**4 October 2017**

Active Duty Dental Plan (ADDP)

for the

MHS Data Repository (MDR)

(Version 1.10.04)

Current Specification

**Revision History**

| **Version** | **Date**  | **Para/Tbl/Fig** | **Originator** | **Description of Change** |
| --- | --- | --- | --- | --- |
| 1.01.00 | 10/30/2009 | * Initial publication
 | L. Wright |  |
| 1.02.00 | 11/18/2009 | * Table 1
 | L. Wright | * Updated file names and location
 |
| 1.03.00 | 05/19/2010 | * Table 1
* Appendix A
 | L. Wright | * Instead of a provider file for each year, one overall provider file is now produced.
 |
|  |  | * Table 3
 |  | * Moved the 5 dollar fields (billed, allowed, approved, OHI and third party liability) to under Internally Derived Fields and updated the business rules.
 |
|  |  | * Appendix A
 |  | * Provider key set to tax id/provider id instead of just provider id.
 |
|  |  | * Table 3
 |  | * Added the MMSO residual indicator, which was a newly added field in the ICD.
 |
|  |  | * Section VI
 |  | * Initial records that have a duplicate in the raw feed are assumed to be a resubmit and should be placed in the dump archive file. There should only be one initial record.
 |
|  |  | * Section X
 |  | * Added a section that covers quality review requirements for monthly processing.
 |
|  |  | * Appendix B
 |  | * Added ADDP claims adjustment update examples.
 |
| 1.04.00 | 06/21/2010 | * Table 3
 |  | * Blank values (unknown) coded as “Z” for several fields.
* RELCODE unknowns coded as “4”.
 |
| 1.05.00 | 07/19/2010 | * Update Process
 | L.Wright | * Added how the processor sorts the records.
 |
| 1.05.01 | 08/26/2010 | * Record Layout
 | L. Wright | * Changed the length from $5 to $6 for “servcat” (beneficiary category). The field positions 229-234 were correct.
 |
| 1.05.02 | 08/08/2012 | * Record Layout
 | L. Wright | * Added transformation rule for DMIS Code of the Referring Dental Treatment Facility.
 |
| 1.06.01 | 10/25/2012 | * Table 3
 | W. Funk | * Added DWV and Number of Services
 |
| 1.06.02 | 01/25/2013 | * Table 3
* Table 2
 | C. Kangas | * Changed DWV table application to be fiscal year based, not calendar year.
* Added reference to DWV external file matching
 |
| 1.06.03 | 01/25/2013 | * Table 3
 | C. Kangas | * Changed DWV external file match wording to be based on the FY of the end date of care.
 |
| 1.07.01 | 11/04/2013 | * Table 3
 | W. Funk | * Added SPA Code. Updated logic for Derived DTF Referral Indicator.
 |
| 1.08.01 | 09/03/2014 | * Table 3
* Section VI
 | W. Funk | * Added Government Charged Amount, Diabetic Indicator, Pregnancy Indicator, Health Care Delivery Program (HCDP) Plan Coverage Code, Health Care Coverage (HCC) Member Category Code, Remote Authorization
* Processing will now be bi-monthly
 |
| 1.09.01 | 11/05/2015 | * Table 3
 | C. Kangas | * Updated logic for Derived DTF Referral Indicator.
 |
| 1.10.01 | 3/25/2015 | * Tables 2 and 3
 | C. Kangas | * Updated logic for application of DWVs
 |
| 1.10.02 | 5/25/2015 | * Section IX
 | C. Kangas | * Added guidance on processing frequency
 |
| 1.10.02 | 9/27/2017 | * Table 2
* Table 3
 | W. Funk | * Added DMIS ID table merge
* Added fields related to NDAA 2017 and T2017
 |
| 1.10.03 | 9/28/2017 | * Table 3
 | W. Funk | * Added ACV Group and Assigned HCDP
 |
| 1.10.04 | 10/4/2017 | * Appendix C
 | W. Funk | * Corrected a typo on ACV Group
 |

**Active Duty Dental Plan (ADDP) for the MDR**

1. Background:

The MDR has contained purchased care dental data provided to active duty service members for many years. The activity that has provided these data in the past has been the Military Medical Support Office (MMSO) in Great Lakes, Illinois. A new contract, called Active Duty Dental Plan (ADDP) has been awarded to take over many of the functions done by the MMSO, including processing of claims for Active Duty Service Member (ADSM) dental care. This file specification describes the new data files that will be made available as a result of the change in source of data. MMSO data files will no longer be provided now that the ADDP contract is operational[[1]](#footnote-1).

1. Source:

There are two primary feeds provided by the ADDP contractor: a claims feed and a provider feed. The Service Area File is also used as a reference file. The formats of these input files are available in the ICD.

1. Transmission (Format and Frequency):

The data feeds are transmitted monthly according to the rules specified in the ADDP contract. The ICD for the feed is the 15th calendar day of each month.

1. Organization and Batching

Source Data: The first step in MDR processing is to store the raw files in

/mdr/raw/dental/addp/claims/d*yymmdd.txt.Z*

and

/mdr/raw/dental/addp/provider/d*yy*mmdd.txt.Z

where “yymmdd” represents the date of the file. Raw batches must be made available (and remain available) to the staff at TMA that will process the raw data.

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

**Table 1: MDR ADDP Processor Output Products**

|  |  |  |
| --- | --- | --- |
| **MDR ADDP File** | **File Naming Convention** | **Member Name** |
| ADDP Claims File  | /mdr/pub/dental/addp/claims/fy\*\* | fy\*\*.sas7bdat |
| ADDP Readiness CDR Extract | /mdr/pub/dental/addp/readiness/fy\*\*/addp\_ready.txt | N/A |
| ADDP Provider File | /mdr/pub/dental/addp/provider | Providers.sas7bdat |

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

1. Receiving Filters

Filters are applied to the source data based on rules described in the ADDP contracts.

1. Update Process

The MDR ADDP files will be updated on a bi-monthly basis.

The raw claims feed comes in at a claim and line item level of detail. The claim ID number and line number is used to identify a unique record. Each claim line can potentially contain multiple line item codes. The MDR processor sorts the records based on claim id number, line number, claim paid date, and adjustment code, and collapses the extra line items into one record per line item before the netting process. For example, the raw feed can contain multiple adjustments in each feed (ADJCODE = null, A, B, C, etc). In this case, the MDR processor will take the initial record and all adjustments and sum the dollar fields (net), (please see Appendix B for examples). In addition, the monthly raw feed is checked for any duplicate non adjusted/rejected records, referred to as an initial claim. A duplicate initial claim is defined as a record with a null adjustment and a null line item rejection code with the same claimid, linenum, claim paid date, claim finalized date, billed amount and allowed amount. Any of these duplicates are sent to the dump archive.

In order to update the fiscal year ADDP file, a new feed is interleaved with the existing database and logic is used to determine how to handle each line item based on the following four scenarios:

1. Line item is rejected. These line items are sent to the dump archive and are not added to the MDR DED file. In addition, any records currently in the MDR ADDP that match these records based on a key of Claim ID and Line Item are pulled out of the MDR ADDP and sent to the dump archive.
2. Line item that is adjusted. These line items are added to the MDR DED File and any records currently in the MDR ADDP that match these records, sorted by claim id number, line number, claim paid date, and adjustment code, and based on a key of Claim ID and Line Item are updated (amounts netted) in the MDR ADDP file and the older version of the record is pulled out of the MDR ADDP and sent to the dump archive.
3. Line item is neither rejected nor adjusted, and does not match based on a key of Claim ID and Line Item number to any records currently residing in the MDR ADDP. These line items are added to the corresponding fiscal year MDR ADDP file.
4. Line item is neither rejected nor adjusted, but has a matching record based on a key of Claim ID and Line Item number to a record currently residing in the MDR ADDP. In this case the initial record is assumed to be a resubmit and is sent to the dump archive, while the original record is kept in the MDR ADDP file. There should only be 1 initial record at the claim/line item level.

Minimal additional processing occurs, including applying routine MDR processing utilities to enhance the content of the data.

Each monthly provider file is a complete replacement of the file of the preceding month. Processing of the ADDP Provider File is described in Appendix A.

1. Field Transformations and Deletions for MDR Core Database

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

**Table 2: External Reference File Merges**

| **Merge** | **Date Matching** | **Additional Matching** |
| --- | --- | --- |
| Master Person Index\* | Most recent MPI is used for fiscal year that matches the end date of care of each record. | See VM-6 Specifications |
| LVM\* | Use LVM file that matches begin date of care on each record.  | EDIPN. See VM-6 Specification |
| Service Area File | Based on patient zip code and month processed |  |
| Relative Value Unit Table | Calendar year of begin date of care with calendar year of RVU Table | CDT / Modifier & Procedure Code / Modifier |
| Dental Weighted Value Table | FY (before 1/1/2016) or CY (starting 1/1/2016) of end date of service with DWV Tables | CDT  |
| DMIS ID Index Table | FY | Enrollment MTF ; Referring MTF |

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 table below describes the content of the MDR Master ADDP Claims File. Other output files are described in the appendices.

**Table 3: MDR ADDP Claims SAS Dataset Structure and Business Rules**

| **Data Element** | **SAS Name** | **Format** | **Input Position in Source Feed** | **Business Rule** |
| --- | --- | --- | --- | --- |
| Last Name | patlname | $35 | 1-35 | No transformation |
| First Name | patfname | $25 | 36-60 | No transformation |
| Middle Name | patmname | $25 | 61-85 | No transformation |
| Sponsor SSN – Raw | rsponssn | $9 | 86-94 | No transformation |
| Sex | patsex | $1 | 95 | No transformation |
| Date Of Birth | patdob | yyyymmdd | 96-103 | No transformation |
| Person Identifier – Raw | redi\_pn | $10  | 104-117 | Left justify and then substring to the 1st 10 characters  |
| Branch of Service | svc | $1 | 118 | No transformation |
| Remote Indicator | dtf\_area | $1 | 119 | No transformation |
| Performing Provider | provid | $9 | 134-142 | No transformation |
| Provider Tax ID | taxid | $9 | 143-151 | No transformation |
| National Provider ID (Ind) | npi | $14 | 152-165 | No transformation |
| National Provider ID (Group) | npigroup | $14 | 166-179 | No transformation |
| Performing Provider Zip Code | provzip | $5 | 180-184 | No transformation |
| Performing Provider Specialty Code | provspec | $3 | 185-187 | No transformation |
| Performing Provider HIPAA Taxonomy | hipaaspec | $10 | 188-197 | No transformation |
| Provider Network Status | network | $1 | 198 | No transformation |
| Provider Suffix | provsuff | $3 | 199-201 | No transformation |
| Claim Number | claimid | $13 | 202-214 | No transformation |
| Claim Line Item Number | linenum | $4 | 215-218 | No transformation |
| Claim Rejection Reason Code | rejrea | $5 | 219-223 | No transformation |
| Line Item Rejection Reason Code | linerej | $5 | 224-228 | No transformation |
| Benefit Category | servcat | $6 | 229-234 | No transformation |
| Date of Service | begdate | YYYYMMDD | 235-242 | No transformation |
| End Date of Care | enddate | YYYYMMDD | 243-250 | No transformation |
| Claim Receipt Date | clmrecdt | YYYYMMDD | 251-258 | No transformation |
| Claim Paid Date | clmpddt | YYYYMMDD | 259-266 | No transformation |
| Claim Finalized Date | clmfindt | YYYYMMDD | 267-274 | No transformation |
| Date of Last Exam | lastexam | YYYYMMDD | 275-282 | No transformation |
| CDT Code  | cdt  | $5 | 283-287 | No transformation |
| CDT Version # | cdtvers | $2 | 288-289 | No transformation |
| Adjustment Reason | adjkey | $2 | 290-291 | No transformation |
| Adjustment Code | adjcode | $1 | 292 | No transformation |
| Tooth Number  | Tooth  |  | 293-294 | No transformation |
| Anterior/Posterior Flag  | ap\_id | $1 | 295 | No transformation |
| Buccal Surface Indicator | buc\_ind | $1 | 296 | No transformation |
| Distal Surface Indicator | dis\_ind | $1 | 297 | No transformation |
| Facial Surface Indicator | fac\_ind | $1 | 298 | No transformation |
| Incisal Surface Indicator | inc\_ind | $1 | 299 | No transformation |
| Lingual Surface Indicator | ling\_ind | $1 | 300 | No transformation |
| Mesial Surface Indicator | mes\_ind | $1 | 301 | No transformation |
| Occlusial Surface Indicator | occl\_ind | $1 | 302 | No transformation |
| Quadrant | quadrant | $2 | 303-304 | No transformation |
| Third Party Liability | Tpliab | 9.2 | 341-349 | No transformation |
| Prior Placement Date | prepldt | YYYYMMDD | 350-357 | No transformation |
| Replacement Reason | replrea | $1 | 358 | No transformation |
| Oral Health Initiative Flag | oral\_ind | $1 | 359 | No transformation |
| Dental Readiness Classification | dentalclass | $1 | 360 | No transformation |
| Referral Number | refnum | $16 | 361-376 | No transformation |
| Authorization Number | authnum | $16 | 377-392 | No transformation |
| DMIS Code of the Referring Dental Treatment Facility | dtf\_dmisid | $4 | 393-396 | If populated on any line item record for a claimid, set all line item records to the same DTF\_DMISID. |
| MMSO Residual Claims Indicator | MMSO\_ind | $1. | 397 | No transformation |
| SPA Code | spa\_code | $2. | 398-399 | No transformation |
| Diabetic Indicator | diabetic\_ind | 3 | 409-411 | No transformation |
| Pregnancy Indicator | pregnancy\_ind | 3 | 412-414 | No transformation |
| Health Care Delivery Program (HCDP) Plan Coverage Code | r\_hcdp | 3 | 415-417 | No transformation |
| Health Care Coverage (HCC) Member Category Code | r\_hcc | 1 | 418 | No transformation |
| Remote Authorization | remote\_auth | 1 | 419 | No transformation |
| **Internally Derived Fields** |
| Billed Charge | Bill | 9.2 | 305-313 | No transformation if initial claim, amounts from adjusted records are summed producing a net amount. |
| Allowed Amount | Allow | 9.2 | 314-322 | No transformation if initial claim, amounts from adjusted records are summed producing a net amount. |
| Amount Paid | approved | 9.2 | 323-331 | No transformation if initial claim, amounts from adjusted records are summed producing a net amount. |
| Other Carrier Payment | Ohi | 9.2 | 332-340 | No transformation if initial claim, amounts from adjusted records are summed producing a net amount. |
| Third Party Liability | Tpliab | 9.2 | 341-349 | No transformation if initial claim, amounts from adjusted records are summed producing a net amount. |
| Government Charged Amount | govt\_chrg | 9.2 | 400-408 | No transformation if initial claim, amounts from adjusted records are summed producing a net amount. |
| FY | Fy | $4 | N/A | FY is created from end date. |
| FM | Fm | $2 | N/A | FM is created from end date. |
| CY | Cy | $4 | N/A |  Calendar year of service date |
| CM | Cm | $2 | N/A |  Calendar month of service date |
| Initial Processing Date (MDR) | procdate | yyyymmdd | N/A | Set to the initial date that this record was prepared for the MDR |
| Change Date (MDR) | chgdate | yyyymmdd | N/A | Set to the most recent date that any data element on the MDR record was changed. For records that never change, this will be equal to the initial processing date. |
| Age | Patage | 3 | N/A |  Patient’s age is calculated from date of birth and end date. |
| Age Group | Agegrp | $1 | N/A | A: ages 0-4; B: ages 5-14, C: ages 15-17, D: ages 18-24, E: 25-34, F: 35-44, G: 45-64, H: 65+, X: All others |
| Ben Cat Common  | Comben | $1 | N/A | If bencat in (‘ACT’ GRD’) then =4, If bencat in (‘DA’ ‘DGR’) then =1;If bencat = ‘RET’ then=2;Otherwise = 3 |
| New Record Flag | new\_rec | $1 | N/A | Set to 1 if this version of the record was received in most recent processing cycle. Otherwise, set to 0. |
| Extract Date | extr\_dt | $7 | N/A | The date the data was processed, dYYMMDD format. |
| Derived DTF Referral Indicator | d\_dtfref | $1 | N/A | If SPA Code in(“TA”,”AT”) then d\_DTFREF = ‘Y’ otherwise d\_DTFREF = ‘N. |
| Number of Services | Svcs | $1 | N/A | Set to 1 |
| ACV Group | acvgroup | $2 | N/A | If begin date is >=1/1/2018 then:f enr\_grp is “P” then set to “PR” elseif enr\_grp is “L” then set to “PL” elseif enr\_group=”U” then set to “DP” elseif (bencat common=4 and pcm\_type=N) then “R” elseif pcm\_type=”O” then “R” elseif elg\_grp in (“R” “S”) then “O” else “O”For logic prior to Jan 2018, see appendix C |
| **Master Person Index Merge** |
| DEERS Person ID – Derived | Edipn | $10 | N/A | See VM-6 Specification |
| Sponsor SSN – Derived | Sponssn | $9 | N/A |
| Person Association Reason Code | Parc | $2 | N/A |
| **Longitudinal DEERS File Merge** |
| DEERS PCM ID | Pcmid | $32  | N/A  | Fill with PCM ID from LVM, if the begin date of care on the claim is between the begin and end date associated with the PCM ID. See VM-6 Specification, Sections G18 and 19 for segment and field position. |
| DEERS Enrollment DMIS Id | denrsite | $4 | N/A | Fill with enrollment DMISID from LVM, if the begin date of care on the claim is between the begin and end date associated with the enrollment site. See VM-6 Specification, Sections G18 and 19 for segment and field position  |
| DEERS Beneficiary Category | bencat | $3  | N/A  | Fill with DEERS beneficiary category from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS beneficiary category. If no match for person, set to “Z”. See VM-6 Specification, Sections G18 and 19 for segment and field position |
| DEERS Medicare Flag | medflag | $1 | N/A | Fill with DEERS medicare flag from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS medicare flag. If no match for person, set to “Z”. See VM-6 Specification, Sections G18 and 19 for segment and field position |
| DEERS Race Code | Race | $1 | N/A | Fill with DEERS race code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS race code. If no match for the person, set to “Z”. See VM-6 Specification, Sections G18 and 19 for segment and field position |
| DEERS Ethnicity Code | Ethnic | $1 | N/A | Fill with DEERS ethnicity code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS ethnicity code. If no match for the person, set to “Z”. See VM-6 Specification, Sections G18 and 19 for segment and field position |
| DEERS Sponsor Service | dsponsvc | $1 | N/A | Fill with DEERS sponsor service from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS sponsor service. If no match for the person, set to “Z”. See VM-6 Specification, Sections G18 and 19 for segment and field position |
| DEERS Sponsor Service Aggregate | dsvcagg | $1 | N/A | Fill with DEERS sponsor service (aggregate) from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS sponsor service (aggregate). If no match for the person, set to “Z”. See VM-6 Specification, Sections G18 and 19 for segment and field position |
| DEERS Alternative Care Value | acv | $1 | N/A | Fill with DEERS ACV from LVM, if the begin date of care on the claim is between the begin and end date associated with the ACV. See VM-6 Specification, Sections G18 and 19 for segment and field position. BLANK FILL AFTER JAN1, 2018 |
| DEERS Medical Privilege Code | privcode | $1 | N/A | Fill with DEERS medical privilege code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS medical privilege code. If no match for the person, set to “Z”. See VM-6 Specification, Sections G18 and 19 for segment and field position |
| DEERS HCDP - Enrolled | hcdp | $3 | N/A  | Fill with DEERS HCDP code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS HCDP code. See VM-6 Specification, Sections G18 and 19 for segment and field position |
| DEERS HCDP - Assigned | hcdp\_assgn | $3 | N/A | Fill with DEERS Assigned HCDP code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS Assigned HCDP code. See VM-6 Specification, Sections G18 and 19 for segment and field position |
| DEERS Zip Code | deerszip | $5 | N/A | Fill with DEERS zip code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS zip code. See VM-6 Specification, Sections G18 and 19 for segment and field position |
| DEERS Relationship to Sponsor | relcode | $1 | N/A | Fill with DEERS relationship to sponsor code from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS relationship to sponsor code. If no match for the person, set to “4”. See VM-6 Specification, Sections G18 and 19 for segment and field position |
| Dental HCDP Flag | dhcdp\_fl | $1 | N/A | IF the HCDP code from LVM is dental and the encounter date is within the Dental HCDP begin and end date, the patient is eligible (Y) if not the patient is not eligible (N). See VM-6 Specification, Sections G18 and 19 for segment and field position |
| Enrollment Group | enr\_grp | $2 |  | Fill with D\_ENR\_GRP\_CD from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS relationship to sponsor code. See VM-6 Specification, Sections G18 and 19 for segment and field position |
| Eligibility Group | elg\_grp | $2 |  | Fill with D\_ENR\_GRP\_CD from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS relationship to sponsor code. See VM-6 Specification, Sections G18 and 19 for segment and field position |
| PCM Type | pcm\_type | $2 |  | Fill with D\_PCM\_TYPE\_CD from LVM, if the begin date of care on the claim is between the begin and end date associated with the DEERS relationship to sponsor code. See VM-6 Specification, Sections G18 and 19 for segment and field position |
| **Service Area File Merge** |
| ADDP Service Area(Remote Active Duty Eligibility Flag) | raddpfl | $1 | N/A | Based on matching patient zip code to the zip code to the monthly Service Area File (SAF). If the Remote Active Duty Field on the SAF file is coded as ‘1’ then the patient is eligible for Remote Active Duty Dental Program (1=eligible) and ‘0’ if not (0=not eligible).  |
| **MDR Omni CAD Merge** |
| Residence Catchment Area | Catch | $4 | N/A | Based on matching FY, FM and deerszip; if sponsvc=A then set equal to ACATCH, if sponsvc = F then set equal to FCATCH; if sponsvc in (M, N) then set equal to NCATCH, otherwise set equal to OCATCH. If zip code not found in MDR Omni-CAD, set equal to ‘0999’ |
| Residence Prism Area | prism | $4 | N/A | Based on matching FY, FM and deerszip; if sponsvc=A then set equal to APRISM, if sponsvc = F then set equal to FPRISM; if sponsvc in (M, N) then set equal to NPRISM, otherwise set equal to OPRISM. If zip code not found in MDR Omni-CAD, set equal to ‘0999’ |
| Residence Region | resreg | $2 | N/A | MOD\_REG, based on matching FY, FM and deerszip |
| Residence TNEX Region  | restnex | $1 | N/A | HSSCREG, based on matching FY, FM and deerszip |
| Patient MTF Service Area | mtfsvcarea | $4 | N/A | Based on matching FY, FM, zip and sponsor service. It returns Service related MTF service area. |
| Provider Catchment Area | pvcatch | $4 | N/A | Based on matching FY, FM and provzip; set = OCATCH. If provzip not found in MDR Omni-CAD, set equal to ‘0999’ |
| Provider Prism Area | pvprism | $4 | N/A | Based on matching FY, FM and provzip; set = OPRISM. If provzip not found in MDR Omni-CAD, set equal to ‘0999’ |
| Provider TNEX Region | pvtnex | $1 | N/A | HSSCREG, based on matching FY, FM and deerszip |
| Provider MTF Service Area | pmtfsvcarea | $4 | N/A | Based on matching FY, FM, provzip. It returns other MTF Service Area. |
| Beneficiary T3 Region | ben\_t3\_reg | $2 | N/A | t3\_reg; Based on matching FY, FM and patzip |
| Beneficiary T2017 Region | ben\_t17\_reg | $2 | N/A | T17\_reg; based on matching FY, FM and patzip |
| Provider T3 Region | prov\_t3\_reg | $2 | N/A | t3\_reg; based on matching FY, FM and provzip |
| Provider T2017 Region | prov\_t17\_reg | $2 | N/A | T17\_reg; based on matching FY/FM and provzip |
| **Reservist Attributes Merge** |
| Reservist Status | res\_stat | $1 | N/A | Populate with reservist status from MDR Reservist format file, if the begin date of care is between the begin and end dates of the reservist status code. |
| Special Operations Code | soc | $2 | N/A | Populate with special operations code from MDR Reservist format file, if the begin date of care is between the begin and end dates of the reservist status code. |
| **Relative Value Unit Table Merge** |
| Work RVU | rvu | 7.2 | N/A | Match to RVU table based on CDT and CY and retrieve purchased care work RVU. |
| Facility Practice Expense RVU | facpervu | 7.2 | N/A | Match to RVU table based on CDT and CY and retrieve practice expense RVU (Facility) |
| Non-facility Practice Expense RVU | nfpervu | 7.2 | N/A | Match to RVU table based on CDT and CY and retrieve practice expense RVU (Non-facility) |
| **Dental Weighted Value Table Merge** |
| DWV | dwv | 7.2 | N/A | Match to DWV tables based on CDT and either FY or CY to retrieve DWV. For date matching, use FY tables before 1/1/2016 and CY table DWVs starting 1/1/2016. Use FY15 DWV table for the 10/2015-12/2015 period.  |
| **DMIS ID Index Table Merge** |
| Enrollment Site T3 Region | enr\_t3\_reg | $2 |  | t3\_reg, based on FY/Enrollment Site |
| Enrollment Site T2017 Region | enr\_t17\_reg | $2 |  | t17\_reg, based on FY/Enrollment Site |
| Referring MTF T3 Region | ref\_t3\_reg | $2 |  | t3\_reg, based on FY/Referring MTF |
| Referring MTF T2017 Region | ref\_t17\_reg | $2 |  | t17\_reg, based on FY/Referring MTF |

1. Refresh Frequency

Frequency of updates, based on end date of care:

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

In order to ensure processing is done correctly, several basic quality review requirements are presented in this section.

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, including the total billed amount should be recorded and checked against the “endoffile” that is in the ingest.lst file. Significant variations in ADDP data should be noted and explored with BEA. The number of claims and records (claims/line items) should be accounted for in this spreadsheet. Record counts of reference files should also be recorded so that expectations of changes in record counts can be ascertained.
2. File Size: Record counts should increase as the files are updated.
3. Proc contents should be reviewed and compared against specifications to ensure conformance.
4. Frequency tabulations should be compared from cycle to cycle for the following variables: ACV, adjustment code, adjustment key, age group, beneficiary category, cdt version, cy, cm, fy, fm, deers enrollment site, dmisid,ethnic code, patient’s sex, privilege code, race, residence region, residence TNEX region, service, common beneficiary.
5. Proc means should be compared from cycle to cycle for dollar amounts: allowed, approved, billed, OHI and third party liability.
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 ADDP processor.
8. Data Marts

N/A

1. Special Outputs

With each ADDP processing, a special output file is prepared. The special output file is the CDA Dental Readiness Extract.

The CDA Dental Readiness Extract is due by the 25th of each month. This file only consists of new records from the most recent /mdr/apub/dental/addp/claims/fyXX/dYYMMDD

**Table 4: MDR CDA Dental Readiness Extract**

| **Variable Name** | **Format** | **Business Rule/****SAS Name** |
| --- | --- | --- |
| Patient Name | $100 | Concatenation of PATLNAME, PATFNAME, PATMNAME |
| Sponsor SSN | $9 | RSPONSSN |
| Patient Type | $5 | SVC |
| Patient Date of Birth | YYYYMMDD | PATDOB |
| EDIPN | $10 | REDI\_PN |
| Start Date | $8 | BEGDATE |
| CDT Code | $5 | CDT |
| DRC | $1 | DENTALCLASS |
| DTF | $100 | DMISNME from DMISID Table Merge by DMISID |
| DMISID | $10 | DTF\_DMISID |

**Appendix A: ADDP Provider File Processing Rules**

The ADDP provider file sent from the ADDP contractor is a full file refresh each month. The initial ADDP feed will simply be placed in a SAS dataset, with content and field transformations as specified in Table 5. Thereafter, an update process must occur. Each month, the feed data is compared with the existing MDR dataset, using the provider tax ID and the provider ID as the basis of comparison. If a tax ID/provider ID exists only in the feed data, that record will be added to the MDR file, with field transformations and additions as appropriate. If the tax ID/provider ID is in both the feed and the existing MDR dataset, then the last record observed for each combination of tax ID/provider ID is retained (sorted on tax ID, provider id, provider ssn and processing date). If the tax ID/provider ID is in the existing MDR file, but not in the feed, then retain the record from the existing file, but set the provider termination flag and code the delete month to the date of the last month of feed data that the tax ID/provider ID was present in.

**Table 5: ADDP Provider Data File Layout**

| **Data Element** | **SAS Name** | **Format** | **Input Position in Source Feed** | **Business Rule** |
| --- | --- | --- | --- | --- |
| Provider Tax ID | taxid | $9 | 1-9 | No transformation |
| Provider ID | provid | $9 | 10-18 | No transformation |
| Individual Provider Name | provname | $53 | 19-71 | No transformation |
| Provider Group Name | provgrpname | $53 | 72-124 | No transformation |
| Provider Specialty | provspec | $3 | 125-127 | No transformation |
| Provider Taxonomy | hipaaprv | $10 | 128-137 | No transformation |
| Provider SSN | provssn | $9 | 138-146 | No transformation |
| Provider Network Status | network | $1 | 147 | No transformation |
| Provider Street Address Line 1 | provadd1 | $36 | 158-193 | No transformation |
| Provider Street Address Line 2 | provadd2 | $36 | 194-229 | No transformation |
| State | provst | $2 | 230-231 | No transformation |
| Provider Zip Code | provzip | $9 | 232-240 | No transformation |
| Country Code | provctry | $3 | 241-243 | No transformation |
| NPI Individual | npi | $14 | 244-257 | No transformation |
| NPI Group | npigroup | $14 | 258-271 | No transformation |
| **Internally Derived Fields** |
| Delete Month | Del\_mnth | YYYYMM | N/A | Last month of feed data that the provider ID was present in. |
| Provider Termination Flag | term\_flg | $1 | N/A | Set to “T” if provider is terminated during file update process, else leave blank. |
| Processing Date | procdate | YYYYMMDD | N/A | Fill with the date this record was added to the MDR dataset initially. |

**Appendix B: ADDP Claims Adjustment Update Examples**

Example #1:

Master ADDP (previous extract)



Current Extract



New Master ADDP (after processing)



Example #2:

Master ADDP (previous extract)



Current Extract



New Master ADDP (after processing)



Example #3:

Master ADDP (previous extract)



Current Extract



New Master ADDP (after processing)



**Appendix C: ACV Group**

For time periods before Jan 1, 2018, ACV is derived as follows:

For FY03 and before:

If ACV = A, D, or E then “PR”

Else if ACV = G or L then “PL”

Else if ACV = U then “DP”

Else if Ben Cat Common = 4 then “R”

Else “O”

For FY04 and after:

If ACV = A, E, H, or J then “PR”

Else if ACV = B or F then “OP”

Else if ACV = G or L then “PL”

Else if ACV = U then “DP”

Else if ACV = R or V then “O”

Else if ACV = M or Q then “R”

Else if Ben Cat Common = 4 then “R”

Else “O”

This is a change in coding schema and it is recognized that not all years may be processed with the new values. The legacy rules are:

For FY03 and before:

If ACV = A, D, or E then “1”

Else if ACV = G or L then “3”

Else if ACV = U then “4”

Else if Ben Cat Common = 4 then “5”

Else “6”

For FY04 and after:

If ACV = A, E, H, or J then “1”

Else if ACV = B or F then “2”

Else if ACV = G or L then “3”

Else if ACV = U then “4”

Else if ACV = R or V then “6”

Else if ACV = M or Q then “5”

Else if Ben Cat Common = 4 then “5”

Else “6”

1. There may be a small period of overlap, where both MMSO and ADDP claims are made available to the MDR. This transition period is not expected to be a long one. [↑](#footnote-ref-1)