15 January 2025

TRICARE Dental Program (TDP)
for the
MHS Data Repository (MDR)
(Version 2.00.01)

Future Specification

Revision History

Version	Date	Para/Tbl/Fig	Originator	Description of Change
2.00.00	12/20/2018	• Initial publication	A. Hong	
2.00.01	1/15/2025	• Table 3	W. Funk	Implemented T5 Region

TRICARE Dental Program (TDP) Processing for the MDR

I. SOURCES

The source data files used to create the MDR TRICARE Dental Program files are provided according to the TDP contracts, via Secure FTP. These data represent claims for care provided to beneficiaries enrolled in the TRICARE Dental Program. A separate TDP Provider file is also sent to the MDR, containing detail information for TDP providers, and is maintained separately from the main TDP claims file.

II. TRANSMISSION (FORMAT AND FREQUENCY)

Source files are provided on a monthly basis. Data are to be provided no later than the 15th calendar day of each month reflecting the previous month's claims activity. If data have not been provided within 7 business days of the expected date of delivery, EIDS shall contact the TDP Program Manager or designee. The format of the data is described in the Interface Control Document (ICD).

III. ORGANIZATION AND BATCHING

The MDR TDP files are stored as fiscal year files, in SAS format. Each month's process incorporates new (and updated) records received from the TDP contractor that month. Each MDR TDP file that has been made available to users shall be archived and made available to authorized users per special request of the functional proponent. Raw files will also be archived and made available as needed.

Source Data: The first step in MDR processing is to store the raw files in
/mdr/raw/dental/tdp/claims/ dyymmdd.txt.Z and
/mdr/raw/dental/tdp/provider/dyymmdd.txt.Z
where "yymmdd" represents the date of the file. Raw batches must be made available (and remain available) to the staff at TMA that will process the raw data.

Output Products: The MDR TDP processor produces the files described in table 1. The preparation of them is described in subsequent sections of this document.

Table 1: MDR TDP Processor Output Products

MDR ADDP File	File Naming Convention	Member Name
TDP Claims File	/mdr/pub/dental/tdp3/claims/fy**	fy**.sas7bdat
TDP Provider File	/mdr/pub/dental/tdp3/provider	Providers.sas7bdat

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.

IV. RECEIVING FILTERS

By the 15th calendar day of each month, the TDP contractor shall provide the MDR with a file containing all records altered or newly created during the previous month. In other words, the feed files will include new records, as well as adjustments to records previously sent.

V. UPDATE PROCEDURES

Within a file of records, there will be updated claims to those received in the previous month's file. Therefore, updating the TDP data consists of two parts, once to the records within the raw monthly file and once to the appended master dataset:

- Within the raw monthly file, the adjustments within the monthly file must be handled first.
    - Adjustments are identified by "CLAIMID LINENUM CLMPDDT"
    - Adjustments must be collapsed into one record and the billed, allowed, paid and OHI amounts should be summed.
    - Header information should be taken from the last record "if last.linenum" after being sorted by "CLAIMID LINENUM ENDDATE CLMPDDT"
- Separate the records by fiscal year and then append all of the records from the current file to the corresponding fiscal year master database and then the master database needs to be updated:
    - identify adjustments by "CLAIMID LINENUM ENDDATE CLMPDDT"
    - Adjustments must be collapsed into one record and the billed, allowed, paid, OHI and patpay amounts should be summed.
    - Header information should be taken from the last record "if last.linenum" after being sorted by "CLAIMID LINENUM ENDDATE CLMPDDT"
    - Only retain records where the record where the "Claim Line Rejection Reason Code" (LINEREJ = '') is blank/null.

VI. FIELD TRANSFORMATIONS, DELETIONS, AND FILE TYPES FOR MDR CORE DATABASES

There are three different types of data elements available in the TDP files. There are data elements that are:

- Read in and retained from the TDP data feeds, or
- Derived from data provided in the TDP feeds, or
- Derived as a result of merges to external files.

The external merges should be applied to the entire database each processing cycle. These merges and associated merge keys are described in Table 2.

Table 2: TDP Data Merges

Merge	Date Matching	Additional Matching
NPPES	N/A	NPI
Master Person Index	N/A	See VM-6 Specifications
Longitudinal VM6 File	End Date of Care on record	EDI_PN if available
Omni-CAD	FY/FM of end date of care, FY/FM of MDR Omni CAD	Subscriber ZIP code & sponsor Service; Also based on provider ZIP code
DMIS ID Index	FY	Enrollment Site
Dental Weighed Value Unit Table	FY (before 1/1/2016) or CY (starting 1/1/2016) of end date of service with DWV Tables	CDT / Modifier & Procedure Code / Modifier
Relative Value Unit Table	Calendar year of begin date of care with calendar year of RVU Table	CDT / Modifier & Procedure Code / Modifier

VII. RECORD LAYOUT AND CONTENT

MDR TDP Claims: The MDR TDP Claims files are stored as SAS data sets, in separate fiscal year files. Table 3 below describes the format, file layout, and field derivation rules for the master TDP file.

Table 3: TDP Claims Data File Layout

Variable Name	SAS Name	Format	Input Position in Source Feed	Business Rule
Sponsor SSN	RSPONSSN	$9.	1	No transformation
EDI_PN	REDI_PN	$10.	10	No transformation
Raw Relationship Code	RELCODE_R	$1.	20	No transformation
Type of Contract	CONTTYPE	$1.	21	No transformation
Patient Date of Birth	PATDOB	$8.	22	No transformation
Raw Branch of Service	SVC	$1.	30	No transformation
Components	COMPONT	$1.	31	No transformation
Performing Provider ID	PROVID	$9.	55	No transformation
Provider Tax ID	TAXID	$9.	64	No transformation
National Provider ID	NPI	$10.	73	No transformation
Performing Provider Zip Code	PROVZIP	$5.	83	No transformation
Performing Provider Specialty	PROVSPEC	$3.	88	No transformation
Provider Network Status	NETWORK	$1.	91	No transformation
Provider Degree	PROVSUFF	$4.	92	No transformation
Billing Provider ZIP	BILLZIP	$5.	96	No transformation
Claim Number	CLAIMID	$13.	101	No transformation
Claim Line-Item Number	LINENUM	$4.	114	No transformation
Line-Item Final Status	FINSTAT	$1.	118	No transformation
Line-Item Rejection Reason	LINEREJ	$1.	119	No transformation
Special Processing Code	SPC	$2.	120	No transformation
Alternate Treatment Code	ALTTREAT	$2.	122	No transformation
Benefit Category	BENEFIT	$35.	124	No transformation
End Date of Service	ENDDATE	$8.	159	No transformation
Claim Receipt Date	CLMRECDT	$8.	167	No transformation
Claim Paid Date	CLMPDDT	$8.	175	No transformation
Claim Finalized date	CLMFINDT	$8.	183	No transformation

Variable Name	SAS Name	Format	Input Position in Source Feed	Business Rule
Date of Last Exam	LASTEXAM	$8.	191	No transformation
Accident Indicatory	ACCIDENTIND	$1.	199	No transformation
CDT Procedure Code 1	CDT	$5.	200	No transformation
CDT Version	CDTVERS	$2.	205	No transformation
Adjustment Reason Code	ADJREAS	$2.	207	No transformation
Adjustment Code	ADJCODE	$1.	209	No transformation
Original Line-Item Number	ORIGLINENUM	$4.	210	No transformation
Tooth Code 1	TOOTH1	$2.	214	No transformation
Tooth Code 2	TOOTH2	$2.	216	No transformation
Tooth Code 3	TOOTH3	$2.	218	No transformation
Tooth Code 4	TOOTH4	$2.	220	No transformation
Anterior / Posterior Indicator 1	AP_ID1	$1.	222	No transformation
Anterior / Posterior Indicator 2	AP_ID2	$1.	223	No transformation
Anterior / Posterior Indicator 3	AP_ID3	$1.	224	No transformation
Anterior / Posterior Indicator 4	AP_ID4	$1.	225	No transformation
First Treated Tooth Surface	SURFACE1	$5.	226	No transformation
Second Treated Tooth Surface	SURFACE2	$5.	231	No transformation
Third Treated Tooth Surface	SURFACE3	$5.	236	No transformation
Fourth Treated Tooth Surface	SURFACE4	$5.	241	No transformation
Quadrant	QUADRANT	$2.	246	No transformation
Provider Charge	BILL	8.	248	See Update Procedures (V.)
Allowed Amount	ALLOW	8.	257	See Update Procedures (V.)
Approved Amount	PAID	8.	266	See Update Procedures (V.)
Other Carrier Payment	OHI	8.	275	See Update Procedures (V.)
Prior Placement Date	PRIORPLACE	$8.	284	No transformation
Ortho Indicator	ORTHO	$1.	292	No transformation
Treatment Type	TRMTTYPE	$1.	293	No transformation

Variable Name	SAS Name	Format	Input Position in Source Feed	Business Rule
Dental Readiness Classification	DRC	$1.	294	No transformation
Pay Grade	PAYGRD	$3.	295	No transformation
Internally Derived Fields				
ACV Group	ACVGROUP	$2.	N/A	If begin date is >=1/1/2018 then:f enr_grp is "P" then set to "PR" elseif enr_grp is "L" then set to "PL" elseif enr_group="U" then set to "DP" elseif (bencat common=4 and pcm_type=N) then "R" elseif pcm_type="O" then "R" elseif elg_grp in ("R" "S") then "O" else "O" For logic prior to Jan 2018, see appendix A
Age Group	AGEGRP	$1.	N/A	If 0 le patage <= 4 then set to "A", else if patage<=14 then set to "B", else if patage<=17 then set to "C", else if patage<=24 then set to "D", else if patage<=34 then set to "E", else if patage<=44 then set to "F", else if patage<=64 then set to "G", else if patage not blank or negative set to "H", else set to "Z"
Change Date (MDR)	CHGDATE	$8.	N/A	Set to the most recent date that any data element on the MDR record was changed. For records that never change, this will be equal to the initial processing date.
Calendar Month	CM	$2.	N/A	Characters 5 and 6 of the end date of care.
Beneficary Category Common	COMBEN	$1.	N/A	Derived from BENCAT: 4 = ACT, GRD 1 = DA, DGR 2 = RET 3 = All others
Calendar Year	CY	$4.	N/A	Characters 1-4 of the end date of care.
Extract Date	EXTR_DT	$7.	N/A	Set to date the raw data is extracted: dyymmdd
Fiscal Month	FM	$2.	N/A	Fiscal month equivalent of calendar month of end date of care
Fiscal Year	FY	$4.	N/A	Fiscal year equivalent of calendar year of end date of care
New Record Flag	NEW_REC	$1.	N/A	Set to 1 if this version of the record was received in most recent processing cycle. Otherwise, set to 0.
Paid Calendar Month	PAIDCM	$2.	N/A	From CLMPDDT
Paid Calendar Year	PAIDCY	$4.	N/A	From CLMPDDT
Paid Fiscal Month	PAIDFM	$2.	N/A	Derive from CLMPDDT
Paid Fiscal Year	PAIDFY	$4.	N/A	Derive from CLMPDDT
Patient Age	PATAGE	8.	N/A	Calculated as age in completed years from variables PATDOB and ENDDATE.

Variable Name	SAS Name	Format	Input Position in Source Feed	Business Rule
Patient Paid Amount - Derived	PATPAY	8.	N/A	Calculate as follows: if network = 1 then patpay = (allow)-(paid)-(ohi) if network = 1 or if network is blank/null then patpay = (bill)-(paid)-(ohi)
Initial Processing Date (MDR)	PROCDATE	$8.	N/A	Set to initial date that this record was prepared for the MDR.
Number of Services	SVCS	8.	N/A	et number of services to the number of teeth populated in tooth1-tooth4 for each record
NPPES Merge				
Provider Specialty, HIPAA	HIPAASPEC	$10.	N/A	Match by NPI
MDR Dental Weighted Value Table Merge				
Dental Weighted Value	DWV	8.	N/A	Match to DWV tables based on CDT and either FY or CY to retrieve DWV. For date matching, use FY tables before 1/1/2016 and CY table DWVs starting 1/1/2016. Use FY15 DWV table for the 10/2015-12/2015 period.
MDR Relative Value Unit Table Merge				
Facility Practice Expense RVU	FACPERVU	8.	N/A	Match to RVU table based on CDT and CY and retrieve practice expense RVU (Facility)
Non-facility Practice Expense RVU	NFPERVU	8.	N/A	Match to RVU table based on CDT and CY and retrieve practice expense RVU (Non-facility)
Work RVU	RVU	8.	N/A	Match to RVU table based on CDT and CY and retrieve purchased care work RVU
Master Person Index Merge				
DEERS Person ID - Derived	EDIPN	$10.	N/A	See MPI specification
Person Association Reason Code	PARC	$2.	N/A	See MPI specification
Patient Gender - Derived	PATSEX	$1.	N/A	See MPI specification
Sponsor SSN - Derived	SPONSSN	$9.	N/A	See MPI specification
Longitudinal DEERS File Merge				
DEERS Alternate Care Value	ACV	$1.	N/A	Fill with ACV from LVM, if the begin date of care on the claim is between the begin and end date associated with the ACV. See VM-6 Specification, Sections G18 and 19 for segment and field positions. BLANK FILL JAN1, 2018 and later

Variable Name	SAS Name	Format	Input Position in Source Feed	Business Rule
DEERS Beneficiary Category	BENCAT	$3.	N/A	Fill with DEERS beneficiary category from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS beneficiary category. If no match for the person, set to "UNK" See VM-6 Specification, Sections G18 and 19 for segment and field positions
DEERS Zip Code	DEERSZIP	$5.	N/A	Fill with DEERS ZIP code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS ZIP code. See VM-6 Specification, Sections G18 and 19 for segment and field positions
DEERS Enrollment DMIS ID	DENRSITE	$4.	N/A	Fill with enrollment DMISID from LVM, if the begin date of care on the claim is between the begin and end date associated with the enrollment site. See VM-6 Specification, Sections G18 and 19 for segment and field positions
Dental HCDP Flag	DHCDP_FL	$1.	N/A	IF the HCDP code from LVM is dental and the encounter date is within the Dental HCDP begin and end date, the patient is eligible (Y) if not the patient is not eligible (N). See VM-6 Specification, Sections G18 and 19 for segment and field positions
DEERS Sponsor Service	DSPONSVC	$1.	N/A	Fill with DEERS sponsor service from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS sponsor service. See VM-6 Specification, Sections G18 and 19 for segment and field positions
DEERS Sponsor Service Aggregate	DSVCAGG	$1.	N/A	Fill with DEERS sponsor service (aggregate) from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS sponsor service (aggregate). See VM-6 Specification, Sections G18 and 19 for segment and field positions
DEERS Ethnicity Code	ETHNIC	$1.	N/A	Fill with DEERS ethnicity code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS ethnicity code. See VM-6 Specification, Sections G18 and 19 for segment and field positions
DEERS Health Care Delivery Program Code - Enrolled	HCDP	$3.	N/A	Fill with DEERS HCDP code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS HCDP code. See VM-6 Specification, Sections G18 and 19 for segment and field positions

Variable Name	SAS Name	Format	Input Position in Source Feed	Business Rule
DEERS Medicare Flag	MEDFLAG	$1.	N/A	Fill with DEERS medicare flag from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS medicare flag. See VM-6 Specification, Sections G18 and 19 for segment and field positions
PCM ID	PCMID	$32.	N/A	Fill with PCM ID from LVM, if the begin date of care one the claim is between the begin and end date associated with the PCM ID. See VM-6 Specification, Sections G18 and 19 for segment and field positions
DEERS Medical Privilege Code	PRIVCODE	$1.	N/A	Fill with DEERS privilege code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS privilege code. See VM-6 Specification, Sections G18 and 19 for segment and field positions
DEERS Race Code	RACE	$1.	N/A	Fill with DEERS race code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS race code. See VM-6 Specification, Sections G18 and 19 for segment and field positions
DEERS Relationship to Sponsor	RELCODE	$1.	N/A	Fill with DEERS relationship to sponsor code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS relationship to sponsor code. See VM-6 Specification, Sections G18 and 19 for segment and field positions
DEERS HCDP – Assigned	HCDP_ASSGN	$3.	N/A	Fill with asgn_hcdp_plan_cvg_cd from LVM, if the begin date of care on the claim is between the begin and end date associated with the segment. See VM-6 Specification, Sections G18 and 19 for segment and field positions
Enrollment Group	ENR_GRP	$1.	N/A	Fill with d_enr_grp_cd code from LVM, if the begin date of care on the claim is between the begin and end date associated with the segment. See VM-6 Specification, Sections G18 and 19 for segment and field positions
Eligibility Group	ELG_GRP	$1.	N/A	Fill with d_elg_grp_cd code from LVM, if the begin date of care on the claim is between the begin and end date associated with the segment. See VM-6 Specification, Sections G18 and 19 for segment and field positions
PCM Type	PCM_TYPE	$1.	N/A	Fill with d_pcm_type_cd code from LVM, if the begin date of care on the claim is between the begin and end date associated with the segment. See VM-6 Specification, Sections G18 and 19 for segment and field positions

Variable Name	SAS Name	Format	Input Position in Source Feed	Business Rule
MDR Omni-CAD Format File Merge Based on Subscriber ZIP Code				
Residence Catchment Area	CATCH	$4.	N/A	Based on matching FY, FM and ZIP Code; if dsvcagg=A then set equal to ACATCH, if dsvcagg = F then set equal to FCATCH; if dsvcagg in (M, N) then set equal to NCATCH, otherwise set equal to OCATCH. If ZIP code not found in MDR Omni-CAD, set equal to '0999'
Residence PRISM Area	PRISM	$4.	N/A	Based on matching FY, FM and ZIP code; if dsvcagg=A then set equal to APRISM, if dsvcagg = F then set equal to FPRISM; if dsvcagg in (M, N) then set equal to NPRISM, otherwise set equal to OPRISM. If ZIP code not found in MDR Omni-CAD, set equal to '0999'
Residence Region	RESREG	$2.	N/A	MOD_REG, based on matching FY, FM and ZIP code. No longer required as of January 2025.
Residence TNEX Region	RESTNEX	$1.	N/A	HSSCREG, based on matching FY, FM and ZIP code. No longer required as of January 2025.
Patient MTF Service Area	MTFSVCAREA	$4.	N/A	Based on matching FY, FM, zip and sponsor service; returns Service related MTF service area
Beneficiary T3 Region	BEN_T3_REG	$2.	N/A	T3_REG, based on matching FY, FM and ZIP code. No longer required as of January 2025.
Beneficiary T2017 Region	BEN_T17_REG	$2.	N/A	T17_REG, based on matching FY, FM and ZIP code
Beneficiary T5 Region	BEN_T5_REG	$2.	N/A	T5_REG, based on matching FY, FM and Zip Code.
MDR Omni-CAD Format File Merge Based on Provider ZIP Code				
Provider Catchment Area	PVCATCH	$4	N/A	Based on matching FY, FM and PROVZIP; set to OCATCH. If PROVZIP not found in MDR Omni-CAD, set equal to '0999'
Provider PRISM Area	PVPRISM	$4.	N/A	Based on matching FY, FM and PROVZIP; set to OPRISM. If PROVZIP not found in MDR Omni-CAD, set equal to '0999'
Provider TNEX Region	PVTNEX	$1.	N/A	HSSCREG, based on matching FY, FM and PROVZIP. No longer required as of January 2025.
Provider MTF Service Area	PMTFSVCAREA	$4.	N/A	Based on matching FY, FM, PROVZIP; returns Other MTF Service Area
Provider T3 Region	PROV_T3_REG	$2.	N/A	T3_REG, based on matching FY, FM and PROVZIP. No longer required as of January 2025.
Provider T2017 Region	PROV_T17_REG	$2.	N/A	T17_REG, based on matching FY, FM and PROVZIP
Provider T5 Region	PROV_T5_REG	$2.	N/A	T5_REG, based on matching FY, FM and PROVZIP

Variable Name	SAS Name	Format	Input Position in Source Feed	Business Rule
From DMIS ID Index Table				
Enrollment Site T3 Region	ENR_T3_REG	$2.	N/A	T3_REG, based on matching FY and Enrollment Site. No longer required as of January 2025.
Enrollment Site T2017 Region	ENR_T17_REG	$2.	N/A	T17_REG, based on matching FY and Enrollment Site
Enrollment Site T5 Region	ENR_T5_REG	$2.	N/A	T5_REG, based on matching FY and Enrollment Site

MDR TDP Provider: The provider feed data is compared with the existing MDR TDP claims dataset each processing cycle, using the provider ID and most recent month of MDR claims data as the basis of comparison. If the provider ID is in the most recent month of the MDR claims data, the delete month and termination flag are set to blank. If the provider ID is in the existing MDR claims data in any month other than the most recent, the provider termination flag is set to 'T' and the delete month is set to the date of the last month of MDR claims data that the provider ID was present in. If the provider ID is not found in the MDR claims data, then the delete month is set to blank and the termination flag is set to 'T'.

Table 3 describes the format and file layout for the TDP Provider file.

Table 3: TDP Provider Data File Layout

Variable Name	SAS Name	Format	Source Position	Business Rule
Provider Tax ID	TAXID	$9.	1	No transformation
Provider Identifier	PROVID	$18.	10	No transformation
Provider/Group Name	PROVGROUP	$53.	28	No transformation
Provider Specialty	PROVSPEC	$3.	81	No transformation
Provider Network Status	NETSTAT	$1	84	No transformation
Provider Telephone Number	PROVTELNO	$23.	85	No transformation
Provider Street Address Line 1	PROVADD1	$50.	108	No transformation
Provider Street Address Line 2	PROVADD2	$50.	158	No transformation
Provider State	PROVST	$2.	208	No transformation
Provider ZIP Code	PROVZIP	$9.	210	No transformation
Provider Country	PROVCTRY	$3.	219	No transformation
National Provider Identifier	NPI	$10.	221	No transformation
Internally Derived Fields				
Delete Month	DEL_MNTH	YYYYMM	N/A	Last month of MDR claim data that the provider ID was present in; if not present set to blank
Last Claim Date	LAST_CLM_DT	YYYYMMDD	N/A	Last end date of MDR claim data that the provider ID was present in.
Provider Termination Flag	TERM_FLG	$1	N/A	Set to "T" if provider is terminated during file update process or not present in MDR claims data, else leave blank.
Processing Date	PROCDATE	YYYYMMDD	N/A	Set to initial date that this record was prepared for the MDR.

VIII. REFRESH FREQUENCY

Frequency of updates, based on end date of care:

- Current and Prior FY: monthly
- All other FYs: twice a year in October and April.
- After 5 years old, stop processing back FYs

IX. DATA QUALITY

It is expected that when the TDP processor is run each month, that basic quality checks are performed. It is recommended that the DHSS vendor develop a spreadsheet which tracks key characteristics of the data across processing cycles; making it relatively easy to understand how the data should generally look. DHSS vendors need to review these statistics each month prior to releasing the data. DHCAPE (the functional proponent and the specification author) should be contacted immediately should any quality issues arise. These checks, at a minimum, should include:

- Total record counts in the claims and provider data feeds should be relatively stable across processing cycles. Any anomalies should immediately be investigated.
- The distribution of all categorical fields (ex. NETWORK, CDT) should be consistent. The results of proc freq analyses will verify this.
- The number of null values for important fields such as SPONSSN, EDIPN, PROVID should be tracked across monthly updates.
- When reading in the TDP claim and provider data feeds, a small number of records should be manually inspected to ensure they have been read in properly.
- Cross tabulations should be reviewed on derived elements to ensure the derivation logic works.
- A data flow tracker should be built to ensure that all records that are intended to make it into the final TDP datasets do. In other words, all inserts, updates, and deletions should be tracked and explained in the data flow worksheet.

Appendix A: ACV Group

For time periods before Jan 1, 2018, ACV is derived as follows:
For FY03 and before:
If ACV = A, D, or E then “PR”
Else if ACV = G or L then “PL”
Else if ACV = U then “DP”
Else if Ben Cat Common = 4 then “R”
Else “O”

For FY04 and after:
If ACV = A, E, H, or J then “PR”
Else if ACV = B or F then “OP”
Else if ACV = G or L then “PL”
Else if ACV = U then “DP”
Else if ACV = R or V then “O”
Else if ACV = M or Q then “R”
Else if Ben Cat Common = 4 then “R”
Else “O”