**14 July 2014**

HIPAA 837 Institutional File Processing Specification for the

Centralized Billing Event Repository (CBER)

(Version 1.01.03)

Future Specification

**Revision History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Version** | **Date** | **Para/Tbl/Fig** | **Originator** | **Description of Change** |
| 1.01.00 | 4/29/2013 | * Whole Document | K. Hofmann | * Initial version |
| 1.01.01 | 7/1/2013 | * Section VIII, Table 4 * Appendix A | K. Hofmann | * Added business rule for Facility Type Code * Changed business rule for Claim Frequency Code * Changed names of Begin and End Dates, Disposition Code, Record ID, Principal Complaint. * Changed business rule for Diagnosis Type Code to include date for transition from ICD-9-CM to ICD-10 * Changed length and rules for all diagnosis fields for transition to ICD-10. * Added rules for identifying external cause of injury codes in ICD-10. * Changed rules for procedure and procedure dates based on updates to SIDR * Changed length and rules for all procedure fields for transition to ICD-10 * Added Attending Provider SSN * Removed CPT dates 1-13. * Updated Ancillary record key, and added Provider SSN. |
| 1.01.02 | 8/1/2013 | * Section IV * Section V * Section VII, Table 3 * Section VIII, Table 4 * Section XII | K. Hofmann | * Description of text output. * Reworded criteria for Ancillary records. * Remove merge to MDR Death File (use dispstat) and "APC Conversion Factor Table" (use DMIS ID Index Table). * Change length of RECORD\_ID. * Consolidate INJDX1-INJDX12, DX2-DX20, PROC1-PROC20, CPT\_1-CPT\_13 and all related fields. * Moved APC Conversion Factor to DMIS ID Index Table Merge section. * Added Process Flag. * Added layout of text output. |
| 1.01.03 (on hold) | 7/14/2014 | * Section I * Section II * Section IV * Section V, Table 2 * Section VI * Section VII, Table 3 * Section VIII, Table 4 * Section X * Section XII, Table 5 * Appendix A, B | K. Hofmann | * Removed mentions of calculating the bill amount. * Removed references to MDR Ancillary File. * Added information about organization and batching. * Edited rule for filters for TPC to include OHI dates. * Edited rule for filters for MSA to include DEERS Sponsor Service, and to exclude Coast Guard records. * Changed CAPER filter to use Facility Flag instead of MEPRS Code. * Reworded which types of ancillary records are included in this file. Drop Resource Sharing records, and remove requirement about providers with restricted billing. * Changed deduping rule for labs to include both 32 and 00. * Added note about deduping file by RECORD\_ID * Removed merge to Ancillary Cancellation File. * Clarify that NPPES merges use admission/begin date. * Added NPPES merge for Rendering Provider. * Changed RECORD\_ID for records from CADRE. * Clarified rules for getting diagnoses on Ancillary data. * Changed which provider goes in the Attending Provider fields, added Rendering Provider. * Changed rules for ADMDX and Complaint to account for transition from ICD-9-CM to ICD-10, and changed the date for this transition to Oct 1, 2015. * CPT variables are taken from CAPER Basic rather than Enhanced. * Added ordering MEPRS code, patient subcategory code, facility flag, injury data from CAPER, CCE status flag, ordering MEPRS Code, APC and ASC codes, sponsor service, bencat, MSA Key, DEERS Eligibility Flag, APC Flag, Injury fields from CAPER, Change Date and Flag, IMET and IAR rates. * Removed APCAGGWT, MIDDLENAME, SUBCOUNTRY, APC\_CONV, INJ\_REL, ANC\_CANCEL PROV\_CLASS, UPDT\_DT PROV\_SIG PLAN\_ASSIGN, BEN\_ASSIGN, RLS\_INFO, CHARGE, PROCESS\_FLAG. * Renamed CPTUOS, ORDER\_DMISID, HOSTDMIS, PATUNIQ, PATCAT\_R. * Changed business rules for DMIS ID attributes that are now in the DMIS ID Index Table, and clarified merge to get NPI. * Clarified Facility Type Code business rule. * Updated length of name fields from NPPES. * Updated rules for the SIDR Cancellation File merge. * Updated HIPAA Taxonomy merge. * Change values for MAC and MSA flags. * Edited QC Requirements. * Edited explanation of Special Outputs. * Removed OHI and SIT fields from output section (to be described in those specs. * Added some housekeeping fields to output section. * Reorganized output section for space, and removing unnecessary fields. * Updated the combined Ancillary table pre-processing. * Updated MSA Key Appendix to account for new treatment services. |

**CBER 837 Institutional (837I)**

1. Background:

The Centralized Billing Event Repository (CBER) project is intended to create data files that the Services can use to bill for care provided in military treatment facilities, under the following programs: Third Party Collections (TPC), Medical Affirmative Claims (MAC), and Medical Services Account (MSA). This processing specification describes the file that is used for billing for institutional services. This data file uses MHS data sources and a series of reference files to ensure that records are coded as close to~~according~~ to HIPAA standards as possible. ~~And to calculate billing amounts, in accordance with TRICARE payment policies.~~

1. Source:

There are ~~four~~three primary sources for the CBER 837I file: The MDR Standard Inpatient Data Record (SIDR), the MDR Comprehensive Ambulatory Professional Encounter Record (CAPER), ~~the MDR Ancillary file,~~ and the MDR CADRE Basic files.

1. Transmission (Format and Frequency):

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

1. Organization and Batching

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

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

Output Products: The CBER 837I processor produces the files described in table 1. The preparation of the compressed SAS data set is described in subsequent sections of this document. The text file is taken from the SAS data set and its layout is described in Section XII.

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

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

Archival of files is also required, so that corresponding “apub” and other files (e.g., log, aprod, etc) are also loaded into the MDR according to routine operating procedures.

1. Receiving Filters

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

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

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

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

Records that meet the criteria in table 2 are further filtered to ensure that the care represented on the MDR SIDR, MDR CAPER or Ancillary Record represents a valid institutional service

* + MDR SIDR: All records are considered institutional.
  + MDR CAPER: Only facility ~~Emergency Department and Same Day Surgery~~ records are considered institutional. These are identified by selecting records with Facility Flag (FAC\_FLAG) = "F". ~~using the MEPRS Code. Emergency Department records are those with MEPRS Code starting with BI\*. Same Day Surgery records are those with MEPRS Code starting with B, and ending with 5 or 7 (or 6 for DMIS ID 0124).~~ 
    - If the disposition code on the CAPER = 7 (Admitted), then exclude. These records will be billed under the inpatient stay.

* + MDR ~~Ancillary and~~ CADRE: ~~Only technical components of Laboratory and Radiology records are only considered institutional. These are identified using the CPT Modifier. Technical components of Lab records are those with modifier 00 or 32, and technical components of Radiology records are those with modifier TC.~~
    - Check for professional and technical components: Ancillary records are held from processing for ~~X~~7 days to ~~give time for~~see if both a professional and technical component ~~records associated with the same~~arrive for a given CHCS Host, Accession Number, Order ID, and CPT code. ~~To arrive. If there are two records present, then only one is billed (the most recent of the two) with the modifier indicating professional or technical component removed and replaced with modifier 00~~
    - For laboratory records, if the record type modifier ("MOD") is not "AP", include on the 837I.
    - Radiology records are not included on the 837I.
    - Duplicate records: If two records show up with the same CHCS Host, Accession Number, Order ID, and CPT code, and one has a modifier 32 or 00 and the other a modifier 90, exclude the record with the modifier 32 or 00.
    - Also exclude ~~laboratory~~ records with ordering MEPRS1 Code is “A”. These records will be billed under the inpatient stay.
    - Records with a branch of service code of B, G, R, 1, 2, 3, 5, or 6 are deleted.
    - ~~For ancillary records that are technical components only, any of the following criteria must be met:~~
      * ~~The restricted taxonomy billing flag on the HIPAA Taxonomy Table is ‘N’ or~~
      * ~~The restricted taxonomy billing flag is ‘Y’ and the restricted CPT billing flag is ‘Y’ or ‘T’~~
    - ~~For ancillary records that are combined technical and professional components, any of the following criteria must be met:~~ 
      * ~~The restricted taxonomy billing flag on the HIPAA Taxonomy Table is ‘N’ or~~
      * ~~The restricted taxonomy billing flag is ‘Y’ and the restricted CPT billing flag is ‘Y’~~

1. Update Process

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

When updating the master database, records are netted by retaining the most recently received record for any given record key (see RECORD\_ID below).

1. Field Transformations and Deletions for CBER Core Database

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

**Table 3: External Reference File Merges**

| **Merge** | **Date Matching** | **Additional Matching** |
| --- | --- | --- |
| MDR Address File | N/A | Match based on Patient EDI\_PN~~SSN~~. If no match use Patient SSN~~EDI\_PN~~. |
| NPPES (Merge 1) | Deactiviation Date has not passed using begin/admission date. | Match Attending Provider NPI to NPI where entity type code is individual. |
| NPPES (Merge 2) | Deactiviation Date has not passed using begin/admission date. | Match Operating Provider NPI to NPI where entity type code is individual. |
| NPPES (Merge 3) | Deactiviation Date has not passed using begin/admission date. | Match Other Operating Provider NPI to NPI where entity type code is individual. |
| NPPES (Merge 4) | Deactiviation Date has not passed using begin/admission date. | Match Rendering Provider NPI to NPI where entity type code is individual. |
| MDR DMIS ID Index Table | Fiscal Year of DMIS ID Table and Fiscal Year of SIDR/CAPER/Ancillary Record (based on end/disposition date) | Match based on Treatment DMIS ID. If no NPI2 is found, some variables will be derived based on ~~then~~ match by~~on~~ Parent Treatment DMIS ID. |
| MDR Injury Reference File | Date of Service/Admission Date between start and stop date of injury information. | Match based on Patient EDI\_PN first, if no match, based on Patient SSN. |
| Patient category code table | Fiscal Year | Patient Category Code and Patient Subcategory Code. |
| SIDR Cancellation File |  | ~~TBD~~MTF and PRN. |
| CAPER Cancellation File |  | CHCS Host and Appointment IEN |
| ~~Ancillary Cancellation File~~ | ~~TBD~~ | ~~TBD (Being added to data)~~ |
| MDR MS-DRG Table | Fiscal Year | Match based on MS-DRG |
| ~~Inpatient Billing Policy~~ Adjusted Standardized Amount Table | Fiscal Year | Match based on Fiscal Year |
| MDR HIPAA Taxonomy File |  | Match based on Attending Provider HIPAA Taxonomy |
| CPT/HCPCS reference table | Calendar Year | ~~CPT/HCPCS~~For CAPER : CPT. For CADRE : CPT and Modifier where setting flag is « PC ». |
| HIPAA Admission Source |  | Match based on Admission Source from SIDR. |
| HIPAA Disposition Code (SIDR and CAPER) |  | Match based on Recoded Disposition Status from SIDR or Disposition Code from CAPER. |
| CHCS Host |  | Match based on Treatment DMIS ID from SIDR. |
| HIPAA Present on Admission Indicator |  | Match based on Present on Admission per Diagnosis Code from SIDR |
| MDR OHI File | Encounter/Admission date is between the begin and end date of the OHI | EDIPN first, and if no match, then patient SSN. |
| MDR SIT File |  | MSA Key |
| MPI | N/A | See MPI Specification |
| LVM |  | See LVM Specification |
| APC Rate Table | CY | APC |
| ASC Rate Table | Encounter/Admisison date is between the begin and end date of the Gen Period | ASC |
| CMAC Rate Table | CY | CPT/HCPCS Code and Modifier |

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

1. Record Layout and Content

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

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

| **Data Element** | **SAS Name** | **Format** | **SIDR** | **CAPER** | **Ancillary Combined** | **Business Rule** |
| --- | --- | --- | --- | --- | --- | --- |
| **From SIDR, CAPER, and/or Ancillary Combined file** | | | | | | |
| Time of Discharge | TIMEDISC | HHMM | TIMEDISC | N/A | N/A | No transformation. |
| Statement Begin and End Dates | DATES | CCYYMMDD-CCYYMMDD | ADMDATE, DISPDATE | ENCDATE | ~~SERV~~ENCDATE | For SIDR: Format dates as CCYYMMDD and concatenate with hyphen dividing the two dates. For CAPER/Ancillary: Use same date for Begin and End Dates, and concatenate with hyphen dividing the two dates. |
| Admission Date/Hour Format | ADMDATEFMT | $2 | N/A | N/A | N/A | If TIMEADM is populated, then set to ‘DT’. Else set to ‘D8’. |
| Admission Date and Time | ADMDATETIME | CCYYMMDD or CCYYMMDDHHMM | ADMDATE, TIMEADM | N/A | N/A | If TIMEADM is populated then concatenate ADMDATE (formatted as CCYYMMDD) and TIMEADM. Else format ADMDATE as CCYYMMDD. |
| Admission Source | ADMSRC | $1 | ADMSRC | N/A | N/A | Apply Admission Source Mapping Format. |
| Patient Status Code | DISPCODE | $2 | RECDISP | DISPCODE | N/A | Apply Disposition Code Mapping Format. |
| Medical Record Number | RECORD\_ID | $41 | MTF, PRN | HOSTDMIS, APPTIDNO | ANC\_RECTYPE, RECORD\_ID~~TYPE, CHCSDMIS, ACCESSNO, ORDERID, CPT, CPTMOD~~ | For SIDR: Concatenate “S” with MTF and PRN. For CAPER: Concatenate “C” with CHCS Host and Appointment IEN. For Ancillary: Concatenate Ancillary Record Type~~“A”~~ with Record ID~~Type, CHCS Host, Accession Number, Order ID, CPT Code, and CPT Modifier~~. |
| Principal Diagnosis | DX1 | $7 | DX1 | DX1 | N/A | For SIDR and CAPER: While MHS is using ICD-9-CM, keep only first five characters. Once MHS switches to ICD-10 (~~admission~~disposition/encounter date ≥ Oct 1, 2015~~4~~), keep first seven characters. ~~For Ancillary: Link to CAPER based on CHCS Host and Appointment ID = Related Record ID, where appointment match flag = ‘LIN’ and retrieve diagnosis codes from the CAPER.~~ ~~Should we be matching to SIDR too?~~ |
| Principal Diagnosis Present on Admission Indicator | DX1POA | $1 | DX1POA | N/A | N/A | Apply Present on Admission Indicator Mapping Format. |
| Admitting Diagnosis | ADMDX | $7 | ADMDX | N/A | N/A | While MHS is using ICD-9-CM, keep only first five characters. Once MHS switched to ICD-10 (disposition date ≥ Oct 1, 2015), keep first seven characters.~~Keep only first five characters.~~ |
| Patient Reason for Visit | COMPLAINT | $7 | N/A | COMPLAINT | N/A | While MHS is using ICD-9-CM, keep only first five characters. Once MHS switched to ICD-10 (encounter date ≥ Oct 1, 2015), keep first seven characters.~~Keep only first five characters.~~ |
| External Cause of Injury 1 – External Cause of Injury 12 | INJDX*i*  where *i* = 1 to 12 | $7 | DX*j* | DX*j* | N/A | For SIDR and CAPER: While MHS is using ICD-9-CM codes, scan DX2-DX20 for ‘E’ diagnosis codes. Store them in these variables, and keep only first five characters. Once MHS switches to ICD-10 (~~admission~~disposition /encounter date ≥ Oct 1, 2015~~4~~), scan DX2-DX20 for codes starting with 'V', 'W', 'X', or 'Y', and keep first seven characters. ~~For Ancillary: Link to CAPER based on CHCS Host and Appointment ID = Related Record ID, where appointment match flag = ‘LIN’ and retrieve diagnosis codes from the CAPER.~~ ~~Should we be matching to SIDR too?~~ |
| External Cause of Injury POA Indicator 1 – External Cause of Injury POA Indicator 12 | INJDXPOA*i*  where *i* = 1 to 12 | $1 | DX*j*POA | N/A | N/A | Use DX*j*POA corresponding to the DX*j* above. Apply Present on Admission Indicator Mapping Format. |
| MS-DRG | MSDRG | $3 | MSDRG | N/A | N/A | No transformation. |
| Diagnosis 2 – Diagnosis 20 | Dx*i*  where *I* = 2 to 20 | $7 | DX*j* | DX*j* | ~~DX~~*~~j~~*N/A | For SIDR and CAPER: While MHS is using ICD-9-CM, Scan DX2-DX20 for diagnosis codes other than ‘E’ Codes. Store them in these variables, and~~,~~ keep only first five characters. Once MHS switches to ICD-10 (~~admission~~disposition /encounter date ≥ Oct 1, 2015~~4~~), scan DX2-DX20 for codes not starting with 'V', 'W', 'X', or 'Y', and keep first seven characters. ~~For Ancillary: Link to CAPER based on CHCS Host and Appointment ID = Related Record ID, where appointment match flag = ‘LIN’ and retrieve diagnosis codes from the CAPER.~~ ~~Should we be matching to SIDR too?~~ |
| Diagnosis Present on Admission Indicator 2 – Diagnosis Present on Admission Indicator 20 | DXPOA*i*  where *i* = 2 to 20 | $1 | DX*j*POA | N/A | N/A | Use DX*j*POA corresponding to the DX*j* above. Apply Present on Admission Indicator Mapping Format. |
| Principal Inpatient Procedure | PROC1 | $7 | PROC1 | N/A | N/A | No transformation. |
| Principal Inpatient Procedure Date | PROCDATE1 | CCYYMMDD | STARTPROC1 | N/A | N/A | No transformation |
| Inpatient Procedure 2 – Inpatient Procedure 20 | PROC*i*  where *i* = 2 to 20 | $7 | PROC*j*  where *j* = 2 to 20 | N/A | N/A | No transformation. |
| Inpatient Procedure Date 2 – Inpatient Procedure Date 20 | PROCDATE*i*  where *i* = 2 to 20 | CCYYMMDD | STARTPROC*j*  where *j* = 2 to 20 | N/A | N/A | No transformation. |
| Attending Provider NPI | ATTNDNPI | $10 | ATTNDNPI | PROVNPI1 | O~~C~~PNPI | No transformation. |
| Attending Provider EDIPN | ATTNDEDIPN | $10 | ATTNDEDIPN | PROVEDIPN1 | O~~C~~PEDIPN | No transformation. |
| Attending Provider SSN | ATTNDSSN | $9 | PROVSSN | N/A | O~~C~~PSSN | No transformation. |
| Attending Provider HIPAA Taxonomy | ATTNDTAX | $10 | HIPAAPRV | PROVHIPAA1 | O~~C~~PHIPAA | No transformation. |
| Operating Physician NPI | OPNPI | $10 | PNA*j*PNPI*n* | N/A | N/A | ~~Scan PROC1-PROC20 for the first surgical procedure.~~ Fill this variable with the first provider (n=1) for th~~at~~e first procedure (j = number of first ~~surgical~~ procedure). |
| Other Operating Physician NPI | OTHOPNPI | $10 | PNA*j*PNPI*n* | N/A | N/A | Use the same j as above, and fill with the next provider if populated (n=2). If not populated, find the next ~~surgical~~ procedure (j), and take the first provider on that procedure (n=1). If that provider is the same as the Operating Physician NPI, continue similarly until a second unique provider is found. |
| Rendering Provider NPI | RENDNPI | $10 | N/A | N/A | CPNPI | No transformation. Generally populated only for pathology labs or radiology. |
| Rendering Provider EDIPN | RENDEDIPN | $10 | N/A | N/A | CPEDIPN | No transformation. Only populate this field if CPNPI is populated. |
| Rendering Provider SSN | RENDSSN | $9 | N/A | N/A | CPSSN | No transformation. Only populate this field if CPNPI is populated. |
| Rendering Provider HIPAA Taxonomy | RENDTAX | $10 | N/A | N/A | CPHIPAA | No transformation. Only populate this field if CPNPI is populated. |
| CPT Code 1 – CPT Code 13 | CPT\_*i*  where *i* = 1 to 13 | $5 | N/A | CPT\_*j*  where *j* = 1 to 13 | CPT | For CAPER: Take from CAPER Basic. For ~~/~~Ancillary: No transformation. |
| CPT Code 1 Modifier 1 – CPT Code 13 Modifier 1 | CPTMOD1\_*i*  where *i* = 1 to 13 | $2 | N/A | CPTMOD1\_*j*  where *j* = 1 to 13 | CPTMOD | For CAPER: Take from CAPER Basic. For ~~/~~Ancillary: No transformation. |
| CPT Code 1 Modifier 2 – CPT Code 13 Modifier 2 | CPTMOD2\_*i*  where *i* = 1 to 13 | $2 | N/A | CPTMOD2\_*j*  where *j* = 1 to 13 | N/A | For CAPER: Take from CAPER Basic~~No transformation~~. |
| CPT Code 1 Modifier 3 – CPT Code 13 Modifier 3 | CPTMOD3\_*i*  where *i* = 1 to 13 | $2 | N/A | CPTMOD3\_*j*  where *j* = 1 to 13 | N/A | For CAPER: Take from CAPER Basic~~No transformation~~. |
| CPT Code 1 Units of Service – CPT Code 13 Units of Service | CPTUNIT~~O~~S\_*i*  where *i* = 1 to 13 | 3. | N/A | CPTUNIT~~O~~S\_*j*  where *j* = 1 to 13 | COUNT | For CAPER: Take from CAPER Basic.  Store as 3. |
| Treatment DMIS ID | DMISID | $4 | MTF | DMISID | ~~TMT~~DMISID | No transformation. |
| Ordering Appointment Number | ORDER\_APPTID | $14 | N/A | N/A | ORD\_APPTIEN~~NO~~ | No transformation. |
| Ordering DMIS ID | ORD~~ER~~\_MTF~~DMISID~~ | $4 | N/A | N/A | ORD\_MTF~~DMIS~~ | No transformation. |
| Ordering MEPRS Code | ORD\_MEPRSCD | $4 | N/A | N/A | ORD\_MEPRSCD | No transformation. |
| CHCS Host | HOST\_DMISID | $4 | N/A | HOSTDMIS | ~~CHCS~~HOST\_DMISID | For SIDR: Obtain CHCS\_PAR from the DMIS ID Index Table~~Apply CHCS Host Mapping Format~~. For CAPER/Ancillary: No transformation. |
| Treatment DMIS ID Military Service | TXSVC | $1 | MTFSVC | TXSVC | N/A | For SIDR/CAPER: No transformation. For Ancillary: Match to DMIS ID Index Table using Treatment DMIS ID. |
| CLIA Number | CLIA | $15~~7~~ | N/A | N/A | CLIA | No transformation. |
| Patient EDIPN | EDI\_PN~~PATUNIQ~~ | $10 | PATUNIQ | EDIPN | EDI\_PN | No transformation. |
| Patient SSN | PATSSN | $9 | PATSSN | PATSSN | PATSSN | No transformation. |
| Patient Category Code 3 | PATCAT~~\_R~~ | $3~~4~~ | PATCAT1 | PATCAT\_R | PATCAT | No transformation. |
| Patient Subcategory Code | PATCAT\_SUBCAT | $1 | PATSUBCODE | PATCAT2 | PATCAT2 | No transformation. |
| Other Health Insurance – Local | OHI | $1 | N/A | OHI | OHI | No transformation. |
| Medical Insurance Billable | INSBILL | $1 | N/A | INSBILL | N/A | No transformation. |
| Patient Hospital Status | HOSPSTAT | $1 | N/A | HOSPSTAT | N/A | For CAPER: No transformation. |
| Inpatient Appointment | INPAPPT | $1 | N/A | INPAPPT | N/A | For CAPER: No transformation. |
| Inpatient Record ID | MTF\_PRN | $11 | MTF, PRN | MTF\_PRN | ~~CHCSDMIS,~~ MTF\_PRN | For SIDR: Concatenate Treatment DMIS ID with PRN. For CAPER/Ancillary: No transformation. ~~For Ancillary: Concatenate CHCS Host with PRN.~~ |
| MEPRS Code | MEPRSCD | $4 | N/A | MEPRSCD | N/A | No transformation. |
| Facility Flag | FAC\_FLAG | $1 | N/A | FAC\_FLAG | N/A | No transformation. |
| Ambulatory Surgery | AMBSURG | $1 | N/A | AMBSURG | N/A | No transformation. |
| Injury Related Flag | INJREL | $1 | N/A | INJREL | N/A | No transformation. |
| Date of Injury | INJDATE | CCYYMMDD | N/A | INJDATE | N/A | No transformation. |
| Injury Related Cause 1 – 3 | INJCODE*j* where *j* = 1 to 3 | $2 | N/A | INJCODE*j* where *j* = 1 to 3 | N/A | No transformation. |
| Injury Geographic Location | INJGEOGLOC | $5 | N/A | INJGEOGLOC | N/A | No transformation. |
| Injury Place of Accident | INJPOA | $54 | N/A | INJPOA | N/A | No transformation. |
| Injury Place of Employment | INJPOE | $54 | N/A | INJPOE | INJPOE | No transformation. |
| Patient Birth Date | PATDOB | CCYYMMDD | BIRTDATE | PATDOB | PATDOB | For SIDR: Format as CCYYMMDD. For CAPER/Ancillary: No transformation. |
| Patient Gender | PATSEX | $1 | DMISSEX | PATSEX | PATSEX | If not “M” or “F” then set to “U”. |
| Bed Days | DAYS | 8. | DMISDAYS | N/A | N/A | No transformation. |
| ~~APC Aggregate Weight~~ | ~~APCAGGWT~~ | ~~8.~~ | ~~N/A~~ | ~~APCAGGWT~~ | ~~N/A~~ | ~~No transformation.~~ |
| Ancillary Record Type | ANC\_RECTYPE | $1 | N/A | N/A | ANC\_RECTYPE | No transformation. |
| APC 1 – APC 13 | APC*i*  where *i* = 1 to 13 | $5 | N/A | APC*j*  where *j* = 1 to 13 | N/A | For CAPER: No transformation. |
| APC Procedure Status Indicator (PSI) 1 – APC PSI 13 | APCPSI*i*  where *i* = 1 to 13 | $2 | N/A | APCPSI*j*  where *j* = 1 to 13 | N/A | For CAPER: No transformation. |
| ASC 1 – ASC 13 | ASC*i*  where *i* = 1 to 13 | $2 | N/A | ASC*j*  where *j* = 1 to 13 | N/A | For CAPER: No transformation. |
| Sponsor Service | SPONSVC | $1. | DSPONSVC | SSVCLVM | SPONSVC | No transformation. |
| Beneficiary Category | BENCAT | $3. | BENCATX | BENCATX | BENCAT | No transformation. |
| CCE Status | CCESTAT | $1. | N/A | CCESTAT | N/A | No transformation. |
| File Date | FILE\_DT | CCYYMMDD | FILEDATE | FILEDATE | FILEDATE | Reformat as CCYYMMDD as necessary. |
| **From Address File Merge: First merge based on Patient EDI\_PN~~SSN~~. If no match found, use Patient SSN~~EDI\_PN~~.** | | | | | | |
| Patient Last Name | LASTNAME | $27 | N/A | N/A | N/A | If C\_UPDT >= D\_UPDT then C\_NAME2, else D\_NAME2. |
| Patient First Name | FIRSTNAME | $20 | N/A | N/A | N/A | If C\_UPDT >=D\_UPDT, then C\_NAME1, else D\_NAME1. |
| ~~Patient Middle Name~~ | ~~MIDDLENAME~~ | ~~TBD~~ | ~~N/A~~ | ~~N/A~~ | ~~N/A~~ | ~~N/A~~ |
| Patient Suffix | SUFFIX | $4 | N/A | N/A | N/A | Set to D\_CADENCY. |
| Patient Address Line 1 | ADDR1 | $40 | N/A | N/A | N/A | If C\_UPDT >=D\_UPDT, then C\_ADDR1, else D\_ADDR1. |
| Patient Address Line 2 | ADDR2 | $40 | N/A | N/A | N/A | If C\_UPDT >=D\_UPDT, then C\_ADDR2, else D\_ADDR2. |
| Patient City | CITY | $20 | N/A | N/A | N/A | If C\_UPDT >=D\_UPDT, then C\_CITY, else D\_CITY. |
| Patient State | STATE | $2 | N/A | N/A | N/A | If C\_UPDT >=D\_UPDT, then ~~apply HIPAA format to~~ C\_STATE, else ~~apply HIPAA format to~~ D\_STATE. |
| Patient ZIP Code | PATZIP | $9 | N/A | N/A | N/A | If C\_UPDT >=D\_UPDT, then C\_ZIP, else concatenate D\_ZIP | DZIP4. |
| Patient Country Code | COUNTRY | $2 | N/A | N/A | N/A | Set to D\_CNTRY. |
| ~~Patient Country Subdivision Code~~ | ~~SUBCOUNTRY~~ | ~~TBD~~ | ~~N/A~~ | ~~N/A~~ | ~~N/A~~ | ~~N/A~~ |
| **From NPPES Merge 1: Merge based on Attending Provider NPI** | | | | | | |
| Attending Provider Last Name | ATTNDLAST | $35~~28~~ | N/A | N/A | N/A | Set to LASTNAME. |
| Attending Provider First Name | ATTNDFIRST | $20~~8~~ | N/A | N/A | N/A | Set to FIRSTNAME. |
| Attending Provider Middle Name | ATTNDMID | $20 | N/A | N/A | N/A | Set to MIDNAME. |
| Attending Provider Suffix | ATTNDSFX | $4 | N/A | N/A | N/A | Set to SUFFIX. |
| Attending Provider HIPAA Taxonomy from NPPES | NPPESTAX | $10 | N/A | N/A | N/A | Set to HIPAA1. |
| **From NPPES Merge 2: Merge based on Operating Physician NPI (SIDR only)** | | | | | | |
| Operating Physician Last Name | OPLAST | $35~~28~~ | N/A | N/A | N/A | Set to LASTNAME. |
| Operating Physician First Name | OPFIRST | $20~~8~~ | N/A | N/A | N/A | Set to FIRSTNAME. |
| Operating Physician Middle Name | OPMID | $20 | N/A | N/A | N/A | Set to MIDNAME. |
| Operating Physician Suffix | OPSFX | $4 | N/A | N/A | N/A | Set to SUFFIX. |
| **From NPPES Merge 3: Merge based on Other Operating Physician NPI (SIDR only)** | | | | | | |
| Other Operating Physician Last Name | OTHOPLAST | $35~~28~~ | N/A | N/A | N/A | Set to LASTNAME. |
| Other Operating Physician First Name | OTHOPFIRST | $20~~8~~ | N/A | N/A | N/A | Set to FIRSTNAME. |
| Other Operating Physician Middle Name | OTHOPMID | $20 | N/A | N/A | N/A | Set to MIDNAME. |
| Other Operating Physician Suffix | OTHOPSFX | $4 | N/A | N/A | N/A | Set to SUFFIX. |
| **From NPPES Merge 4: Merge based on Rendering Provider NPI (Ancillary only)** | | | | | | |
| Rendering Provider Last Name | RENDLAST | $35 | N/A | N/A | N/A | Set to LASTNAME. |
| Rendering Provider First Name | RENDFIRST | $20 | N/A | N/A | N/A | Set to FIRSTNAME. |
| Rendering Provider Middle Name | RENDMID | $20 | N/A | N/A | N/A | Set to MIDNAME. |
| Rendering Provider Suffix | RENDSFX | $4 | N/A | N/A | N/A | Set to SUFFIX. |
| **From DMIS ID Index Table Merge: ~~First m~~Merge based on Treatment DMIS ID. ~~If no NPI2 is found,~~ Some fields may require merge based on Parent Treatment DMIS ID.** | | | | | | |
| Parent Treatment DMIS ID | PARENT | $4 | N/A | N/A | N/A | Set to UBU\_PAR. |
| Billing Provider NPI | BILLNPI | $10 | N/A | N/A | N/A | Use NPI2 of Treatment DMIS ID. If there is no NPI2, use NPI2 of Parent Treatment DMIS ID. |
| Billing Provider HIPAA Taxonomy | BILLTAX | $10~~1~~ | N/A | N/A | N/A | ~~N/A~~if there is an NPI2 for the Treatment DMIS ID, set to NPITAX of the Treatment DMIS ID. Else set to the NPITAX of the Parent Treatment DMIS ID. |
| Billing Provider Name | BILLNAME | $35 | N/A | N/A | N/A | If there is an NPI2 for the Treatment DMIS ID, ~~S~~set to ~~INSTALNM~~BILL\_PROV\_NAME of the Treatment DMIS ID. Else set to the BILL\_PROV\_NAME of the Parent Treatment DMIS ID. |
| Billing Provider Address First Line | BILLADDR1 | ~~TBD~~$60 | N/A | N/A | N/A | ~~N/A~~Set to BILL\_ADDRESS1. |
| Billing Provider Address Second Line | BILLADDR2 | ~~TBD~~$60 | N/A | N/A | N/A | ~~N/A~~Set to BILL\_ADDRESS2. |
| Billing Provider City | BILLCITY | $32 | N/A | N/A | N/A | Set to ~~FAC~~BILL\_CITY. |
| Billing Provider State | BILLSTATE | $2 | N/A | N/A | N/A | Set to ~~FAC~~BILL\_STATE. |
| Billing Provider ZIP Code | BILLZIP | $5 | N/A | N/A | N/A | Set to ~~FAC~~BILL\_ZIP. |
| Billing Provider Country Code | BILLCOUNTRY | $2 | N/A | N/A | N/A | Set to ~~FACCNTRY~~BILL\_COUNTRY. |
| Billing Provider Country Subdivision Code | BILLSUBCOUNTRY | ~~TBD~~$5 | N/A | N/A | N/A | ~~Add to DMISID Table. Need a reference table~~ Set to BILL\_COUNTRY\_SUB. |
| Billing Provider Tax ID | BILLTAXID | ~~TBD~~$11 | N/A | N/A | N/A | ~~N/A~~Set to BILL\_TAX\_ID. |
| Treatment DMIS ID Name | DMISIDNAME | $35 | N/A | N/A | N/A | Set to INSTALNM of Treatment DMIS ID. |
| CMAC Locality Code | LOCALITY | $2 | N/A | N/A | N/A | Set to LOCALITY |
| GPCI Carrier Code | GPCI\_CAR | $5 | N/A | N/A | N/A | Set to ~~GPCI\_~~CARRIER. |
| Work GPCI | GPCI\_WORK | 6.4 | N/A | N/A | N/A | Set to GPCI\_CMS\_WORK |
| PE GPCI | GPCI\_PE | 6.4 | N/A | N/A | N/A | Set to GPCI\_CMS\_PE |
| CBER IP Start Date | IP\_START | ~~TBD~~8. (SAS Date) | N/A | N/A | N/A | ~~No transformation.~~ Set to IP\_START. |
| CBER IP Stop Date | IP\_STOP | ~~TBD~~8. (SAS Date) | N/A | N/A | N/A | ~~No transformation.~~ Set to IP\_END. |
| VA MSA Carrier ID | VA\_CARRIER | $9 | N/A | N/A | N/A | ~~No transformation.~~ Set to MSA\_KEY. |
| Wage Index | WAGE\_INDEX | ~~8.~~6.4 | N/A | N/A | N/A | ~~Needs to be added to DMIS ID table.~~ Set to WAGE\_INDEX. |
| Number of Interns & Residents | INTERNS | 8. | N/A | N/A | N/A | ~~Needs to be added to DMIS ID table.~~ Set to INTERNS. |
| Number of Beds | BEDS | 8. | N/A | N/A | N/A | ~~Needs to be added to DMIS ID table.~~ Set to BEDS. |
| ~~APC Conversion Factor~~ | ~~APC\_CONV~~ | ~~8.~~ | ~~N/A~~ | ~~N/A~~ | ~~N/A~~ | ~~Get APC\_CNV\_CMS\_Q~~*~~i~~* ~~where~~ *~~I~~* ~~is the appropriate quarter based on the statement begin date.~~ |
| **~~From Injury Reference File Merge: First merge based on Patient EDI\_PN. If no match found, use Patient SSN.~~** | | | | | | |
| ~~Injury Related Record Flag~~ | ~~INJ\_REL~~ | ~~$1~~ | ~~N/A~~ | ~~N/A~~ | ~~N/A~~ | ~~Set to 1 if the record is added to the 837I filed because it meets the criteria for injury reporting in table 2, else set to 0.~~ |
| **From SIDR Cancellation File** | | | | | | |
| SIDR Record Cancel Date | SIDR\_CANCEL | CCYYMMDD | N/A | N/A | N/A | ~~TBD~~ If record source is "S" then set to the cancellation date (FILEDATE) by matching to the SIDR Cancellation File by the Record ID (MTF and PRN). If there is no match in the SIDR Cancellation file, leave blank. |
| **From CAPER Cancellation File Merge: Merge based on CHCS Host and Appointment IEN** | | | | | | |
| CAPER Record Cancel Date | CAPER\_CANCEL | CCYYMMDD | N/A | N/A | N/A | If record source is “C” then set to the cancellation date by matching to the CAPER Cancellation file by CHCS Host and Appointment IEN. If there is no match in the CAPER Cancellation file, leave blank. |
| **~~From Ancillary Cancellation File~~** | | | | | | |
| ~~Anc Record Cancel Date~~ | ~~ANC\_CANCEL~~ | ~~CCYYMMDD~~ | ~~N/A~~ | ~~N/A~~ | ~~N/A~~ | ~~TBD~~ |
| **From MDR MS-DRG Table Merge: Merge based on MS-DRG** | | | | | | |
| MS-DRG Weight | MSDRG\_WEIGHT | 8. | N/A | N/A | N/A | No transformation. |
| Geometric Mean Length of Stay | GMLOS | 8. | N/A | N/A | N/A | No transformation. |
| Long Stay Threshold (National) | LST | 8. | N/A | N/A | N/A | No transformation. |
| **From ~~Inpatient Billing Policy~~ Adjusted Standardized Amount Table Merge: Merge based on FY** | | | | | | |
| Adjusted Standardized Amount (ASA) | ASA | 8. | N/A | N/A | N/A | ~~TBD~~Set to Adjusted Standardized Amount. |
| Labor Portion | LABOR | 8. | N/A | N/A | N/A | If Wage Index <= 1 then use Labor Portion for Wage Index <=1. Else use Labor Portion for Wage Index > 1. |
| Non-Labor Portion | NON\_LABOR | 8. | N/A | N/A | N/A | If Wage Index <= 1 then use Non-Labor Portion for Wage Index <=1. Else use Non-Labor Portion for Wage Index > 1. |
| IDME Factor Multiplier | IDME\_MULT | 8. | N/A | N/A | N/A | ~~TBD~~Set to IDME Factor Multiplier |
| Long Length of Stay Marginal Cost Factor | LONGLOS | 8. | N/A | N/A | N/A | ~~TBD~~Set to Long LOS Marginal Cost Factor |
| IAR Factor | IAR | 8. | N/A | N/A | N/A | Set to IAR Factor |
| IMET Factor | IMET | 8. | N/A | N/A | N/A | Set to IMET Factor |
| **From MDR HIPAA Taxonomy File Merge: Merge based on Attending Provider HIPAA Taxonomy** | | | | | | |
| ~~Provider Class~~ | ~~PROV\_CLASS~~ | ~~$1~~ | ~~N/A~~ | ~~N/A~~ | ~~N/A~~ | ~~TBD~~ |
| Restricted Billing Flag | REST\_BILLING | $1 | N/A | N/A | N/A | No transformation. |
| Physician/Non-Physician Rate Code | PHYS\_RATE\_FLAG | $1 | N/A | N/A | N/A | No transformation. |
| **Internally Derived Fields** | | | | | | |
| Original Record Source | SOURCE | $1 | N/A | N/A | N/A | If the source of the record is a SIDR, set to S. Else if the source is a CAPER, set to C. Else set to A. |
| Initial CBER Processing Date | INITDATE | CCYYMMDD | N/A | N/A | N/A | Date this record was first processed into the CBER 837I file. |
| ~~Last CBER Update Date~~ | ~~UPDT\_DT~~ | ~~CCYYMMDD~~ | ~~N/A~~ | ~~N/A~~ | ~~N/A~~ | ~~Date this record was last updated in the CBER 837I file.~~ |
| Fiscal Year | FY | $4 | N/A | N/A | N/A | Derive from disposition date for SIDR, encounter date for CAPER/Ancillary |
| Fiscal Month | FM | $2 | N/A | N/A | N/A | Derive from disposition date for SIDR, encounter date for CAPER/Ancillary |
| Calendar Year | CY | $4 | N/A | N/A | N/A | Derive from disposition date for SIDR, encounter date for CAPER/Ancillary |
| Calendar Month | CM | $2 | N/A | N/A | N/A | Derive from disposition date for SIDR, encounter date for CAPER/Ancillary |
| MSA Flag | MSA | $1 | N/A | N/A | N/A | Set to 1 if the patcat indicates that this record is MSA. Set to 2 if the sponsor service from DEERS indicates that this record is MSA. Set to 3 if both indicate this record is MSA. ~~If this record meets the criteria for MSA billing from Section V, e~~Else set to 0. |
| MAC Flag | MAC | $1 | N/A | N/A | N/A | Set to 1 if the injury reference file includes this person due to the injury flag on the CAPER. Set to 2 if the injury reference file includes this person due to an injury diagnosis code. Set to 3 if the injury reference file includes this person for both reasons. ~~If this record meets the criteria for MAC billing from Section V, e~~Else set to 0. |
| TPC Flag | TPC | $1 | N/A | N/A | N/A | Set to 1 if this record meets the criteria for TPC billing from Section V, else set to 0. |
| Implementation Version Guide | VERSION | $10 | N/A | N/A | N/A | Set to ‘005010X222’ |
| APC Flag | APC\_FLAG | $1 | N/A | N/A | N/A | For CAPER: Set to 1 if any of the following criteria are met: (1) MEPRS code = BIA; (2) 4th digit of the MEPRS code is 5; (3) MTF is 0124 and the 4th digit of the MEPRS code is 6. Else set to 0.  For SIDR/Ancillary: Set to 0. |
| Facility Type Code | FACTYPE | $2 | N/A | ~~MEPRSCD~~N/A | N/A | For SIDR: Set to '21'. For CAPER: If record is ER (MEPRS Code = BIA), set to '23'. If one of the APC codes is populated, and there are no inpatient services at that DMIS ID (based on IP\_START and IP\_STOP from ~~see~~ DMIS ID merge), set to '24'. If one of the APC Codes is populated and there are inpatient services at that DMIS ID, set to '22'. Else set to '11'. For Ancillary: If ordering MEPRS Code is 'A', set to '21'. Otherwise, link to the order (based on CHCS Host and Ordering Appointment ID). If one of the APC codes is populated on the ordering record, and there are inpatient services at that DMIS ID, s~~S~~et to '22'. Otherwise, set to '49'. |
| Claim Frequency Type Code | CLAIM\_FREQ | $1 | N/A | N/A | N/A | Set to ‘1’ for initial record. Set to '~~7~~6' for replacement (updated) record. Set to '8' for cancelled (deleted) record. |
| ~~Provider/Supplier Signature Indicator~~ | ~~PROV\_SIG~~ | ~~$1~~ | ~~N/A~~ | ~~N/A~~ | ~~N/A~~ | ~~Set to ‘Y’.~~ |
| ~~Assignment/Plan Participation Code~~ | ~~PLAN\_ASSIGN~~ | ~~$1~~ | ~~N/A~~ | ~~N/A~~ | ~~N/A~~ | ~~Set to ‘A’.~~ |
| ~~Benefits Assignment Certification Indicator~~ | ~~BEN\_ASSIGN~~ | ~~$1~~ | ~~N/A~~ | ~~N/A~~ | ~~N/A~~ | ~~Set to ‘Y’.~~ |
| ~~Release of Information Code~~ | ~~RLS\_INFO~~ | ~~$1~~ | ~~N/A~~ | ~~N/A~~ | ~~N/A~~ | ~~Set to ‘Y’.~~ |
| Diagnosis Type Code | DX\_TYPE | $~~3~~2 | N/A | N/A | N/A | Code list qualifier code: If ~~admission~~disposition /encounter/service date is before Oct 1, 2015~~4~~, set to '09'. Otherwise, once MHS has implementedICD-10, set to '10'. This will inform all of the Diagnosis Type Codes. |
| DEERS Eligibility Flag | DEERS\_ELIG | $1. | N/A | N/A | N/A | If BENCAT is blank then set to 0, else set to 1. |
| MSA Key | MSA\_KEY | $9 | N/A | N/A | N/A | If PATCAT is K61, then set to VA\_CARRIER. Else see Appendix B. |
| Admission Type | ADMTYPE | $1 | N/A | N/A | N/A | Only required for Inpatient claims. If the claim is admitted from ER, use 1. If the claim is for a Newborn, use 4. Else use 3. |
| ~~Total Charge Amount~~ | ~~CHARGE~~ | ~~10.2~~ | ~~N/A~~ | ~~N/A~~ | ~~N/A~~ | ~~See Appendix B.~~ |
| ~~Process Flag~~ | ~~PROCESS\_FLAG~~ | ~~$1~~ | ~~N/A~~ | ~~N/A~~ | ~~N/A~~ | ~~Set to “N” if this is a new record for CBER (based on CHCS Host/RX number). Set to “U” if this record has been in the CBER dataset, but has changed. Set to “D” if the record has been cancelled.~~ |
| Change Date | CHG\_DT | CCYYMMDD | N/A | N/A | N/A | Match this batch of CBER data to the previous batch based on record key. If any of the values on an existing record changed from the last batch to this one, fill the change date on the new record with the processing date. |
| Change Flag | CHG\_FLAG | $1 | N/A | N/A | N/A | Match this batch of CBER data to the previous batch based on record key. If any of the values on an existing record changed from the last batch to this one, fill the change flag on the new record with “U”, else fill with N. |

1. Refresh Frequency

Weekly

1. Quality Review Requirements

In order to ensure processing is done correctly, several basic quality review requirements are presented in this section. ~~THIS IS STILL FROM A PROCESSOR I USED AS A TEMPLATE. I will fill this in later.~~

1. Basic Data Flow Process Check: A spreadsheet should be maintained that tracks record counts associated with each data step used in processing. Record counts from the raw monthly feeds should be recorded and checked. ~~Significant variations in DED data should be noted and explored with BEA.~~
2. Record counts should be maintained for each type of inclusion (section V) and compared to previous processing cycles for consistency.
3. File Size: Record counts should increase as the files are updated.
4. Proc contents should be reviewed and compared against specifications to ensure conformance.
5. ~~Frequency tabulations should be compared from cycle to cycle for the following variables: ACV, age group, beneficiary category, cdt, cy, cm, fy, fm, deers enrollment site, dmisid,ethnic code, patient’s sex, privilege code, race, residence region, residence TNEX region, service, common beneficiary.~~
6. Each month the values observed in certain fields should be checked to see if new or modified values are introduced. Fields that should be checked include raw fields used by the processor to derive other fields, and raw fields used to control the flow of processing.
7. Routine feed and file management procedures should be followed for the MDR ~~DED~~ 837-I processor.
8. Data Marts
9. Special Outputs

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

The Services will receive a text output file derived from the CBER 837I SAS Dataset. The file will be a delimited text file with a caret (^) as the delimiter. To prepare this file initially, text output is simply written in the format described below. Each week thereafter, only new, changed, or cancelled records are provided to the Services. Records are included if the CBER Change Date is greater than or equal to the most recent processing date. New records are those that are newly identified as billable. For changed records, you will have already been sent an initial version of the record. The initial version of the record will have the same record ID (RECORD\_ID, output position 107) as the changed one. The change on the record may require a modification to a bill that has already been sent. Cancelled records should not be billed. The Change Flag variable will be edited for the service extract to represent the change from the point of view of the services. If the file has been changed since the last service extract (the most recent processing date), the Change Flag will be "U". Otherwise, it will be "N". The layout of the data is contained in Table 5.

**Table 5: Layout of Output to the Services**

| **Loop #** | **Segment** | **Element #** | **Data Element Name** | **Output Position** | **Format** | **Rule** |
| --- | --- | --- | --- | --- | --- | --- |
| N/A | N/A | N/A | Implementation Version Guide | 1 | $10 | VERSION |
| ~~N/A~~ | ~~N/A~~ | ~~N/A~~ | ~~Process Flag~~ | ~~2~~ | ~~$1~~ | ~~PROCESS\_FLAG~~ |
| N/A | N/A | N/A | Original Record Source | 2 | $1 | SOURCE |
| N/A | N/A | N/A | Initial CBER Processing Date | 3 | CCYYMMDD | INITDATE |
| ~~N/A~~ | ~~N/A~~ | ~~N/A~~ | ~~Last CBER Update Date~~ | ~~5~~ | ~~CCYYMMDD~~ | ~~UPDT\_DT~~ |
| N/A | N/A | N/A | Change Date | 4 | CCYYMMDD | CHG\_DT |
| N/A | N/A | N/A | Change Flag | 5 | $1 | See above |
| N/A | N/A | N/A | Treatment DMIS ID | 6 | $4 | DMISID |
| N/A | N/A | N/A | Treatment DMIS ID Military Service | 7 | $1 | TXSVC |
| ~~N/A~~ | ~~N/A~~ | ~~N/A~~ | ~~Billing Provider NPI~~ | ~~6~~ | ~~$10~~ | ~~BILLNPI~~ |
| N/A | N/A | N/A | CHCS Host | 8 | $4 | HOST\_DMISID |
| N/A | N/A | N/A | Sponsor Service | 9 | $1 | SPONSVC |
| N/A | N/A | N/A | Beneficiary Category | 10 | $3 | BENCAT |
| N/A | N/A | N/A | Patient Category | 11 | $3 | PATCAT |
| N/A | N/A | N/A | Patient Subcategory Code | 12 | $1 | PATCAT\_SUBCAT |
| N/A | N/A | N/A | Fiscal Year | 13 | $4 | FY |
| N/A | N/A | N/A | Fiscal Month | 14 | $2 | FM |
| N/A | N/A | N/A | Calendar Year | 15 | $4 | CY |
| N/A | N/A | N/A | Calendar Month | 16 | $2 | CM |
| N/A | N/A | N/A | MSA Flag | 17 | $1 | MSA |
| N/A | N/A | N/A | MAC Flag | 18 | $1 | MAC |
| N/A | N/A | N/A | TPC Flag | 19 | $1 | TPC |
| N/A | N/A | N/A | MSA Key | 20 | $9 | MSA\_KEY |
| N/A | N/A | N/A | Patient EDIPN | 21 | $10 | EDI\_PN |
| N/A | N/A | N/A | Patient SSN | 22 | $9 | PATSSN |
| N/A | N/A | N/A | DEERS Eligibility Flag | 23 | $1 | DEERS\_ELIG |
| N/A | N/A | N/A | File Date | 24 | CCYYMMDD | FILE\_DT |
| N/A | N/A | N/A | SIDR Record Cancel Date | 25 | CCYYMMDD | SIDR\_CANCEL |
| N/A | N/A | N/A | CAPER Record Cancel Date | 26 | CCYYMMDD | CAPER\_CANCEL |
| N/A | N/A | N/A | Cancel Flag | 27 | $1 | If SIDR\_CANCEL or CAPER\_CANCEL are populated, set to Y, else N |
| N/A | N/A | N/A | Bed Days | 28 | 8. | DAYS |
| N/A | N/A | N/A | Wage Index | 29 | 6.4 | WAGE\_INDEX |
| N/A | N/A | N/A | Number of Interns & Residents | 30 | 8. | INTERNS |
| N/A | N/A | N/A | Number of Beds | 31 | 8. | BEDS |
| N/A | N/A | N/A | MS-DRG Weight | 32 | 8. | MSDRG\_WEIGHT |
| N/A | N/A | N/A | Geometric Mean Length of Stay | 33 | 8. | GMLOS |
| N/A | N/A | N/A | Long Stay Threshold (National) | 34 | 8. | LST |
| N/A | N/A | N/A | Adjusted Standardized Amount | 35 | 8. | ASA |
| N/A | N/A | N/A | Labor Portion | 36 | 8. | LABOR |
| N/A | N/A | N/A | Non-Labor Portion | 37 | 8. | NON\_LABOR |
| N/A | N/A | N/A | IDME Factor Multiplier | 38 | 8. | IDME\_MULT |
| N/A | N/A | N/A | Long Length of Stay Marginal Cost Factor | 39 | 8. | LONGLOS |
| N/A | N/A | N/A | IAR Factor | 40 | 8. | IAR |
| N/A | N/A | N/A | IMET Factor | 41 | 8. | IMET |
| N/A | N/A | N/A | CMAC Locality Code | 42 | $2 | LOCALITY |
| N/A | N/A | N/A | Restricted Billing Flag | 43 | $1 | REST\_BILLING |
| N/A | N/A | N/A | Physician/Non-Physician Rate Code | 44 | $1 | PHYS\_RATE\_FLAG |
| 1000A | Submitter Name | 1 | Entity Identifier Code | 45 | $2 | Set to "41" |
| 1000A | Submitter Name | 2 | Entity Type Qualifier | 46 | $1 | Set to "2" |
| 1000A | Submitter Name | 3 | Submitter Name Last or Organization Name | 47 | $35 | BILLNAME (MTF Name from DMISID Table) |
| 1000A | Submitter Name | 8 | Identification Code Qualifier | 48 | $2 | Set to "46" |
| 1000A | Submitter Name | 9 | Submitter Identifier | 49 | $10 | BILLNPI (MTF NPI) |
| 1000A | Submitter EDI Contact Information | 1 | Contact Function Code | 50 | $2 | Set to "IC" |
| 2000A | Billing Provider Hierarchical Level | 3 | Hierarchical Level Code | 51 | $2 | Set to "20" |
| ~~2000A~~ | ~~Billing Provider Hierarchical Level~~ | ~~4~~ | ~~Hierarchical Child Code~~ | ~~27~~ |  | ~~Not sure what to do when there are no hierarchies?~~ |
| 2000A | Billing Provider Specialty Information | 1 | Provider Code | 52 | $2 | Set to "BI" |
| 2000A | Billing Provider Specialty Information | 2 | Reference Identification Qualifier | 53 | $3 | Set to "PXC" |
| 2000A | Billing Provider Specialty Information | 3 | Provider Taxonomy Code | 54 | $10~~1~~ | BILLTAX |
| 2010AA | Billing Provider Name | 1 | Entity Identifier Code | 55 | $2 | Set to "85" |
| 2010AA | Billing Provider Name | 2 | Entity Type Qualifier | 56 | $1 | Set to "2" |
| 2010AA | Billing Provider Name | 3 | Billing Provider Last or Organization Name | 57 | $35 | BILLNAME |
| 2010AA | Billing Provider Name | 8 | Identification Code Qualifier | 58 | $2 | Set to "XX" |
| 2010AA | Billing Provider Name | 9 | Billing Provider Identifier | 59 | $10 | BILLNPI |
| 2010AA | Billing Provider Address | 1 | Billing Provider Address, Line 1 | 60 |  | BILLADDR1 |
| 2010AA | Billing Provider Address | 2 | Billing Provider Address, Line 2 | 61 |  | BILLADDR2 |
| 2010AA | Billing Provider City, State, ZIP Code | 1 | Billing Provider City Name | 62 | $32 | BILLCITY |
| 2010AA | Billing Provider City, State, ZIP Code | 2 | Billing Provider State/Province | 63 | $2 | BILLSTATE |
| 2010AA | Billing Provider City, State, ZIP Code | 3 | Billing Provider ZIP Code | 64 | $5 | BILLZIP |
| 2010AA | Billing Provider City, State, ZIP Code | 4 | Billing Provider Country Code | 65 | $2 | BILLCOUNTRY |
| 2010AA | Billing Provider City, State, ZIP Code | 7 | Billing Provider Country Subdivision Code | 66 |  | BILLSUBCOUNTRY |
| 2010AA | Billing Provider Tax Identification | 1 | Reference Identification Qualifier | 67 | $2 | Set to "EI" |
| 2010AA | Billing Provider Tax Identification | 2 | Billing Provider Tax Identification Number | 68 | $11 | BILLTAXID |
| ~~2000B~~ | ~~Subscriber Information~~ | ~~1~~ | ~~Payer Responsibility Sequence Number Code~~ | ~~33~~ |  | ~~Link to OHI. Primary, Secondary or Tertiary~~ |
| ~~2000B~~ | ~~Subscriber Information~~ | ~~2~~ | ~~Individual Relationship Code~~ | ~~34~~ |  | ~~Link to OHI.~~ |
| ~~2000B~~ | ~~Subscriber Information~~ | ~~3~~ | ~~Subscriber Group or Policy Number~~ | ~~35~~ |  | ~~Link to OHI.~~ |
| ~~2000B~~ | ~~Subscriber Information~~ | ~~4~~ | ~~Subscriber Group Name~~ | ~~36~~ |  | ~~Link to OHI.~~ |
| ~~2000B~~ | ~~Subscriber Information~~ | ~~9~~ | ~~Claim Filing Indicator Code~~ | ~~37~~ |  | ~~Link to OHI.~~ |
| ~~2010BA~~ | ~~Subscriber Name~~ | ~~1~~ | ~~Entity Identification Code~~ | ~~38~~ | ~~$2~~ | ~~Set to "IL".~~ |
| ~~2010BA~~ | ~~Subscriber Name~~ | ~~2~~ | ~~Entity Type Qualifier~~ | ~~39~~ | ~~$1~~ | ~~Set to "1"~~ |
| ~~2010BA~~ | ~~Subscriber Name~~ | ~~3~~ | ~~Subscriber Last Name~~ | ~~40~~ |  | ~~From OHI if TPC, LASTNAME if MAC or MSA~~ |
| ~~2010BA~~ | ~~Subscriber Name~~ | ~~4~~ | ~~Subscriber First Name~~ | ~~41~~ |  | ~~From OHI if TPC, FIRSTNAME if MAC or MSA~~ |
| ~~2010BA~~ | ~~Subscriber Name~~ | ~~5~~ | ~~Subscriber Middle Name~~ | ~~42~~ |  | ~~From OHI if TPC, MIDDLENAME for MAC or MSA~~ |
| ~~2010BA~~ | ~~Subscriber Name~~ | ~~7~~ | ~~Subscriber Name Suffix~~ | ~~43~~ |  | ~~From OHI if TPC, SUFFIX if MAC or MSA~~ |
| ~~2010BA~~ | ~~Subscriber Name~~ | ~~8~~ | ~~Identification Code Qualifier~~ | ~~44~~ | ~~$2~~ | ~~Set to "MI"~~ |
| ~~2010BA~~ | ~~Subscriber Name~~ | ~~9~~ | ~~Subscriber Primary Identifier~~ | ~~45~~ |  | ~~From OHI if TPC, Need rule for non-TPC~~ |
| ~~2010BA~~ | ~~Subscriber Address~~ | ~~1~~ | ~~Subscriber Address Line 1~~ | ~~46~~ |  | ~~FROM OHI if TPC, ADDR1 if MAC or MSA~~ |
| ~~2010BA~~ | ~~Subscriber Address~~ | ~~2~~ | ~~Subscriber Address Line 1~~ | ~~47~~ |  | ~~FROM OHI if TPC, ADDR2 if MAC or MSA~~ |
| ~~2010BA~~ | ~~Subscriber City, State, ZIP Code~~ | ~~1~~ | ~~City Name~~ | ~~48~~ |  | ~~From OHI if TPC, CITY if MAC or MSA~~ |
| ~~2010BA~~ | ~~Subscriber City, State, ZIP Code~~ | ~~2~~ | ~~Subscriber State Code~~ | ~~49~~ |  | ~~From OHI if TPC, STATE if MAC or MSA~~ |
| ~~2010BA~~ | ~~Subscriber City, State, ZIP Code~~ | ~~3~~ | ~~Subscriber ZIP Code~~ | ~~50~~ |  | ~~From OHI if TPC, PATZIP if MAC or MSA~~ |
| ~~2010BA~~ | ~~Subscriber City, State, ZIP Code~~ | ~~4~~ | ~~Country Code~~ | ~~51~~ |  | ~~From OHI if TPC, COUNTRY if MAC or MSA~~ |
| ~~2010BA~~ | ~~Subscriber City, State, ZIP Code~~ | ~~7~~ | ~~Country Subdivision Code~~ | ~~52~~ |  | ~~From OHI if TPC, SUBCOUNTRY if MAC or MSA~~ |
| 2010BA | Subscriber Demographic Information | 1 | Date Time Period Qualifier | 69 | $2 | Set to "D8" |
| 2010BA | Subscriber Demographic Information | 2 | Subscriber Date of Birth | 70 | CCYYMMDD | PATDOB |
| 2010BA | Subscriber Demographic Information | 3 | Subscriber Gender | 71 | $1 | PATSEX |
| ~~2010BB~~ | ~~Payer Name~~ | ~~1~~ | ~~Entity Type Code~~ | ~~56~~ | ~~$2~~ | ~~Set to "PR"~~ |
| ~~2010BB~~ | ~~Payer Name~~ | ~~2~~ | ~~Entity Type Qualifier~~ | ~~57~~ | ~~$1~~ | ~~Set to "2"~~ |
| ~~2010BB~~ | ~~Payer Name~~ | ~~3~~ | ~~Payer Name~~ | ~~58~~ |  | ~~Link to OHI, then SIT~~ |
| ~~2010BB~~ | ~~Payer Name~~ | ~~8~~ | ~~Identification Code Qualifier~~ | ~~59~~ |  | ~~Link to OHI, then SIT~~ |
| ~~2010BB~~ | ~~Payer Name~~ | ~~9~~ | ~~Payer Identifier~~ | ~~60~~ |  | ~~Link to OHI, then SIT~~ |
| ~~2010BB~~ | ~~Payer Address~~ | ~~1~~ | ~~Payer Address Line 1~~ | ~~61~~ |  | ~~Link to OHI, then SIT~~ |
| ~~2010BB~~ | ~~Payer Address~~ | ~~2~~ | ~~Payer Address Line 2~~ | ~~62~~ |  | ~~Link to OHI, then SIT~~ |
| ~~2010BB~~ | ~~Payer City, State, ZIP Code~~ | ~~1~~ | ~~Payer City Name~~ | ~~63~~ |  | ~~Link to OHI, then SIT~~ |
| ~~2010BB~~ | ~~Payer City, State, ZIP Code~~ | ~~2~~ | ~~Payer State/Province~~ | ~~64~~ |  | ~~Link to OHI, then SIT~~ |
| ~~2010BB~~ | ~~Payer City, State, ZIP Code~~ | ~~3~~ | ~~Payer ZIP Code~~ | ~~65~~ |  | ~~Link to OHI, then SIT~~ |
| ~~2010BB~~ | ~~Payer City, State, ZIP Code~~ | ~~4~~ | ~~Payer Country Code~~ | ~~66~~ |  | ~~Link to OHI, then SIT~~ |
| ~~2010BB~~ | ~~Payer City, State, ZIP Code~~ | ~~7~~ | ~~Payer Country Subdivision Code~~ | ~~67~~ |  | ~~Link to OHI, then SIT~~ |
| ~~2000C~~ | ~~Patient Hierarchical Level~~ | ~~1~~ | ~~Hierarchical ID Number~~ | ~~68~~ |  |  |
| ~~2000C~~ | ~~Patient Hierarchical Level~~ | ~~2~~ | ~~Hierarchical Parent ID Number~~ | ~~69~~ |  |  |
| ~~2000C~~ | ~~Patient Hierarchical Level~~ | ~~3~~ | ~~Hierarchical Level Code~~ | ~~70~~ |  |  |
| ~~2000C~~ | ~~Patient Hierarchical Level~~ | ~~4~~ | ~~Hierarchical Child Code~~ | ~~71~~ |  |  |
| ~~2000C~~ | ~~Patient Information~~ | ~~1~~ | ~~Individual Relationship Code~~ | ~~72~~ |  | ~~Link to OHI~~ |
| 2010CA | Patient Name | 1 | Entity Identifer Code | 72 | $2 | Set to "QC" |
| 2010CA | Patient Name | 2 | Entity Type Qualifier | 73 | $1 | Set to "1" |
| 2010CA | Patient Name | 3 | Patient Last Name | 74 | $27 | LASTNAME |
| 2010CA | Patient Name | 4 | Patient First Name | 75 | $20 | FIRSTNAME |
| ~~2010CA~~ | ~~Patient Name~~ | ~~5~~ | ~~Patient Middle Name or Initial~~ | ~~52~~ |  | ~~MIDDLENAME~~ |
| 2010CA | Patient Name | 7 | Patient Name Suffix | 76 | $4 | SUFFIX |
| 2010CA | Patient Address | 1 | Patient Address Line | 77 | $40 | ADDR1 |
| 2010CA | Patient Address | 2 | Patient Address Line | 78 | $40 | ADDR2 |
| 2010CA | Patient City, State, ZIP Code | 1 | Patient City Name | 79 | $20 | CITY |
| 2010CA | Patient City, State, ZIP Code | 2 | Patient State Code | 80 | $2 | STATE |
| 2010CA | Patient City, State, ZIP Code | 3 | Patient Postal Zone or ZIP Code | 81 | $9 | PATZIP |
| 2010CA | Patient City, State, ZIP Code | 4 | Country Code | 82 | $2 | COUNTRY |
| ~~2010CA~~ | ~~Patient City, State, ZIP Code~~ | ~~7~~ | ~~Country Subdivision Code~~ | ~~60~~ |  | ~~SUBCOUNTRY~~ |
| 2010CA | Patient Demographic Information | 1 | Date Time Period Format Qualifier | 83 | $2 | Set to "D8" |
| 2010CA | Patient Demographic Information | 2 | Patient Date of Birth | 84 | CCYYMMDD | PATDOB |
| 2010CA | Patient Demographic Information | 3 | Patient Gender | 85 | $1 | PATSEX |
| ~~2300~~ | ~~Claim Information~~ | ~~2~~ | ~~Total Claim Charge Amount~~ | ~~62~~ | ~~8.2~~ | ~~CHARGE~~ |
| 2300 | Claim Information | 5-1 | Facility Type Code | 86 | $1 | FACTYPE |
| 2300 | Claim Information | 5-2 | Facility Code Qualifier | 87 | $1 | Set to "A" |
| 2300 | Claim Information | 5-3 | Claim Frequency Code | 88 | $1 | CLAIM\_FREQ |
| 2300 | Claim Information | 7 | Assignment or Plan Participation Code | 89 | $1 | ~~PLAN\_ASSIGN~~Set to "A" |
| 2300 | Claim Information | 8 | Benefits Assignment Certification Code | 90 | $1 | ~~BEN\_ASSIGN~~ Set to "Y" |
| 2300 | Claim Information | 9 | Release of Information Code | 91 | $1 | ~~RLS\_INFO~~ Set to "Y" |
| 2300 | Discharge Hour | 1 | Date Time Qualifier | 92 | $3 | Set to "096" |
| 2300 | Discharge Hour | 2 | Date Time Period Format Qualifier | 93 | $2 | Set to "TM" |
| 2300 | Discharge Hour | 3 | Discharge Time | 94 | HHMM | TIMEDISC |
| 2300 | Statement Dates | 1 | Date Time Qualifier | 95 | $3 | Set to "434" |
| 2300 | Statement Dates | 2 | Date Time Period Format Qualifier | 96 | $3 | Set to "RD8" |
| 2300 | Statement Dates | 3 | Statement From and To Date | 97 | CCYYMMDD-CCYYMMDD | DATES |
| 2300 | Admission Date/Hour | 1 | Date Time Qualifier | 98 | $3 | Set to "435" |
| 2300 | Admission Date/Hour | 2 | Date Time Period Format Qualifier | 99 | $2 | ADMDATEFMT |
| 2300 | Admission Date/Hour | 3 | Admission Date and Hour | 100 | CCYYMMDD or CCYYMMDDHHMM | ADMDATETIME |
| 2300 | Institutional Claim Code | 1 | Admission Type Code | 101 | $1 | ADMTYPE |
| 2300 | Institutional Claim Code | 2 | Admission Source Code | 102 | $1 | ADMSRC |
| 2300 | Institutional Claim Code | 3 | Patient Status Code | 103 | $2 | DISPCODE |
| 2300 | Auto Accident State | 1 | Reference Identification Qualifier | 104 | $2 | Set to "LU" |
| 2300 | Auto Accident State | 2 | Auto Accident State or Province Code | 105 | $5 | If MAC, INJGEOGLOC~~merge from Injury Reference File~~ |
| 2300 | Medical Record Number | 1 | Reference Identification Qualifier | 106 | $2 | Set to "EA" |
| 2300 | Medical Record Number | 2 | Medical Record Number | 107 | $41 | RECORD\_ID |
| 2300 | Principal Diagnosis | 1-1 | Code List Qualifier Code | 108 | $3 | If DX\_TYPE = '09' then set to "BK". Else if DX\_TYPE = '10' then set to "ABK". |
| 2300 | Principal Diagnosis | 1-2 | Principal Diagnosis Code | 109 | $7 | DX1 |
| 2300 | Principal Diagnosis | 1-9 | Present on Admission Indicator | 110 | $1 | DX1POA |
| 2300 | Admitting Diagnosis | 1-1 | Code List Qualifier Code | 111 | $3 | If DX\_TYPE = '09' then set to "BJ". Else if DX\_TYPE = '10' then set to "ABJ". |
| 2300 | Admitting Diagnosis | 1-2 | Admitting Diagnosis Code | 112 | $7 | ADMDX |
| 2300 | Patient's Reason for Visit | 1-1 | Code List Qualifier Code | 113 | $3 | If DX\_TYPE = '09' then set to "PR". Else if DX\_TYPE = '10' then set to "APR". |
| 2300 | Patient's Reason for Visit | 1-2 | Patient Reason for Visit | 114 | $7 | COMPLAINT |
| 2300 | External Cause of Injury | (1-12)-1 | Code List Qualifier Code | 115 | $3 | If DX\_TYPE = '09' then set to "BN". Else if DX\_TYPE = '10' then set to "ABN". |
| 2300 | External Cause of Injury | (1-12)-2 | External Cause of Injury Code | 116-127 | $7 | INJDX1-INJDX12 |
| 2300 | External Cause of Injury | (1-12)-9 | Present on Admission Indicator | 128-139 | $1 | INJDX1POA-INJDX12POA |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~2-1~~ | ~~Code List Qualifier Code~~ | ~~97~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BN". Else if DX\_TYPE = '10' then set to "ABN".~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~2-2~~ | ~~External Cause of Injury Code~~ | ~~98~~ | ~~$7~~ | ~~INJDX2~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~2-9~~ | ~~Present on Admission Indicator~~ | ~~99~~ | ~~$1~~ | ~~INJDX2POA~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~3-1~~ | ~~Code List Qualifier Code~~ | ~~100~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BN". Else if DX\_TYPE = '10' then set to "ABN".~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~3-2~~ | ~~External Cause of Injury Code~~ | ~~101~~ | ~~$7~~ | ~~INJDX3~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~3-9~~ | ~~Present on Admission Indicator~~ | ~~102~~ | ~~$1~~ | ~~INJDX3POA~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~4-1~~ | ~~Code List Qualifier Code~~ | ~~103~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BN". Else if DX\_TYPE = '10' then set to "ABN".~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~4-2~~ | ~~External Cause of Injury Code~~ | ~~104~~ | ~~$7~~ | ~~INJDX4~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~4-9~~ | ~~Present on Admission Indicator~~ | ~~105~~ | ~~$1~~ | ~~INJDX4POA~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~5-1~~ | ~~Code List Qualifier Code~~ | ~~106~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BN". Else if DX\_TYPE = '10' then set to "ABN".~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~5-2~~ | ~~External Cause of Injury Code~~ | ~~107~~ | ~~$7~~ | ~~INJDX5~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~5-9~~ | ~~Present on Admission Indicator~~ | ~~108~~ | ~~$1~~ | ~~INJDX5POA~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~6-1~~ | ~~Code List Qualifier Code~~ | ~~109~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BN". Else if DX\_TYPE = '10' then set to "ABN".~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~6-2~~ | ~~External Cause of Injury Code~~ | ~~135~~ | ~~$7~~ | ~~INJDX6~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~6-9~~ | ~~Present on Admission Indicator~~ | ~~136~~ | ~~$1~~ | ~~INJDX6POA~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~7-1~~ | ~~Code List Qualifier Code~~ | ~~137~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BN". Else if DX\_TYPE = '10' then set to "ABN".~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~7-2~~ | ~~External Cause of Injury Code~~ | ~~138~~ | ~~$7~~ | ~~INJDX7~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~7-9~~ | ~~Present on Admission Indicator~~ | ~~139~~ | ~~$1~~ | ~~INJDX7POA~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~8-1~~ | ~~Code List Qualifier Code~~ | ~~140~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BN". Else if DX\_TYPE = '10' then set to "ABN".~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~8-2~~ | ~~External Cause of Injury Code~~ | ~~141~~ | ~~$7~~ | ~~INJDX8~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~8-9~~ | ~~Present on Admission Indicator~~ | ~~142~~ | ~~$1~~ | ~~INJDX8POA~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~9-1~~ | ~~Code List Qualifier Code~~ | ~~143~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BN". Else if DX\_TYPE = '10' then set to "ABN".~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~9-2~~ | ~~External Cause of Injury Code~~ | ~~144~~ | ~~$7~~ | ~~INJDX9~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~9-9~~ | ~~Present on Admission Indicator~~ | ~~145~~ | ~~$1~~ | ~~INJDX9POA~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~10-1~~ | ~~Code List Qualifier Code~~ | ~~146~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BN". Else if DX\_TYPE = '10' then set to "ABN".~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~10-2~~ | ~~External Cause of Injury Code~~ | ~~147~~ | ~~$7~~ | ~~INJDX10~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~10-9~~ | ~~Present on Admission Indicator~~ | ~~148~~ | ~~$1~~ | ~~INJDX10POA~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~11-1~~ | ~~Code List Qualifier Code~~ | ~~149~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BN". Else if DX\_TYPE = '10' then set to "ABN".~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~11-2~~ | ~~External Cause of Injury Code~~ | ~~150~~ | ~~$7~~ | ~~INJDX11~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~11-9~~ | ~~Present on Admission Indicator~~ | ~~151~~ | ~~$1~~ | ~~INJDX11POA~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~12-1~~ | ~~Code List Qualifier Code~~ | ~~152~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BN". Else if DX\_TYPE = '10' then set to "ABN".~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~12-2~~ | ~~External Cause of Injury Code~~ | ~~153~~ | ~~$7~~ | ~~INJDX12~~ |
| ~~2300~~ | ~~External Cause of Injury~~ | ~~12-9~~ | ~~Present on Admission Indicator~~ | ~~154~~ | ~~$1~~ | ~~INJDX12POA~~ |
| 2300 | Diagnosis Related Group (DRG) Information | 1-1 | Code List Qualifier Code | 140 | $2 | Set to "DR" |
| 2300 | Diagnosis Related Group (DRG) Information | 1-2 | Diagnosis Reltaed Group (DRG) Code | 141 | $3 | MSDRG |
| 2300 | Other Diagnosis Information | (1-12)-1 | Code List Qualifier Code | 142 | $3 | If DX\_TYPE = '09' then set to "BF". Else if DX\_TYPE = '10' then set to "ABF". |
| 2300 | Other Diagnosis Information | (1-12)-2 | Other Diagnosis | 143-154 | $7 | DX2-DX13 |
| 2300 | Other Diagnosis Information | (1-12)-9 | Present on Admission Indicator | 155-166 | $1 | DX2POA-DX13POA |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~2-1~~ | ~~Code List Qualifier Code~~ | ~~160~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BF". Else if DX\_TYPE = '10' then set to "ABF".~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~2-2~~ | ~~Other Diagnosis~~ | ~~161~~ | ~~$7~~ | ~~DX3~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~2-9~~ | ~~Present on Admission Indicator~~ | ~~162~~ | ~~$1~~ | ~~DX3POA~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~3-1~~ | ~~Code List Qualifier Code~~ | ~~163~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BF". Else if DX\_TYPE = '10' then set to "ABF".~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~3-2~~ | ~~Other Diagnosis~~ | ~~164~~ | ~~$7~~ | ~~DX4~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~3-9~~ | ~~Present on Admission Indicator~~ | ~~165~~ | ~~$1~~ | ~~DX4POA~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~4-1~~ | ~~Code List Qualifier Code~~ | ~~166~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BF". Else if DX\_TYPE = '10' then set to "ABF".~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~4-2~~ | ~~Other Diagnosis~~ | ~~167~~ | ~~$7~~ | ~~DX5~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~4-9~~ | ~~Present on Admission Indicator~~ | ~~168~~ | ~~$1~~ | ~~DX5POA~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~5-1~~ | ~~Code List Qualifier Code~~ | ~~169~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BF". Else if DX\_TYPE = '10' then set to "ABF".~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~5-2~~ | ~~Other Diagnosis~~ | ~~170~~ | ~~$7~~ | ~~DX6~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~5-9~~ | ~~Present on Admission Indicator~~ | ~~171~~ | ~~$1~~ | ~~DX6POA~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~6-1~~ | ~~Code List Qualifier Code~~ | ~~172~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BF". Else if DX\_TYPE = '10' then set to "ABF".~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~6-2~~ | ~~Other Diagnosis~~ | ~~173~~ | ~~$7~~ | ~~DX7~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~6-9~~ | ~~Present on Admission Indicator~~ | ~~174~~ | ~~$1~~ | ~~DX7POA~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~7-1~~ | ~~Code List Qualifier Code~~ | ~~175~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BF". Else if DX\_TYPE = '10' then set to "ABF".~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~7-2~~ | ~~Other Diagnosis~~ | ~~176~~ | ~~$7~~ | ~~DX8~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~7-9~~ | ~~Present on Admission Indicator~~ | ~~177~~ | ~~$1~~ | ~~DX8POA~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~8-1~~ | ~~Code List Qualifier Code~~ | ~~178~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BF". Else if DX\_TYPE = '10' then set to "ABF".~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~8-2~~ | ~~Other Diagnosis~~ | ~~179~~ | ~~$7~~ | ~~DX9~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~8-9~~ | ~~Present on Admission Indicator~~ | ~~180~~ | ~~$1~~ | ~~DX9POA~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~9-1~~ | ~~Code List Qualifier Code~~ | ~~181~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BF". Else if DX\_TYPE = '10' then set to "ABF".~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~9-2~~ | ~~Other Diagnosis~~ | ~~182~~ | ~~$7~~ | ~~DX10~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~9-9~~ | ~~Present on Admission Indicator~~ | ~~183~~ | ~~$1~~ | ~~DX10POA~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~10-1~~ | ~~Code List Qualifier Code~~ | ~~184~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BF". Else if DX\_TYPE = '10' then set to "ABF".~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~10-2~~ | ~~Other Diagnosis~~ | ~~185~~ | ~~$7~~ | ~~DX11~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~10-9~~ | ~~Present on Admission Indicator~~ | ~~186~~ | ~~$1~~ | ~~DX11POA~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~11-1~~ | ~~Code List Qualifier Code~~ | ~~187~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BF". Else if DX\_TYPE = '10' then set to "ABF".~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~11-2~~ | ~~Other Diagnosis~~ | ~~188~~ | ~~$7~~ | ~~DX12~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~11-9~~ | ~~Present on Admission Indicator~~ | ~~189~~ | ~~$1~~ | ~~DX12POA~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~12-1~~ | ~~Code List Qualifier Code~~ | ~~190~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BF". Else if DX\_TYPE = '10' then set to "ABF".~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~12-2~~ | ~~Other Diagnosis~~ | ~~191~~ | ~~$7~~ | ~~DX13~~ |
| ~~2300~~ | ~~Other Diagnosis Information~~ | ~~12-9~~ | ~~Present on Admission Indicator~~ | ~~192~~ | ~~$1~~ | ~~DX13POA~~ |
| 2300 | Principal Procedure Information | 1-1 | Code List Qualifier Code | 167 | $3 | If DX\_TYPE = '09' then set to "BR". Else if DX\_TYPE = '10' then set to "BBR". |
| 2300 | Principal Procedure Information | 1-2 | Principal Procedure Code | 168 | $7 | PROC1 |
| 2300 | Principal Procedure Information | 1-3 | Date Time Period Format Qualifier | 169 | $2 | Set to "D8" |
| 2300 | Principal Procedure Information | 1-4 | Principal Procedure Date | 170 | CCYYMMDD | PROCDATE1 |
| 2300 | Other Procedure Information | (1-12)-1 | Code List Qualifier Code | 171 | $3 | If DX\_TYPE = '09' then set to "BQ". Else if DX\_TYPE = '10' then set to "BBQ". |
| 2300 | Other Procedure Information | (1-12)-2 | Procedure Code | 172-183 | $7 | PROC2-PROC13 |
| 2300 | Other Procedure Information | (1-12)-3 | Date Time Period Format Qualifier | 184 | $2 | Set to "D8" |
| 2300 | Other Procedure Information | (1-12)-4 | Procedure Date | 185-196 | CCYYMMDD | PROCDATE2-PROCDATE13 |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~2-1~~ | ~~Code List Qualifier Code~~ | ~~201~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BQ". Else if DX\_TYPE = '10' then set to "BBQ".~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~2-2~~ | ~~Procedure Code~~ | ~~202~~ | ~~$7~~ | ~~PROC3~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~2-3~~ | ~~Date Time Period Format Qualifier~~ | ~~203~~ | ~~$2~~ | ~~Set to "D8"~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~2-4~~ | ~~Procedure Date~~ | ~~204~~ | ~~CCYYMMDD~~ | ~~PROCDATE3~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~3-1~~ | ~~Code List Qualifier Code~~ | ~~205~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BQ". Else if DX\_TYPE = '10' then set to "BBQ".~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~3-2~~ | ~~Procedure Code~~ | ~~206~~ | ~~$7~~ | ~~PROC4~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~3-3~~ | ~~Date Time Period Format Qualifier~~ | ~~207~~ | ~~$2~~ | ~~Set to "D8"~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~3-4~~ | ~~Procedure Date~~ | ~~208~~ | ~~CCYYMMDD~~ | ~~PROCDATE4~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~4-1~~ | ~~Code List Qualifier Code~~ | ~~209~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BQ". Else if DX\_TYPE = '10' then set to "BBQ".~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~4-2~~ | ~~Procedure Code~~ | ~~210~~ | ~~$7~~ | ~~PROC5~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~4-3~~ | ~~Date Time Period Format Qualifier~~ | ~~211~~ | ~~$2~~ | ~~Set to "D8"~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~4-4~~ | ~~Procedure Date~~ | ~~212~~ | ~~CCYYMMDD~~ | ~~PROCDATE5~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~5-1~~ | ~~Code List Qualifier Code~~ | ~~213~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BQ". Else if DX\_TYPE = '10' then set to "BBQ".~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~5-2~~ | ~~Procedure Code~~ | ~~214~~ | ~~$7~~ | ~~PROC6~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~5-3~~ | ~~Date Time Period Format Qualifier~~ | ~~215~~ | ~~$2~~ | ~~Set to "D8"~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~5-4~~ | ~~Procedure Date~~ | ~~216~~ | ~~CCYYMMDD~~ | ~~PROCDATE6~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~6-1~~ | ~~Code List Qualifier Code~~ | ~~217~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BQ". Else if DX\_TYPE = '10' then set to "BBQ".~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~6-2~~ | ~~Procedure Code~~ | ~~218~~ | ~~$7~~ | ~~PROC7~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~6-3~~ | ~~Date Time Period Format Qualifier~~ | ~~219~~ | ~~$2~~ | ~~Set to "D8"~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~6-4~~ | ~~Procedure Date~~ | ~~220~~ | ~~CCYYMMDD~~ | ~~PROCDATE7~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~7-1~~ | ~~Code List Qualifier Code~~ | ~~221~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BQ". Else if DX\_TYPE = '10' then set to "BBQ".~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~7-2~~ | ~~Procedure Code~~ | ~~222~~ | ~~$7~~ | ~~PROC8~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~7-3~~ | ~~Date Time Period Format Qualifier~~ | ~~223~~ | ~~$2~~ | ~~Set to "D8"~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~7-4~~ | ~~Procedure Date~~ | ~~224~~ | ~~CCYYMMDD~~ | ~~PROCDATE8~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~8-1~~ | ~~Code List Qualifier Code~~ | ~~225~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BQ". Else if DX\_TYPE = '10' then set to "BBQ".~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~8-2~~ | ~~Procedure Code~~ | ~~226~~ | ~~$7~~ | ~~PROC9~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~8-3~~ | ~~Date Time Period Format Qualifier~~ | ~~227~~ | ~~$2~~ | ~~Set to "D8"~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~8-4~~ | ~~Procedure Date~~ | ~~228~~ | ~~CCYYMMDD~~ | ~~PROCDATE9~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~9-1~~ | ~~Code List Qualifier Code~~ | ~~229~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BQ". Else if DX\_TYPE = '10' then set to "BBQ".~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~9-2~~ | ~~Procedure Code~~ | ~~230~~ | ~~$7~~ | ~~PROC10~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~9-3~~ | ~~Date Time Period Format Qualifier~~ | ~~231~~ | ~~$2~~ | ~~Set to "D8"~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~9-4~~ | ~~Procedure Date~~ | ~~232~~ | ~~CCYYMMDD~~ | ~~PROCDATE10~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~10-1~~ | ~~Code List Qualifier Code~~ | ~~233~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BQ". Else if DX\_TYPE = '10' then set to "BBQ".~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~10-2~~ | ~~Procedure Code~~ | ~~234~~ | ~~$7~~ | ~~PROC11~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~10-3~~ | ~~Date Time Period Format Qualifier~~ | ~~235~~ | ~~$2~~ | ~~Set to "D8"~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~10-4~~ | ~~Procedure Date~~ | ~~236~~ | ~~CCYYMMDD~~ | ~~PROCDATE11~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~11-1~~ | ~~Code List Qualifier Code~~ | ~~237~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BQ". Else if DX\_TYPE = '10' then set to "BBQ".~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~11-2~~ | ~~Procedure Code~~ | ~~238~~ | ~~$7~~ | ~~PROC12~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~11-3~~ | ~~Date Time Period Format Qualifier~~ | ~~239~~ | ~~$2~~ | ~~Set to "D8"~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~11-4~~ | ~~Procedure Date~~ | ~~240~~ | ~~CCYYMMDD~~ | ~~PROCDATE12~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~12-1~~ | ~~Code List Qualifier Code~~ | ~~241~~ | ~~$3~~ | ~~If DX\_TYPE = '09' then set to "BQ". Else if DX\_TYPE = '10' then set to "BBQ".~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~12-2~~ | ~~Procedure Code~~ | ~~242~~ | ~~$7~~ | ~~PROC13~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~12-3~~ | ~~Date Time Period Format Qualifier~~ | ~~243~~ | ~~$2~~ | ~~Set to "D8"~~ |
| ~~2300~~ | ~~Other Procedure Information~~ | ~~12-4~~ | ~~Procedure Date~~ | ~~244~~ | ~~CCYYMMDD~~ | ~~PROCDATE13~~ |
| 2310A | Attending Provider Name | 1 | Entity Identifier Code | 197 | $2 | Set to "71" |
| 2310A | Attending Provider Name | 2 | Entity Type Qualifier | 198 | $1 | Set to "1" |
| 2310A | Attending Provider Name | 3 | Attending Provider Last Name | 199 | $28 | ATTNDLAST |
| 2310A | Attending Provider Name | 4 | Attending Provider First Name | 200 | $28 | ATTNDFIRST |
| 2310A | Attending Provider Name | 5 | Attending Provider Middle Name or Initial | 201 | $20 | ATTNDMID |
| 2310A | Attending Provider Name | 7 | Attending Provider Name Suffix | 202 | $4 | ATTNDSFX |
| 2310A | Attending Provider Name | 8 | Identification Code Qualifier | 203 | $2 | Set to "XX" |
| 2310A | Attending Provider Name | 9 | Attending Provider Primary Identifier | 204 | $10 | ATTNDNPI |
| 2310A | Attending Provider Specialty Information | 1 | Provider Code | 205 | $2 | Set to "AT" |
| 2310A | Attending Provider Specialty Information | 2 | Reference Identification Qualifier | 206 | $3 | Set to "PXC" |
| 2310A | Attending Provider Specialty Information | 3 | Provider Taxonomy Code | 207 | $10 | ATTNDTAX |
| 2310B | Operating Provider Name | 1 | Entity Identifier Code | 208 | $2 | Set to "72" |
| 2310B | Operating Provider Name | 2 | Entity Type Qualifier | 209 | $1 | Set to "1" |
| 2310B | Operating Provider Name | 3 | Operating Provider Last Name | 210 | $28 | OPLAST |
| 2310B | Operating Provider Name | 4 | Operating Provider First Name | 211 | $28 | OPFIRST |
| 2310B | Operating Provider Name | 5 | Operating Provider Middle Name or Initial | 212 | $20 | OPMID |
| 2310B | Operating Provider Name | 7 | Operating Provider Name Suffix | 213 | $4 | OPSFX |
| 2310B | Operating Provider Name | 8 | Identification Code Qualifier | 214 | $2 | Set to "XX" |
| 2310B | Operating Provider Name | 9 | Operating Provider Primary Identifier | 215 | $10 | OPNPI |
| 2310C | Other Operating Provider Name | 1 | Entity Identifier Code | 216 | $2 | Set to "ZZ" |
| 2310C | Other Operating Provider Name | 2 | Entity Type Qualifier | 217 | $1 | Set to "1" |
| 2310C | Other Operating Provider Name | 3 | Other Operating Provider Last Name | 218 | $28 | OTHOPLAST |
| 2310C | Other Operating Provider Name | 4 | Other Operating Provider First Name | 219 | $28 | OTHOPFIRST |
| 2310C | Other Operating Provider Name | 5 | Other Operating Provider Middle Name or Initial | 220 | 420 | OTHOPMID |
| 2310C | Other Operating Provider Name | 7 | Other Operating Provider Name Suffix | 221 | $4 | OTHOPSFX |
| 2310C | Other Operating Provider Name | 8 | Identification Code Qualifier | 222 | $2 | Set to "XX" |
| 2310C | Other Operating Provider Name | 9 | Other Operating Provider Primary Identifier | 223 | $10 | OTHOPNPI |
| 2310D | Rendering Provider Name | 1 | Entity Identifier Code | 224 | $2 | Set to "82" |
| 2310D | Rendering Provider Name | 2 | Entity Type Qualifier | 225 | $1 | Set to "1" |
| 2310D | Rendering Provider Name | 3 | Rendering Provider Last Name | 226 | $28 | RENDLAST |
| 2310D | Rendering Provider Name | 4 | Rendering Provider First Name | 227 | $28 | RENDFIRST |
| 2310D | Rendering Provider Name | 5 | Rendering Provider Middle Name or Initial | 228 | 420 | RENDMID |
| 2310D | Rendering Provider Name | 7 | Rendering Provider Name Suffix | 229 | $4 | RENDSFX |
| 2310D | Rendering Provider Name | 8 | Identification Code Qualifier | 230 | $2 | Set to "XX" |
| 2310D | Rendering Provider Name | 9 | Rendering Provider Primary Identifier | 231 | $10 | RENDNPI |
| ~~2320~~ | ~~Other Subscriber Information~~ | ~~1~~ | ~~Payer Responsibility Sequence Number Code~~ | ~~221~~ |  | ~~From OHI~~ |
| ~~2320~~ | ~~Other Subscriber Information~~ | ~~2~~ | ~~Individual Relationhip Code~~ | ~~222~~ |  | ~~From OHI~~ |
| ~~2320~~ | ~~Other Subscriber Information~~ | ~~3~~ | ~~Insured Group or Policy Number~~ | ~~223~~ |  | ~~From OHI~~ |
| ~~2320~~ | ~~Other Subscriber Information~~ | ~~4~~ | ~~Other Insured Group Name~~ | ~~224~~ |  | ~~From OHI~~ |
| ~~2320~~ | ~~Other Subscriber Information~~ | ~~9~~ | ~~Claim Filing Indicator Code~~ | ~~225~~ |  | ~~From OHI~~ |
| ~~2320~~ | ~~Other Insurance Coverage Information~~ | ~~3~~ | ~~Benefits Assignment Certification Indicator~~ | ~~277~~ |  | ~~From OHI~~ |
| ~~2320~~ | ~~Other Insurance Coverage Information~~ | ~~6~~ | ~~Release of Information Code~~ | ~~278~~ |  | ~~From OHI~~ |
| ~~2330A~~ | ~~Other Subscriber Name~~ | ~~1~~ | ~~Entity Identifier Code~~ | ~~279~~ |  | ~~From OHI~~ |
| ~~2330A~~ | ~~Other Subscriber Name~~ | ~~2~~ | ~~Entity Type Qualifier~~ | ~~280~~ |  | ~~From OHI~~ |
| ~~2330A~~ | ~~Other Subscriber Name~~ | ~~3~~ | ~~Other Insured Last Name~~ | ~~281~~ |  | ~~From OHI~~ |
| ~~2330A~~ | ~~Other Subscriber Name~~ | ~~4~~ | ~~Other Insured First Name~~ | ~~282~~ |  | ~~From OHI~~ |
| ~~2330A~~ | ~~Other Subscriber Name~~ | ~~5~~ | ~~Other Insured Middle Name~~ | ~~283~~ |  | ~~From OHI~~ |
| ~~2330A~~ | ~~Other Subscriber Name~~ | ~~7~~ | ~~Other Insured Name Suffix~~ | ~~284~~ |  | ~~From OHI~~ |
| ~~2330A~~ | ~~Other Subscriber Name~~ | ~~8~~ | ~~Identification Code Qualifier~~ | ~~285~~ |  | ~~From OHI~~ |
| ~~2330A~~ | ~~Other Subscriber Name~~ | ~~9~~ | ~~Other Insured Identifier~~ | ~~286~~ |  | ~~From OHI~~ |
| ~~2330A~~ | ~~Other Subscriber Address~~ | ~~1~~ | ~~Other Insured Address Line~~ | ~~287~~ |  | ~~From OHI~~ |
| ~~2330A~~ | ~~Other Subscriber Address~~ | ~~2~~ | ~~Other Insured Address Line~~ | ~~288~~ |  | ~~From OHI~~ |
| ~~2330A~~ | ~~Other Subscriber City, State, ZIP Code~~ | ~~1~~ | ~~Other Insured City Name~~ | ~~289~~ |  | ~~From OHI~~ |
| ~~2330A~~ | ~~Other Subscriber City, State, ZIP Code~~ | ~~2~~ | ~~Other Insured State Code~~ | ~~290~~ |  | ~~From OHI~~ |
| ~~2330A~~ | ~~Other Subscriber City, State, ZIP Code~~ | ~~3~~ | ~~Other insured Postal Zone or ZIP Code~~ | ~~291~~ |  | ~~From OHI~~ |
| ~~2330A~~ | ~~Other Subscriber City, State, ZIP Code~~ | ~~4~~ | ~~Country Code~~ | ~~292~~ |  | ~~From OHI~~ |
| ~~2330A~~ | ~~Other Subscriber City, State, ZIP Code~~ | ~~7~~ | ~~Country Subidivision Code~~ | ~~293~~ |  | ~~From OHI~~ |
| ~~2330B~~ | ~~Other Payer Name~~ | ~~1~~ | ~~Entity Identifier Code~~ | ~~294~~ |  | ~~From OHI then SIT~~ |
| ~~2330B~~ | ~~Other Payer Name~~ | ~~2~~ | ~~Entity Type Qualifier~~ | ~~295~~ |  | ~~From OHI then SIT~~ |
| ~~2330B~~ | ~~Other Payer Name~~ | ~~3~~ | ~~Other Payer Last or Organization Name~~ | ~~296~~ |  | ~~From OHI then SIT~~ |
| ~~2330B~~ | ~~Other Payer Name~~ | ~~8~~ | ~~Identificaiton Code Qualifier~~ | ~~297~~ |  | ~~From OHI then SIT~~ |
| ~~2330B~~ | ~~Other Payer Name~~ | ~~9~~ | ~~Other Payer Primary Identifier~~ | ~~298~~ |  | ~~From OHI then SIT~~ |
| ~~2330B~~ | ~~Other Payer Address~~ | ~~1~~ | ~~Other Payer Address Line~~ | ~~299~~ |  | ~~From OHI then SIT~~ |
| ~~2330B~~ | ~~Other Payer Address~~ | ~~2~~ | ~~Other Payer Address Line~~ | ~~300~~ |  | ~~From OHI then SIT~~ |
| ~~2330B~~ | ~~Other Payer City, State, ZIP Code~~ | ~~1~~ | ~~Other Payer City Name~~ | ~~301~~ |  | ~~From OHI then SIT~~ |
| ~~2330B~~ | ~~Other Payer Name (City, State, ZIP)~~ | ~~2~~ | ~~Other Payer State Code~~ | ~~302~~ |  | ~~From OHI then SIT~~ |
| ~~2330B~~ | ~~Other Payer Name (City, State, ZIP)~~ | ~~3~~ | ~~Other Payer Postal Zone or ZIP Code~~ | ~~303~~ |  | ~~From OHI then SIT~~ |
| ~~2330B~~ | ~~Other Payer Name (City, State, ZIP)~~ | ~~4~~ | ~~Country Code~~ | ~~304~~ |  | ~~From OHI then SIT~~ |
| ~~2330B~~ | ~~Other Payer Name (City, State, ZIP)~~ | ~~7~~ | ~~Country Subidivision Code~~ | ~~305~~ |  | ~~From OHI then SIT~~ |
| ~~2400~~ | ~~Institutional Service Line~~ | ~~1~~ | ~~Service Line Revenue Code~~ | ~~208~~ |  | ~~?~~ |
| 2400 | Institutional Service Line | 2-1 | Product or Service ID Qualifier | 232 | $2 | Set to "HC" |
| 2400 | Institutional Service Line | 3 | Line Item Charge Amount | 233 | 1. | Set to 0 |
| 2400 | Institutional Service Line | 4 | Unit or Basis for Measurement | 234 | $2 | Set to "UN" |
| 2400 | Date – Service Date | 1 | Date Time Qualifier | 235 | $3 | Set to "472" |
| 2400 | Date – Service Date | 2 | Date Time Period Format Qualifier | 236 | $3 | Set to "RD8" |
| 2400 | Service Line Number | 1 | Assigned Number | 237  +9(*i*-1) | 2. | Increment for every CPT code sent |
| 2400 | Institutional Service Line | 2-2 | Procedure Code | 238  +9(*i*-1) | $5 | CPT\_*i*, where *i* is equal to the Service Line Number |
| 2400 | Institutional Service Line | 2-3 | Procedure Modifier | 239  +9(*i*-1) | $2 | CPTMOD1\_*i*, where *i* is equal to the Service Line Number |
| 2400 | Institutional Service Line | 2-4 | Procedure Modifier | 240  +9(*i*-1) | $2 | CPTMOD2\_*i*, where *i* is equal to the Service Line Number |
| 2400 | Institutional Service Line | 2-5 | Procedure Modifier | 241  +9(*i*-1) | $2 | CPTMOD3\_*i*, where *i* is equal to the Service Line Number |
| 2400 | Institutional Service Line | 5 | Service Count | 242  +9(*i*-1) | 3. | CPTUNIT~~O~~S\_*i*, where *i* is equal to the Service Line Number |
| ~~2400~~ | ~~Date – Service Date~~ | ~~3~~ | ~~Service Date~~ | ~~318~~ | ~~CCYYMMDD-CCYYMMDD~~ | ~~DATES~~ |
| N/A | N/A | N/A | APC | 243  +9(*i*-1) | $5 | APC\_*i*,where *i* is equal to the Service Line Number |
| N/A | N/A | N/A | APC Procedure Status Indicator (PSI) | 244  +9(*i*-1) | $5 | APCPSI\_*i*,where *i* is equal to the Service Line Number |
| N/A | N/A | N/A | ASC | 245  +9(*i*-1) | $5 | ASC\_*i*,where *i* is equal to the Service Line Number |

Appendix A: ~~Combination of MDR Ancillary and MDR CADRE~~Laboratory and Radiology Preprocessing

~~MDR Ancillary and MDR CADRE Basic records are merged by Record Type, CHCS Host, Accession Number, Order ID, CPT Code, and CPT Modifier to append the fields noted below to the MDR Ancillary Record, keeping only records that are found in both files.~~ The CADRE Laboratory Basic Accession Table, CADRE Laboratory Basic Test Table, and the CADRE Radiology Basic Table are pre-processed so that CBER ancillary information can be read in one layout. First, the CADRE Laboratory Basic files (Accession Table and Test Table) are merged by CHCS Host, Accession Number, Order ID, CPT, and CPT Modifier. If there is not a match in both tables, delete the record. Then the combined Laboratory file and CADRE Radiology Basic Table are appended, with the Ancillary Record Type flag derived based on which table the record came from. Once all the ancillary files have been combined, the file must be merged to the MPI and LVM to obtain additional variables. The layout is described below.

**Table 6: Combined CADRE Ancillary Table**

| **Data Element** | **SAS Name** | **Format** | **~~CADRE~~Lab Accession Table** | **Lab Test Table** | **Radiology Table** | **Transformation** | **~~MDR Ancillary~~** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| CHCS Host | HOST\_DMISID | $4 | CHCSDMIS | CHCSDMIS | CHCSDMIS |  | ~~CHCSDMIS~~ |
| Accession Number | ACCESSNO | $17 | ACCESSNO | ACCESSNO | ACCESSNO |  |  |
| Record Number | RECNO | $14 | RECNO | RECNO | N/A |  |  |
| Order ID | ORDERID | $12 | N/A | ORDERID | ORDERID |  |  |
| Procedure Code | CPT | $5 | N/A | CPT | CPT |  |  |
| Procedure Code Modifier | CPTMOD | $2 | N/A | CPTMOD | CPTMOD |  |  |
| Treatment DMISID | DMISID | $4 | TMTDMIS | N/A | TMTDMIS |  | ~~TMTDMIS~~ |
| Ordering Appointment Number | ORD~~ER~~\_APPTIEN~~ID~~ | $14 | N/A | APPTNO | APPTNO |  | ~~APPNO~~ |
| Ordering DMIS ID | ORD~~ER~~\_MTF~~DMISID~~ | $4 | N/A | ORDDMIS | ORDDMIS |  | ~~ORDDMIS~~ |
| Ordering MEPRS Code | ORD\_MEPRSCD | $4 | N/A | MEPRSCD | MEPRSCD |  |  |
| CLIA Number | CLIA | $15~~7~~ | CLIA | N/A | N/A |  |  |
| Patient EDIPN | EDI\_PN~~PATUNIQ~~ | $10 | REDIPN | N/A | REDIPN |  | ~~EDIPN~~ |
| Patient SSN | PATSSN | $9 | PATSSN | N/A | PATSSN |  | ~~PATSSN~~ |
| ~~Patient DOB~~ | ~~PATDOB~~ | ~~CCYYMMDD~~ |  |  |  |  | ~~DOB~~ |
| ~~Patient Gender~~ | ~~PATSEX~~ | ~~$1~~ |  |  |  |  | ~~SEX~~ |
| Patient Category Code 3 | PATCAT~~\_R~~ | $3 | PATCAT | N/A | PATCAT |  | ~~PATCAT~~ |
| Other Health Insurance – Local | OHI | $1 | OHI | N/A | OHI |  | ~~OHI~~ |
| Encounter Date | ~~DATES~~ENCDATE | CCYYMMDD | N/A | SERVDATE | SERVDATE |  | ~~SERVDATE~~ |
| ~~Inpatient Record ID~~ | ~~MTF\_PRN~~ | ~~$12~~ |  |  |  |  | ~~PRN~~ |
| Ordering Provider NPI | ~~ATTND~~OPNPI | $10 | ~~CPNPI~~ | OPNPI | OPNPI |  |  |
| Ordering Provider NPI Type | OPNPI\_TYP | $1 | N/A | N/A | N/A | Leave blank |  |
| Ordering Provider EDIPN | ~~ATTND~~OPEDIPN | $10 | ~~CPEDIPN~~ | OPEDIPN | OPEDION |  |  |
| Ordering Provider SSN | ~~ATTND~~OPSSN | $9 | ~~CPSSN~~ | OPSSN | OPSSN |  |  |
| Ordering Provider Taxonomy | ~~ATTNDTAX~~OPHIPAA | $11 | ~~CPHIPAA~~ | OPHIPAA | OPHIPAA |  |  |
| Certifying Provider NPI | CPNPI | $10 | N/A | CPNPI | CPNPI |  |  |
| Certifying Provider NPI Type | CPNPI\_TYP | $1 | N/A | N/A | N/A | Leave blank |  |
| Certifying Provider EDIPN | CPEDIPN | $10 | N/A | CPEDIPN | CPEDIPN |  |  |
| Certifying Provider SSN | CPSSN | $9 | N/A | CPSSN | CPSSN |  |  |
| Certifying Provider Taxonomy | CPHIPAA | $11 | N/A | CPHIPAA | CPHIPAA |  |  |
| Units of Service | COUNT | 3 | N/A | COUNT | COUNT |  |  |
| Patient Subcategory Code | PATCAT2 | $1 | PATCAT2 | N/A | PATCAT2 |  |  |
| File Date | FILEDATE | CCYYMMDD | FILEDATE | N/A | FILEDATE |  |  |
| Inpatient Record ID | MTF\_PRN | $12 | ORDDMIS, PRN | N/A | ORDDMIS, PRN | Concatenate ORDDMIS and PRN. |  |
| Record ID | RECORD\_ID | $41 | CHCSDMIS, ACCESSNO, ORDERID, CPT, CPTMOD | CHCSDMIS, ACCESSNO, ORDERID, CPT, CPTMOD | CHCSDMIS, ACCESSNO, ORDERID, CPT, CPTMOD | Concatenate CHCSDMIS, ACCESSNO, ORDERID, CPT, and CPTMOD. |  |
| Record Type Modifier | MOD | $2 | MOD | N/A | MOD |  |  |
| Ancillary Record Type | ANC\_RECTYPE | $1 | N/A | N/A | N/A | If the record is from Lab, set to 'L'. If the record is from Rad, set to 'R'. |  |
| Patient DOB | PATDOB | CCYYMMDD | N/A | N/A | N/A | From MPI |  |
| Patient Gender | PATSEX | $1 | N/A | N/A | N/A | From MPI |  |
| Sponsor Service | SPONSVC | $1 | N/A | N/A | N/A | From LVM |  |
| Beneficiary Category | BENCAT | $3 | N/A | N/A | N/A | From LVM |  |
| ~~Procedure Code~~ | ~~CPT\_1~~ | ~~$5~~ |  |  |  |  | ~~CPT~~ |
| ~~Proc Code Modifier 1 – 3~~ | ~~CPTMOD1\_1~~ | ~~$2~~ |  |  |  |  | ~~CPTMOD~~ |
| ~~Units of Service~~ | ~~CPTUOS\_1~~ | ~~3~~ |  |  |  |  | ~~COUNT~~ |

~~Appendix B: Addition of Total Charge Amount to HIPAA 837I Claims~~

~~Section B.1 Inpatient Claims (SIDR, SOURCE = “S”)~~

~~Inpatient Claims are paid based on the MS-DRG with a few adjustments.~~

~~First calculate the “inlier” MS-DRG amount: INLIER = (ASA\*LABOR\*WAGE\_INDEX + ASA\*NON\_LABOR\*WAGE\_INDEX) \* MSDRG\_WEIGHT.~~

~~Then calculate the Long-Stay Outlier amount: LONG\_STAY = LONGLOS \* (INLIER/GMLOS) \* (DAYS – LST).~~

~~Then calculate the IDME adjustment: IDME = 1 + IDME\_MULT \* ([1 + INTERNS/BEDS]~~~~0.5795~~ ~~– 1).~~

~~The Long-Stay Outlier amount only applies if the Bed Days is greater than the Long Stay Threshold:~~

~~If DAYS > LST, then CHARGE = (INLIER + LONG\_STAY) \* IDME.~~

~~Else CHARGE = INLIER \* IDME.~~

~~Section B.2 APC Claims (CAPER, SOURCE = “C”)~~

~~Emergency Department and Same Day Surgery Claims are paid based on the Ambulatory Payment Classification (APC) Codes. The APC Grouper provides the weights (discounted) for each APC (for each CPT) on a CAPER record. The sum of these weights is provided in the variable APCAGGWT. The only adjustment is to apply the wage index (same wage index as that used for the MS-DRG based payment), and to multiply by the conversion factor for that calendar year:~~

~~CHARGE = (APCAGGWT \* 0.6 \* WAGE\_INDEX + APCAGGWT \* 0.4) \* APC\_CONV.~~

~~Section B.3 Ancillary Claims (Ancillary Combined, SOURCE = “a”)~~

~~Ancillary Claims are paid based on the CMAC.~~

~~For Laboratory claims (ANC\_RECTYPE = “L”), only records with CPT modifier 00 and 32 are considered institutional and billable. Both represent both the technical and professional components. If PROV\_CLASS = “P” (Physician), then use the Facility CMAC for physician/LLP class. If PROV\_CLASS = “N” (Non-Physician), then use the Facility CMAC for nonphys. class.~~

~~For Radiology claims (ANC\_RECTYPE = “R”), only records with CPT modifier TC are considered institutional. If PROV\_CLASS = “P”, then use the Physician class Tech. Component CMAC. If PROV\_CLASS = “N”, then use the Nonphysician class TC CMAC.~~

~~In all cases, the final charge is simply equal to the appropriate CMAC (locality adjustment?):~~

~~CHARGE = CMAC.~~

Appendix ~~C~~B: MSA Key

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Category | Patient Category Code | DMISID Information | MSA Key Value |
| NOAA | B\*, except B29 with subcat A | N/A | NOAMD9999 |
| Coast Guard | C\*, except C28 and C29 with subcat A | N/A | CGDDC9999 |
| USPHS | P\*, except P29 with subcat A | UBU\_Service is A, B, 1 | PHSMD9991 |
| USPHS | P\*, except P29 with subcat A | UBU\_Service is F, G, 3 | PHSMD9992 |
| USPHS | P\*, except P29 with subcat A | UBU\_Service is N, R, 2 | PHSMD9993 |
| USPHS | P\*, except P29 with subcat A | UBU\_Service is P, 5, 6 | PHSMD9994 |