27 January 2025

TRICARE Encounter Data – Institutional
(TED-I)
for the
MHS Data Repository (MDR)
(Version 2.00.02)

Future Specification

Revision History

Version	Date	Originator	Para/Tbl/Fig	Description of Change
1.03.00	07/21/2009	J. Huber	• Appendix O	• Modified the DRG and MS-DRG grouper input and output layouts.
1.04.00	09/09/2009	J. Huber	• Tables O-1 through O-4	• Format changes to grouper (v2009.3.3).
1.05.00	02/04/2010	J. Huber	• Page 11 • Page 16	• Provider Group NPI added. • Blank fill Hosp Dept Number.
1.06.00	02/25/2010	J. Huber	• Appendix O	• DRG Grouper changes (v2010.0.1).
1.06.01	04/05/2010	J. Huber	• Page 19	• Clarification in the rule for Hospital Department Number; changed "as of October 1, 2009" to "if cycle date is after October 1, 2009.
1.06.02	05/11/2010	J. Huber	• Page 20	• Added the field AHRQPVADM. No change to the processor.
1.06.03	08/13/2010	J. Huber	• Internally Derived Fields	• Added contractor numbers 04 and 15 to TED Indicator derivation. • Added contractor numbers 04 and 15 to Contract Type derivation.
1.06.04	10/12/2010	K. Hutchinson for J. Huber	• Appendix O	• Clarified grouping so it is the same as SIDR. No change to the processor.
1.06.05	04/20/2011	M. North for J. Huber	• Appendix I	• Replaced algorithm for MERHCF flag derivation in Appendix I. Recalculate for all TED-I datasets, starting with most recent and working back to FY01.
1.06.05	05/04/2011	J. Huber	• Page 8	• PAYGRD - change value of OO (letters) to 00 (numbers).
1.06.05	04/25/2011	J. Huber	• Page 15	• Add field: Accrual Fund Indicator.
1.06.05	05/04/2011	J. Huber	• Page 16	• DSPONSVC - change blank to Z.
1.06.05	05/04/2011	J. Huber	• Page 16	• RACE - change blank to Z.
1.06.05	05/04/2011	J. Huber	• Page 16	• ETHNIC - change blank to Z.
1.06.05	05/04/2011	J. Huber	• Page 17	• PARC - change blank to ZZ.
1.06.05	05/04/2011	J. Huber	• Page 17	• Drop DDS for FY09+.
1.06.05	05/04/2011	J. Huber	• Page 21	• Add derived field: ACVGROUP.
1.06.05	05/10/2011	J. Huber	• Page 21	• Add derived field: Age Group Common.
1.06.06	10/25/2011	J. Huber	• Appendix O	• Clarified grouping so it is the same as SIDR.
1.07.01	10/12/2012	K. Hutchinson for J. Huber	• Appendix O	• Changed file layout for new DRG and MS-DRG grouper. It is the same as SIDR.
1.07.01	10/12/2012	J. Huber	• Table 1	• Add Enrollment MEPRS Code and Medical Home Flag.
1.07.02	2/12/2013	J. Huber	• Internally Derived Fields, Appendix I	• Add Contractor Numbers 05,08. • Delete contractor numbers 16,17,18.
1.07.03	4/23/2013	M. North	• Table 1	• Increase field sizes for ICD10.6 Removed TED source position column.
1.08.01	6/6/2013	J. Huber	• Table 1	• Added MSMDC to Derived MDC FY09+. • Added PCM_ID. • Modified ACV Group algorithm. • Files will need to be reprocessed back through FY 2009.
1.08.02	11/18/2013	D. McDonald	• Table 1	• Add TRICARE Young Adult Flag.
1.09.01	11/18/2014	J. Huber	• Table 1	• Added POA flags, additional ICD fields, and ICD Edition Number.

Version	Date	Originator	Para/Tbl/Fig	Description of Change
1.09.02	2/3/2015	J. Huber	• Tables O-2 and O-3	HACPOA='0' ALLOWS HAC/POA PROCESSING in Grouper.
1.09.02	2/6/2015	J. Huber	• Table 0-3	Highlight one HACPOA reference missed on 2/3/2015
1.09.03	4/1/2015	W. Funk for J. Huber	• Section VI • Table 1	• Added merge to MDR TED Revenue File. • Added ICU Flag.
1.10.01	5/27/2015	W. Funk	• Entire document • Section II • Table 1 • Table 2 • Appendix J • Appendix L	• Formatting changes, re-numbered appendices. Removed reference to HCSR from main document and moved to appendix.' • Added ICD Number. • Added new merge files (Summarized TED NI for professional tail and enrollment MEPRS Code, MTF Network Referral File, MTF Referral File.). Moved language about AHRQ software from appendix to table 1. • Added source field number column, added rules for new geography fields, added new rule for professional tail, bencat common from DEERS, admit from ER Flag, Referral information (CHCS Host and Order Number, MTF, Provider, MEPRS Code, Access to Care Category, Referral Date). Changed name of old bencat common to bencat common of record. Removed administrative tail, medical home flag, type of submission legacy, hospital department number. • Updated AHRQ Quality Indicator logic, adding Appendix L. • Took programming code and changed to two tables for easier interpretation by non-SAS users.
1.10.02	11/10/2015	W. Funk	• Table 1 • Table 2 • Appendix J • Appendix K • Appendix M	• Updated merge table rule for referral information. • Updated information from referral and MTF/MCSC Referral file. • Update the DRG grouping rule for selecting a version. • Added merge rules for MTF-MCSC merge. • Added merge rules for referral file merge.
1.10.04	11/19/2015	W. Funk	• Table 2 • Appendix L • Appendix M	• Updated rules for number of births and clarified that MTF Service area is FY06+ • Switched the flowchart for AHRQ logic • Updated rules for referral match.
1.10.05	12/1/2015	W.Funk	• Table 2	• Reintroduced several DRG related fields.
1.10.06	10/24/2016	W.Funk	• Table J-2 • Table 2	• Changed HACPOA rule for grouping. • Dropped 2 fields.
1.10.07	6/7/2017	W. Funk	• Table 2	• Added the new critical access hospital institution type to the logic for deriving acute care hospital indicator.
1.10.08	9/14/2018	W. Funk	• Table 1 • Table 2	• Added merge to DRG Surgical Reference file (also used in SIDR processing). • Add Med/Surg Flag.

Version	Date	Originator	Para/Tbl/Fig	Description of Change
1.10.09	9/10/19	W. Funk	• Table 1 • Table A-3	• Updated merge logic for MS DRG Weight table. • Updated merge logic for MS DRG Weight table.
1.10.10	1/21/21	W.Funk	• Appendix K	• Updated rules to merge with MTF Network Referral File.
1.10.11	2/22/21	W. Funk	• Table 1 • Table 2	• Added PCM Identity lookup table; removed old version from AHRQ merge. • Added fields from the PCM Lookup table and modified the med/surg flag.
2.00.00	4/30/2021	W. Funk	• Throughout	• Changed update frequency to weekly.
2.00.01	1/21/2025	W. Funk	• Table 1 and 2	• Added and deleted fields.
2.00.02	1/27/2025	W. Funk	• Table 1	• Removed requirements for some merged data. • Added/delete fields. Altered logic on ICU flag.

MDR Institutional Data File

I. SOURCE:

The source system is the TMA-Aurora HCSR/TED acceptance system's Net Master Databases or the Purchased Care Data Warehouse Databases. Two types of source data have historically been sent each week, with each file containing accepted or provisionally accepted claims with end dates of care in the fiscal years required. The types of source data are:

- Pure net TED records
- HCSRs (incorporating adjustments, both TED and HCSR)

These source files have historically been combined in the MDR processor, to produce complete fiscal year claims files for the MDR. Beginning with January 2009, HCSRs and TED Adjustments to HCSRs ceased to be processed/provided.

The TED data are now required on a weekly basis.

II. TRANSMISSION (FORMAT AND FREQUENCY):

Purchased care data files are normally transmitted via secure FTP from TMA-Aurora to the MDR according to ICD 1300-1642-04. Files are sent weekly. Purchased care data records consist of institutional claims[1], non-institutional claims, and provider records. This specification deals solely with institutional records.

III. ORGANIZATION AND BATCHING

There are four final MDR TED institutional files[2]. The files include:

- Master TED Institutional File: The master file contains most raw fields (except revenue line items) from the source data, as well as appended fields described in this document. This file is the core MDR TED Institutional Database.
- Revenue File: Each record represents a revenue line item from the revenue file. This file contains a TED Number, cycle year and week, the end date of care, the revenue line item number and associated detail. There are two appended fields, described in this document. This file is intended to be used in combination with the master TED institutional file.
- Cancellation and Denial Master File: Contains all claims with allowed amount (field number 1-125) less than or equal to 0. The format is the same as the TED interface with the MDR, with no appended fields.
- Cancellation and Denial Revenue File: Contains all revenue segments for claims with allowed amount (field number 1-125) less than or equal to 0. The format is the same as the revenue segment interface with the MDR, with no appended fields.

The master TED Institutional and Revenue Files are segmented by fiscal year, based on end date of care in the claim header.[3] The cancellation and denial files are cumulative, spanning all years of data. If the cancellation and denial files get too large, they may be segmented.

The initial file load is a one-time requirement and should represent all care with end date of care in FY04 or later. Previous year's data will be incorporated into the new processor described herein, but this will occur at a later time.
Refreshes to the MDR institutional files are received and processed weekly.

IV. RECEIVING FILTERS

Only net records are provided to the MDR, as described in Section I. Only accepted or provisionally accepted records are provided in the source data. For the initial load, records are included if the end date of care on the net claim is in the fiscal year. Fiscal year files will be created for FY04 and later.

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[1] A TED or HCSR is not technically a "claim," rather, these records are reports of claims. However, the term "claim" shall be used in this document for simplicity.
[2] Though these files are called "TED" files, they will contain both TED records and HCSRs in some years.

Each weekly TED update batch includes records accepted or provisionally accepted by the TMA-Aurora system in the previous week. This should include initial records, adjustments to records previously sent, and cancellations and denials.

For the revenue file, each weekly update includes all TED revenue line items for TED Numbers contained in the weekly Master Institutional data feed. This means that the feed will include all line items associated with the new records, as well as all revenue line items associated with updated records. That is, when a claim is updated for any reason, all revenue line items should be provided in the weekly revenue line item data feed.

V. UPDATE PROCESS

This section describes the update process to use for TED feeds. Rules for combined TED/HCSR files are provided in appendix H. When the incremental raw feeds of Institutional data are processed, records that are denied or cancelled (records with an allowed amount less than or equal to 0) are separated out and added to the master cancellation data files (header and revenue). Then, records from the wrong fiscal year are dropped from all data feeds.

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

To update the master fiscal year MDR Institutional TED data sets it is important to apply updates and prepare data sets in the following order;

- Master Institutional TED File:
  Next, the processor appends variables to the incremental header data feed. Then it combines incremental and master header data sets, interleaving records by TED number and cycle date. The processor retains only the most recent version of the TED, as identified by TED number[4]. Then the processor uses the previous fiscal year data set to remove from the master data set any records that have moved to a subsequent fiscal year. This is done to ensure that records are not in two fiscal years.

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

- Revenue File:
  The processor first identifies which records are in both the incremental and the master revenue data sets and deletes those records from the master data set. Next the processor combines the incremental and modified master data sets to produce an updated master data set. The processor then uses the previous fiscal year file to remove any matching TED revenue segments from the updated master revenue data set. Finally, the intermediate cancellation data set is used to remove cancelled TEDs from the updated master revenue data set.

Note that the fiscal years must be processed in order, with the most recent fiscal year being processed first.

VI. FIELD TRANSFORMATIONS AND DELETIONS FOR MDR CORE DATABASE

This section of this functional specification describes the data merges that are necessary to append many of the fields in the MDR TED Institutional file. This table only includes merges needed for processing of TEDs. For merge rules for combined TED/HCSR data, see appendix H.

The table below describes each reference (or data) file being used to append fields to each MDR Institutional record. This table also lists whether the merge should be accomplished against the weekly feed (increment) or whether it is necessary to re-merge the corresponding file to each of the MDR Institutional records during each weekly process[5]. The basis upon which the MDR institutional records should be merged to the reference (or data) files is also described.

[5] This is a functional requirement, because if reference files are subject to change retroactively, data in the existing MDR database will be incorrect if the changed table is not re-applied to old records routinely.

Table 1: Merge Table

Merge	Merge to	Date Matching	Additional Matching
Longitudinal VM File	Master	Begin Date of Care on TED, with begin and end dates for each changeable demographic segment.	EDI_PN if available.
Master Person Index	Master	None	For records with blank EDI_PN, match TED ~~and ATOI records~~ by sponssn, patsex, patdob and grouped member relationship code.
DRG Weight Table	Increment	FY of end date of care and FY of MDR DRG Weight Table for FY 2008 and earlier. For FY 2009 and later, match 2008 weight table to TEDs.	Derived DRG from institutional data record, DRG from weight table. No longer required as of January 2025.
MS DRG Weight Table	Increment	FY of end date of care and FY of MDR DRG Weight Table through September 2019. From Sept 2019 through Dec 2019, match to FY 2019. From then on, match by calendar year.	MSDRG from institutional data record, DRG from weight table.
Diagnosis and Procedure Code Mapping Format	Increment	FY of Admission Date and Associated Version Number of DRG Grouper Software (see Appendix J on DRG Grouping).	
DMISID	Master	FY of end date of care, FY of MDR DMISID SAS format file.	Application based on enrollment DMISID, DEERS enrollment DMISID and catchment area DMISID.
Omni-CAD	Increment	FY/FM of end date of care, FY/FM of MDR Omni CAD format file.	Patient zip code & sponsor Service. Also based on provider zip.
Reservist GWOT file	Master	Admission date and dates associated with each reservist benefit type segment in the MDR Reservist format files.	Sponsor social security number.
TED Episode Reference File	Master	Begin date of care	EDI_PN
3M Core Grouping Software	Increment	See appendix J for description of processing.	
AHRQ Preventable Admission Indicator Software	Master	http://www.qualityindicators.ahrq.gov/pqi_download.htm. In the TED-I file, many data elements are added based on SAS "proc format" statements that are developed and maintained by AHRQ. These format statements can be downloaded from the AHRQ Website. The process for applying these formats is to format the data to ensure they run properly, and then to assign indicator variables based on the value contained with the format.	
MDR TED Institutional Revenue File	Master	N/A	TED Number (tedno)
Summarized MDR TED NI (by admitting TED No)	Master	N/A	Admitting TED Number
Enrollment MEPRS Code	Master	Begin date of care on claim is contained in the begin/end date window of the enrollment.	Person ID. No longer required as of January 2025.
MTF Network Referral File	Master	N/A	See Appendix K
MDR Referral File	Master	N/A	Appendix M

Merge	Merge to	Date Matching	Additional Matching
MDR DRG Surgical Format File	Master	N/A	MS-DRG
PCM Identity Lookup	Master	End Date of Care is between the start and stop date of the PCM Identifier segment.	EDIPN

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

VII. RECORD LAYOUT AND CONTENT

The MDR TED files are stored as SAS data sets, in separate fiscal year files. There are two primary TED-Institutional Datasets for each fiscal year: The Master TED data file, and the Revenue data file. Records in the cancellation files remain in the format contained in the feed to the MDR (text). This table includes business rules used for processing TED records only. For rules regarding the processing of combined HCSR/TED data, see Appendix H.

The table below describes the format, file layout and field derivation rules for the master institutional database.

Table 2 Master MDR Institutional Header TED SAS Dataset

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
TED Number	tedno	$24	1-015	12	No transformation.
		$24	1-020	12	No transformation.
		$24	1-025	12	No transformation.
		$24	1-030	12	No transformation.
		$24	1-035	12	No transformation.
Process to Completion Date	procdate	yyyymmdd	1-040	13	Convert to SAS Date.
Sponsor SSN	sponssn	$9	1-050	15	No transformation.
Sponsor SSN Type Code	idtype	$1	1-051	16	No transformation.
Sponsor Pay Plan	payplan	$5	1-057	18	No transformation.
Service Branch	sponsvc	$1	1-060	19	No transformation.
AGR Service Legal Authority	agrauth	$1	1-065	20	No transformation.
Sponsor Status	memcat	$1	1-066	21	No transformation.
Member Relationship Code	memrln	$1	1-070	22	No transformation
Last Name	lastname	$35	1-076	23	No transformation.
First Name	frstname	$25	1-077	24	No transformation.
Middle Name	midlname	$25	1-078	25	No transformation.
Cadency	cadency	$10	1-079	26	No transformation.
Patient SSN	patssn	$9	1-080	27	No transformation.
Patient SSN Type Code	pidtype	$1	1-081	28	No transformation.
Date of Birth	patdob	yyyymmdd	1-085	29	Convert to SAS Date.
DEERS Patient ID	deersid	$11	1-097	31	No transformation.
Gender	patsex	$1	1-100	32	No transformation.
Patient Zip Code	patzip	$5	1-105	33	No transformation.
Patient Zip Code + 4	patzip4	$4	1-105	34	No transformation.
HCDP	hcdp	$3	1-111	36	No transformation.
TED Region	tedreg	$1	1-112	37	No transformation.
Enrollment DMISID	enrsite	$4	1-115	38	No transformation.
Total Amount Billed	bill	SN9.2	1-120	39	No transformation.
Total Amount Allowed	allow	SN9.2	1-125	40	No transformation.
Total OHI Paid	ohi	SN9.2	1-130	41	No transformation.
Type of Other Government Health Insurance	govins	$1	1-131	42	No transformation.

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
Begin Reason Code for Other Government Ins	govinbeg	$1	1-132	43	No transformation.
Total Patient Cost Share	patcost	SN9.2	1-135	44	No transformation.
Copayment Factor	copayfac	$1	1-136	45	No transformation
Total Amount Paid	paid	SN9.2	1-140	46	No transformation.
Total Interest Paid	intpaid	SN9.2	1-145	47	No transformation.
Reason for Interest	intreas	$2	1-150	48	No transformation.
Override Code 1 - 3	ovride1-3	$2	1-160	49-51	3 separate fields.
Submission Code	subcode	$1	1-165	52	No transformation.
Care Authorization/NAS Number	authnum	$15	1-170	53	No transformation.
Care Authorization/NAS Issue Reason	authrsn	$1	1-175	54	No transformation.
Care Authorization/NAS Exc Reason	authexcp	$2	1-180	55	No transformation.
Special Processing Code 1 - 4	sprocd1-4	$8	1-185	56-59	4 separate fields.
Health Care Delivery Program Special Entitlement Code	hcdpspec	$2	1-186	60	No transformation.
Pricing Rate Code	pricert	$2	1-190	61	No transformation.
Provider State/Country Code	provloc	$3	1-195	62	No transformation.
Provider Tax ID	taxid	$9	1-200	63	No transformation.
Multiple Provider Suffix	multprov	$4	1-205	64	No transformation.
Provider Individual NPI	provnpi	$10	N/A	65	No transformation.
Provider Group NPI	grpnpi	$10	1-215	66	No transformation. Not populated prior to January 1, 2009.
Provider Zip	provzip	$5	1-220	67	No transformation.
Provider Zip +4	provzip4	$4	1-220	68	No transformation.
Provider Participation Indicator	provpart	$1	1-225	69	No transformation.
Provider Network Status Indicator	network	$1	1-230	70	No transformation.
Type of Institution	insttype	$2	1-235	71	No transformation.
Claim Form Type	clmform	$1	1-240	72	No transformation.
Billing Frequency Code	billfreq	$1	1-250	73	No transformation.

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
Type of Admission	admtype	$1	1-255	74	No transformation.
Source of Admission	admsrc	$1	1-260	75	No transformation.
Admission Date	admdate	yyyymmdd	1-265	76	Convert to SAS date.
Disposition Status	dispstat	$2	1-270	77	No transformation.
Begin Date of Care	begdate	yyyymmdd	1-275	78	Convert to SAS date.
End Date of Care	enddate	yyyymmdd	1-280	79	Convert to SAS date.
Administrative Clin 1 - 3	admcln1 - 3	$6	1-283	80-83	Parse into three separate fields.
Authorized Days	authdays	SN3	1-285	84	No transformation.
Raw DRG	rawdrg	$3	1-290	85	No transformation.
SNF HIPPS Code	hipps	$5	1-292	86	No transformation.
ICD Version	icdver	$1	1-293	201	No transformation.
Admitting Diagnosis	admdx	$7	1-295	87	No transformation.
Principal Diagnosis	dx1	$7	1-300	88	No transformation.
Diagnosis 2 - 12	dx2 - 12	$7	1-305	89-99	No transformation.
Diagnosis 13 - Diagnosis 24	dx13-dx25	$7		149-161	Parse into 12 separate fields.
Diagnosis 2-25 POA Indicator	poa2-poa25	$1	1-300 through 1-328	175-199	No transformation.
Procedure 1 - Procedure 12	proc1 - proc 12	$7	1-345 through 1-361	100-111	No transformation.
Procedure 13 - Procedure 25	proc13-proc25	$7	1-361 through 1-373	162-174	No transformation.
Primary Diagnosis, POA	poa1	$1	TBD		No transformation.
TED Record Correction Indicator	reccrt	$1	1-374	112	No transformation.
Number of Revenue Segments	revsegs	3	1-375	113	No transformation.
Administrative Claim Count Code 1 – 3	clmcnt1 - 3	SN1	Derived in TED ODS	114-116	Parse into 3 separate fields.
Benefit Claim Count Code	benclmct	1	Derived in TED ODS	120	No transformation.
FY	fy	$4	Derived in TED ODS	121	No transformation.
Contractor Number	konum	$2	Derived in TED ODS	123	No transformation.
Cycle Number	cycle	$8	Derived in TED ODS	124	No transformation.
Diagnosis Code Edition Number	dxedit	$1	Derived in TED ODS	125	No transformation.
TNEX Region	rawtreg	$1	Derived in TED ODS	127	No transformation. No longer required as of January 2025.
Region	rawreg	$2	Derived in TED ODS	128	No transformation.
Initial Transmission Date	trnsdate	yyyymmdd	Derived in TED ODS	130	No transformation.

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
Patient Age	patage	3	Derived in TED ODS	136	No transformation.
Acceptance Date	accptdt	yyyymmdd	Derived in TED ODS	144	Convert to SAS date.
TMA Batch/Voucher Processing	vouchdt	yyyymmdd	Derived in TED ODS	145	No transformation.
Bed Days	days	SN3	Derived in TED ODS	146	No transformation.
Accrual Fund Eligibility Indicator	accrual_fund_ind	$1	Derived in TED ODS	148	No transformation.
From LVM Merge					
DEERS Enrollment DMISID	denrsite	$4	N/A		Fill with enrollment DMISID, if the begin date of care on the claim is between the begin and end date associated with the enrollment site.
DEERS Alternate Care Value	acv	$1	N/A		Fill with ACV, if the begin date of care on the claim is between the begin and end date associated with the ACV. No longer required as of January 2018.
DEERS Health Care Delivery Program Code	dhcdp	$3	N/A		Fill with DEERS health care delivery program coverage code if the begin date of care on the claim is between the begin and end date associated with the DEERS health care delivery program coverage code.
DEERS Beneficiary Category	bencat	$3	N/A		Fill with DEERS beneficiary category if the begin date of care on the claim is between the begin and end date associated with the DEERS beneficiary category. Change blank and Z to UNK.
DEERS Sponsor Service Aggregate	dsponsvc	$1	N/A		Fill with DEERS sponsor service (aggregate), if the begin date of care on the claim is between the begin and end date associated with the DEERS sponsor service (aggregate). Change blank to Z.
DEERS Zip Code	deerszip	$5	N/A		Fill with DEERS zip code, if the begin date of care on the claim is between the begin and end date associated with the DEERS zip code.
DEERS Medical Privilege Code	privcode	$1	N/A		Fill with DEERS privilege code from, if the begin date of care on the claim is between the begin and end date associated with the DEERS privilege code.
DEERS Race Code	race	$1	N/A		Fill with DEERS Race Code. Change blank to Z.
DEERS Ethnicity Code	ethnic	$1	N/A		Fill with DEERS Ethnicity Code. Change blank to Z.
DEERS Dependent Suffix	DDS	$2	N/A		Fill with DDS if a match is found, else if no match is found fill DDS from record, else DDS is blank. No longer required for FY2009+.

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
TRICARE Prime Remote Eligibility Flag	tprelig	$1	N/A		Fill with TPR Eligibility code, if the begin date of care on the claim is between the begin and end date associated with the TPR eligibility code.
Primary Care Manager ID	pcmidlvm	$18	N/A		Fill with PCM ID if the begin date of care on the record is between the begin and end dates associated with the PCM ID.
TRICARE Young Adult Flag	tyaflag	$1	N/A		Fill with TYA Flag if the begin date of care on the record is between the begin and end dates associated with the TYA Flag. If no match is found or a match is found but the date window criteria do not apply then set to "0".
DEERS Eligibility Group	elg_grp	$1	N/A		Fill with eligibility group if the begin date of care on the record is between the begin and end dates associated with the TYA Flag. If no match is found or a match is found but the date window criteria do not apply then set to "Z".
DEERS Enrollment Group	eng_grp	$1	N/A		Fill with enrollment group if the begin date of care on the record is between the begin and end dates associated with the TYA Flag. If no match is found or a match is found but the date window criteria do not apply then set to "Z".
Assigned HCDP	hcdp_assgn	$3	N/A		Fill with assigned HCDP if the begin date of care on the record is between the begin and end dates associated with the TYA Flag. If no match is found or a match is found but the date window criteria set to blank.
DEERS PCM Type Code	pcm_type	$1	N/A	N/A	Fill with PCM Type if the begin date of care on the record is between the begin and end dates associated with the TYA Flag. If no match is found or a match is found but the date window criteria do not apply then set to "Z".
From MPI Merge (see MPI Specification)					
Person Association Reason Code	parc	$2	N/A		See MPI specification. Change blank to ZZ.
EDI_PN	edi_pn	$10	1-095		See MPI Specification.
From DRG Weight Table					
Relative Weighted Product	rwp	8.4	N/A		See Appendix A.
From MS DRG Weight Table					

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
MS RWP	msrwp	8.4	N/A		Use the same logic as RWP, except apply the MS RWP DRG Weight table, and use 'msdrg', instead of the AC_DRG. Only populated for FY07+. See appendix A for more details.
~~MS Professional RWP~~	~~msprofrwp~~	~~8.4~~	~~N/A~~	~~-~~	~~Set to 0.~~
~~MS Full RWP~~	~~msfullrwp~~	~~8.4~~	~~N/A~~	~~-~~	~~Set to 0.~~
From MDR DMISID Index					
Residence Catchment Area Service Branch	catchsvc	$1	N/A		UBU_SVC, based on matching FY and catch.
Enrollment Region	enrreg	$2	N/A		MOD_REG, based on matching FY and denrsite. No longer required as of January 2025.
Enrollment HSSC Region	enrhssc	$1	N/A		HSSCREG, based on matching FY and denrsite. No longer required as of January 2025.
Enrollment T3 Region	enr_t3_reg	$2	N/A		T3_Reg, based on matching FY and denrsite. No longer required as of January 2025.
Enrollment T17 Region	enr_t17_reg	$2	N/A		T17_Reg, based on matching FY and denrsite.
Enrollment T5 Region	enr_t5_reg	$2	N/A		T5_Reg, based on matching FY and denrsite.
Enrollment Site of Record T3 Region	enr_of_rec_t3_reg	$2	N/A		T3_Reg, based on matching FY and enrsite. No longer required as of January 2025.
Enrollment Site of Record T17 Region	enr_of_rec_t17_reg	$2	N/A		T17_Reg, based on matching FY and enrsite.
Enrollment Site of Record T5 Region	enr_of_rec_t5_reg	$2	N/A		T5_Reg, based on matching FY and enrsite.
Enrollment Site Service	enrsvc	$1	N/A		UBU_SVC, based on matching FY and denrsite.
PPS Enrollment Parent DMIS ID	ppsprnt	$4	N/A		PPS_PAR, based on matching FY and denrsite.
Referring MTF T3 Region	ref_mtf_t3_reg	$2	N/A		T3_REG, based on matching FY and referring MTF. No longer required as of January 2025.
Referring MTF T17 Region	ref_mtf_t17_reg	$2	N/A		T17_REG, based on matching FY and referring MTF.
Referring MTF T5 Region	ref_t5_reg	$2	N/A		T3_REG, based on matching FY and referring MTF.
From OMNI CAD (based on patzip)					
Residence Catchment Area	catch	$4	N/A		If sponsvc=A then set to ACATCH, if sponsvc = F then set to FCATCH; if sponsvc in (M, N) then set to NCATCH, otherwise set to OCATCH. If zip code not found in MDR Omni-CAD, set equal to '0999'.

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
Residence PRISM Area	prism	$4	N/A		If sponsvc=A then set to APRISM, if sponsvc = F then set to FPRISM; if sponsvc in (M, N) then set to NPRISM, otherwise set to OPRISM. If zip code not found in MDR Omni-CAD, set equal to '0999'
Residence TPR Flag	tprflag	$1	N/A		TPRFLAG.
Residence Region	resreg	$2	N/A		MOD_REG. No longer required as of January 2025.
Residence TNEX Region	restnex	$1	N/A		HSSCREG. No longer required as of January 2025.
Residence T3 Region	ben_t3_reg	$2	N/A		T3_Reg, based on matching FY/FM and beneficiary zip code, where service = O on the OMNI CAD. No longer required as of January 2025.
Residence T17 Region	ben_t17_reg	$2	N/A		T17_Reg, based on matching FY/FM and beneficiary zip code, where service = O on the OMNI CAD.
Residence T5 Region	ben_t5_reg	$2	N/A		T5_Reg, based on matching FY/FM and beneficiary zip code, where service = O on the OMNI CAD.
Residence Market Area ID	resmkt	$3	N/A		LAMARKET (when added to Omni-CAD format file).
Residence MTF Service Area	resmtfsvc	$4	N/A		If sponsvc=A then set to AMTFSVC_AREA, if sponsvc = F then set to FMTFSVC_AREA; if sponsvc in (M, N) then set to NMTFSVC_AREA, otherwise set to OMTFSVC_AREA. If zip code not found in MDR Omni-CAD, set equal to '0999' (when added to Omni-CAD format file). FY06+.
Residence Prime Service Area	respsa	$1	N/A		PSAFLAG.
From OMNI CAD (based on provider zip)					
Provider Catchment Area	pvcatch	$4	N/A		Set = OCATCH. If pvzip not found in MDR Omni-CAD, set equal to '0999'.
Provider PRISM Area	pvprism	$4	N/A		Set = OPRISM. If pvzip not found in MDR Omni-CAD, set equal to '0999'.
~~Provider Region~~	~~provrgn~~	~~$2~~	~~N/A~~	-	~~Defer until update of CAD format file to include market area ID and MTF Service Area. Must be done prior to, or along with development of Institutional Summary File. No longer required as of January 2025.~~
Provider Market Area	provmkt	$1	N/A		LAMARKET.

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
Provider Prime Service Area	provpsa	$1	N/A		PSAFLAG.
Provider Tnex Region	provtnex	$1	N/A		HSSCREG. No longer required as of January 2025.
Provider T3 Region	prov_t3_reg	$2	N/A		T3_REG, based on matching FY, FM and Provider Zip, where service = "O". No longer required as of January 2025.
Provider T17 Region	prov_t17_reg	$2	N/A		T17_REG, based on matching FY, FM and Provider Zip, where service = "O".
Provider T5 Region	prov_t5_reg	$2	N/A		T5_REG, based on matching FY, FM and Provider Zip, where service = "O".
Provider TPR Flag	pvtpr	$1	N/A		TPRFLAG.
From Reservist File Merge					
Reservist Status	res_stat	$1	N/A		Fill with reservist status, if the admission date is between the begin and end dates of the reservist status code.
Special Operations Code	soc	$2	N/A		Fill with special operations code, if the admission date is between the begin and end dates of the reservist status code.
From TED Episode Reference Table merge					
Admitting TED Number	admtedno	$24	N/A		Gather TED records with the same admission date, the same provider ID and the same person identifier (EDI_PN if available, otherwise Sponsor SSN and DDS). If the admission date is the same as the begin date of care, fill the admtedno with the TED Number for that claim. If the admission date is not equal to the begin date of care: fill all claims with matched provider ID, person ID and admission date, with the value of the TED number on the claim that did have matching admission and begin dates.
From 3M Core Grouper					
Derived DRG	drg	$3	N/A		See appendix J Set to MS-DRG for FY09 and later. Else set to DRG.
Derived MDC	mdc	$2	N/A		See Appendix J Set to MS-MDR for FY09 and later. Else set to MDC.
Acute Care DRG	ac_drg	$3	N/A		If acute care indicator is 1 then fill with derived DRG, otherwise fill with '000'. No longer required as of January 2025.
MS DRG (Acute Care)	msdrg	$3	N/A		Only populated FY07 forward. If acute care indicator is not 1, then set to '000' else set to DRG.

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
MS DRG (All Care)	msdrg_all	$3	N/A		MS-DRG (text format) from 3M Core Grouping Software. Only populated FY07 forward. See appendix O for specifics.
From AHRQ Preventable Admission Software					
AHRQ Prevention Indicator Flag	ahrqpvadm	$1	N/A		If astdiab = 1 then ahrqpvadm = A. If apappd = 1 then ahrqpvadm = B. If altdiab = 1 then ahrqpvadm = C. If acopd = 1 then ahrqpvadm = D. If ahyptn = 1 then ahrqpvadm = E. If achf = 1 then ahrqpvadm = F. If albw = 1 then ahrqpvadm = G. If adhyd = 1 then ahrqpvadm = H. If abacpn = 1 then ahrqpvadm = I. If auti = 1 then ahrqpvadm = J. If aawp = 1 then ahrqpvadm = K. If auncdiab = 1 then ahrqpvadm = L. If aasth = 1 then ahrqpvadm = M. If aampdiab = 1 then ahrqpvadm = N. If pasth = 1 then ahrqpvadm = P. If pstdiab = 1 then ahrqpvadm = Q. If pgastro = 1 then ahrqpvadm = R. If pappd = 1 then ahrqpvadm = S. If puti = 1 then ahrqpvadm = T. Else ahrqpvadm = O.
Short Term Diabetes Complications	astdiab	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, substring diagnosis codes (all of them) to 5 characters. If MDC = 14 then astdiab = 0. If age <18 then astdiab = 0. If transferred from another institution then astdiab = 0. If primary diagnosis is not in the format $ACDIASD then astdiab = 0. Else if primary diagnosis is in $ACDIASD then astdiab = 1.
Perforated Appendix	apappd	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, Substring diagnosis codes (all of them) to 5 characters. If MDC = 14 then apappd = 0. If age < 18 then apappd = 0. If transferred from another institution than apappd = 0. If any diagnosis is in format $ACSAP2D and not in format $ACSAPPD then apappd = 2. Else if any diagnosis is in $ACSAPPD then apappd = 1.

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
Diabetes Long Term Complications	altdiab	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, Substring diagnosis codes (all of them) to 5 characters. If MDC = 14 then altdiab = 0. If age < 18 then altdiab = 0. If transferred from another institution then altdiab = 0. If primary diagnosis is not in format $ACDIALD then altdiab = 0. Else if primary diagnosis is in format $ACDIALD then altdiab = 1.
Chronic Obstructive Pulmonary Disorder	acopd	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, substring diagnosis codes (all of them) to 5 characters. If MDC = 14 then acopd = 0. If age < 40 then acopd = 0. If transferred from another institution then acopd = 0. If primary diagnosis is in format $ACCOPDD or primary diagnosis is in $ACCPD2D and any secondary diagnosis is in $ACCOPDD then acopd = 1. Else acopd = 0.
Hypertension Admission	ahyptn	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, substring diagnosis codes (all of them) to 5 characters. If MDC = 14 then ahyptn = 0. If age <18 then ahyptn = 0. If any procedure code is in format $ACSCARP then ahyptn = 0. If any procedure code is in format $ACSHYPP then ahyptn = 0. If any diagnosis is in format $ACSHY2D then ahyptn = 0. If transferred from another institution then ahyptn = 0. If primary diagnosis is not in format $ACSHYPD then ahyptn = 0. Else if primary diagnosis is in format $ACSHYPD then ahyptn = 1.
Congestive Heart Failure Admission	achf	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, substring diagnosis codes (all of them) to 5 characters. If MDC = 14 then achf = 0. If age < 18 then achf = 0. If transferred from another institution then achf = 0. If any procedure code is in format $ACSCARP then achf = 0. If primary diagnosis is not in format $ACSCHFD then achf = 0. Else if primary diagnosis is in format $ACSCHFD then achf = 1. If discharge date ≥ 10/1/2015 and ICD-10 Diagnosis Codes are used, use format $ACSCH2D in place of $ACSCHFD.
Low Birth Weight	albw	$1	N/A		If DOB is missing set to 3. If there is no diagnosis code in the format $LIVEBND then set to 0 else: If any diagnosis is in the format $ACSLBWD then 1 or (if age = 0 and admission type = 4 and admission source = L then 2. (no code change)

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
Dehydration	adhyd	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, substring diagnosis codes (all of them) to 5 characters. If MDC = 14 then adhyd = 0. If age < 18 then adhyd = 0. If transferred from another institution then adhyd = 0. If any diagnosis is in format $CRENLFD then adhyd = 0. If primary diagnosis is in format $ACSDEHD or primary diagnosis is in $HYPERID, $ACPGASD, or $PHYSIDB and any secondary diagnosis is in $ACSDEHD then adhyd = 1.
Bacterial Pneumonia	abacpn	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, substring diagnosis codes (all of them) to 5 characters. If MDC = 14 then abacpn = 0. If age < 18 then abacpn = 0. If transferred from another institution then abacpn = 0. If any diagnosis is in format $ACSBA2D then abacpn = 0. If any diagnosis is in format $IMMUNID then abacpn = 0. If any procedure is in format $IMMUNIP then abacpn = 0. If primary diagnosis is not in format $ACSBACD then abacpn = 0. Else if primary diagnosis is in $ACSBACD then abacpn = 1.
Urinary Tract Infection	auti	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, substring diagnosis codes (all of them) to 5 characters. If MDC = 14 then auti = 0. If age < 18 then auti = 0. If transferred from another institution then auti = 0. If any diagnosis is in format $IMMUNID then auti = 0. If any diagnosis is in format $KIDNEY then auti = 0. If any procedure is in format $IMMUNIP then auti = 0. Else if primary diagnosis is in format $ACSUTID then auti = 1.
Angina without Procedure	aawp	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, substring diagnosis codes (all of them) to 5 characters. If MCD = 14 then aawp = 0. If age < 18 then aawp = 0. If transferred from another institution then aawp = 0. If any procedure code is in format $ACSCARP then aawp = 0. If primary diagnosis is not in format $ACSANGD then aawp = 0. Else if primary diagnosis is in format $ACSANGD then aawp = 1.

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
Uncontrolled Diabetes	auncdiab	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, substring diagnosis codes (all of them) to 5 characters. If MDC = 14 then auncdiab = 0. If age < 18 then auncdiab = 0. If transferred from another institution then auncdiab = 0. If Primary diagnosis is not in format $ACDIAUD then auncdiab = 0. Else if primary diagnosis is in format $ACDIAUD then auncdiab = 1.
Adult Asthma	aasth	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, substring diagnosis codes (all of them) to 5. IF MDC =14 then aasth = 0. If age < 18 then aasth = 0. If any diagnosis is in format $RESPAN then aasth = 0. If transferred from another institution then aasth = 0. If primary diagnosis is not in format $ACSASTD then aasth = 0. Else if primary diagnosis is in format $ACSASTD then aasth = 1.
Lower-extremity Amputation among patients with Diabetes	aampdiab	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, substring diagnosis codes (all of them) to 5 characters. If MDC = 14 then aampdiab = 0. If age < 18 then aampdiab = 0. If any diagnosis codes are in format $ACLEA2D then aampdiab = 0. If any procedure is in format $TOEAMIP then aampdiab = 0. If transferred from another institution then aampdiab = 0. Else if any diagnosis codes are in format $ACSLEAD and any procedure codes are format $ACSLEAP then aampdiab = 1.
Adult Overall Composite	aovall	$1	N/A		IF astdiab = 1 OR altdiab = 1 OR acopd = 1 OR ahyptn = 1 OR achf = 1 OR adhyd = 1 OR abacpn = 1 OR auti = 1 OR aawp = 1 OR auncdiab = 1 OR aasth = 1 OR aampdiab = 1 THEN aovall = 1.
Adult Acute Composite	aacute	$1	N/A		IF adhyd = 1 OR abacpn = 1 OR auti = 1 THEN aacute = 1.
Adult Chronic Composite	achron	$1	N/A		IF astdiab = 1 OR altdiab = 1 OR acopd = 1 OR ahyptn = 1 OR achf = 1 OR aawp = 1 OR auncdiab = 1 OR aasth = 1 OR aampdiab = 1 THEN achron = 1.

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
Pediatric Asthma Admission	pasth	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, substring diagnosis codes to 5 characters. If MDC = 14 then pasth = 0. If age < 2 then pasth = 0. If age > 17 then pasth = 0. If any diagnosis is in format $RESPAN then pasth = 0. If transferred from another institution then pasth = 0. If primary diagnosis is not in format $ACSASTD then pasth = 0. Else if primary diagnosis is in format $ACSASTD then pasth = 1.
Pediatric Short term Diabetes	pstdiab	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, substring diagnosis codes (all of them) to 5 characters. If MDC = 14 then pstdiab = 0. If age < 6 then pstdiab = 0. If age > 17 then pstdiab = 0. If transferred from another institution then pstdiab = 0. If primary diagnosis is not in $ACDIASD then pstdiab = 0. Else if primary diagnosis is in $ACDIASD then pstdiab = 1.
Pediatric Gastroenteritis	pgastro	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, substring diagnosis codes (all of them) to 5 characters. If MDC = 14 then pgastro = 0. If age < 3 months pgastro = 0. If age > 17 then pgastro = 0. If any diagnosis codes are in format $ACGDISD then pgastro = 0. If any diagnosis code is in format $ACBACGD then pgastro = 0. If transferred from another institution then pgastro = 0. If primary diagnosis is in format $ACPGASD then pgastro = 1. If primary diagnosis is in $ACSDEHD and any secondary diagnosis is in $ACPGASD then pgastro =1. Else pgastro = 0.
Perforated Appendix (Pediatric)	pappd	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, substring diagnosis codes (all of them) to 5 characters. If MDC = 14 then pappd = 0. If age < 1 then pappd = 0. I age > 17 then pappd = 0. If transferred from another institution then pappd = 0. ~~If DRG is in format $ADULTDR then pappd = 0.~~ If any diagnosis is in format $ACSAP2D and no diagnosis is in format $ACSAPPD then pappd = 2. If any diagnosis is in $ACSAPPD then pappd = 1. Else pappd = 0.

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
Pediatric Urinary Tract Infection	puti	$1	N/A		If the discharge date is < 10/1/15, and ICD-9-CM diagnosis codes are used, substring diagnosis codes (all of them) to 5 characters. If MDC = 14 then puti = 0. if age < 3 months then puti = 0. If age > 17 then puti = 0. If any diagnosis is in format $IMMUNHD then puti = 0. If any diagnosis is in format $KIDNEY then puti = 0. IF any diagnosis is in format $IMMUITD then puti = 0. If any diagnosis is in format $HEPFA2D then puti = 0. If any diagnosis is in format $HEPFA3D then puti = 0. If any procedure is in format $TRANSPP then puti = 0. ~~If DRG is in format $ADULTDR then puti = 0.~~ Else if primary diagnosis is in format $ACSUTID then puti = 1.
Pediatric Overall Composite	povall	$1	N/A		IF pasth = 1 OR pstdiab = 1 OR pgastro = 1 OR puti = 1 THEN povall = 1; else povall = 0.
Pediatric Chronic Composite	pchron	$1	N/A		IF pasth = 1 OR pstdiab = 1 THEN pchron = 1. Else pchron = 0.
Pediatric Acute Composite	pacute	$1	N/A		IF pgastro = 1 OR puti = 1 THEN pacute = 1; else pacute =0.
Combined Overall Adult and Pediatric Composite	padcdovl	$1	N/A		IF aovall = 1 OR povall = 1 THEN padcdovl = 1; else padcdovl =0.
Combined Chronic Adult and Pediatric Composite	padcdchn	$1	N/A		If achron = 1 or pchron = 1 then padcdchn = 1; else padcdchn =0.
Combined Acute Adult and Pediatric Composite	padcdact	$1	N/A		aacute = 1 OR pacute = 1 THEN padcdact = 1; else padcdact =0.
From merge to TED Revenue File					
ICU Flag	icuflag	$1	N/A		If any associated line item from the Revenue File has a revenue code (revcode) of 0170-0174, 0233 or between 0200 and 0209 (inclusive) then set to 1, else set to 0.
OR Flag	orflag	$1	N/A		If any associated line item from the Revenue File has a revenue code (revcode) of 036* then set to 1, else set to 0.
From merge to PCM Lookup Table					
PCM NPI	pcm_npi	$10	N/A		PCM NPI.

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
PCM Name	pcm_name	$10	N/A		PCM Name.
From Summarized TED-N File					
Professional Services Tail	proftail	5.2	N/A		Summarize the TED-I by admitting TED number and tabulate the frequency of claims for each admtedno. (Should mostly be 1). Summarize the amount paid in non-institutional data by admitting TED number. Match to the TED-I by admitting TED number and set the non-institutional tail to the amount paid for the matched records in TEDN. If there is more than one record for a given admtedno, then append amount paid/number of claims with that admtedno.
From Enrollment MEPRS Code File					
Enrollment MEPRS Code	med_home_meprs	$4	N/A		FY11+ . Fill with MEPRS_CODE if the begin date of care is included in the begin and end date of enrollment. No longer required as of January 2025.
From MTF Network Referral File					
Referring MTF	ref_mtf	$4			. See Appendix K and Appendix M for matching and derivation logic.
CHCS Order Number Issuing Referral	ref_order_num	$13			See Appendix K and Appendix M for matching and derivation logic.
UIN	uin	$17			See Appendix K for matching and derivation logic.
MTF Network Referral Match Flag	mtfref_flag	$1			See Appendix M for derivation.
From MDR Referral File					
Referring Provider	ref_provid	$9	REFBYPRV_ID		See Appendix K and Appendix M for matching and derivation logic.
Referral Provider EDIPN	ref_edipn	$10	REFBYPRV_EDIPN		See Appendix K and Appendix M for matching and derivation logic.
Referring Provider NPI	ref_npi	$10	REFBYPRV_NPI		See Appendix K and Appendix M for matching and derivation logic.
Referral Date	refdate	SAS	REFDATE		REFDATE.
Referral Begin Date	ref_begdate	SAS	BEGDATE		See Appendix K and Appendix M for matching and derivation logic.
Referral End Date	ref_enddate	SAS	ENDDATE		See Appendix K and Appendix M for matching and derivation logic.
Referring MEPRS Code	ref_meprscd	$4	REFBYPRV_MEPRS		See Appendix K and Appendix M for matching and derivation logic.
ATC Category	ref_atc_cat	$1	ATC_CAT		See Appendix K and Appendix M for matching and derivation logic.

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
From DRG Surgical Reference File					
Med/Surg Flag	msflag	$1			Merge to med/surg ref file (CY<2- use universal med/surg criteria format file else use cy specific file based on end date of care. FY16+.
Internally Derived Fields					
Admission Count	adm	8	N/A		If the submission code, legacy equal ('C', 'D' or 'E') or authorized days <= 0 or type of institution is '70' then admission count is 0; else if (type if institution is 78 or 79 (Hospice) and no revenue codes are 0655 or 0656 then admission count is 0; else if bill frequency code is 1, 2 7 or (bill frequency code is 3 or 4 and submission code, legacy is not I, R or O) then admission count is 1, else admission count is 0.
Category of Care	catcare	$2	N/A		See Appendix.
MERHCF Flag	tflflag	$1	N/A		See Appendix.
Fiscal Year of Acceptance Date	fyaccpt	$4	N/A		Fiscal year of acceptance date.
Fiscal Month of Acceptance Date	fmaccpt	$2	N/A		Fiscal month of acceptance date.
Provider Choice	prvchc	$3	N/A		If any of the special processing codes (1-4) are "PO" then set = "POS" (prime point of service); otherwise, if enrollment status is "V" then set = "EXT" (extra); otherwise if enrollment status is "T" then set = "STD" (standard), otherwise leave blank.
Total Bed Days this Episode	totdays	8	N/A		End Date – Admission Date +1, for claims where disposition status is not 30; otherwise set to 0.
Acute Care Hospital Indicator	acute	$1	N/A		If institution type is in (10, 11, 12, 44, 45, 47, 49, 50, 51, 55, 57, 59, 90, 91, 93) then set = 1, otherwise set = 0.
IBNR Category	ibnrcat	$1	N/A		if enrstat in ('FE' 'FS') then set ibnrcat=1; otherwise ibnrcat=2.
Fiscal Month	fm	$2	N/A		Fiscal month equivalent of calendar month of end date of care.
Calendar Year	cy	$4	N/A		Characters 1-4 of the end date of care.
Calendar Month	cm	$2	N/A		Characters 5 and 6 of the end date of care.

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
TED Indicator	tedind	$1	N/A		If the last byte of the TED Number is either 0 (zero) or 5, then set the TED Indicator to 'T'; else if the contractor number is in (02,04,05,08,15,61,62,63,64,65,70,71,99) then set the TED Indicator to 'A'; else set the TED Indicator to 'H'. No longer required as of January 2025.
Program Indicator Code	pic	$1	N/A		If any of the special processing codes have the value "PF", then set program indicator code equal to H, otherwise set to I.
Coverage Category	cvgcat	$1	N/A		If any of the special processing codes (up to 4) have the value ("FF", "FS", "FG", "R", "T") or enrollment status is 'PS' then set to "T" (TDEFIC/TFL), else if enrollment status is V then set to "E" (Extra), else if enrollment status is T then set to "S" (Standard), else if enrollment status is "W" or starts with an "S" then set to "A" (Supp Care) else if any of the special processing codes are "PO" then set to "X" (POS), else if enrollment status in ('U', "Z", "WF" "X" "XF") then set to "P" (Prime), else set to "O" (Other).
Number of Births	births	8	N/A		For FY15 and earlier: If the 1st 4 characters of any of the principle or secondary dx codes is V270 or V271, set number of births to 1, else if the 1st 4 characters of any of the dx codes is V272, V273, or V274, then set number of births to 2, else if the 1st 4 characters of any of the dx codes is V275, V276, V277 or V279 then set number of births to 3, else set number of births to 0. For FY16 and later: If the 1st 4 characters of any of the dx codes are Z370 or Z371 then set to 1, else if the 1st 4 chars of any of the dx codes is between Z372-Z374 or Z3750 or Z3759 or Z3760 or Z3769 or the 1st 4 chars are Z377 then set to 2, else if any of the 1st 5 chars of the dx codes is Z3751 or Z3761 then set to 3 else if any of the 1st 5 chars of the dx codes is Z3752 or Z3762 then set to 4, else if the 1st 5 chars of any of the dx codes is Z3753 or Z3763 then set to 5 else if the 1st 5 chars of any of the dx codes is Z3754 or Z3764 then set to 6.

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
Monthly Transaction Amount	mnamt	8	N/A		If the claim is an initial claim, set to amount paid. If claim is an adjustment record, set to difference between the amount paid on the adjustment record and the amount paid on the record in the database.
Age Group Code	agegrp	$1	N/A		If 0 <= patage <= 4 then set to “A”, else if patage<=14 then set to “B”, else if patage<=17 then set to “C”, else if patage<=24 then set to “D”, else if patage<=34 then set to “E”, else if patage<=44 then set to “F”, else if patage<=64 then set to “G”, else if patage not blank or negative set to “H”, else set to “Z”.
Provisional Acceptance Indicator	provaccp	$1	N/A		If positions 690-696 (these are the provisional acceptance indicators) are blank in the TED data feed, then set to 0, otherwise set to 1.
Amount Patient Pay	patpay	8	N/A		Amount patient pay=total amount allowed-total amount paid.
Hybrid Enrollment Site	hybenr	$4	N/A		If TED Indicator is T then no transformation. Otherwise, if comben=’4’ and HCDP not in (401, 402, 405-412) or if enrollment HSSC region (ENRHSSC) is “O” or blank, then set to DEERS Enrollment Site (denrsite); else set to enrollment site (enrsite).
Space A (reliant) Flag	spacea	$1	N/A		For FY04+: If DEERS ACV in A, E, H, J, M, Q then space A flag is N. Else space A flag is Y. Prior to FY04, if enrollment status is U, Z, W or WF, or bencat is 4 then space A flag is N, else Y.
Underwritten Flag	undflag	$1	N/A		If TED indicator is ‘T’ then apply transformation (See Appendix), otherwise set to blank. No longer required as of January 2025.
Admission Fiscal Year	admfy	$4			If month in 10, 11, 12 then set to the first 4 characters of the admission date + 1; else set to first 4 characters of the admission date. If the resulting number is less than 2001, set to 2001.
ACV Group	acvgroup	$15	N/A		If ACV in (A, E, H or J) then set to “Prime”, else if ACV in (B, F) then set to “Overseas Remote”, else if ACV in (G, L) then set to “Plus”, else if ACV is U then set to “Desig Prov”, else if ACV in (R, V) then set to “Other”, else if ACV in (M, Q) then set to “Reliant”, else if Bencat Common = 4 then set to “Reliant”, else set to “Other”.

MDR TED Field	SAS Name	Format	Source Element	Field Number	Business Rule
Age Group Common	expage	$1	N/A		If 0 <= patage <= 4 then set to “A”, else if patage<=14 then set to “B”, else if patage<=17 then set to “C”, else if patage<=24 then set to “D”, else if patage<=34 then set to “E”, else if patage<=44 then set to “F”, else if patage<=64 then set to “G”, else if patage<=69 then set to “H” else if patage<=74 then set to “I” else if patage<=79 then set to “J” else if patage<=84 then set to “K” else if patage not blank or negative set to “L” else to “Z”.
Enrollment Status	enrstat	$2	1-110	35	If Enrollment DMISID begins with 69 and enrollment status is not “U”, then set to “U”. Otherwise, fill with enrollment status from the data feed.
TED Sponsor Pay Grade	paygrd	$2	1-056	17	If paygrd="OO" set to "00" else no transformation.
Beneficiary Category Common of Record	comben	$1	Derived in TED ODS	119	If HCDP in (401, 402, 405-412): if patient is a sponsor (memrln=’A’) then set to 2, else set to 3. else set to comben from the feed
Beneficiary Category Common	dcomben	$1			If DEERS beneficiary category is ACT or GRD then set to 4, else if DEERS beneficiary category is DA or DGR then set to 1, else if DEERS beneficiary category is RET then set to 2, else set to 3.
Admitted from ER Flag	adm_from_er	$1			If admtype is 1 then set to 1, else 0.
~~Acute Care DRG~~	~~ac_drg~~	~~$3~~			~~If acute care indicator is 1, then fill with the derived DRG. Otherwise fill with ‘000’. No longer required as of January 2025.~~
~~MS DRG (Acute Care)~~	~~msdrg~~	~~$3~~			~~Only populated FY07 forward. If acute care indicator is not 1, then set to ‘000’ else set to DRG.~~
~~MS-DRG (Applied to all records, even when DRG not applicable)~~	~~msmdc~~	~~$2~~			~~MS-DRG (text format) from 3M Core Grouping Software. Only populated FY07 forward. See appendix O for specifics.~~

The table below contains the file layout for the MDR Institutional TED Revenue Code dataset. Each record represents a line item from a non-institutional HCSR or TED, where the end date of care on the claim is within the fiscal year of the file.

Table 3: Master MDR Institutional Revenue TED SAS Dataset

MDR TED Field	SAS Name	Format	Source Element - TED	Source Position - TED	Business Rule
TED Number	tedno	$24	1-015	1-7	Concatenate.
		$24	1-016	8-10	Concatenate.
		$24	1-020	11-17	Concatenate.
		$24	1-025	18-23	Concatenate.
		$24	1-030	24	Concatenate.
Cycle Number	cycle	$8	Derived in TED ODS	25-32	No transformation.
End Date of Care	enddate	YYMMDD	1-285	33-40	Convert to SAS Date.
Revenue Line Item Number	linum	$3	1-385	41-43	No transformation.
Revenue Code	revcode	$4	1-365	44-47	No transformation.
Units of Service	svcs	SN10	1-370	48-57	No transformation.
Amount Billed	revbill	SN9.2	1-395	58-66	No transformation.
Adjustment/Denial Reason Code	adjcode	$5	1-400	67-71	No transformation.
Provisional Acceptance Line Item Indicator	provact	$7	Derived in TED ODS	76-82	No transformation.
~~Fields from the PCM Identity table~~					
~~PCM NPI~~	~~pcm_npi~~	~~$10~~			~~PCM NPI.~~
~~PCM Name~~	~~pcm_name~~	~~$40~~			~~PCM Name.~~
Internally Derived Fields					
Adjustment Reason Derived Code	dadjcd	$2	N/A	N/A	Apply adjustment reason format[1] file to the adjustment/denial reason code (1-400). If the type of reason code for the revenue line item is “B”, then set adjustment reason derived code according to the format. Otherwise, if the type of reason is C, then if the type of submission is “O’, then set according to the format, otherwise set to blank.

MDR TED Field	SAS Name	Format	Source Element - TED	Source Position - TED	Business Rule
Denial Reason Derived Code	denial	$2	N/A	N/A	Apply denial reason format[8] file to the adjustment/denial reason code (1-400). If the type of reason code for the revenue line item is “D”, then set denial reason derived code to the format, else if the type of reason code for the revenue line item is “C” and type of submission code is not “O” then set according to the format.

VIII. DATA MARTS

Data feeds are prepared in MDR processing and provided to the M2 on a weekly basis, as described in M2 TRICARE Encounter Data Specification.

IX. SPECIAL OUTPUTS

There are three types of special outputs prepared during processing of the institutional TED file: A death file and the TED Institutional episode reference file.

- Death File: The death file contains records for beneficiaries where the TED disposition status code indicates that the patient died. See "MDR Encounter Death File Specification" for business rules and a file layout.
- TED Institutional Episode Reference File: This file is used in processing the MDR TED Institutional and Non Institutional Files. Specifically, the admission date and greatest end date of care are retained for each person for each acute hospital stay. Each record in this file represents a person who has an admission in the TED-Institutional Data, with a variable length set of information about each of this person's admissions. This file is merged to TED Institutional and Non-Institutional records, to assign the admitting TED number to each TED Institutional and Non-Institutional record for care that is likely associated with the acute care hospital stay.

Episode files are updated weekly after the master TED-I files have been updated and processed through the usual processing steps. The episode program reads in weekly updated TED-I files from current FY and going back to (FY??). Priority is given to create episode files using TED-I master files FY04 and forward first before creating episode files using FY03 and prior. Episode files are parsed into fiscal year files where any episode with admit date and end date falling within the FY is output to their respective FY episode file. Each fiscal year episode file will then be used to update the Admitting TED number field on the corresponding FY TED-I master file. The layout of this reference table is provided in Table 4

Table 4: Layout of Episode Reference File

Data Element	Name	Format	Business Rule
DEERS EDI_PN	edi_pn	$char10	No transformation.
Occurrence Count	occ	2	Number of occurrences of episodes in episode format file.
Repeating Episode Segments			
Admission Date$_1$ - Admission Date$_n$	admdate$_n$	YYYYMMDD	Admission date of episode. One field per admission in TED Institutional File (all years after FY02).
End Date$_1$ - End Date$_n$	enddate$_n$	YYYYMMDD	One field per admission in TED Institutional File (all years after FY02). ENDDATE contains the greatest end date of all claims with matching person identifier (EDI_PN), admission date, and provider ID.
Admitting TED Number$_1$ – Admitting TED Number$_n$	admtedno$_n$	$24	Admitting TEDNO of episode. One field per admission in TED Institutional File (all years after FY02).
Disposition Flag$_1$ – Disposition Flag$_n$	disp$_n$	$1	Disposition flag of episode. If patient is still in the institution set disposition flag='N' else set flag to 'Y'. One field per admission in TED Institutional File (all years after FY02).

APPENDIX A: Relative Weighted Products

Relative weighted products (RWPs) are intended to reflect the relative resource intensity of acute care confinements. Two different types of RWPs are calculated in the MDR TED processor. Since the rules for the preparation of each of these data elements is essentially the same, the process is only described once, using the generic "DRG". The only places where the rules are different are when DRG Numbers are referenced. This document describes the process of deriving RWPs in institutional TED data.

Selection Rules: Relative weighted products are only applied to records where the institution indicates that the care was provided in an acute care hospital. The institution type values which represent acute care facilities are defined in Table A-1:

Table A-1: Acute Care Institution Types

Code	Institution Type
10	General medical and surgical
11	Hospital unit of an institution (prison hospital, college infirmary etc.)
12	Hospital unit within an institution for the mentally retarded
44	Obstetrics and gynecology
45	Eye, ear, nose and throat
47	Orthopedic
49	Other specialty
50	Children's general
51	Children's hospital unit of an institution
55	Children's eye, ear, nose, and throat
57	Children's orthopedic
59	Children's other specialty
90	Cancer
91	Sole community

Methodology:

RWPs for both the interim claim length of stay and the previous length of stay for the episode are calculated. Previous length of stays are not calculated where the bill frequency code indicates the record to be an initial claim, admitted through a discharge or transfer HCSR. The bill frequency values which represent this are defined in Table A-2:

Table A-2: Bill Frequency Acute Care Institution Types

Code	Bill Frequency
1	Admit through discharge HCSR
2	Interim - initial HCSR

RWPs should be calculated according to the following algorithm:

1. Merge TED to the TRICARE DRG tables according to the following:

Table A-3: DRG Table Merge Rules

Date Matching (End Date)	TRICARE DRG Weight Table Year	MS-DRG Weight Table Year
CY2020	CY2020	CY2020
FY 2009-Dec 2019	FY 2008	Matching FY. Continue to use FY2019 through Dec 2019
FY 2008	FY 2008	FY 2009
FY 2007	FY 2007	FY 2009
<=FY 2006	Matching FY	N/A

2. Using the long and short stay outlier thresholds from the DRG weight table, calculate a variable for both the interim claim and previous claim to indicate whether the patient was an:
    a. Inlier: Short stay threshold < length of stay < long stay thresholds
    b. Short Stay Outlier: length of stay <= short stay threshold
    c. Long Stay Outlier: length of stay >= long stay threshold

Where the length of stay for the interim claim is max("enddate - admdate",1) and for the previous claim is "begdate - admdate".

3. Calculate the interim claim and previous claim RWP for the appropriate threshold.
    a. For Inlier RWP calculations, there are three separate cases based on the following criteria:
        i. Case 1: When the record is considered a "transfer out" but not a "transfer in" and the DRG on the record was not a newborn DRG.
        Calculation: minimum (base weight, ((2*per diem)+(per diem)(length of stay - 1))
        ii. Case 2: When the record is considered a "transfer out" but not a "transfer in" but contained a newborn DRG.
        Calculation: minimum (base weight, (2*per diem)+(1.25*per diem*(length of stay - 1))
        iii. Case 3: When the record is neither Case1 nor Case 2 the calculation is simply the base weight.

    b. For Short Stay Outlier RWP calculations there are four separate cases based on the following criteria:
        i. Case 1:
            a. Case 1a: For DRG RWP: When the record contained a DRG of ('600' '601' '603' '605' or '608') the calculation is simply the base weight.
            b. Case 1b: For MS-DRG RWP: When the record contained a MS-DRG of ('610' '611' '613' '632' '635')
        ii. Case 2: When the record is considered a "transfer out" but not a "transfer in" and the DRG on the record was not a newborn DRG.
        Calculation: minimum (base weight, (((2*per diem)+(per diem)(length of stay-1))
        iii. Case 3: When the record is considered a "transfer out" but not a "transfer in" and the DRG on the record was a newborn DRG.
        Calculation: minimum (base weight, ((2*per diem)+(1.25*per diem*(length of stay-1))
        iv. Case 4: When the record did not meet the criteria for Case 1, 2 or 3.
        Calculation: minimum (base weight, 2*per diem*length of stay)

    c. Long Stay Outlier
        Calculation: (base weight + per diem*.33*(length of stay - long stay threshold))

In the calculations above the per diem is the base weight divided by the GLOS. Transfer indicators are defined based on "admission source" and "disposition status". The admission source values which represent "transfers in" are defined in Table A-4:

Table A-4: Transfers In

Code	Admission Source
4	Transfer from a Hospital
5	Transfer from a skilled nursing facility
6	Transfer from another health care facility
A	Transfer from a critical access hospital

The disposition status values which represent "transfers out" are defined in Table A-5:

Table A-5: Transfers Out

Code	Disposition Status
02	Transferred
05	Discharged/Transferred to another type of institution (including distinct parts).
43	Transfer to a federal facility

Newborn TRICARE DRGs are defined in Table A-6:

Table A-6: Newborn DRGs

Code	DRG
602	NEONATE, BWT <750G DISCH ALIVE
604	NEONATE, BWT 750-999G, D/C ALIVE
606	NEONATE, BWT 100-1499G W/OR
607	NEONATE, BWT 100-1499G, W/O OR
609	N 1500-1999G W/OR W/> 1 PROB
610	N 1500-1999G W/OR W/O > 1 PROB
611	N 1500-1999G W/O OR W/> 1 PROB
612	N 1500-1999G W/O OR, W/PROB
613	N 1500-1999G W/O OR W/MIN PROB
614	N 1500-1999G W/O OR W/OTH PROB
615	N 2000-2499G W/OR W/> 1 PROB
616	N 2000-2499G W/ OR W/O > 1 PROB
617	N 2000-2499G W/O OR W/> 1 PROB
618	N 2000-2499G W/O OR W/PROB
619	N 2000-2499G W/O OR W/MIN PROB
621	NEO 2000-2499G W/O OR W/OTH PROB
622	NEO > 2499G W/OR W/> 1 PROB
623	NEO > 2499G W/O OR W/> 1 PROB
624	NEO > 2499G W/MIN ABDOMINAL PROC
626	NEO > 2499G W/O OR W/> 1 PROB
627	NEO > 2499G W/O OR W/MAJ PROB
628	NEO > 2499G W/O OR W/MIN PROB
630	NEO > 2499G W/O OR W/OTH PROB
635	NEONATAL, AFTERCARE FOR WEIGHT GAIN
636	NEONATAL DIAGN0SIS, AGE > 28 DAYS

Newborn TRICARE MS-DRGs are defined in Table A-7:

Table A-7: Newborn DRGs

MS-DRG	Description
631	Neonate, birthwt 750-999g, discharged alive
632	Neonate, birthwt 750-999g, died
633	Neonate, birthwt 1000-1499g, w signif O.R. proc, discharged alive
634	Neonate, birthwt 1000-1499g, w/o signif O.R. proc, discharged alive
635	Neonate, birthwt 1000-1499g, died
636	Neonate, birthwt 1500-1999g, w signif O.R. proc, w mult major prob
646	Neonate, birthwt 1500-1999g, w signif O.R. proc, w/o mult major prob
647	Neonate, birthwt 1500-1999g, w/o signif O.R. proc, w mult major prob
648	Neonate, birthwt 1500-1999g, w/o signif O.R. proc, w major prob
649	Neonate, birthwt 1500-1999g, w/o signif O.R. proc, w minor prob
650	Neonate, birthwt 1500-1999g, w/o signif O.R. proc, w other prob
651	Neonate, birthwt 2000-2499g, w signif O.R. proc, w mult major prob
676	Neonate, birthwt 2000-2499g, w signif O.R. proc, w/o mult major prob
677	Neonate, birthwt 2000-2499g, w/o signif O.R. proc, w mult major prob
678	Neonate, birthwt 2000-2499g, w/o signif O.R. proc, w major prob
679	Neonate, birthwt 2000-2499g, w/o signif O.R. proc, w minor prob
680	Neonate, birthwt 2000-2499g, w/o signif O.R. proc, w other prob
681	Neonate, birthwt >2499g, w signif O.R. proc, w mult major prob
787	Neonate, birthwt >2499g, w signif O.R. proc, w/o mult major prob
788	Neonate, birthwt >2499g, w minor abdom procedure
789	Neonate, birthwt >2499g, w/o signif O.R. proc, w mult major prob

MS-DRG	Description
790	Neonate, birthwt >2499g, w/o signif O.R. proc, w major prob
791	Neonate, birthwt >2499g, w/o signif O.R. proc, w minor prob
792	Neonate, birthwt >2499g, w/o signif O.R. proc, w other prob
793	Neonatal aftercare for weight gain
794	Neonatal diagnosis, age > 28 days
795	Normal newborn
796	Multiple, other and unspecified congenital anomalies, w CC/MCC
797	Multiple, other and unspecified congenital anomalies, w/o CC/MCC

4. The final step in calculating the RWP is to subtract the previous length of stay RWP from the interim claim length of stay RWP and to reset cases with ungroupable DRGs or DRG 000 to 0. (Ungroupable TRICARE DRGs are 469, 470; ungroupable MS-DRGs are 998 and 999)

Examples: The following example illustrates the RWP calculation method. Assuming the record had appropriate Institution Type Code and the record was an interim claim (Bill Frequency Code indicating an interim claim for this example), that the record was considered a "transfer out" but not a "transfer in", and given the following information:

DRG 302 (Kidney Transplant)
Admission date – 01/10/04
Begin date – 01/11/04
End date – 01/20/04

From Weight Table for DRG 302:
Weight 3.9582
ALOS 3.9582
GLOS 8.5
Short Stay Threshold 1
Long Stay Threshold 31

The Interim Claim Length of Stay would be considered an "inlier" and the Previous Claim Length of Stay would be considered a "short stay length of stay".
Interim Claim Length of Stay = max(End date – Admission date,1) = max(01/20/04 - 01/10/04,1) = max(10,1)=10
Previous Claim Length of Stay= Begin date – Admission date = 01/11/04 – 01/10/04 = 1

RWP for Interim Claim
For this example - Case 1: When the record is considered a "transfer out" but not a "transfer in" and the DRG on the record was not a newborn DRG.
Inlier Calculation: minimum (base weight, ((2*per diem)+(per diem)(length of stay-1))
=minimum(3.9582,((2*(3.9582/8.5))+(3.9582/8.5)(10-1))
=minimum(3.9582, 5.122376)
=3.9582

RWP for Previous Claim
For this example - Case 2: When the record is considered a "transfer out" but not a "transfer in" and the DRG on the record was not a newborn DRG.
Short Stay Calculation: minimum (base weight, (((2*per diem)+(per diem)(length of stay-1))
=3.9582
if billfrq in ('1' '2' '5') then prevrwp=0;
rwp=revrwp-prevrwp;

RWP CALCULATION
=RWP for Interim Claim - RWP for Previous Claim
=3.9582 - 3.9582
=0

Now if the above information was the same but, the record was for an initial claim (based on the Bill Frequency Code) the RWP calculation would be as follows:

RWP for Previous Claim = 0 (not calculated or zero, since in this example there is no previous claim, the record is an initial claim)

RWP for Interim Claim (actually an initial claim)
For this example - Case 1: When the record is considered a “transfer out” but not a “transfer in” and the DRG on the record was not a newborn DRG.
Inlier Calculation: minimum (base weight, ((2*per diem)+(per diem)(length of stay-1))
=minimum(3.9582,((2*(3.9582/8.5))+(3.9582/8.5)(10-1))
=minimum(3.9582, 5.122376)
=3.9582

RWP CALCULATION
=3.9582 – 0
=3.9582

Appendix B: Preventable Admission Indicator

The preventable admission indicator is used to determine cases where sufficient access to ambulatory care may have prevented a hospital admission. Preventable admission indicators are always set to 0 if the patient's age is less than 18. Otherwise, the table below describes the rules used to create the preventable admission indicator values.

Code	Description	Business Rule
C	COPD	First three characters of the primary diagnosis codes are 491, 492, 494 or 496, or the first four characters of the primary diagnosis code is 4660 and the first three characters of any of the secondary diagnosis codes are 491, 492, 494 or 496.
B	Bacterial Pneumonia	First three characters of the primary diagnosis code is 481, 483, 485, 486 or the first four characters of the primary diagnosis code is 4822, 4823, 4829 AND none of the first four characters of the secondary diagnosis codes (check all of them) is 2826.
A	Asthma	First three digits of the primary diagnosis code is 493.
H	Congestive Heart Failure	First 4 characters of the primary diagnosis code is 5184 or the first 3 characters of the primary diagnosis code is 428 or the primary diagnosis code is 40201, 40211, or 40291 AND none of the procedure codes are 3601, 3602, 3605 AND none of the first three characters of the procedure codes are 361, 375, 377.
P	Angina	First four characters of the primary diagnosis code is 4111, 4118 or the first three characters of the primary diagnosis code is 413.
T	Cellulitis (Step 1)	DRG is 263, 264 or the first three characters of the primary diagnosis code is 681, 682, 683 or 686 AND.
D	Diabetes	First four characters of the primary diagnosis code are one of 2501, 2502, 2503, 2508, 2509 or 2500.
G	Gastroenteritis	First four characters of the primary diagnosis code are 5589.
U	Kidney/Urinary Infections	First three characters of the primary diagnosis are 590 or the first four characters of the primary diagnosis of 5990 or 5999.
T	Cellulitis (last step)	If the value of the preventable admission indicator code is T, then if the first three characters of any of the procedure codes are blank or 860, or the first two characters of any of the procedure codes are between 87 and 99 inclusive.
0	Not a preventable admission	Any record that doesn't meet any of the criteria described in this table, or any record where the patient is less than 18.

Appendix C: TED Episode Reference File

The purpose of the TED Episode Reference file is to allow the linking of claims that are part of an episode of care. Only acute care stays are included. Methodology used to create episode reference table for acute care stays is described below. Episode table is refreshed week at the same time when processing of weekly TED-I occurs.

TED-I – 1st pass (creating episode table)

- A total table refresh will be generated every week using Master TED-I files from current FY and prior. Priority is given to create episode files using TED-I master files FY04 and forward first before creating episode files using FY03 and prior.
- Include acute care hospitals only. Use acute care flag (TED-I) or institution type (HCSRi) based on same institution type that TED-I defined as acute care.
- Include only claims where allowed amount is greater than 0.
- Keep in data cube person id (EDIPN), provider tax id, DRG, admit date, enddate, cycle date, TEDno, and disposition flag (Y or N to identify if patient has been discharged).

TED-I Deduping rules (in order):

- Remove non-acute care claims based on acute care flag.
- If person id, admit date and enddate do not overlap then output as is and assign admitting tedno to tedno of claim.
- If person id, admit date and enddate overlap then do the following in order:
    1. If transfer (defined by same person, different provider id and no more than 1 day overlap) then output as is and assign admitting tedno to tedno of respective claim.
    2. Exclude claims that are entirely overlap with another claim.
    3. If same provider and same day overlap then do;
        - If same DRG then count as 1 continuous stay and output admit date and greatest enddate, keeping admit tedno from earliest admit date
        - If different DRG then count as different stays. Keeping admit tedno from their respective stays.
        - If same provider and consecutive stays where end date of 1st stay is consecutive to admit date of 2nd stay then count as 2 diff stays. Output as is and assign admitting tedno to tedno of respective claim.
    4. If different providers and dates overlap then shorten end date of 1st claim equal to admit date of 2nd claim minus 1 day. Keep 2nd claim as is. Output both claims and assign admitting tedno to tedno of respective claim.
- Upon completion of the deduplication process above you should have a clean episode table that includes person id (EDIPN), occurrence count representing the number of episodes for each EDIPN, admit date, end date, admitting TEDno and disposition flag (identify if patient has been discharged).
- If an episode has a disposition flag='N' (not disposition), then 60 days to the end date of care. If the addition of 60 days to end date of care overlaps with the next episode then set end date of care of the episode to admit date of next episode minus 1 day. This is to account for long institutional stays where non-institutional claims may arrive earlier than the institutional claim.
- Episode table should be in format file so that it can be easily apply to TED-I and TEDni by patient id (EDI_PN). Format files are fiscal year specific and includes episodes where admit date and end date falls within the specified fiscal year. For example, if a person has an episode spanning across 2 fiscal years (admit date=9/30/2004 and enddate=10/2/2004) then this episode would be in both FY04 and FY05 episode files.
- Episode table should resemble format below. The first line in the format file is the statement "proc format". The format value is $EPIFMT. Each line thereafter consists of unique EDI_PN and a concatenated string containing the following values, in order. Variables Admit Date of Care, End Date of Care, Admitting TED Number and Discharge Flag will repeat if number of episode segment is greater than 1.

Table C-1: Internal Episode Format Table

Variable Name	Format	Start Position of 1st Episode	Start Position of 2nd Episode (where i>1)	Length
Number of Episode Segments (i)	NN	1	N/A	2
Admit Date of Care$_i$	YYYYMMDD	3	2 + ((i - 1) * 41) +1	8
End Date of Care$_i$	YYYYMMDD	11	2 + ((i - 1) * 41) + 9	8
Admitting TED Number$_i$	12345678901234567890123 4	19	2 + ((i - 1) * 41) + 17	24
Discharge Flag$_i$	Y or N	43	2 + ((i - 1) * 41) + 41	1

- The last line in each format file is the SAS "other=" statement, i.e. other = "blank spaces"; which is used by SAS to assign values to EDI_PN that are not found in the Episode Format Table.

  For example, the Episode Format Table for a given year would resemble:

  PROC FORMAT;
  VALUE $EPIFMT
  'EDI_PN1' = ' 1YYYYMMDDYYYYMMDD12345678901234567890123 4Y'
  'EDI_PN2' = ' 2YYYYMMDDYYYYMMDD12345678901234567890123 4Y
  YYYYMMDDYYYYMMDD12345678901234567890123 4N'
  .
  .
  .
  other = ' ';

TED-I – 2st pass (applying Episode Table to TED-I)

- Apply Admitting TED number to master TED-I file using corresponding FY episode file.
- Merge episode table to acute care claims (use acute care flag)
- If begin date of a claim is between admit date and end date on episode table and does not have overlap with any other episode segments then populate claim admitting TEDno with episode admitting TEDno.
- If begin date of a claim is an overlap between 2 episode segments then populate claim admitting TEDno with 2nd episode admitting TEDno.

IF PRINCIPAL TREATMENT DIAGNOSIS CODE(first 3 characters) is greater than or equal to '290' and less than or equal to '316') then IF the value of the field PATIENT AGE is less than ‘19’ then the value of the field CATEGORY OF CARE is ‘A1’
ELSE the value of the field CATEGORY OF CARE is ‘A ’
ELSE IF the value of PRINCIPAL TREATMENT DIAGNOSIS CODE relates to obstetrics (first 3 characters between '630' and '676' or is equal to 'V22' or 'V23' or 'V24' or 'V28') then
IF ((the value of the field PRINCIPAL TREATMENT DIAGNOSIS CODE (first 3 characters) is greater than or equal to '640' and the value of the field PRINCIPAL TREATMENT DIAGNOSIS CODE (first 3 characters) is less than or equal to '669')
and the value of the field PRINCIPAL TREATMENT DIAGNOSIS CODE (position 5) is equal to '1 ' OR '2 ')
or the value of the field PRINCIPAL TREATMENT DIAGNOSIS CODE (first 3 characters is equal to '650' then
IF the value of the field PATIENT AGE is less than ‘19’ then the value of the field CATEGORY OF CARE is ‘B3’
ELSE the value of the field CATEGORY OF CARE is ‘B2’
ELSE IF the value of the field PATIENT AGE is less than ‘19’ then the value of the field CATEGORY OF CARE is ‘B1’
ELSE the value of the field CATEGORY OF CARE is ‘B ’
ELSE IF the value of PRINCIPAL TREATMENT DIAGNOSIS CODE relates to gynecology (value range of first 3 characters between '614' and '629' or is equal to 'V25' or 'V26') then
IF the value of the field PATIENT AGE is less than ‘19’ then the value of the field CATEGORY OF CARE is ‘C1’
ELSE the value of the field CATEGORY OF CARE is ‘C ’
ELSE IF (the PRINCIPAL OPERATION/NONSURGICAL PROCEDURE CODE
is within an operation/non-surgical procedure code range (first 3 characters greater than or equal to '001' and less than or equal to '869)')
and (the value of at least one REVENUE CODE (line item) position 1-3 indicates surgery (value of ’036’ (operating room services) or‘045’ (emergency room) or ‘072’ (labor room/delivery))) then
IF the value of the field PATIENT AGE is less than ‘19’ then the value of the field CATEGORY OF CARE is ‘D1’
ELSE the value of CATEGORY OF CARE is equal to ‘D ’
ELSE IF the any occurrence of the field SPECIAL PROCESSING CODE is equal to 'PF' (Program for Persons with Disability) then
IF the value of the field PATIENT AGE is less than ‘19’ then the value of the field CATEGORY OF CARE is ‘H1’
ELSE the value of the field CATEGORY OF CARE is ‘H ’
ELSE
IF the value of the field PATIENT AGE is less than ‘19’ then the value of the field CATEGORY OF CARE is ‘E1’
ELSE the value of the field CATEGORY OF CARE is ‘E ’.

Appendix E: Type of Submission

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

IF AMOUNT ALLOWED TOTAL > 0,
and AMOUNT PAID BY OTHER HEALTH INSURANCE > 0,
and AMOUNT PAID BY GOVERNMENT CONTRACTOR < or = 0, then
the value of TYPE OF SUBMISSION, DERIVED is 'O' (100% paid by Other Health insurance)

ELSE
IF AMOUNT ALLOWED TOTAL < OR = 0,
and all Line Items (except for the line with revenue code 0001) contain a value in DENIAL REASON DERIVED CODE,
and the AMOUNT PAID BY OTHER HEALTH INSURANCE = TOTAL AMOUNT BILLED,
then the value of TYPE OF SUBMISSION, DERIVED is 'O' (100% paid by Other Health insurance)

ELSE
IF AMOUNT ALLOWED TOTAL < OR = 0,
and all Line Items (except for the line with revenue code 0001) contain a value in DENIAL REASON DERIVED CODE, then
the value of TYPE OF SUBMISSION, DERIVED is 'D' (Complete contractor denial initial TED Record submission)

ELSE
IF SUBMISSION CODE on the raw TED Record = 'D' (Complete contractor denial initial TED Record submission), and
AMOUNT ALLOWED (TOTAL) not = 0, and AMOUNT PAID GOVERNMENT CONTRACTOR > 0, then
the value of TYPE OF SUBMISSION, DERIVED is 'I', (Initial TED Record submission)

ELSE
IF SUBMISSION CODE on the raw TED Record = 'D' (Complete contractor denial initial TED Record submission) then
the value of TYPE OF SUBMISSION, DERIVED is 'D' (Complete contractor denial initial TED Record submission)

ELSE
IF SUBMISSION CODE on raw TED Record = 'A' (Adjustment to TED Record data) or
'B' (Adjustment to non-TED Record (HCSR) data or 'I' (Initial TED Record submission),
then the value of TYPE OF SUBMISSION, DERIVED is 'I,' (Initial TED Record submission

ELSE
IF SUBMISSION CODE on raw TED Record =
'C' (Complete cancellation of TED record data) or
'E' (Complete cancellation of non-TED Record (HCSR) data)
then the value of TYPE OF SUBMISSION, DERIVED is 'C' (Complete cancellation of TED record data)

ELSE
The value of TYPE OF SUBMISSION, DERIVED is the value of SUBMISSION CODE on the raw Record.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix I: Underwritten Flag

The purpose of Underwritten Flag is to code which TNex region the responsible for the claim. This methodology is verified and approved the TMA and MCSC. For Regional jurisdiction, Prime beneficiaries (defined by enrollment status) are assigned to each contractor based on enrollment region and enrollment DMIS IDs (for the 69XXs and 79XXs ids). Non-Prime beneficiaries are assigned based on residence region. The 69XX (managed care contractor) and 79XX (remote) series of enrollment DMIS IDs are being assigned to enrollment region "00". Thus, those enrollment DMIS ids must be included with the enrollment regions. There are 4 values in which this variable may contain (N, S, W, blank). This flag should only be applied to TED claims (based on TED indicator).

Below are rules used to determine underwritten flag.

1. Active Duty (based on common beneficiary code=4) claims are not underwritten.
2. USFHP enrollees (based on alternate care value=U) claims are not underwritten.
3. TRICARE Senior Pharmacy, Senior Supplement, Senior Prime, TRICARE for Life (based on enrollment status=PS,TS,BB,FE,FS and special processing codes=FF,FS,FG) claims are not underwritten.
4. Supplemental care (based on enrollment status= SN,SO,SR,ST) claims are not underwritten.
5. TRICARE Reserve Select (based on HCDP code=401-402,405-412)) claims are not underwritten.
6. CHCBP (based on enrollment status=AA,Y) claims are not underwritten.
7. Foreign claims (based on provider state/country code) claims are not underwritten.
8. TRICARE Dual Eligibles ages less than 65 (based on special processing codes=R,T,RS) claims are not underwritten.
9. Cancer-clinical trials, utero fetal surgery, CCTP or ICMP (based on special processing codes=CL,CT,CM) claims are not underwritten.
10. For remaining claims not identified above as not underwritten do the following:
    - Determine prime enrollment based on enrollment status codes in ('U' 'Z' 'W' 'WF' 'WA' 'WO' 'X' 'XF').
    - If claim is prime enrollment and enrollment region in (01, 02, 05, 17) or enrollment site in (6917, 7917) then set underwritten flag='N' (North).
    - Else If claim is prime enrollment and enrollment region in (03, 04, 06, 18) or enrollment site in (6918, 7918) then set underwritten flag='S' (South).
    - Else If claim is prime enrollment and enrollment region in (07, 08, 09, 10, 11, 12, 19) or enrollment site in (6919, 7919) then set underwritten flag='W' (West).
    - Else if claim is not prime enrollment and residence region in (01, 02, 05, 17) then set underwritten flag='N' (North).
    - Else if claim is not prime enrollment and residence region in (03, 04, 06, 18) then set underwritten flag='S' (South).
    - Else if claim is not prime enrollment and residence region in (07, 08, 09, 10, 11, 12, 19) then set underwritten flag='W' (West).
    - Else set underwritten flag equal to blank.
11. If underwritten flag='W' and enrollment site in ('6919' '7919') and residence region equal 'AK' then set underwritten flag equal blank.
12. All other claims where underwritten flag not in ('N' 'S' 'W') are assigned blank.
13. If TED indicator is not 'T' then assign underwritten flag equal to blank.

Appendix J: TRICARE DRG Grouping

The 3M Core Grouper Software is used to assign TRICARE DRG information to institutional TED data (All Care DRG, MDC and All Care MS-DRG). The process for using the DRG Grouper is to assign a unique record number to each TED record. This number will be used to merge DRG Grouper output back into the TED data later. The TED data is then used to prepare a file which is formatted as the grouper software expects. ~~This file is transferred to a special PC which is used to operate the grouper software~~. The grouper versions to use are based on the admission fiscal year and the version number in table J-1.

Table J-1

Admission Fiscal Year	Processed with FY Data	DRG Grouper Version Number
2009-2012	2008	25
2008	2008	25
2007	2007	24
<=2006	Matching FY	<= 23

FY 2012 will be the last year the DRG is assigned to the data.

The software is then executed for each year and the output concatenated and merged back into the TED data by 'recnum'; retaining the "new DRG" as "All Care DRG", and the "new MDC" as "MDC". The grouper inputs and outputs are described in the tables below. For years prior to FY16, the begin date of care is used to assign the DRG version. For FY16 and later, the end date of care is used.

Table J-2: Input File for TRICARE DRG Grouper

Variable	Format	Position	Business Rule
RECNUM	Num	1-8	Sequential counter assigned to TED records. This number will be used to merge the grouper output back into the TED data.
UK1	$15	74-88	Set to 0001.
UK2	$15	89-103	Set to blank.
FADMIT	$8	104-111	Format at MMDDYY.
FDISP	$8	112-119	Format at MMDDYY.
FBIRTH	$8	120-127	Format at MMDDYY.
AGEY	$3	128-130	Set to blank.
AGED	$3	131-133	Set to blank.
RECSEX	$1	134	If patsex=M then set to 1 else if patsex = F then set to 2 else set to 0.
RECDISP	$2	135-136	Set to dispstat.
DIAG1 – DIAG12	$5	174-269	12 separate fields. Substring diagnosis code to 5 characters, apply diagnosis format file and then concatenate in order.
PR1 – PR12	$4	574-657	X separate fields. Substring procedure code to 4 characters, apply procedure format file and concatenate in order.
HACPOA	$1	$1,418	Set to 0 for FY2015+ else set to 1.

See the SIDR specification for the directions for running the TRICARE grouping software.

Table J-3 Output File for the TRICARE MS-DRG Grouper

Variable	Format	SAS Name	Business Rule
Record Number	Num	RECNUM	Positions 1-8 of grouper output
MS-DRG	$3	MSDRG	Positions 2364-2366 of grouper output
MS-MDC	$2	MSMDC	Positions 2367-2368 of grouper output
MS Return Code	$2	MSRTC	Positions 2369-2370 of grouper output
MSMEDSURG	$1	MSMEDSURG	Position 3518 of grouper output
Primary Diagnosis	$5	DIAG1	Positions 174-181 of grouper output
Principle Procedure	$4	PR1	Positions 574-580 of grouper output
Disposition Status	$2	RECDISP	Positions 135-136 of grouper output
Birth Date	MMDDYY	FBIRTH	Positions 120-127 of grouper output
Admission Date	MMDDYY	FADMIT	Positions 104-111 of grouper output
End Date	MMDDYY	FDISP	Positions 112-119 of grouper output

Merge the output from Table J-3 to the TED data by record number to append MSDRG, MSMDC and MSMEDSURG.

Appendix K: Merge to MTF Network Referral File

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

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

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

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

TEDNO: 2015071MI X59JR 3134505
TED TCN: 2015071MIX59JR
MCSC Claim Number: 2015071X59JR

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

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

From MTF Referral File:

```
length claim13 $13. claim15 $15.;
if ted_tcn='' then do;
  claim15='';
  claim13=region||substr(mcsc_claim_num,1,12);
end;
else do;
   claim15=region||ted_tcn;
   claim13='';
end;
```

From the TED claims:

```
length claim15 $15 claim13 $13.;
claim15=tedreg||substr(tedno,1,9)||substr(tedno,11,5);
claim13=tedreg||substr(tedno,1,7)||substr(tedno,11,5);
```

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

```
proc sort data=teds;
  by claim15 linum;
proc sort data=ref;
  by claim15 linum;
data match nomatch;
  merge teds(in=a) ref(in=b keep=claim15 linum uin ted_tcn mcsc_claim_num begdate subdmis);
  by claim15 linum;
```

```
  if a and b and claim15 ne '' then output match;
  else if a and not b then output nomatch;

proc sort data=nomatch;
  by claim13 linum;
proc sort data=ref;
  by claim13 linum;

data match2;
  merge nomatch(in=a) ref(in=b keep=claim13 linum uin ted_tcn mcsc_claim_num begdate subdmis);
  by claim13 linum;
  if a and b then output match2;

data matched;
  set match match2;
run;
```

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

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

Appendix M: Merge to MDR Referral File

The MDR Referral dataset contains many fields describing the MTF-to-Network referrals. Once the UIN has been added to the TED header records as described in Appendix K, the UIN field can be used to merge to the MDR Referral data directly and the associated fields described in Table 2 can be added. For these claim records that are identified directly through the UIN, the MTF Network Referral Match Flag should be set to 'U'.

Additionally, there are TED claims associated with an MTF-to-Network referral that can be identified heuristically by checking the begin (ref_begdate) and end dates (ref_enddate) of the referral obtained from the MDR Referral dataset. Any TED claims that fall within the date window of a directly identified MTF-to-Network referral, and have the same Provider Individual NPI (provnpi) and patient (edi_pn first, then patssn) as any directly identified MTF-to-Network referred claims, can be flagged as associated with that referral as well. For these records, the MTF Network Referral Match Flag should be set to "H", and all the associated referral fields from the MTF Network Referral File and the MDR Referral Files described in Table 2 can be populated.

APPENDIX H: HCSR Processing

Appendix H1: Update Processing Rules

Historically, the data in the HCSR feed were first mapped to TED format, and then appended to the corresponding TED feeds[6]. When the incremental raw feeds of Institutional data are processed, three types of records are removed from them. First, records that are denied or cancelled (records with an allowed amount less than or equal to 0) are separated out and added to the master cancellation data files (header and revenue). Then, ATOH records are removed from the TED feeds, if there are any, and records from the wrong fiscal year are dropped from all data feeds.

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

To update the master fiscal year MDR Institutional TED data sets it is important to apply updates and prepare data sets in the following order;

- Master Institutional TED File:
  Next, the processor appends variables to the incremental header data feed. Then it combines incremental and master header data sets, interleaving records by TED number and cycle date. The processor retains only the most recent version of the TED, as identified by TED number[7]. Then the processor uses the previous fiscal year data set to remove from the master data set any records that have moved to a subsequent fiscal year. This is done to ensure that records are not in two fiscal years.

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

- Revenue File:
  The processor first identifies which records are in both the incremental and the master revenue data sets and deletes those records from the master data set. Next the processor combines the incremental and modified master data sets to produce an updated master data set. The processor then uses the previous fiscal year file to remove any matching TED revenue segments from the updated master revenue data set. Finally, the intermediate cancellation data set is used to remove cancelled TEDs from the updated master revenue data set.

Note that the fiscal years must be processed in order, with the most recent fiscal year being processed first.

[6] This process occurred FY05 and earlier.
[7] Certain field values are retained from the initial database when updating HCSRs with ATOHs. These fields are identified in the layout table.

Appendix H2: Merge Table

Merge	Merge to	Date Matching	Additional Matching
Longitudinal VM4 File	Master	Begin Date of Care on TED, with begin and end dates for each changeable demographic segment.	EDI_PN if available.
DEERS Person Demographics file	Increment		Match to HCSR or ATOH records based on SPONSSN and DDS (if both fields are no blank), otherwise, merge on PATSSN.
DEERS Dependent Suffix and EDI_PN File[8]	Initial HCSR and ATOH	FY based on end date of care.	Match to HCSR or ATOH records by TED Key. One time requirement to add EDI_PN and DDS (if empty); only needed to build the initial datasets. Must be done prior to application of LVM4 and the DEERS Person Demographics file. Retain DDS and EDI_PN values in subsequent processing.
Longitudinal Enrollment	Master	Fiscal year and calendar month of begin date of care on NI record, with enrollment information from corresponding monthly enrollment segment.	Sponsor social and DDS. One time requirement for FY03 and earlier only. Only needed to apply the DEERS ACV and DEERS Enrollment site variables. Retain values in subsequent processing.
Master Person Index	Master	None.	For records with blank EDI_PN, match TED and ATOH records by sponssn, patsex, patdob and grouped member relationship code.
DRG Weight Table	Increment	FY of end date of care and FY of MDR DRG Weight Table for FY 2008 and earlier. For FY 2009 and later, match 2008 weight table to TEDs.	Derived DRG from institutional data record, DRG from weight table.
MS DRG Weight Table	Increment	FY of end date of care and FY of MDR DRG Weight Table for FY 2009 and later. For FY 2008 and FY 2007, use FY 2009 table.	MSDRG from institutional data record, DRG from weight table.
Diagnosis and Procedure Code Mapping Format	Increment	FY of Admission Date and Associated Version Number of DRG Grouper Software (see Appendix O on DRG Grouping).	
DMISID	Master	FY of end date of care, FY of MDR DMISID SAS format file.	Application based on enrollment DMISID, DEERS enrollment DMISID and catchment area DMISID.
Omni-CAD	Increment	FY/FM of end date of care, FY/FM of MDR Omni CAD format file.	Patient zip code & sponsor Service. Also based on provider zip.

[8] The DDS and EDI_PN file is a one-time requirement, intended to fill in missing person identifying information available historically in the MDR, but dropped from the HCSR Operational data store. The preparation of this data file is described in an appendix.

Merge	Merge to	Date Matching	Additional Matching
Inpatient Professional Services Tail file[9]	Increment	FY of end date of care and FY of MDR inpatient professional services format file.	Derived DRG, bed days, amount allowed, and coverage category.
~~Administrative Tail file~~	~~Increment~~	~~FY of end date of care and FY of MDR administrative tail format file.~~	~~Contract type.~~
Reservist GWOT file	Master	Admission date and dates associated with each reservist benefit type segment in the MDR Reservist format files.	Sponsor social security number.
Final HCSR Payment Amount Reference file	Initial HCSR and ATOH	FY of reference file and FY of claim file.	TED Number. One time requirement; only needed to build the initial datasets. Retain values in subsequent processing.
TED Episode Reference File	Master	Begin date of care.	EDI_PN.
3M Core Grouping Software	Increment	See appendix for description of processing to add DRGs to MDR Institutional Records.	
AHRQ Preventable Admission Indicator Software	Master	See appendix.	
MDR TED Institutional Revenue File	Master	N/A	TED Number (tedno).

Appendix H3: Layout and Business Rules for Combined HCSR/TED

MDR TED Field	SAS Name	Format	Source Element - HCSR	Source Position - HCSR	Source Element - TED	Business Rule
TED Number	tedno	$24	1-015	65-71	1-015	No transformation.
		$24	1-016	72-74	1-020	No transformation.
		$24	1-020	75-81	1-025	No transformation.
		$24	1-021	82-87	1-030	No transformation.
		$24	1-025	88	1-035	No transformation.
Process to Completion Date	procdate	yyyymmdd	1-035	89-96	1-040	Convert to SAS Date.
Sponsor SSN	sponssn	$9	1-045	105-113	1-050	No transformation.
Sponsor SSN Type Code	idtype	$1	DEERS	DEERS	1-051	If TED indicator is T then no transformation. Otherwise: merge in from DEERS demographic merge file (appendix J). Field may not be populated for HCSRs and ATOHs in FY03 and prior.

9The Inpatient Professional Services Tail reference file is described in an appendix to the document.

MDR TED Field	SAS Name	Format	Source Element - HCSR	Source Position - HCSR	Source Element - TED	Business Rule
TED Sponsor Pay Grade	paygrd	$2	1-050	115-116	1-056	If TED indicator is T then no transformation. Otherwise, apply mapping in appendix A. Change value of OO (letters) to 00 (numbers). Apply retroactively to all TED-I datasets, working backwards from current year to FY01.
Sponsor Pay Plan	payplan	$5	1-050	117-121	1-057	If TED indicator is T then no transformation. Otherwise, apply mapping in appendix A.
Service Branch	sponsvc	$1	1-055	122	1-060	If TED indicator is T then no transformation. Otherwise, apply mapping in appendix A.
AGR Service Legal Authority	agrauth	$1	DEERS	DEERS	1-065	If TED indicator is T then no transformation. Otherwise: merge in from DEERS demographic merge file (appendix J). If agrauth from DEERS merge is blank then assign to 'Z'. Field may not be populated for HCSRs and ATOHs in FY03 and prior.
Sponsor Status	memcat	$1	1-065	124	1-066	If TED indicator is T then no transformation. Otherwise, apply mapping in appendix A.
Member Relationship Code	memrln	$1	1-070	125	1-070	If TED indicator is T then no transformation. Otherwise, apply mapping in appendix A.
Last Name	lastname	$35	1-075	126-160	1-076	If TED indicator is T, then no transformation. Otherwise, parse into separate fields.
First Name	frstname	$25	1-075	161-185	1-077	
Middle Name	midlname	$25	1-075	186-210	1-078	
Cadency	cadency	$10	DEERS	DEERS	1-079	If TED indicator is T then no transformation. Otherwise: merge in from DEERS demographic merge file (appendix J). Field may not be populated for HCSRs and ATOHs in FY03 and prior, should the HCSR be adjusted with an ATOH.

MDR TED Field	SAS Name	Format	Source Element - HCSR	Source Position - HCSR	Source Element - TED	Business Rule
Patient SSN	patssn	$9	1-080	221-229	1-080	If TED indicator is T then no transformation. Otherwise, if TED indicator is not T and patssn is empty: merge in from DEERS demographic merge file (appendix J). Field may not be populated for HCSRs and ATOHs in FY03 and prior.
Patient SSN Type Code	pidtype	$1	DEERS	DEERS	1-081	If TED indicator is T then no transformation. Otherwise: merge in from DEERS demographic merge file (appendix J). Field may not be populated for HCSRs and ATOHs in FY03 and prior.
Date of Birth	patdob	yyyymmdd	1-085	231-238	1-085	No transformation.
EDI_PN	edi_pn	$10	N/A	N/A	1-095	No transformation.
DEERS Patient ID	deersid	$11	DEERS	DEERS	1-097	If TED indicator is T then no transformation. Otherwise: merge in from DEERS demographic merge file (appendix J). Field may not be populated for HCSRs and ATOHs in FY03 and prior.
Gender	patsex	$1	1-095	260	1-100	No transformation.
Patient Zip Code	patzip	$5	1-100	261-265	1-105	If TED indicator is T then no transformation. Otherwise, if the content of the patient zip code is not numeric, apply mapping to take HCSR state codes to TED values.
Patient Zip Code + 4	patzip4	$4	1-100	266-269	1-105	No transformation.
Enrollment Status	enrstat	$2	1-105	270-271	1-110	If Enrollment DMISID begins with 69 and enrollment status is not “U”, then set to “U”. Otherwise, fill with enrollment status from the data feed.
HCDP	hcdp	$3	DEERS	DEERS	1-111	If TED indicator is T, no transformation. Otherwise, fill with DEERS HCDP from LVM4 merge.
TED Region	tedreg	$1	N/A	N/A	1-112	If TED indicator is T then no transformation. Otherwise leave blank.
Enrollment DMISID	enrsite	$4	1-205	277-280	1-115	No transformation.
Total Amount Billed	bill	SN9.2	1-115	281-289	1-120	No transformation.
Total Amount Allowed	allow	SN9.2	1-120	290-298	1-125	No transformation.
Total OHI Paid	ohi	SN9.2	1-125	299-307	1-130	No transformation.

MDR TED Field	SAS Name	Format	Source Element - HCSR	Source Position - HCSR	Source Element - TED	Business Rule
Type of Other Government Health Insurance	govins	$1	N/A	N/A	1-131	If TED indicator is T then no transformation. Otherwise set to blank.
Begin Reason Code for Other Government Ins	govinbeg	$1	N/A	N/A	1-132	If TED indicator is T then no transformation. Otherwise set to blank.
Total Patient Cost Share	patcost	SN9.2	D	780-787, 788-795	1-135	If TED indicator is T then no transformation. Otherwise, sum of patient coinsurance and patient copayment (read in from feed to derive this field, but then don't retain separately).
Copayment Factor	copayfac	$1	D	D	1-136	If the TED indicator is T then no transformation. Otherwise, if comben is '4' (AD) and not TRS (HCDP not in (401,402, 405-412)), then if rank is E4 or below (payplan='ME' and paygrd in ('00' '01' '02' '03' '04') or payplan='MC' and paygrd='01'), set to A. If comben is '4' (AD) and not TRS (HCDP not in (401,402, 405-412)), then if rank is E5 or greater, set to B. If comben in ('2' '3') or (comben is '4' (AD) and TRS (HCDP in (401,402, 405-412)), then C, else W.
Total Amount Paid	paid	SN9.2	1-155	320-328	1-140	No transformation.
Total Interest Paid	intpaid	SN9.2	N/A	N/A	1-145	No transformation.
Reason for Interest	intreas	$2	N/A	N/A	1-150	No transformation.
Override Code 1	ovride1	$2	1-170	340-345	1-160	Parse into separate fields.
Override Code 2	ovride2	$2	1-170	340-345	1-160	Parse into separate fields.
Override Code 3	ovride3	$2	1-170	340-345	1-160	Parse into separate fields.
Submission Code	subcode	$1		346	1-165	If TED indicator is T then no transformation. Otherwise, apply mapping in appendix A.
Care Authorization/NAS Number	authnum	$15	1-110	347-361	1-170	No transformation.
Care Authorization/NAS Issue Reason	authrsn	$1	1-202	362	1-175	No transformation.
Care Authorization/NAS Exc Reason	authexcp	$2	1-180	363-364	1-180	No transformation.

MDR TED Field	SAS Name	Format	Source Element - HCSR	Source Position - HCSR	Source Element - TED	Business Rule
Special Processing Code 1	sprocd1	$2	1-197	365-372	1-185	If TED indicator is T then no transformation. Otherwise, apply mapping in appendix A.
Special Processing Code 2	sprocd2	$2	1-197	365-372	1-185	
Special Processing Code 3	sprocd3	$2	1-197	365-372	1-185	
Special Processing Code 4	sprocd4	$2	N/A	365-372	1-185	No transformation.
Health Care Delivery Program Special Entitlement Code	hcdpspec	$2	N/A	N/A	1-186	No transformation.
Pricing Rate Code	pricert	$2	1-198	798	1-190	No transformation.
Provider State/Country Code	provloc	$3	1-210	377-379	1-195	If TED indicator is T then no transformation. Otherwise, apply mapping in appendix A.
Provider Tax ID	taxid	$9	1-212	380-388	1-200	No transformation.

Appendix H4: Layout and Business Rules for Revenue File

MDR TED Field	SAS Name	Format	Source Element - HCSR	Source Position - HCSR	Source Element - TED	Source Position - TED	Business Rule
TED Number	tedno	$24	1-015	1-7	1-015	1-7	
		$24	1-016	8-10	1-020	8-10	
		$24	1-020	11-17	1-025	11-17	
		$24	1-021	18-23	1-030	18-23	
		$24	1-025	24	1-035	24	
Cycle Number	cycle	$8	D	25-32	D	25-32	No transformation.
End Date of Care	enddate	yyyymmdd	1-285	33-40	1-280	33-40	Convert to SAS Date.
Revenue Line Item Number	linum	3	1-385	41-43	1-375	41-43	
Revenue Code	revcode	$4	1-365	44-47	1-385	44-47	If TED indicator is T then no transformation. Otherwise, add leading zero to first 3 substring of revcode. If revcode is blank then assign revcode='0000'.
Units of Service	svcs	SN10	1-370		1-390	48-57	
Amount Billed	revbill	SN9.2	1-375		1-395	58-66	
Adjustment/Denial Reason Code	adjcode	$5			1-400	67-71	Set to blank if TED indicator is not T.
Provisional Acceptance Line Item Indicator	provact	$7			D	76-82	Set to blank if TED indicator is not T.
Internally Derived Fields							
Adjustment Reason Derived Code	dadjcd	$2	N/A	N/A	N/A	N/A	Apply adjustment reason format[1] file to the adjustment/denial reason code (1-400). If the type of reason code for the revenue line item is “B”, then set adjustment reason derived code according to the format. Otherwise, if the type of reason is C, then if the type of submission is “O’, then set according to the format, otherwise set to blank.

MDR TED Field	SAS Name	Format	Source Element - HCSR	Source Position - HCSR	Source Element - TED	Source Position - TED	Business Rule
Denial Reason Derived Code	denial	$2	1-380	72-73	N/A	N/A	If TED indicator is T then apply denial reason format[8] file to the adjustment/denial reason code (1-400). If the type of reason code for the revenue line item is "D", then set denial reason derived code to the format, else if the type of reason code for the revenue line item is "C" and type of submission code is not "O" then set according to the format, otherwise set to blank. If TED indicator is not T then populate from HCSR denial reason code.

Appendix H5: Intermediate ATOH File

- Intermediate ATOH File: The intermediate ATOH file is used to determine the amount of a record that was paid under the old managed care support contracts (HCSRPAY). This reference file is prepared from the ATOH data feeds provided to the MDR. To keep the intermediate ATOH file updated, the monthly ATOH feed is appended to the existing ATOH file. If this results in more than one record per key, the record with the greatest cycle date is retained. The file layout for the interim ATOH file is contained in the table below.

Data Element	SAS Name	Business Rule
TED Number	tedno	No transformation
Cycle Number	cycle	No transformation
Amount Paid	paid	No transformation

Appendix H6: Mapping HCSR Elements to TED Schema

Table H6-1: Sponsor Pay Plan

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

Table H6-2: Sponsor Pay Grade

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

Table H6-3: Branch of Service

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

Table H6-4: Sponsor Status

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

Table H6-5: Patient Relationship to Sponsor

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

Table H6-6: Submission Code

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

Table H6-7: Special Processing Codes

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

Table H6-8: Source of Admission

HCSR Source of Admission	TED Source of Admission
A	1
B	2
C	3
D	4
R	A
S	B
T	C
All Other	No Change

Table H6-9: HCSR Country Code to TED County Code: Used in mapping provider zip, patient zip, provider state/country code.

HCSR State/ Country Code	TED State/ Country Code
AW	ABW
AF	AFG
AO	AGO
AI	AIA
AX	ALA
AL	ALB
AD	AND
AN	ANT
AE	ARE
AR	ARG
AM	ARM
AS	ASM
AQ	ATA
TF	ATF
AG	ATG
AU	AUS
AT	AUT
AZ	AZE
BI	BDI
BE	BEL
BJ	BEN
BF	BFA
BD	BGD
BG	BGR
BH	BHR
BS	BHS
BA	BIH
BY	BLR
BZ	BLZ
BM	BMU
BO	BOL
BR	BRA
BB	BRB
BN	BRN

HCSR State/ Country Code	TED State/ Country Code
KM	COM
CV	CPV
CR	CRI
CU	CUB
CX	CXR
KY	CYM
CY	CYP
CZ	CZE
DE	DEU
DJ	DJI
DM	DMA
DK	DNK
DO	DOM
DZ	DZA
EC	ECU
EG	EGY
ER	ERI
EH	ESH
ES	ESP
EE	EST
ET	ETH
FI	FIN
FJ	FJI
FK	FLK
FR	FRA
FO	FRO
FM	FSM
FX	FXX
GA	GAB
GB	GBR
GE	GEO
GH	GHA
GI	GIB
GN	GIN

HCSR State/ Country Code	TED State/ Country Code
HT	HTI
HU	HUN
ID	IDN
IN	IND
IO	IOT
IE	IRL
IR	IRN
IQ	IRQ
IS	ISL
IL	ISR
IT	ITA
JM	JAM
JO	JOR
JP	JPN
KZ	KAZ
KE	KEN
KG	KGZ
KH	KHM
KI	KIR
KN	KNA
KR	KOR
KW	KWT
LA	LAO
LB	LBN
LR	LBR
LY	LBY
LC	LCA
LI	LIE
LK	LKA
LS	LSO
LT	LTU
LU	LUX
LV	LVA
MO	MAC

HCSR State/ Country Code	TED State/ Country Code
MS	MSR
MQ	MTQ
MU	MUS
MW	MWI
MY	MYS
YO	MYT
NA	NAM
NC	NCL
NE	NER
NF	NFK
NG	NGA
NI	NIC
NU	NIU
NL	NLD
NO	NOR
NP	NPL
NR	NRU
NZ	NZL
OM	OMN
PK	PAK
PA	PAN
PN	PCN
PE	PER
PH	PHL
PW	PLW
PG	PNG
PL	POL
PR	PRI
KP	PRK
PT	PRT
PY	PRY
PF	PYF
QA	QAT
RE	REU

HCSR State/ Country Code	TED State/ Country Code
SO	SOM
PM	SPM
ST	STP
SR	SUR
SK	SVK
SI	SVN
SE	SWE
SZ	SWZ
SC	SYC
SY	SYR
TC	TCA
TD	TCD
TG	TGO
TH	THA
TJ	TJK
TM	TKM
TP	TMP
TT	TTO
TN	TUN
TR	TUR
TV	TUV
TW	TWN
TZ	TZA
UG	UGA
UA	UKR
UM	UMI
UY	URY
BQ	USA
UZ	UZB
VA	VAT
VC	VCT
VE	VEN
VG	VGB
VI	VIR

HCSR State/ Country Code	TED State/ Country Code
09	CT
10	DE
11	DC
12	FL
13	GA
15	HI
16	ID
17	IL
18	IN
19	IA
20	KS
21	KY
22	LA
23	ME
24	MD
25	MA
26	MI
27	MN
28	MS
29	MO
30	MT
31	NE
32	NV
33	NH
34	NJ
35	NM
36	NY
37	NC
38	ND
39	OH
40	OK
41	OR
42	PA
44	RI

HCSR State/ Country Code	TED State/ Country Code
BT	BTN
BV	BVT
BW	BWA
CF	CAF
CA	CAN
CC	CCK
CH	CHE
CL	CHL
CN	CHN
CI	CIV
CM	CMR
CD	COD
CG	COG
CK	COK
CO	COL

HCSR State/ Country Code	TED State/ Country Code
GP	GLP
GM	GMB
GW	GNB
GQ	GNQ
GR	GRC
GD	GRD
GL	GRL
GT	GTM
GF	GUF
GU	GUM
GY	GUY
HK	HKG
HM	HMD
HN	HND
HR	HRV

HCSR State/ Country Code	TED State/ Country Code
MA	MAR
MC	MCO
MD	MDA
MG	MDG
MV	MDV
MX	MEX
MH	MHL
MK	MKD
ML	MLI
MT	MLT
MM	MMR
MN	MNG
MP	MNP
MZ	MOZ
MR	MRT

HCSR State/ Country Code	TED State/ Country Code
RO	ROM
RS	RUS
RW	RWA
SA	SAU
CS	SCG
SD	SDN
SN	SEN
SG	SGP
GS	SGS
SH	SHN
SJ	SJM
SB	SLB
SL	SLE
SV	SLV
SM	SMR

HCSR State/ Country Code	TED State/ Country Code
VN	VNM
VU	VUT
WF	WLF
WS	WSM
YE	YEM
YU	YUG
ZA	ZAF
ZM	ZMB
ZW	ZWE
01	AL
02	AK
04	AZ
05	AR
06	CA
08	CO

HCSR State/ Country Code	TED State/ Country Code
45	SC
46	SD
47	TN
48	TX
49	UT
50	VT
51	VA
53	WA
54	WV
55	WI
56	WY

Appendix H7: DEERS Person Demographic File

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

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

To create the DEERS merge files:

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

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

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

[10] It is recognized that the values in these fields may change as a result of the ATOH process, but it is unlikely. A review should be conducted after a year or so, to determine whether subsequent adjustments do change the content of any of these data values. If so, a periodic retrofit may be in order. (Of course, considering the volume of ATOH, periodic retrofits may not be in order for long.)

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

Appendix H8: DEERS Dependent Suffix and EDI_PN File

The DEERS dependent suffix reference file is a one-time requirement, prepared from the historical MDR Institutional claims files. This reference file is prepared by extracting the HCSR Key from the MDR HCSR Institutional File (positions 87 – 100), the DEERS Dependent Suffix (186-187), the person id EDI_PN (76-85) and process to completion date (112-119). The data file should be sorted by HCSR Key and matched to the initial set of HCSRs delivered for this processor. Retain value from initial DDS and EDI_PN merge should the HCSR be adjusted with an ATOH.