
| Procedure | 2400 | Service Line Number | 3 | Unit or Basis for Measurement Code | 97 |  $2 | Set to "UN" |
| Procedure | 2400 | Service Line Number | 4 | Service Count Code | 98 |  4 | CTPUNITS |
| Procedure | 2400 | Service Line Number \_ Date of Service | 1 | Date/Time Qualifier | 99 | $3  | Set to "472" |
| Procedure | 2400 | Service Line Number \_ Date of Service | 2 | Date Time Period Format Qualifier | 100 | $2  | Set to "D8" |
| Procedure | 2400 | Service Line Number \_ Date of Service | 3 | Date /Time Period (Service Date) | 101 | CCYYMMDD | ENCDATE |
| Housekeeping | N/A | Supplemental Patient Information |   | Sponsor Service | 102 | $1  | SPONSVC |
| Housekeeping | N/A | Supplemental Patient Information |   | Beneficiary Category | 103 | $3  | BENCAT |
| Housekeeping | N/A | Supplemental Patient Information |   | Patient Category | 104 | $3  | PATCAT |
| Housekeeping | N/A | Supplemental Patient Information |   | Patient Subcategory | 105 | $1  | PATCAT\_SUBCAT |
| Housekeeping | N/A | Processing Information |   | Record ID | 106 | $41  | RECORD\_ID |
| Housekeeping | N/A | Processing Information |   | File Date | 107 | CCYYMMDD | FILEDATE |
| Housekeeping | N/A | Processing Information |   | Change Date | 108 | CCYYMMDD | CHANGE DATE |
| Housekeeping | N/A | Processing Information |   | Change Flag | 109 |   | CHANGE FLAG |
| Housekeeping | N/A | Processing Information |   | Cancellation Date | 110 | CCYYMMDD | CAPER\_CANCEL |
| ~~Pricing~~ | ~~N/A~~ | ~~Pricing~~ |  | ~~ASC Group~~ | ~~112~~ | ~~$2~~  | ~~ASC\_GROUP~~ |
| ~~Pricing~~ | ~~N/A~~ | ~~Pricing~~ |  | ~~APC~~ | ~~113~~ | ~~$5~~  | ~~APC~~ |
| ~~Pricing~~ | ~~N/A~~ | ~~Pricing~~ |  | ~~APC Weight~~ | ~~114~~ | ~~9.4~~ | ~~APC\_WT~~ |
| Housekeeping | N/A | Processing Information |  | Cancel Flag | 111 | $1 | If CAPER\_CANCEL is populated, set to Y, else N |
| Housekeeping | N/A | Supplemental Patient Information |  | MSA Flag | 112 | $1 | MSA\_FLAG |
| Housekeeping | N/A | Supplemental Patient Information |  | OHI Flag | 113 | $1 | OHI\_FLAG |
| Housekeeping | N/A | Supplemental Patient Information |  | MAC Flag | 114 | $1 | MAC\_FLAG |
| Housekeeping | N/A | Pricing Information |  | CMAC Locality Code | 115 | $3 | LOCALITY |
| Housekeeping | N/A | Housekeeping |  | VA MSA Carrier ID | 116 | $9 | VA\_CARRIER |
| Housekeeping | N/A | Housekeeping |  | MSA Key | 117 | $9 | MSA\_KEY |
| Housekeeping | N/A | Pricing Information |  | Bilateral Flag | 118 | $1 | BILATERAL |
|  |  |  |  | ~~Payment Status Indicator~~ | ~~120~~ | ~~$1~~ | ~~RVU\_PSI~~ |
| Housekeeping | N/A | Pricing Information |  | Multiple Procedure Code | 119 | $1 | MULT\_PROC |
| Housekeeping | N/A | Pricing Information |  | CPT Restricted Billing Flag | 120 | $1 | RESTRICT\_CPT |
| Housekeeping | N/A | Pricing Information |  | Provider Restricted Billing Flag | 121 | $1 | REST\_TAX |
| Housekeeping | N/A | Pricing Information |  | Provider CMAC Category | 122 | $1 | CMAC\_CLASS |
| Housekeeping | N/A | Processing Information |  | Provider Number | 123 | 3 | PROVNUM |
| Housekeeping | N/A | Processing Information |  | Procedure Number | 124 | 3 | PROCNUM |
| Housekeeping | N/A | Processing Information |  | CHCS Host DMISID | 125 | $4 | HOST\_DMISID |
| Housekeeping | N/A | Processing Information |  | Treatment DMISID | 126 | $4 | DMISID |
| Housekeeping | N/A | Processing Information |  | Appointment ID Number | 127 | $10 | APPTID\_NO |
| Procedure | N/A | Procedure Information |  | Anesthesia Base Units | 128 | TBD | BASE\_UNITS |

Appendix A: Transformation of CAPERs into Provider/Procedure Line Items.

To prepare the procedure/provider line item interim file, only records that meet the CBER criteria noted in section V are included. To accomplish the transformation, a record must be created each time (1) a provider / procedure linkage indicates that the provider participated in the procedure, or (2) the only listed provider is the appointment provider and the record created indicates the E&M code and the appointment provider.

| Data Element | SAS Name  | Format | Source Element or Business Rule |
| --- | --- | --- | --- |
| The elements in this section are taken directly from each CAPER that meet the criteria noted above. |
| CHCS Host | HOST\_DMISID | $4 | Key.  |
| Tx DMISID | DMISID | $4 |   |
| Patient Category Code | PATCAT | $3 | Set to the 1st three characters of patcat\_r |
| Patient Subcategory Code | PATCAT2 | $1 | Set to the 4th character of patcat\_r |
| Appt IEN | APPTIDNO | $10 | Key |
| Patient EDIPN | EDI\_PN | $10 |  |
| Patient SSN | PATSSN | $9  |  |
| Patient DOB | PATDOB | CCYYMMDD | Transform to CCYYMMDD  |
| Patient Gender | PATSEX | $1 |  |
| Beneficiary Category | BENCATX | $3 |  |
| Patient Category | PATCAT\_R | $5 |  |
| Other Health Insurance | OHI | $1 |   |
| Medical Insurance Billable | INSBILL | $1 |   |
| Patient Hospital Status | HOSPSTAT | $1 |   |
| Encounter Date | ENCDATE | CCYYMMDD | Transform to CCYYMMDD  |
| Inpatient Appointment | INPAPPT | $1 |   |
| Inpatient Record ID | MTF\_PRN |  |   |
| Disposition Code | DISPCODE | $1 |   |
| MEPRS Code | MEPRSCD | $4 |   |
| CCE Status | CCESTAT | $1 |  |
| Ambulatory Surgery | AMBSURG | $1 |   |
| Injury Related Flag | INJREL | $1 |   |
| Date of Injury | INJDATE | CCYYMMDD | CCYYMMDD. Leave blank if no injury cause code is 'AA' |
| Injury Related Cause Codes (1-3)  | INJCODEn | $2 | Three separate data elements. |
| Injury Geographic Location | INJGEOGLOC |  |  |
| Injury Place of Accident | INJPOA |  |  |
| Injury Place of Employment | INJPOE |  |   |
| Chief Complaint | COMPLAINT | $5 |   |
| Person Association Reason Code | PARC | N/A |   |
| File Date | FILEDATE | CCYYMMDD |  |
| ~~CBER Date~~ | ~~CBERDATE~~ | ~~CCYYMMDD~~ |  |
| ~~CBER Code~~ | ~~CBERCODE~~ | ~~$1~~ |  |
| Sponsor Service | RSPONSVC | $1 |  |
| Beneficiary Category | BENCATX | $3 |  |
| E&M Flag | EM\_FLAG | $1 | Set to Y if the procedure originally was reported in positions 1-3, else set to 0. |
| These data elements are taken from the provider:procedure linkage (or the assumed linkage on E&M Code and the appointment provider as a sole provider) |
| Provider Number | PROVNUM | 3 | Key. 1 - 5. Indicates this provider’s number on the record. (i.e. means that the procedure (procnum) represented on this record was done by provider (provnum)). |
| Procedure Number | PROCNUM |  3 | Key. 1-13. Indicates the procedure number on the record. (ie. Means that the procedure (procnum) represented on this record was done by provider (provnum)).  |
| Diagnosis 1 - Diagnosis 10 | DXn | $7 | If diagnosis pointer matches the procedure and diagnosis code type = “BF” then substring diagnosis code to 1st 5 characters (CPTDX\_x\_), else set to diagnosis code from the record.  |
| Provider NPI | PROVNPI | $10 |  For provider (provnum) |
| Provider EDIPN | PROVEDIPN | $10 |  |
| Provider NPI Type | PROVNPITYPE |  $1 |  For provider (provnum)) |
| Provider Taxonomy | PROVHIPAA |  | For provider (provnum) |
| Procedure Code | PROC | $5 | For procedure (procnum), taken from CAPER BASIC (matched by CHCS Host and Appt ID No) |
| CPT Modifier 1 - CPT Modifier 3 | CPTMODx | $2 | Taken from CAPER Basic CPTMODx\_procnum. X = 1 to 3.  |
| CPT Units of Service | CPTUNITS | 3 |  Taken from CAPER Basic CPTUNITS\_procnum from CAPER BASIC (matched by CHCS Host and APPT ID No). |
| APC  | APC | $5 | Taken from APC(procnum)  |
| APC Weight Discounted | APC\_WT | 9.4 | Taken from APCWT (procnum) |
| Supervising Provider 1 - x | SUPNPI | $10 | For procedure (procnum), if there is more than one provider on the procedure, check to see if any of the providers (other than the one on this record) is a supervising provider based on provider role. If so, fill with the supervising provider's NPI. Else leave blank. |

Appendix B: MSA Key

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Category  | Patient Category Code | DMISID Information | MSA Key Value |
| NOAA | B\*, except B29 with subcat A | N/A | NOAMD9999 |
| Coast Guard | C\*, except C28 and C29 with subcat A | N/A | CGDDC9999 |
| USPHS | P\*, except P29 with subcat A | UBU\_Service is A, B | PHSMD9991 |
| USPHS | P\*, except P29 with subcat A | UBU\_Service is F, G | PHSMD9992 |
| USPHS | P\*, except P29 with subcat A | UBU\_Service is N, R | PHSMD9993 |

Appendix C: Laboratory and Radiology preprocessing

The CADRE Laboratory Basic Accession Table, CADRE Laboratory Basic Test Table, and the CADRE Radiology Basic Table are pre-processed so that CBER ancillary information can be read in one layout. First, the CADRE Laboratory Basic files (Accession Table and Test Table) are merged by CHCS Host, Accession Number, Order ID, CPT and CPT Modifier. If there is not a match in both tables, delete the record. Then the combined Laboratory file and CADRE Radiology Basic Table are appended, with the Ancillary Record Type flag derived based on which table the record came from. ~~If the record came from laboratory, set the RECORD\_ID to a concatenation of 'L', CHCS Host, Accession Number, and Record Number. If it came from radiology, set the RECORD\_ID to a concatenation of 'R', CHCS Host, Accession Number, Order ID, Procedure Code, and Procedure Code Modifier~~. Once all the ancillary files have been combined, the file must be merged to the MPI and LVM to obtain additional variables. The layout is described below.

**Combined CADRE Ancillary Table**

| **Data Element** | **SAS Name** | **Format** | **Lab Accession Table** | **Lab Test Table** | **Radiology Table** | **Transformation** |
| --- | --- | --- | --- | --- | --- | --- |
| CHCS Host | HOST\_DMISID | $4  | CHCSDMIS | CHCSDMIS | CHCSDMIS |   |
| Accession Number | ACCESSNO | $17  | ACCESSNO | ACCESSNO | ACCESSNO |   |
| Record Number | RECNO | $14  | RECNO | RECNO | N/A |   |
| Order ID | ORDERID | $12 | N/A | N/A | ORDERID |   |
| Procedure Code | CPT | $5  | N/A | CPT | CPT |   |
| Procedure Code Modifier | CPTMOD | $2  | N/A | CPTMOD | CPTMOD |   |
| Treatment DMISID | DMISID | $4  | TMTDMIS | N/A  | TMTDMIS |  |
| Ordering Appointment Number | ORD\_APPTIEN | $14  | N/A | APPTNO | APPTNO |   |
| Ordering DMIS ID | ORD\_MTF | $4  | N/A | ORDDMIS | ORDDMIS |   |
| Ordering MEPRS Code | ORD\_MEPRSCD | $4 | N/A | MEPRSCD | MEPRSCD |  |
| CLIA Number | CLIA | $7  | CLIA | N/A | N/A |   |
| Patient EDIPN | EDI\_PN | $10  | REDIPN | N/A | REDIPN |   |
| Patient SSN | PATSSN | $9  | PATSSN | N/A | PATSSN |   |
| Patient Category Code 3 | PATCAT | $3  | PATCAT | N/A | PATCAT |   |
| Other Health Insurance – Local | OHI | $1  | OHI | N/A | OHI |   |
| Encounter Date | ENCDATE | CCYYMMDD | N/A | SERVDATE | SERVDATE |   |
| Ordering Provider NPI | OPNPI | $10  | N/A | OPNPI | OPNPI |   |
| Ordering Provider NPI Type | OPNPI\_TYP | $1  | N/A | N/A | N/A | Leave blank |
| Ordering Provider EDIPN | OPEDIPN | $10  | N/A | OPEDIPN | OPEDIPN |   |
| Ordering Provider SSN | OPSSN | $9 | N/A | OPSSN | OPSSN |  |
| Ordering Provider Taxonomy | OPHIPAA | $11  | N/A | OPHIPAA | OPHIPAA |   |
| Certifying Provider NPI | CPNPI | $10  | N/A | CPNPI | CPNPI |   |
| Certifying Provider NPI Type | CPNPI\_TYP | $1  | N/A | N/A | N/A | Leave blank |
| Certifying Provider EDIPN | CPEDIPN | $10  | N/A | CPEDIPN | CPEDIPN |   |
| Certifying Provider SSN | CPSSN | $9 | N/A | CPSSN | CPSSN |  |
| Certifying Provider Taxonomy | CPHIPAA | $11  | N/A | CPHIPAA | CPHIPAA |   |
| Units of Service | COUNT | 3 | N/A | COUNT | COUNT |   |
| Patient Subcategory Code | PATCAT2 | $1  | PATCAT2 | N/A | PATCAT2 |  |
| File Date | FILEDATE | CCYYMMDD | FILEDATE | N/A | FILEDATE |  |
| ~~Change Date~~ | ~~CBERDATE~~ | ~~CCYYMMDD~~ | ~~CBERDATE~~ | ~~N/A~~ | ~~CBERDATE~~ |  |
| ~~Change Flag~~ | ~~CBERCODE~~ | ~~$1~~  | ~~CBERCODE~~ | ~~N/A~~ | ~~CBERCODE~~ |  |
| Inpatient Record ID | MTF\_PRN | $12  | TMTDMIS, PRN | N/A | TMTDMIS, PRN | Concatenate TMTDMIS (ID) and PRN.  |
| Record ID | RECORD\_ID | $41 | CHCSDMIS (ID), ACCESSNO, ORDERID, CPT, CPTMOD | CHCSDMIS (ID), ACCESSNO, ORDERID, CPT, CPTMOD | CHCSDMIS (ID), ACCESSNO, ORDERID, CPT, CPTMOD | Concatenate CHCSDMIS (ID) | ACCESSNO | ORDERID | CPT | CPTMOD |
| Ancillary Record Type | ANC\_RECTYPE | $1 | N/A | N/A | N/A | If the record is from Lab, set to 'L'. If the record is from Rad, set to 'R'. |
| Patient DOB | PATDOB | CCYYMMDD | N/A | N/A | N/A | From MPI |
| Patient Gender | PATSEX | $1  | N/A | N/A | N/A | From MPI |
| Sponsor Service | SPONSVC | $1 | N/A | N/A | N/A | From LVM |
| Beneficiary Category | BENCAT | $3 | N/A | N/A | N/A | From LVM |

1. These records will need to be reviewed by billers to determine if they are related to an accident. Records that qualify based on these criteria may not be billable. [↑](#footnote-ref-1)