**SDD Interface Control Document**

**Version: Re-Baseline**

**ICD Describing the Data Exchange of**

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

Data Set: **TED-NI**

Source System: **DHA Decision Support Division**

Receiving System: **MDR**

Document Number: **ICD 1300-1642-02**

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**ICD Describing the Data Exchange of**

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**Final Approval**

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**Document History**

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| Mod 1 | Jan 26, 2010 | Hosp Dept Number Blank filled Add Indiv and Group NPI | A-15, A-21 |  |
| Mod 2 | April 25, 2011 | Added Accrual Fund Eligibility Indicator field | A-35 |  |
| Mod 3 | September 06, 2013 | File format changed to pipe ("|") delimited | 1-1, A1-32 |  |
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| Baseline | September 24, 2015 | Re-baseline:  Updates data values throughout , adds DX and POA codes and ICD Code Version | All |  |

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# : Scope

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

## System Overview

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

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

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

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

## Reference Documents

* EIDS Program Office, CEIS Operational Requirements Document (ORD), Falls Church, VA, December 1997.
* EIDS Program Office, Initial Capabilities Document (ICD), dated March 2006.
* TMA, TRICARE Systems Manual 7950.1-M, Falls Church, VA, 1 Aug 2002.

## Operational Agreement

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

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

# : Interface Specification

## Identification of Interface

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

* TRICARE Encounter Data (TED) Non-Institutional (TED-NI) records.

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

## Precedence and Criticality of Requirements

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

## Communications Methods

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

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

## Performance Requirements

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

## Security and Integrity

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

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

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

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

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

### Data Integrity and Quality

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

File Format

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

Record Layout

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

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

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

File Operational Context

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

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

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

| **Field Number** | **Field Name**  **(logical name)** | **Field Length** | **Data Type** | **Data Units** | **Value Range** | **Functional Description** |
| --- | --- | --- | --- | --- | --- | --- |
|  | Header Type Indicator | 1 | A-Numeric | NA | 0, 5, 6, 9 | Code to indicate whether the record is a batch header or voucher header, and whether a voucher contains admin rate eligible records. Coded as follows:  0 Batch header (used on all provider and pricing batches, and for institutional/non- institutional financially underwritten non- admin claim rate TED records)  5 Voucher header (used only for institutional/ non-institutional non-financially underwritten non-admin claim rate eligible TED records)  6 Voucher header (used only for institutional/ non-institutional non-financially underwritten admin claim rate eligible TED records)  9 Batch header (institutional/non-institutional financially underwritten admin claim rate eligible TED records) |
|  | Contract Number | 13 | A-Numeric | NA | None | The unique 13-character contract number assigned to a contract. |
|  | Batch/Voucher Identifier | 1 | A-Numeric | NA | 3, 5 | Identifies the type of records submitted in the batch/voucher. Coded as follows:  3 Provider (Batch Only)  5 Institutional/Non-Institutional (Batch/Voucher) |
|  | Batch/Voucher ASAP Account Number | 8 | A-Numeric | NA | DHA assigned | Used to identify the ASAP Account Number the voucher will be drawn from. |
|  | Batch/Voucher Date | 7 | Numeric | NA | None | Date the contractor first created the batch/voucher for transmission to DHA. This date will not change through the resubmission process. Format YYYYDDD, where YYYY = Calendar Year and DDD = Julian Date. |
|  | Batch/Voucher Sequence Number | 2 | A-Numeric | NA | None | A sequential number assigned by the contractor to identify the batch/voucher. Once assigned, the number remains with the batch/voucher through resubmission process if applicable. |
|  | Batch/Voucher Resubmission Number | 2 | A-Numeric | NA | None | Identifies the number of submissions for the batch/voucher. |
|  | Total Number of Records | 7 | A-Numeric | NA | None | Total number of records submitted in the batch or voucher, exclusive of the header and trailer records. |
|  | Total Amount Paid | 14 | A-Numeric | NA | None | The total benefit dollars paid by the contractor and the interest paid for the TED records contained in either the batch or the voucher. |
|  | Fund Accounting | 12 | Numeric | NA | None | Contains the total Government drug cost dollars dispensed by the contractor. |
|  | Record Type Indicator | 1 | A-Numeric | NA | 1, 2, 3 | Code to indicate the type of record. Coded as follows  1 institutional record  2 non-institutional record  3 provider record |
|  | TED Record Indicator | 24 | A-Numeric | NA | None | Concatenation of the following fields:  Filing Date (length 7) - date the claim was received by the contractor (YYYYDDD)  Filing State/Country Code (length 3) - code that indicates the state or country where the care was provided  Sequence Number (length 7) - unique code assigned by the contractor within the filing date and state/country code.  Time Stamp (length 6) - system time assigned by the claims processor (MMSSHH (minutes, seconds, hundredths))  Adjustment Key (length 1) - for adjustment to a HCSR record, contains the HCSR Suffix. For TED records, contains the indicator for the type of financial record, coded as follows:  0 Batch  5 Voucher |
|  | Date Record Processed to Completion | 8 | A-Numeric | NA | None | Date the contractor processed the claim/treatment encounter data to completion (Yyyymmdd). |
|  | Date Adjustment Identified | 8 | A-Numeric | NA | None | Date the contractor determined an adjustment TED record was required, not applicable to provisional error correction adjustment (YYYYMMDD). |
|  | Person Identifier (Sponsor) | 9 | A-Numeric | NA | None | The identifier that represents the sponsor. This attribute will usually contain the sponsor’s SSN. |
|  | Person Identifier Type Code (Sponsor) | 1 | A-Numeric | NA | D, F, I, P, R, S, Z | The code that represents a specific kind of person identifier. Coded as follows:  D Special 9-digit code created for individuals (i.e. babies) who do not have or have not provided an SSN when the record is added  to DEERS  F Special 9-digit created for foreign military and nationals. Known as a Foreign Identifier Number (FIN)  I TIN  P Special 9-digit code created for U.S. military personnel before switch to SSNs  R Special 9-digit code created for a DoD contractor who refused to give his or her SSN to RAPIDS  S SSN  Z Not applicable |
|  | Service Branch Classification Code (Sponsor) | 1 | A-Numeric | NA | A, C, D, F, H, M, N, O, X, Z, 1, 2, 3, 4 | The code that represents the branch classification of Service with which the sponsor is affiliated.  A Army  C Coast Guard  D Office of Secretary of Defense  F Air Force  H Commissioned Corps of the Public Health Service  M Marine Corps  N Navy  O Commissioned Corps of the National Oceanographic and Atmospheric Administration (NOAA)  X Not applicable  Z Not provided from DEERS  1 Foreign Army  2 Foreign Navy  3 Foreign Marine Corps  4 Foreign Air Force |
|  | AGR Service Legal Authority Code | 1 | A-Numeric | N/A | A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, X, Z | The code that represents the source of the legal authority for Active Guard and Reserve (AGR) service. Code values are defined in the TRICARE Systems Manual. |
|  | Person Last Name (Patient) | 35 | A-Numeric | NA | None | Last name of the patient. |
|  | Person First Name (Patient) | 25 | A-Numeric | NA | None | First name of the patient. |
|  | Person Middle Name (Patient) | 25 | A-Numeric | NA | None | Middle name of the patient. |
|  | Person Cadency Name (Patient) | 10 | A-Numeric | NA | None | The cadency name (i.e., Sr, Jr, III, etc.) of the patient. |
|  | Person Identifier (Patient) | 9 | A-Numeric | NA | None | The identifier that represents the patient. This attribute will usually contain the patient’s SSN. |
|  | Person Identifier Type Code (Patient) | 1 | A-Numeric | NA | D, F, I, P, R, S, Z | The code that represents a specific kind of person identifier. Coded as follows:  D Special 9-digit code created for individuals (i.e. babies) who do not have or have not provided an SSN when the record is added  to DEERS  F Special 9-digit created for foreign military and nationals. Known as a Foreign Identifier Number (FIN)  I TIN  P Special 9-digit code created for U.S. military personnel before switch to SSNs  R Special 9-digit code created for a DoD contractor who refused to give his or her SSN to RAPIDS  S SSN  Z Not applicable |
|  | Person Birth Calendar Date (Patient) | 8 | Numeric | NA | None | The date when the patient was born. If patient is on DEERS, date is downloaded. If not on DEERS, date is reported from health care data received by contractor (YYYYMMDD). |
|  | DEERS Dependent Suffix (DDS) | 2 | Character | N/A | Blank | Obsolete - blank filled. |
|  | Patient Identifier (DoD) | 10 | A-Numeric | NA | None | The identifier associated with a particular patient. It is used to represent a patient within a Department of Defense Electronic Data Interchange. It is the EDIPN. |
|  | DEERS Identifier (Patient) | 11 | A-Numeric | NA | None | A DEERS identifier created from the combination of the DEERS assigned 9-digit DEERS Family Identifier and 2-digit DEERS Beneficiary Identifier. |
|  | Person Sex (Patient) | 1 | A-Numeric | NA | F, M, Z | Code defining sex of the patient. Coded as follows:  F Female  M Male  Z Unknown |
|  | Patient ZIP Code | 5 | A-Numeric | NA | None | First five digits of the U.S. Postal Zip Code or the foreign country code for the patient’s legal residence at the time service was rendered. |
|  | Patient ZIP Code 4 | 4 | A-Numeric |  | None | Digits 6 thru 9 of the patient ZIP code. |
| 32-34 | Override Code 1  Override Code 2  Override Code 3 | 2  (3 times) | A-Numeric | NA | 11-15, A, B, C, D, E, F, G, H, I, J, K, M, N, P, Q, R, S, U, V, Y, Z, H1, H2, NC, NS | Three occurrences of two-position codes which indicate that certain questionable data has been identified and approved by the contractor and that normal editing and processing rules should be bypassed for this record. Code values are defined in the TRICARE Systems Manual. |
|  | Type of Submission | 1 | A-Numeric | NA | A, B, C, D, E, I, O, R | Code indicating the TED submission type. Coded as follows:  A Adjustment to TED record data  B Adjustment to non-TED record (HCSR) data  C Complete cancellation to TED record data  D Complete denial initial TED record submission  E Complete cancellation of non-TED (HCSR) data  I Initial TED record submission  O Zero payment TED due to 100% OHI  R Resubmission of an initial TED record that was rejected due to errors |
|  | Claim Form Type/EMC Indicator | 1 | A-Numeric | NA | B,C, F, G, H,I,J | The code associated with the primary claim form submitted.  B DD form 2642  C HCFA form 1500  F UB-92  G electronic institutional claim submission  H electronic non-institutional claim submission  I electronic drug claim submission  J other |
| 37-39. | Administrative CLIN 1  Administrative CLIN 2  Administrative CLIN 3 | 2  (3 times) | A-Numeric | NA | None | Three occurrences of the six-position administrative Contract Line Item Number (CLIN) for which an administrative fee is requested.  To be reported on contracts awarded prior to 08/2007 only. |
| 40. | PCM Location DMIS-ID | 4 | A-Numeric | NA | None | The 4-digit code that indicates the DMIS ID code of the Primary Care Manager (PCM). Identifies and distinguishes MTF/Clinic enrollments from network enrollments. |
|  | Amount Interest Payment | 11 | Numeric | NA | None | Used by the contractor to report/record any dollar amounts associated with the delivery of health care that could not otherwise be reported in existing TED records fields. |
|  | Reason for Interest Payment | 2 | A-Numeric | NA | A, B, C, D, E | Used to determine the fiscal responsibility for the interest payment based on the following hierarchy:  A Claims pended at government direction that the government has specifically directed the contractor to hold for an extended period  B Claims requiring government intervention  C Claims requiring development for potential third party liability  D Claims requiring an action/interface with another prime contractor  E Claims retained by the contractor that do not fall into one of the above categories |
|  | Principal Treatment Diagnosis | 7 | A-Numeric | NA | None | The condition established, after study, to be the major cause for the patient to obtain medical care as coded on the claim form or otherwise indicated by the provider. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-1 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-2 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-3 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-4 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-5 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-6 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-7 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | TED Record Correction Indicator | 1 | A-Numeric | NA | Blank, 1, 2, 3 | Indicates the type of correction/adjustment  Blank Not applicable  1 Correction to provisional error  2 Non-provisional correction/adjustment  3 Both provisional and non-provisional |
|  | Total Occurrence/Line Item Count | 3 | A-Numeric | NA | 001-099 | The number of sets of procedure codes and related utilization data elements that occur on the claim. |
|  | Administrative Claim Count Code - 1 | 1 | Numeric | NA | 0-9 | Indicates status of administrative payment record processing. On the net TED database, this is the sum of all history records (original, adjustments, and cancellations). If multiple adjustments/ cancellations are processed, the code could be greater than one. Only one cancellation is permitted.  1 or greater – positive administrative payment  0 – no administrative payment |
|  | Administrative Claim Count Code - 2 | 1 | Numeric | NA | 0-9 | Indicates status of administrative payment record processing. On the net TED database, this is the sum of all history records (original, adjustments, and cancellations). If multiple adjustments/ cancellations are processed, the code could be greater than one. Only one cancellation is permitted.  1 or greater – positive administrative payment  0 – no administrative payment |
|  | Administrative Claim Count Code - 3 | 1 | Numeric | NA | 0-9 | Indicates status of administrative payment record processing. On the net TED database, this is the sum of all history records (original, adjustments, and cancellations). If multiple adjustments/ cancellations are processed, the code could be greater than one. Only one cancellation is permitted.  1 or greater – positive administrative payment  0 – no administrative payment |
|  | Amount Allowed (Total) | 13 | Numeric | NA | None | Total amount allowed for all authorized services on the TED record. |
|  | Amount Applied Toward Deductible Total | 11 | Numeric | NA | None | Portion of amount allowed which is applied toward the patient or family deductible for the fiscal year. |
|  | Amount Billed (Total) | 13 | Numeric | NA | None | Total amount billed for all services on the TED record. |
|  | Amount Paid by Government Contractor (Total) | 13 | Numeric | NA | None | The portion of total amount allowed that was paid by government contractor for all services reported on the TED record. |
|  | Amount Paid By Other Health Insurance | 13 | Numeric | NA | None | Total amount paid by other health insurance, including TPL, for all services reported. |
|  | Amount Patient Cost-Share Total | 13 | Numeric | NA | None | The total amount of money the beneficiary is responsible for paying in connection with covered services, other than the annual fiscal year deductible and any disallowed amounts. |
|  | Amount Total Patient Pay | 13 | Numeric | NA | None | If provider participation indicator = 'Y' (yes), total patient pay = amount allowed-amount paid by contractor. If provider participation indicator = 'N' (no), total patient pay = amount billed-amount paid by contractor. |
|  | Beneficiary Category | 1 | A-Numeric | NA | 1, 2, 3, 4 | Categorization of beneficiaries based on a given sponsor status for cost sharing and reporting purposes. For non-availability statements, categorization of beneficiaries is based on the sponsor's status and the patient's relationship to that sponsor. Coded as follows:  1 – active-dependent  2 – retired-sponsor  3 – retired/deceased-dependent and all other patients  4 – active duty sponsor |
|  | Benefit Claim Count Code | 1 | Numeric | NA | 0, 1 | Code indicating whether a claim has been cancelled.  0 - Claim has been cancelled  1 - Claim has not been cancelled |
|  | Care End Fiscal Year | 4 | Numeric | NA | None | The fiscal year that the delivery of care was completed. |
|  | Contractor Number | 2 | A-Numeric | NA | None | Identification code for the contractor. It is used to identify each contractor submitting health care service records and provider file records. |
|  | Cycle Number | 8 | Numeric | NA | None | Derived processing cycle Format: YyyymmNN where NN equals a sequential number within the month. |
|  | Deductible Flag | 1 | A-Numeric | NA | None | Indicates deductible classification of a claim, whether a claim is deductible only, partial deductible, or no deductible. |
|  | Diagnosis Edition Identifier | 1 | A-Numeric | NA | None | Identifies the edition number of the diagnosis related grouper which is used to determine the DRG. |
|  | Health Services Region Code (TNEX) | 2 | A-Numeric | NA | None | The TNEX health service region defined by contractor responsibility. |
|  | Health Services Region Code (Non-TNEX) | 2 | A-Numeric | NA | None | The Non-TNEX health service region defined by zip codes |
|  | Hospital Department Number | 2 | A-Numeric | NA | None | The hospital department categorization for a given diagnosis code. No longer derived as of October 1, 2009. Blank filled. |
|  | Initial Transmission Date | 8 | Numeric | NA | None | The derived date when the claim was initially transmitted to DHA. Format: Yyyymmdd. |
|  | MDC | 2 | A-Numeric | NA | None | The derived Medical Diagnostic Category (MDC). |
|  | MTF Branch of Service | 1 | A-Numeric | NA | 1-6 | Identifies the branch of service responsible for the military treatment facility/area.  1 Army  2 Navy  3 Air Force  4 Coast Guard  5 Public Health Service  6 State Non-Catchment Area |
|  | MTF/Non-Catchment Code | 4 | A-Numeric | NA | None | Four digit DMIS code from the catchment area directory identifying the catchment or non-catchment area of residence. |
|  | Patient Age | 3 | Numeric | NA | None | Age of patient calculated based on earliest begin date of care versus patient's date of birth. |
|  | Provisional Acceptance Common Indicator | 7 | A-Numeric | NA | None | Seven occurrences of a 1-character code indicating the categories of errors which caused a record to be provisionally accepted. |
|  | Provisional Acceptance Correction Date -1 | 8 | Numeric | NA | None | The date of the correction to the provisional acceptance of the claim record. Format: YYYYMMDD. |
|  | Provisional Acceptance Correction Date -2 | 8 | Numeric | NA | None | The date of the correction to the provisional acceptance of the claim record. Format: YYYYMMDD. |
|  | Provisional Acceptance Correction Date -3 | 8 | Numeric | NA | None | The date of the correction to the provisional acceptance of the claim record. Format: YYYYMMDD. |
|  | Provisional Acceptance Date - 1 | 8 | Numeric | NA | None | The date of the provisional acceptance of the claim record. Format YYYYMMDD. |
|  | Provisional Acceptance Date – 2 | 8 | Numeric | NA | None | The date of the provisional acceptance of the claim record. Format: YYYYMMDD. |
|  | Provisional Acceptance Date – 3 | 8 | Numeric | NA | None | The date of the provisional acceptance of the claim record. Format: YYYYMMDD. |
|  | TED Acceptance Date | 8 | Numeric | NA | None | Date the record was first accepted into TED. Format: YYYYMMDD. |
|  | TMA Batch/Voucher Processing Date | 8 | Numeric | NA | None | The derived date that DHA processed the claim. Format: YYYYMMDD. |
|  | Type of Submission, Derived | 1 | A-Numeric | NA | A, B, C, D, E, I, O, R | Code indicating the derived TED submission type. Coded as follows:  A Adjustment to TED record data  B Adjustment to non-TED record (HCSR) data  C Complete cancellation to TED record data  D Complete denial initial TED record submission  E Complete cancellation of non-TED (HCSR) data  I Initial TED record submission  O Zero payment TED due to 100% OHI  R Resubmission of an initial TED record that was rejected due to errors |
|  | Occurrence/Line Item Number | 3 | A-Numeric | NA | 001-099 | A unique number for each utilization/revenue data  occurrence within the TED record |
|  | Begin Date of Care | 8 | A-Numeric | NA | None | Earliest date of care for the procedure/service reported on this line item (YYYYMMDD). |
|  | End Date of Care | 8 | A-Numeric | NA | None | Latest date of care for the procedure/service reported on this line item (YYYYMMDD). |
|  | Procedure Code | 5 | A-Numeric | NA | CPT-4 codes | Code that identifies the procedure performed or describes the care received. |
| 92-95. | Procedure Code Modifier 1  Procedure Code Modifier 2  Procedure Code Modifier 3  Procedure Code Modifier 4 | 2  (4 times) | A-Numeric | NA | HCPCS codes | Up to four occurrences of two-digit codes per line item. Each two-digit code provides the means by which the health care professional can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. |
|  | National Drug Code (NDC) | 11 | Numeric | NA | None | Number assigned to pharmaceutical products by the Food and Drug Administration (FDA). |
|  | Number of Services | 3 | Numeric | NA | None | Number of procedures performed, services or supplies rendered for medical, dental, and mental health care. |
|  | Amount Billed By Procedure Code | 11 | Numeric | NA | None | Amount billed by the provider for this (these) service(s)/supply (ies). |
|  | Amount Allowed by Procedure Code | 11 | Numeric | NA | None | Total amount allowed for this (these) service(s)/ supply (ies). |
|  | Amount Paid By Other Health Insurance | 11 | Numeric | NA | None | Amount paid by other health insurance, including TPL, for service(s) on this line item. |
|  | Other Government Program Type Code | 1 | A-Numeric | NA | A, B, C, H, I, J, L, N, V | The code that represents what type of other government program the person has. Coded as follows:  A Medicare Part A  B Medicare Part B  C Medicare Part A & B  H Medicare Part D  I Medicare Part A & D  J Medicare Part B & D  L Medicare Part A, B, & D  N No Medicare  V CHAMPVA |
|  | Other Government Program Begin Reason Code | 1 | A-Numeric | NA | A, B, D, E, F, G, N, P, R, V, W | The code that indicates the reason that the person’s period of eligibility for a non-DoD Other Government Program began. Coded as follows:  A Eligible for Medicare. Eligibility began after age 65 (person did not have enough quarters of Social Security contributions to qualify at age 65).  B Enrollment in Medicare Part B; over or under age 65.  D Eligible for Medicare under age 65 because of disability.  E Eligible for Medicare at age 65.  F Eligibility for Medicare defaulted at age 65; verification not received from Center for Medicare and Medicaid Services (CMS). Applies to Medicare Part A only.  G Enrollment in Medicare Part B declined by beneficiary.  N Not eligible for Medicare. At age 65 this indicates eligibility could not begin because person did not have enough quarters of Social Security contributions to qualify.  P Eligible for Medicare at or after age 65 because of purchase.  R Eligible for Medicare under age 65 because of end-stage renal disease.  V Eligible for CHAMPVA.  W Not applicable. |
|  | Amount Applied to Deductible | 7 | Numeric | NA | None | Portion of amount allowed which is applied toward the patient or family deductible for the fiscal year for the services reported on the occurrence/line item. |
|  | Amount Patient Cost-Share | 11 | Numeric | NA | None | The total amount of money the beneficiary is responsible for paying in connection with covered services, other than any disallowed amounts for services reported on this occurrence/line item. |
|  | Health Care Coverage Copayment Factor Code | 1 | A-Numeric | NA | A, B, C, W, Z | The code used to identify for each insured in managed care the category of copayment and deductible they must pay based on external forces for a particular health care coverage period. Actual rates depend on Health Care Delivery Program Plan Coverage Code. Coded as follows:  A Active duty E4 and below rate  B Active duty E5 and above rate  C Retiree rate  W Unknown copayment factor  Z Not applicable |
|  | Amount Paid by Government Contractor By Procedure Code | 11 | Numeric | NA | None | The amount paid by the government contractor for the line item. |
|  | Adjustment/ Denial Reason Code | 5 | A-Numeric | NA | None | Code identifying the reason for non-payment of services or adjustment of the detail line item. Codes defined in TRICARE Systems Manual. |
|  | Provider Individual NPI Number | 10 | A-Numeric | NA | None | Standard unique health identifier for individual providers. Populated as of January 1, 2009. |
|  | Provider Group NPI Number | 10 | A-Numeric | NA | None | Standard unique health identifier for organizational providers. Populated as of January 1, 2009. |
|  | Provider State or Country Code | 3 | A-Numeric | NA | Codes are located in the TRICARE Systems Manual | Code assigned to identify the state or foreign country in which the care was received. Codes defined in TRICARE Systems Manual. |
|  | Provider Taxpayer Number | 9 | A-Numeric | NA | None | 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. |
|  | Provider Sub-Identifier | 4 | A-Numeric | NA | None | Identification number that uniquely identifies multiple providers using the same taxpayer identification number (TIN). |
|  | Provider Zip Code | 5 | A-Numeric | NA | None | The first five digits of the ZIP code or the three-character country code of the location where the care was provided. |
|  | Provider ZIP code 4 | 4 | A-Numeric | NA | None | Digits 6 thru 9 of the ZIP code of the location where care was provided. |
|  | Provider Specialty | 10 | A-numeric | NA | Codes are located in the TRICARE Systems Manual | Provider Taxonomy code describing the provider’s specialty. |
|  | Provider Participation Indicator | 1 | A-Numeric | NA | N,Y | Indicates whether or not the provider accepted assignment of benefits for services rendered.  N no  Y yes |
|  | Provider Network Status Indicator | 1 | A-Numeric | NA | 1, 2 | Indicates whether or not the provider is a network or non-network provider.  1 Network provider  2 Non-network provider |
|  | Physician Referral Number | 13 | A-Numeric | NA | None | The identifying number of the referring physician. Consists of the individual NPI; or Provider Taxpayer Number and Provider Sub-Identifier, as applicable |
|  | Place of Service | 2 | A-Numeric | NA | 3-9, 11-19, 20-26, 31-34, 41, 42, 49, 50-57, 60, 61, 62, 65, 71, 72, 81, 99 | Code to indicate the location of provided health care. Codes defined in TRICARE Systems Manual. |
|  | Type of Service (1) | 1 | A-Numeric | NA | A, C, I, K, M, N, O, P | The first of a two-character code used to indicate the type of service provided. Coded as follows:  A Ambulatory surgery cost – share as inpatient (ADFMs only)  I Inpatient  K Emergency room admission cost-shared as inpatient  M Outpatient maternity cost-shared as inpatient  N Outpatient cost-shared as inpatient  O Outpatient, excluding M, P, or N  P Outpatient partial psychiatric hospitalization cost-shared as inpatient |
|  | Type of Service (2) | 1 | A-Numeric | NA | 1-9, A, B, C, D, E, F, G, H, I, J, K, L, M | The second of two-character codes used to indicate the type of service provided. Coded as follows:  1 Medical care  2 Surgery  3 Consultation  4 Diagnostic/therapeutic x-ray  5 Diagnostic laboratory  6 Radiation therapy  7 Anesthesia  8 Assistance at surgery  9 Other medical service & supplies  A DME rental/purchase  B Retail drugs Supplies, Prescription  Authorizations and Reviews  C Ambulatory surgery  D Hospice  E Second opinion on elective surgery  F Maternity  G Dental  H Mental health care  I Ambulance  J ECHO (formerly PFPWD)  K Physical/occupational therapy  L Speech therapy  M Mail order pharmacy drugs Supplies,  Prescription Authorizations and Reviews |
|  | Health Care Coverage Member Category Code | 1 | A-Numeric | NA | 1, A – W, Y, Z | The member category code during Health Care Coverage period. Coded as follows:  1 Transitional compensation not eligible for retirement  A Active duty  B Presidential appointee  C DoD civil service employee  D Disabled American veteran  E DoD contract employee  F Former member  G National Guard member  H Medal of Honor recipient  I Other Government agency employee  J Academy student  K Non-Appropriated Fund DoD employee  L Lighthouse service  M Non-government agency personnel  N National Guard member  O Other Government contract employee  P Transitional Assistance Management Program (TAMP) member  Q Reserve retiree not eligible for retired pay  R Retired military eligible for retired pay  S Reserve member (mobilized or AD for 31days or more)  T Foreign military member  U Foreign national employee  V Reserve member (not AD for 30 days)  W DoD beneficiary, person receiving DoD benefits based on prior association, condition or authorization, e.g., a former spouse  Y Service affiliates (including ROTC and Merchant Marines)  Z Unknown |
|  | Pay Grade Code (Sponsor) | 2 | A-Numeric | NA | OO-ZZ, 00-11 | The code that represents the level of pay (The combination of pay plan code and pay grade code represents the sponsor’s pay category). Coded as follows:  00 Unknown  OO-ZZ Civil service  01 Cadet  01-05 Warrant Officer  01-09 Enlisted  01-11 Officer |
|  | Pay Plan Code (Sponsor) | 5 | A-Numeric | N/A | Codes are located in the TRICARE Systems Manual | The code that represents the type of pay category (The combination of pay plan code and pay grade code represents the sponsor’s pay category). Code values are defined in the TRICARE Systems Manual. |
|  | Health Care Coverage Member Relationship Code | 1 | A-Numeric | NA | A – L, Z | The member relationship for the Health Care Coverage period. Coded as follows:  A Self (i.e., the person and the other person are the same person)  B Spouse  C Child or stepchild  D Pre-adoptive child  E Ward (court ordered)  F Dependent parent, dependent stepparent, dependent parent-in-law, or dependent step-parent-in-law  G Surviving spouse  H Former spouse (20/20/20)  I Former spouse (20/20/15)  J Former spouse (10/20/10)  K Former spouse (transitional assistance (composite))  L Foster child  Z Unknown |
|  | Enrollment/ Health Plan Code | 2 | A-Numeric | NA | AA, BB, FE, FS, PS, SN, SO, SR, ST, SU, T, TS, U, V, W, WA, WF, WO, X, XF, Y, Z | Code indicating whether the patient is enrolled with the contractor (Prime) or not (non-Prime), or the care was received under the Standard TRICARE Program, or a special care program. Coded as follows:  AA CHCBP Extra  BB TRICARE Senior Prime  FE TRICARE For Life (TFL) – Extra  FS TFL – Standard  PS TRICARE Senior Pharmacy (TSP)  SN Supplemental Health Care Program (SHCP) – Non MTF Referred  SO SHCP – Non TRICARE Eligible  SR SHCP – Referred Care  ST SHCP – Claims for TRICARE eligible  SU SHCP – Referral Designation  T TRICARE Standard Program  TS TRICARE Senior Supplement (TSS)  U TRICARE Prime, Civilian PCM  V TRICARE Extra  W TRICARE Prime Remote (TPR) - Active Duty Claims USA  WA TPR – Foreign ADSM  WF TPR for enrolled Active Duty Family Member (ADFM) residing with a TPR eligible Active Duty Service Member (ADSM)  WO TPR Foreign (ADSM & family)  X Foreign ADSM  XF Foreign ADFM  Y Continued Health Care Benefit Program (CHCBP) Standard  Z TRICARE Prime, MTF/PCM |
|  | Health Care Delivery Program Plan Coverage Code | 3 | Numeric | NA | Code values are found in the TRICARE Systems Manual. | The code that represents the plan coverage a family member or sponsor has within a health care delivery program type. Code values are defined in the TRICARE Systems Manual. |
|  | Region Indicator | 2 | A-Numeric | NA | Blank, NC, OC, SC, WC | The region of the Managed Care Support Contractor (MCSC) responsible for the care provided. Coded as follows:  Blank Blank  NC North contract  OC Overseas contract  SC South contract  WC West contract |
| 129-132. | Special Processing Code 1  Special Processing Code 2  Special Processing Code 3  Special Processing Code 4 | 2  (4 times) | A-Numeric | NA | 0, 1, 3-7, 10-12, 14, 16, 17, 49, 50, A, E, Q, R, S, T, U, V, W, X, Y, Z, AB-AG, AN, AP, AR, AS, AU, BA, BD, CA, CE, CL, CM, CP, CT, DC, DE, DF, EF, EU, FF, FG, FS, GF, GU, KO, LD, L2, MH, MM, MN, MS, NE, PD, PF, PH, PO, PS, PV, RB, RI, RS, SC, SE, SM, SN, SP, SS, ST, WR | Four occurrences of two alphanumeric characters that indicate special processing is required. Codes values are defined in the TRICARE Systems Manual. |
|  | Health Care Delivery Program Special Entitlement Code | 2 | A-Numeric | NA | 00, 01, 02, 03, 04, 05, 06, 07, 30, 31 | Code used to identify for each insured in managed care any special category that they may have been given for copayment and deductible for a particular health care coverage period. Coded as follows:  00 Not applicable  01 Bosnian Special entitlement  02 Noble Eagle Special entitlement  03 Enduring Freedom  04 TA 60 Benefits After Special Operation  05 TA 120 Benefits After Special Operation  06 Kosovo Special Entitlement  07 Iraqi Freedom Participation Special Entitlement  30 TSP Exception – Grandfathered  31 TSP Exception – Direct Care over 65  Members with Medicare A & B but no TFL |
|  | CA/NAS Number | 15 | A-Numeric | NA | None | The unique number assigned by the MTF when issuing the Care Authorization (CA) or Non Availability Statement (NAS).  NAS requirement eliminated for dates of care on or after 28 Mar 2013. |
|  | CA/NAS Reason for Issuance | 1 | A-Numeric | NA | 1,2,3,4,5,6 | Indicates why the care was not or cannot be provided by a MTF. Coded as follows:  1 Facility not available  2 Professional capability not available  3 Medically inappropriate  4 Facility temporarily not available  5 Professional capability temporarily not available  6 Facility or professional capability permanently not available  NAS requirement eliminated for dates of care on or after 28 Mar 2013. |
|  | CA/NAS Exception Reason | 2 | A-Numeric | NA | B, C, K, L, M, Q, S, 1, 2, 3, 5, 6, 7, 9 | Code that describes the reason for bypassing the requirement of a CA/NAS. Coding:  B Former spouse w/ pre-existing condition  C Good faith payment  K CHCBP  L Hospice  M Abused family member  Q Active duty claims  S Home Health Agency (HHA)  1 Other primary insurance plan  2 Emergency medical treatment  3 Inpatient in college infirmary  5 Residential treatment center  6 Partnerships  7 Specialized Treatment Facility (STF)  9 TRICARE demonstration projects  NAS requirement eliminated for dates of care on or after 28 Mar 2013. |
|  | Pricing Rate Code | 2 | A-Numeric | NA | 0- 5, A-J, N-W, BR, CA, GG, GP, LC, P1, P2, P3, P5 | Code to indicate the contractor’s pricing methodology used in determining the amount allowed for the service(s) / supplies. Code values are defined in the *TRICARE Systems Manual*.: |
|  | Adjustment Reason Derived Code | 2 | A-Numeric | NA | None | No longer derived. Blank filled. |
|  | Category of Care | 2 | A-Numeric | NA | None | 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. |
|  | Denial Reason Derived Code | 2 | A-Numeric | NA | None | No longer derived. Blank filled. |
|  | Inpatient Outpatient Indicator | 1 | A-Numeric | NA | I, O | An indicator of whether the patient was treated as an inpatient or outpatient. Coded as follows:  I Inpatient  O Outpatient |
|  | Number of Visits | 2 | Numeric | NA | 1-99 | The total number of visits represented by this claim. |
|  | Primary Procedure Flag | 1 | A-numeric | NA | None | Indicator that the record pertains to the primary procedure. |
|  | Provider Specialty Group Derived Code | 2 | A-numeric | NA | Codes are located in the TRICARE Systems Manual | Code describing the provider’s specialty as derived from the health group that the provider is associated with. |
|  | Provisional Acceptance Line Item Indicator | 7 | A-numeric | NA | None | Seven 1 character codes indicating the categories of the errors which caused a line item to be provisionally accepted. |
|  | Ambulatory Payment Classification Code (APC) | 5 | A-numeric | NA | Codes are located at <http://www.tricare.mil/opps/> | Grouping that categorizes outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed when paid under the Outpatient Prospective Payment System (OPPS). |
|  | OPPS Payment Status Indicator Code | 2 | A-numeric | NA | A,B,C,E,F,G,H,K,N,P,Q,R,S,T,U,V,W,X,Z,TB,Q1,Q2,Q3 | Identifies how a service or procedure is paid under the Outpatient Prospective Payment System (OPPS).  Code values are defined in the TRICARE Systems Manual. |
|  | Accrual Fund Eligibility Indicator | 1 | A-numeric | NA | E, I | Indicates accrual fund eligibility. Coded as follows:  E = Eligible for Accrual Fund  I = Ineligible for Accrual Fund |
|  | Secondary Treatment Diagnosis-8 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-9 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-10 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-11 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-12 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-13 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-14 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-15 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-16 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-17 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-18 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-19 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-20 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-21 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-22 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-23 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Secondary Treatment Diagnosis-24 | 7 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. Decimal point is not included. |
|  | Present on Admission - Principal Dx | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 1 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 2 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 3 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 4 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 5 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 6 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 7 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 8 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 9 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 10 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 11 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 12 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 13 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 14 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 15 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 16 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 17 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 18 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 19 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 20 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 21 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 22 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 23 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | Present on Admission - Secondary Dx 24 | 1 | A-Numeric | NA | Blank, 1, N, U,W,Y | Blank = Not reported  1 = Unreported/Not Used - Exempt from POA reporting  N = No - Not present at time of admission  U = Unknown - Documentation insufficient to determine if the condition was present at time of admission  W = Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission  Y = Yes - Present at time of admission |
|  | ICD Version | 1 | A-Numeric | NA | 9,0 | 9 denotes ICD-9 diagnosis codes, 0 denotes ICD-10 diagnosis codes used for all diagnoses |

*Notes:*

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

| **Acronym** | **Name** |
| --- | --- |
| **AD** | Active Duty |
| **ADFM** | Active Duty Family Member |
| **ADSM** | Active Duty Service Member |
| **AGR** | Active Guard and Reserve |
| **APC** | Ambulatory Payment Classification Code |
| **ASAP** | Automated Standard Application for Payments |
| **B2B** | Business-to-Business |
| **CA** | Consultation Appointment |
| **CAM** | Complementary and Alternative Medicine |
| **CCB** | Configuration Management Board |
| **CEIS** | Corporate Executive Information System |
| **CHAMPVA** | Civilian Health and Medical Program for the Department of Veterans Affairs |
| **CHCBP** | Continued Health Care Benefit Program |
| **CLIN** | Contract Line Item Number |
| **DCN** | Document Change Notice |
| **DDS** | DEERS Dependent Suffix |
| **DECC** | Defense Enterprise Computing Center |
| **DEERS** | Defense Enrollment Eligibility Reporting System |
| **DHA** | Defense Health Agency |
| **DHA-A** | Defense Health Agency-Aurora |
| **DME** | Durable Medical Equipment |
| **DMIS** | Defense Medical Information System |
| **DMDC** | Defense Manpower Data Center |
| **DoD** | Department of Defense |
| **DRG** | Diagnosis Related Group |
| **EIDS** | Executive Information/Decision Support |
| **EIN** | Employer Identification Number |
| **EMC** | Electronic Media Claims |
| **FDA** | Food and Drug Administration |
| **FI** | Financial Intermediary |
| **FIN** | Foreign Identifier Number |
| **FIPS** | Federal Information Processing Standards |
| **HCFA 1500** | Health Care Financing Administration Professional Fee Billing Claim |
| **HCPCS** | Healthcare Common Procedure Coding System |
| **HCSR** | Health Care Service Record |
| **HCSR-NI** | HCSR Non-Institutional |
| **HHA** | Home Health Agency |
| **HIPAA** | Health Insurance Portability and Accountability Act |
| **HMO** | Health Maintenance Organization |
| **HSSC** | Health Service Support Contractor |
| **ICD** | Interface Control Document |
| **ICD-9** | International Classification of Diseases (9th revision) |
| **ICD-10** | International Classification of Diseases (10th revision) |
| **ICN** | Internal Control Number |
| **IP** | Inpatient |
| **M2** | MHS MART |
| **MCSC** | Managed Care Support Contractor |
| **MDC** | Medical Diagnostic Category |
| **MDR** | MHS Data Repository |
| **MHS** | Military Health System |
| **MTF** | Medical Treatment Facility |
| **NAS** | Non Availability Statement |
| **NATO** | North Atlantic Treaty Organization |
| **NDC** | National Drug Code |
| **NOAA** | National Oceanographic and Atmospheric Administration |
| **NPI** | National Provider Identifier |
| **OCHAMPUS** | Office of Civilian Health and Medical Program of the Uniformed Services |
| **ODS** | Operational Data Store |
| **OHI** | Other Health Insurance |
| **OPPS** | Outpatient Prospective Payment System |
| **ORD** | Operational Requirements Document |
| **PCDW** | Purchased Care Data Warehouse |
| **PCM** | Primary Care Manager |
| **RAPIDS** | Real-Time Automated Personnel Identification System |
| **SDD** | Solution Delivery Division |
| **SHCP** | Supplemental Health Care Program |
| **SSN** | Social Security Number |
| **STF** | Specialized Treatment Facility |
| **STIG** | Security Technical Implementation Guide |
| **TAMP** | Transitional Assistance Management Program |
| **TED** | TRICARE Encounter Data |
| **TED-NI** | TED Non-Institutional |
| **TFL** | TRICARE For Life |
| **TIN** | Taxpayer Identification Number |
| **TNEX** | TRICARE Next Generation Contract |
| **TPL** | Third Party Liability |
| **TPR** | TRICARE Prime Remote |
| **TSP** | TRICARE Senior Prime |
| **TSS** | TRICARE Senior Supplement |
| **UB04** | Uniform Billing Claim Form |
|  |  |