EIDS Program Management

Interface Control Document  
Describing the HCSR Institutional Data Exchange to MDR  
BASELINE

Version



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ICD Describing the HCSR Institutional Data Exchange to MDR

Version

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ICD Describing the HCSR Institutional Data Exchange to MDR

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Preface

This document describes the interface that provides the EIDS Program Office’s MHS Data Repository (MDR) with the Health Care Service Record (HCSR) Institutional dataset. The raw data is sent from the TRICARE Management Activity – Aurora (TMA-A).

This document is under EIDS project configuration control. Changes to this document will be made by document change notice (DCN) or by complete revision.

Questions on proposed changes concerning this plan should be addressed to:

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Abstract

The Executive Information Decision Support (EIDS) Program Office is developing the Military Health System (MHS) Data Repository (MDR) as the core repository for MHS clinical, beneficiary population, enrollment, costing and workload data. MDR collects, catalogues and organizes data files from several systems. This document is the Interface Control Document (ICD) that specifies the Health Care Service Record (HCSR) Institutional datasets that are provided for the MDR by TRICARE Management Activity – Aurora (TMA-A). Information and meta data regarding the data feed are detailed in this ICD.

**Keywords:** Decision Support, Executive Information, Health Care Service Record, Interface Control Document, MHS Data Repository, DS, EI, HCSR, ICD, MDR

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Contents

Preface vii

Abstract ix

Section 1: Introduction 1-1

1.1 Document Identification 1-1

1.2 Scope 1-1

1.3 System Overview 1-1

1.4 Reference Documents 1-2

1.5 Operational Agreement 1-2

Section 2: Data Specification 2-1

2.1 Identification of Data Exchanges 2-1

2.2 Precedence and Criticality of Requirements 2-1

2.3 Communications Methods 2-1

2.4 Performance Requirements 2-1

2.5 Security and Integrity 2-1

2.5.1 Data Integrity and Quality 2-2

Appendix A: HCSR-I Dataset A-1

A.1 File Format A-1

A.2 Record Layout A-1

A.3 File Operational Context A-1

Appendix B: Acronyms B-1

**Figures**

[Figure 1‑1 HCSRs Interface Flow 1-2](#_Toc130888767)

**Tables**

Table A‑1 HCSR-I Record Data Elements A-2

Table A‑2 HCSR-I Revenue Record Data Elements A-22

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# Introduction

## Document Identification

This document describes the interface that provides the Health Care Service Record (HCSR) Institutional (HCSR-I) purchased care medical record to the MHS Data Repository (MDR). HCSR-I is the legacy interface being replaced by the TRICARE Encounter Data (TED) Institutional (TED-I).

## Scope

This document describes and identifies the parameters and specifies the file layout of the HCSR-I that the MDR receives from TRICARE Management Activity-Aurora (TMA-Aurora) and the EIDS Program Office. The HCSR-I is a key dataset for MHS EIDS products. It is the only source of purchased care clinical and claims related data.

## System Overview

The TMA (formerly OCHAMPUS) captures outpatient and inpatient records from the TRICARE purchased care programs. The HCSR captures and stores the following types of information:

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

HCSR data is based on clinical encounters submitted on the UB92 (Uniform Billing Claim Form) and HCFA 1500 (Health Care Financing Administration Professional Fee Billing Claim). HCSRs are submitted by the MCSCs, audited and claims paid by the Financial Intermediary (FI), and sent to the TED system for final auditing and government payment. The TED replaced the Health Care Service Record (HCSR).

HCSRs provide the purchased health care data for both inpatient and outpatient visits. HCSRs consist of: Institutional claims, Non-Institutional claims, Provider, and Pricing records. Operations are managed by the Director, TMA-A.

This particular ICD describes the HCSR Institutional records that are sent from the TMA-A’s TED ODS to EIDS’ MDR. HCSRs and TEDs are transmitted to TMA-A via Informatica Power Channel using a 24 by 7 operational schedule. The TED system is part of an EIDS central host, an IBM RS/6000SP multi-node processor located at Defense Enterprise Computing Center (DECC) at Denver. The HCSRs are collected in the PCDW.

MSCSs to Feed Nodes to TED Processing Module and ODS to PCDW to TED Systems.

Figure ‑ HCSRs Interface Flow

## Reference Documents

EIDS Program Office, *CEIS Operational Requirements Document (ORD)*, Falls Church, VHA, December 1997.

TMA, *TRICARE Systems Manual 7950.1-M*, Falls Church, VA, 1 Aug 2002.

## Operational Agreement

The EIDS Program Office manages all information technology aspects of the purchased care system. TMA-A manages the contracts pertinent to the MCSC. TMA and EIDS will coordinate and ensure processing and operations respond to purchased care requirements. Modifications to the ICD will be made by the EIDS Program Office as required, and a copy of the revised ICD will be sent to TMA-A.

Appendix A delineates the HCSR-I data elements that will be sent from TMA-A to the MDR.

# Data Specification

## Identification of Data Exchanges

This ICD addresses the following data exchange from TED ODS to MDR:

* Health Care Service Record (HCSR) Institutional (HCSR-I) records.

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

## Precedence and Criticality of Requirements

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

## Communications Methods

TED ODS will transmit the HCSR-I datasets on a monthly basis using Power Channel, a secure file transfer process, to the MDR Feeds Nodes.

## Performance Requirements

The data needs to be provided to EIDS on monthly basis.

## Security and Integrity

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

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

### 

### Data Integrity and Quality

Validation checks related to such items as record counts, file formats, source stamps, and date-time stamps will be performed on the data transferred from TED ODS to MDR as defined in the design documentation. When errors are discovered in the data exchange, TMA-A will be notified immediately by EIDS Operations personnel. If there are systemic problems, appropriate EIDS and TMA-A counterparts will be engaged to work issues.

**Appendix A: HCSR-I Dataset**

**A.1 File Format**

The EIDS Feed Nodes receives the Health Care Service Record (HCSR) Institutional (HCSR-I) datasets on a monthly basis. For EIDS application purposes, this data is processed and stored in the MDR. Extracts are provided for user applications such as the MHS MART (M2).

**A.2 Record Layout**

Table A-1 describes the HCSR-I records. A monthly dataset to MDR will consist of a number of HCSR-I records. The records are fixed length and separated by a carriage return character.

All Alpha-Numeric data fields are left-justified, with spaces added to the right to fill the field length. All non-date Numeric data fields are right-justified, with zero’s added to the left to fill the field length.

Institutional HCSRs are generated for claims associated with hospitals and clinics whereas Non-Institutional HCSRs are generated for claims associated with individual health care providers, supplies and services.

**A.3 File Operational Context**

TED-I replaced HCSR-I as the claims format under the TNEX contracts in 2005. However, because of the delay in claims submission and updates to the claims, HCSRs continue to be submitted under Adjustment to Original HCSR (ATOH). The adjustments typically deal with cost updates.

Table ‑ HCSR-I Record Data Elements

| Field Name  (logical name) | Field Length | Position | Data Type | Data Units | Value Range | Functional Description |
| --- | --- | --- | --- | --- | --- | --- |
| Filler | 14 | 1-14 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Batch/Voucher Identifier | 1 | 15 | A-Numeric | NA | 3, 4, 5 | Identifies the type of records submitted in the batch/voucher. Coded as follows:  3 Provider (Batch Only)  4 Pricing (Batch Only)  5 Institutional/Non-Institutional (Batch/Voucher) |
| Filler | 49 | 16-64 | A-numeric | NA | None | Field that serves as filler between record fields. |
| *HCSR Number (65-88)* | | | | | | |
| Filing Date | 7 | 65-71 | Numeric | NA | None | Date the request for payment of services rendered was received by the contractor for processing (Yyyyddd). |
| Filing State/Country Code | 3 | 72-74 | A-Numeric | NA | None | Code that indicates the state or country where the primary care was provided. |
| Sequence Number | 7 | 75-81 | A-Numeric | NA | None | A sequential number assigned by the contractor to identify the individual HCSR record. Once assigned, the sequence number cannot be reused with the same Filing Date and Filing State/Country. |
| Time Stamp | 6 | 82-87 | A-Numeric | NA | None | Unique system time assigned by the claims processor’s computer system when issuing an initial HCSR record. |
| HCSR Suffix | 1 | 88 | A-Numeric | NA | A thru Y | Code to uniquely identify when treatment encounter data is split into groupings for HCSR reporting purposes.  Assigned in alphabetic order  a no split required  b first split  c second split  d-y etc. |
| Date HCSR Processed to Completion | 8 | 89-96 | A-Numeric | NA | None | Date the contractor processed the claim/treatment encounter data to completion. This date does not change for re-submissions unless previously coded in error (Yyyymmdd). |
| Filler | 8 | 97-104 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Sponsor SSN | 9 | 105-113 | A-Numeric | NA | None | Sponsor social security account number or veterans administration file number. All numeric - normal claims. All blanks - nato & security agent claims (extremely rare).  First 3 digits zeroes - deceased sponsor only.  Note: prior to May, 1978, VA file number could contain alpha characters. If CHAMPVA, user VA file number without alpha prefix (left-filled with zeroes). |
| Filler | 1 | 114 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Sponsor Pay Grade | 2 | 115-116 | A-Numeric | NA | 00-14,19-31, 40-58,90,95,99 | Sponsor's pay grade code. HCSR code definitions:  00 unknown enlisted  01 – 09 enlisted (E1 – E9)  10 unknown warrant officer  11-14 warrant officer (W1 – W4)  19 academy of navy OCS students  20 unknown officer  21-31 officer (O1-O11)  40 unknown civil service  41-58 GS1-GS18  90 unknown  95 not applicable (including CHAMPVA)  99 other |
| Filler | 5 | 117-121 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Sponsor Branch of Service | 1 | 122 | A-Numeric | NA | A,E,F,I,M,N,P,C | Sponsor's uniformed service branch or organization that creates entitlement to the health care. Codes for HCSR:  A Army  E Public Health Service  F Air Force  I NOAA  M Marines  N Navy  P Coast Guard  C CHAMPVA |
| Filler | 1 | 123 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Sponsor Status | 1 | 124 | A-Numeric | NA | A, B, C, D, E, F, H, I, J, K, N, O, P, Q, R, S, T, U, V, W, X, Z | *Patient Category* - category of patient type downloaded from DEERS. If unavailable from DEERS, is reported from healthcare data received by contractor. Sponsor Status code indicating official status of sponsor in regard to a current level of participation in a uniformed branch of service/affiliation.  A Active duty  B Recalled to active duty  C Civilian  D Retired - 100% disabled  E Active duty - MEPCOM enlistee  F Retired – former memberH Medal of honor  I Retired – permanently disabled  J Active duty – academy/Navy OCS  K Deceased  N Active duty – National Guard  O Retired – temporarily disabled  P TAMP designee  Q Incarcerated  R Retired  S Service secretary designee  T Active duty – foreign military  U Foreign national  V Reserve  W Retired - Title III retiree  X Other  Z Unknown |
| Patient Relationship to Sponsor | 1 | 125 | A-Numeric | NA | A, B, C, D, E, F, G, H, I, J, K | The code that represents how DoDI 1000.13 views relationships between a person and another person in a family. For example, a person is a child or stepchild of another person. (This attribute is similar to person association reason code.)  A Self (i.e., the person and the other person are the same person)  B Spouse  C Child or stepchild  D Ward (not court ordered)  E Ward (court ordered)  F Dependent parent, dependent stepparent, dependent parent-in-law, or dependent step-parent-in-law  G Surviving spouse  H Former spouse (20/20/20)  I Former spouse (20/20/15)  J Former spouse (10/20/10)  K Former spouse (transitional assistance (composite)) |
| Patient Name | 35 | 126-160 | A-Numeric | NA | None | Legal name of patient, downloaded from DEERS. (if unavailable from DEERS, the name comes from the health care data submitted to contractor.) The last name is at least two characters, followed by a comma. |
| Filler | 60 | 161-220 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Patient SSN | 9 | 221-229 | A-Numeric | NA | None | Patient social security number. If unknown, blank fill. |
| Filler | 1 | 230 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Patient Date of Birth | 8 | 231-238 | Numeric | NA | None | Date patient was born. If patient is on DEERS, date is downloaded. If not on DEERS, date is reported from health care data received by contractor (YYYYMMDD). |
| Filler | 21 | 239-259 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Patient Sex | 1 | 260 | A-Numeric | NA | M,F | Sex of patient/beneficiary. Codes for HCSR:  M male  F female |
| Patient Zip Code | 9 | 261-269 | A-Numeric | NA | None | US postal zip code or foreign country code for patient's legal residence at the time service was rendered. Must not be the zip code of a post office box. If the code is a two-character foreign country code, it must be left justified. |
| Enrollment Status | 2 | 270-271 | A-Numeric | NA | A, AA, B, BB, C, D, E, F, FE, FF, FS, G, H, I, J, K, L, M, O, P, PS, Q, R, S, SO, SN, SR, ST, T, TS, U, V, W, X, Y, Z | Code that describes which benefit program the patient is enrolled in. Coded as follows:  A Foundation Health Plan  AA CHCBP Extra  B Partners Health Plan  BB TRICARE Senior Prime  C Queen’s Health Care Plan  D MCS TRICARE Tidewater Prime  E MCS – TRICARE Prime  F FI Standard CHAMPUS  FE TFL – Extra  FF TFL (First Payor)  FS TFL – (Second Payor)  G MCS TRICARE Tidewater Extra  H MCS Homestead Enrolled  I MCS Homestead Network Provider  J MCS Homestead Standard CHAMPUS  K MCS CA/HI Enrolled  L MCS CA/HI Network Provider  M MCS CA/HI Standard CHAMPUS  O New Orleans Prime |
| Filler | 5 | 272-276 | A-numeric | NA | None | Field that serves as filler between record fields. |
| PCM Location DMIS-ID Code | 4 | 277-280 | A-Numeric | NA | None | The 4-digit code that indicates the DMIS ID code of the Primary Care Manager (PCM). Identifies and distinguishes MTF/Clinic enrollments from network enrollments. |
| Amount Billed | 9 (7,2) | 281-289 | Numeric | NA | None | Total amount billed for all services on the HCSR record. |
| Amount Allowed | 9 (7,2) | 290-298 | Numeric | NA | None | Total amount allowed for all authorized services on the HCSR record. |
| Amount Paid By Other Health Insurance | 9 (7,2) | 299-307 | Numeric | NA | None | Total amount paid by other health insurance, including TPL, for all services reported. |
| Filler | 12 | 308-319 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Amount Paid by Government FI Contractor | 9 (7,2) | 320-328 | Numeric | NA | None | The portion of total amount allowed that was paid by government contractor for all services reported on the HCSR record. |
| Filler | 11 | 329-339 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Override Code | 6 | 340-345 | A-Numeric | NA | K, L, U, V | The first of three codes that indicate that certain questionable data has been identified and approved by the contractor and that normal editing and processing rules should be bypassed for this record.  K Catastrophic loss  L Non-DRG reimburseable using DRG- related cost sharing calculation  U Beneficiary indemnification payment  V AD Family member services provided in TRICARE Europe |
| Type of Submission Code | 1 | 346 | A-Numeric | NA | A, B, C, D, E, F, G, I, O, R | Code indicating the HCSR submission type. Coded as follows:  A Adjustment to prior HCSR data  B Adjustment to non-HCSR data  C Complete cancellation of prior HCSR data  D Complete FI/contractor denial initial HCSR submission  E Complete cancellation of non-HCSR data  F Adjustment to prior HCSR data, additional HCSR suffix  G Additional DRG interim billing  I Initial HCSR submission  O Zero payment HCSR due to 100% reimbursement by OHI-Third Party Liability  R Resubmission of an initial HCSR that was rejected due to errors |
| NAS Number | 15 | 347-361 | A-Numeric | NA | None | The unique number assigned by the MTF when issuing the Non Availability Statement (NAS). |
| NAS Reason for Issuance | 1 | 362 | A-Numeric | NA | 1,2,3,4,5,6 | Indicates why the care was not or cannot be provided by a MTF. Coded as follows:  1 Facility not available  2 Professional capability not available  3 Medically inappropriate  4 Facility temporarily not available  5 Professional capability temporarily not available  6 Facility or professional capability permanently not available |
| NAS Exception Reason | 2 | 363-364 | A-Numeric | NA | B, C, K, L, M, Q, S, 1, 2, 3, 5, 6, 7, 9 | Code that describes the reason for bypassing the requirement of a NAS. Coding:  B Former spouse w/ pre-existing condition  C Good faith payment  K CHCBP  L Hospice  M Abused family member  Q Active duty claims  S Home Health Agency (HHA)  1 Other primary insurance plan  2 Emergency medical treatment  3 Inpatient in college infirmary  5 Residential treatment center  6 Partnerships  7 Specialized Treatment Facility (STF)  9 TRICARE demonstration projects |
| Special Processing Code | 8 | 365-372 | A-Numeric | NA | 0, 1, 3-7, 10-12, 14, 16, 17, A, E, Q, R, S, T, U, V, W, X, Y, Z, AB, AD, AN, AR, BD, CA, CE, CL, CM, CT, EU, FF, FG, FS, GF, GU, KO, MH, MN, MS, NE, PD, PF, PO, RI, RS, SC, SE, SM, SN, SP, SS, ST, WR | Four occurrences of two alphanumeric characters that indicate special processing is required. Codes values are defined in the *TRICARE Systems Manual*. |
| Filler | 4 | 373-376 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Provider State or Country Code | 3 | 377-379 | A-Numeric | NA | Codes are located in the *TRICARE Systems Manual* | Code assigned to identify the state or foreign country in which the care was received. Codes defined in *TRICARE Systems Manual.* |
| Provider Taxpayer Number | 9 | 380-388 | A-Numeric | NA | None | For institutions, it must be the employer identification number (EIN). For individual providers it must be the EIN or SSN, if available. If not available, the contractor will report the contractor-assigned number. All nines are used for transportation services under program for Persons with Disabilities and for the Drug Program when the services are from a non-participating pharmacy. |
| Provider Sub-Identifier | 4 | 389-392 | A-Numeric | NA | None | Identification number that uniquely identifies multiple providers using the same taxpayer identification number (TIN). |
| Filler | 20 | 393-412 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Provider Zip Code | 9 | 413-421 | A-Numeric | NA | None | The zip code of the location where the care was provided. Must be a valid zip code, or if a foreign country must use the 3-character foreign country code. Left justified. |
| Provider Participation Indicator | 1 | 422 | A-Numeric | NA | N,Y | Indicates whether or not the provider accepted assignment of benefits for services rendered.  N no  Y yes |
| Filler | 1 | 423 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Type of Institution | 2 | 424-425 | A-Numeric | NA | Codes are located in the *TRICARE Systems Manual* | A code describing the type of institution for institutional providers. Codes defined in *TRICARE Systems Manual.* |
| Claim Form Type | 1 | 426 | A-Numeric | NA | A,B,C,D,F,G.H,I,J | The code associated with the primary claim form submitted.  A DD form 2520 (long)  B DD form 2520 (short)  C HCFA form 1500  D UBF-1  F UB-92  G electronic institutional claim submission  H electronic professional claim submission  I electronic drug submission  J other |
| Frequency Code | 1 | 427 | A-Numeric | NA | 1, 2, 3, 4, 7, 8, 9 | A code that describes the frequency of billing from the institution. Valid codes for TEDs:  1 admit thru discharge TED record  2 interim - initial TED record  3 interim - interim TED record  4 interim - final TED record  7 replacement of prior claim  8 void/cancel of prior claim  9 Final claim for Home Health Agency (HHA) episode |
| Type of Admission | 1 | 428 | A-Numeric | NA | 1, 2, 3, 4 | A code indicating the type of this admission.  1 emergency  2 urgent  3 elective  4 newborn |
| Source of Admission | 1 | 429 | A-Numeric | NA | 1-9, A, B, C | A code indicating admission referral source. Coded as follows:  1 Physician referral  2 Clinic referral  3 HMO referral  4 Transfer from a hospital  5 Transfer from a Skilled Nursing Facility (SNF)  6 Transfer from another health care facility  7 Emergency  8 Court/law enforcement  9 Information not available  A Transfer from Critical Access Hospital (CAH)  B Transfer from another HHA  C Readmission to the same HHA  1 For newborn, normal delivery  2 For newborn, premature delivery  3 For newborn, sick baby  4 For newborn, extramural baby |
| Admission Date | 8 | 430-437 | Numeric | NA | None | Date of the patient was first admitted to the institution for this episode. Format: YYYYMMDD. |
| Discharge Status | 2 | 438-439 | A-Numeric | NA | 01, 02, 03, 04, 05, 06, 07, 08, 20, 30, 40, 41, 42, 50, 51, 61, 62, 63, 64, 71, 72 | Code indicating patient status as of the end date of care on the TED record. Coded as follows:  01 Discharged  02 Transferred  03 Discharged/transferred to Skilled Nursing Facility (SNF)  04 Discharged/transferred to Intermediate Care Facility (ICF)  05 Discharged/transferred to another type of institution  06 Discharged/transferred to home under care organized home health service organization  07 Left against medical advice or discont care  08 Discharged/transferred to home under care of a home IV provider  20 Expired (or did not recover – Christ Science)  30 Still patient (remaining)  40 Died at home  41 Died in a medical facility  42 Place of death unknown  50 Discharged to hospice – home  51 Discharged to hospice – medical facility  61 Discharged/transferred within this institution  62 Discharged/transferred to another rehab fac  63 Discharged/transfer to long term care hosp  64 Discharged/transferred to a nursing facility  71 Discharged/transferred/referred to another institution for OP services  72 Discharged/transferred/referred to this institution for OP services |
| Begin Date of Care | 8 | 440-447 | A-Numeric | NA | None | Earliest date of care reported on this HCSR record (YYYYMMDD). |
| End Date of Care | 8 | 448-455 | A-Numeric | NA | None | Latest date of care reported on this HCSR record (YYYYMMDD). |
| Filler | 18 | 456-473 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Government Authorized Bed Days | 3 | 474-476 | Signed Numeric | NA | None | Number of hospital days authorized for services where there was allowance by the contractor. The day of admission is counted as a hospital day. The day of discharge is not counted as a hospital day |
| DRG Number | 3 | 477-479 | A-Numeric | NA | None | Identifies the diagnosis related group (drg) determined for this care. |
| Filler | 5 | 480-484 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Admission Diagnosis | 6 | 485-490 | A-Numeric | NA | None | ICD-9-CM code identifying diagnosis under which the patient was admitted to the institution. |
| Principal Treatment Diagnosis | 6 | 491-496 | A-Numeric | NA | None | The condition established, after study, to be the major cause for the patient to obtain medical care as coded on the claim form or otherwise indicated by the provider. |
| Secondary Treatment Diagnosis-1 | 6 | 497-502 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Treatment Diagnosis-2 | 6 | 5030508 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Treatment Diagnosis-3 | 6 | 509-514 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Treatment Diagnosis-4 | 6 | 515-520 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Treatment Diagnosis-5 | 6 | 521-526 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Treatment Diagnosis-6 | 6 | 527-532 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Treatment Diagnosis-7 | 6 | 533-538 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. |
| Secondary Treatment Diagnosis-8 | 6 | 539-544 | A-Numeric | NA | None | Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. |
| Filler | 18 | 545-562 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Principal Operation/Non-Surgical Procedure Code | 5 | 563-567 | A-Numeric | NA | None | The code that identifies the principal procedure performed during the period covered by this TED record as coded on the UB-92. |
| Secondary Operation/Non-Surgical Procedure Code-1 | 5 | 568-572 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
| Secondary Operation/Non-Surgical Procedure Code-2 | 5 | 573-577 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
| Secondary Operation/Non-Surgical Procedure Code-3 | 5 | 578-582 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
| Secondary Operation/Non-Surgical Procedure Code-4 | 5 | 583-587 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
| Secondary Operation/Non-Surgical Procedure Code-5 | 5 | 588-592 | A-Numeric | NA | None | Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED record. |
| Filler | 31 | 593-623 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Revenue Data Occurrence Count | 3 | 624-626 | A-Numeric | NA | None | Institutional: The number of sets of revenue codes and related data elements that occur on the record.  Non-Institutional: The number of sets of procedure codes and related utilization data elements that occur on the record. |
| Administrative Claim Count Code | 1 | 627 | Numeric | NA | 0-9 | Indicates administrative payment record, on the net HCSR database, this is the sum of all history records (original, adjustments, cancellations). If multiple adjustments/ cancellations are processed, the code could be greater than one. Only one cancellation is permitted.  1 or greater – positive administrative payment  0 – no administrative payment |
| Filler | 14 | 628-633 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Beneficiary Category | 1 | 642 | A-Numeric | NA | 1, 2, 3, 4 | Categorization of beneficiaries based on a given sponsor status for cost sharing and reporting purposes. For non-availability statements,  categorization of beneficiaries is based on the sponsor's status and the patient's relationship to that sponsor. Coded as follows:  1 – active-dependent  2 – retired-sponsor  3 – retired/deceased-dependent and all other patients  4 – active duty sponsor |
| Benefit Claim Count Code | 1 | 643 | Numeric | NA | -1, 0, 1 | Claim count that represents the primary care the beneficiary receives exclusive of any supplemental billings, adjustments or cancellations from the provider. Coded as follows:  -1 – negative benefit count  0 – no benefit count  +1 – positive benefit count |
| Care End Fiscal Year | 4 | 644-647 | Numeric | NA | None | The fiscal year that the delivery of care was completed. |
| Filler | 2 | 648-649 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Contractor Number | 2 | 650-651 | A-Numeric | NA | None | Identification code for the contractor. It is used to identify each contractor submitting health care service records, pricing file records, and provider file records. |
| Cycle Number | 8 | 652-659 | Numeric | NA | None | Derived processing cycle Format: YyyymmNN where NN equals a sequential number for the month. |
| Diagnosis Edition Identifier | 1 | 660 | A-Numeric | NA | None | Identifies the edition number of the diagnosis related grouper which is used to determine the DRG. |
| DRG Derived Code | 3 | 661-663 | A-Numeric | NA | None | The DRG code derived by OCHAMPUS returned by the grouper software package. Elements used principal and secondary diagnosis, procedure codes, discharge status, sex, birth date, admission date, and discharge date. |
| Filler | 2 | 664-665 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Health Services Region Code | 2 | 666-667 | A-Numeric | NA | None | The health service region defined by zip codes |
| Filler | 11 | 668-678 | A-numeric | NA | None | Field that serves as filler between record fields. |
| MDC | 2 | 679-680 | A-Numeric | NA | None | The derived Medical Diagnostic Category (MDC). |
| Filler | 6 | 681-686 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Patient Age | 3 | 687-689 | Numeric | NA | None | Age of patient calculated based on earliest begin date of care versus patient's date of birth. |
| Filler | 55 | 690-744 | A-numeric | NA | None | Field that serves as filler between record fields. |
| HCSR Acceptance Date | 8 | 745-752 | Numeric | NA | None | The last date that the HCSR record was accepted with any corrections. Format: YYYYMMDD. |
| Filler | 8 | 753-760 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Total Bed Days | 3 | 761-763 | Numeric | NA | None | Total number of days of hospital care during the period covered by the TED/HCSR whether or not allowable. |
| Filler | 1 | 764 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Batch Date | 7 | 765-771 | Numeric | NA | None | Date the contractor first created the batch/voucher for transmission to TMA. This date will not change through the resubmission process. Format YYYYDDD. |
| Voucher Processing Date | 8 | 772-779 | Numeric | NA | None | Date the contractor first created the voucher for transmission to TMA (Yyyymmdd). |
| Patient Coinsurance Amount | 8 (6,2) | 780-787 | Signed Numeric | Amount | None | The amount of allowed charges that beneficiaries are required to pay under TRICARE. |
| Patient Copayment Amount | 8 (6,2) | 788-795 | Signed Numeric | Amount | None | A predetermined, fixed amount charged by the MCSC under TRICARE prime, or other demonstrations, or the fixed amounts under the standard champus program that the beneficiary is liable for paying for covered services. |
| DEERS Dependent Suffix Code (DDS) | 2 | 796-797 | A-Numeric | NA | 0 thru 99 | Code that indicates the relationship of a dependent to his or her sponsor. Coded as follows:  01-19 dependent child  20 sponsor  30-39 spouse of sponsor  40-44 mother of sponsor  45-49 father of sponsor  50-54 mother-in-law of sponsor  55-59 father-in-law of sponsor  60-69 children where number greater than 19  98 service secretary designee  99 not classified elsewhere |
| Special Rate Code | 2 | 798-799 | A-Numeric | NA | A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V | Code to indicate which special rates apply in calculating patient cost share or government contractor pay amount. Coded as follows:  BLANK No special rate  A DRG reimbursement 4 percent discount  B DRG reimbursement 3 percent discount  C DRG reimbursement 2 percent discount  D Discount rate agreement  E DRG reimbursement 1 percent discount  F DRG reimbursement no discount  G TRICARE DRG, long stay outlier  H TRICARE DRG, short stay outlier  I TRICARE DRG, cost outlier  J TRICARE DRG, no outlier  K Hospital-specific psychiatric per diem  L Region-specific psychiatric per diem  M Discounted DRG, ling stay outlier  N Discounted DRG, short stay outlier  O Discounted DRG, cost outlier  P Per diem rate agreement  Q Discounted DRG, no outlier  R Ambulatory surgery facility payment rate  S Discounted amb surg facility payment rate  T Non-participating provider 10% payment reduction  U Supplemental health care program claim or active duty member GSU claim paid outside normal limits  V Medicare reimbursement rate |
| Net Record Type Code | 1 | 800 | A-Numeric | NA | I, R, F, C, O, D, B, E, X | After possible multiple submissions have been netted, resultant type of submission of net record. Coded as follows:  I Initial  R Resubmission  F Adjustment to HCSR new suffix  C Cancelled  O Zero payment  D Denied  B Adjusted to non-HCSR data  E Cancelled non-HCSR data  X All other, no activity permitted |

Table ‑ HCSR-I Revenue Record Data Elements

| Field Name  (logical name) | Field Length | Position | Data Type | Data Units | Value Range | Functional Description |
| --- | --- | --- | --- | --- | --- | --- |
| Filing Date | 7 | 1-7 | Numeric | NA | None | Date the request for payment of services rendered was received by the contractor for processing (Yyyyddd). |
| Filing State/Country Code | 3 | 8-10 | A-Numeric | NA | None | Code that indicates the state or country where the primary care was provided. |
| Sequence Number | 7 | 11-17 | A-Numeric | NA | None | A sequential number assigned by the contractor to identify the individual TED record. Once assigned, the sequence number cannot be reused with the same Filing Date and Filing State/Country. |
| Time Stamp | 6 | 18-23 | A-Numeric | NA | None | Unique system time assigned by the claims processor’s computer system when issuing an initial TED record. |
| HCSR Suffix | 1 | 24 | A-Numeric | NA | A thru Y | Code to uniquely identify when treatment encounter data is split into groupings for HCSR reporting purposes.  Assigned in alphabetic order  a no split required  b first split  c second split  d-y etc. |
| Cycle Number | 8 | 25-32 | Numeric | NA | None | Derived processing cycle Format: YyyymmNN where NN equals a sequential number for the month. |
| End Date of Care | 8 | 33-40 | A-Numeric | NA | None | Latest date of care reported on this TED record (YYYYMMDD). |
| Occurrence Number | 3 | 41-43 | A-Numeric | NA | 1 thru 999 | The unique number for each utilization/revenue data occurrence within the TED record. Line item must be assigned in sequential ascending order. |
| Revenue Code | 4 | 44-47 | A-Numeric | NA | UB-92 revenue codes | Code which identifies revenue categories associated with the type of service rendered. Like revenue codes should be summarized to one occurrence for reporting on the TED record. |
| Units of Service By Revenue Code | 10 | 48-57 | Numeric | NA | None | The number of services rendered or number of days, by revenue category. |
| Total Charge by Revenue Code | 9 (7,2) | 58-66 | Numeric | NA | None | Amount billed for this revenue code. |
| Filler | 5 | 67-71 | A-numeric | NA | None | Field that serves as filler between record fields. |
| Denial Reason Code | 2 | 72-73 | A-Numeric | NA | None | The code describing the derived reason for the payment denial of the line item. |

**Appendix B: Acronyms**

|  |  |
| --- | --- |
| **AD** | Active Duty |
| **ATOH** | Adjustments To Original HCSR |
| **CAH** | Critical Access Hospital |
| **CCB** | Configuration Management Board |
| **CEIS** | Corporate Executive Information System |
| **CHAMPVA** | Civilian Health and Medical Program for the Department of Veterans Affairs |
| **CHCBP** | Continued Health Care Benefit Program |
| **DCN** | Document Change Notice |
| **DDS** | DEERS Dependent Suffix |
| **DECC** | Defense Enterprise Computing Center |
| **DEERS** | Defense Enrollment Eligibility Reporting System |
| **DMIS** | Defense Medical Information System |
| **DoD** | Department of Defense |
| **DRG** | Diagnosis Related Group |
| **EIDS** | Executive Information Decision Support |
| **EIN** | Employer Identification Number |
| **FI** | Financial Intermediary |
| **HCFA 1500** | Health Care Financing Administration Professional Fee Billing Claim |
| **HCSR** | Health Care Service Record |
| **HCSR-I** | HCSR Institutional |
| **HHA** | Home Health Agency |
| **HIPAA** | Health Insurance Portability and Accountability Act |
| **HMO** | Health Maintenance Organization |
| **ICD** | Interface Control Document |
| **ICF** | Intermediate Care Facility |
| **M2** | MHS MART |
| **MCSC** | Managed Care Support Contractor |
| **MDC** | Medical Diagnostic Category |
| **MDR** | MHS Data Repository |
| **MEPCOM** | Military Entrance Processing Command |
| **MHS** | Military Health System |
| **MTF** | Medical Treatment Facility |
| **NAS** | Non Availability Statement |
| **NATO** | North Atlantic Treaty Organization |
| **NOAA** | National Oceanographic and Atmospheric Administration |
| **OCHAMPUS** | Office of Civilian Health and Medical Program of the Uniformed Services |
| **OCS** | Officer Candidate School |
| **ODS** | Operational Data Store |
| **OHI** | Other Health Insurance |
| **OP** | Outpatient |
| **ORD** | Operational Requirements Document |
| **PCDW** | Purchased Care Data Warehouse |
| **PCM** | Primary Care Manager |
| **SSN** | Social Security Number |
| **STF** | Specialized Treatment Facility |
| **TAMP** | Transitional Assistance Management Program |
| **TED** | TRICARE Encounter Data |
| **TED-I** | TED Institutional |
| **TFL** | TRICARE For Life |
| **TIN** | Taxpayer Identification Number |
| **TMA** | TRICARE Management Activity |
| **TMA-A** | TMA Aurora |
| **TNEX** | TRICARE Next Generation Contract |
| **TPL** | Third Party Liability |
| **UB92** | Uniform Billing Claim Form |