RESOURCE AND PATIENT MANAGEMENT SYSTEM

PCC Data Transmission System
(APCP)

Statistical Database Record Layout

Version 2.0
September 2003

Information Technology Support Center
Division of Information Resources
Albuquerque, New Mexico

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1.0 STATISTICAL DATABASE SYSTEM

All visits entered into the PCC database are passed to the Statistical Database System (SDB).

The following table defines the statistical database record:

1.1 Header Record AD0

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
Record Code	1	3	Y		Will always be AD0.
Static ASUFAC of exporting box	2	6	Y		Static ASUFAC taken from the RPMS Site file entry on the computer where the export is done.
Name of exporting box's site	3	30	Y		Name of the exporting box's site. Taken from the RPMS Site file entry.
Date export run	4	8	Y		Date export was run. Format YYYYMMDD. If the export runs over multiple days, this is the date the export was ended and the file was written to a host file.
Beginning Date	5	8	Y		Beginning export date. This is the first creation/modification date that is included in this export.
Ending Date	6	8	Y		Ending export date. This is the ending creation/modification date that is included in this export.
Re-export?	7	8	Y		This field will contain an "R" if this is a re-export either by a REDO or a Re-export by date range.
# of statistical database records	8	9	Y		Total number of records in this file. Does not include the header record, includes all AD1, AD2, AD3, AD4, AD5 and AD6's
Total # of PCC Visits exported	9	9	Y		The total number of pcc visits that are contained in this export.
Total # of PCC visits skipped (reviewed but not exported)	10	9	Y		The total number of PCC visits that were reviewed but not exported because of errors (e.g. no primary provider) OR they did not meet the criteria for export. 2 examples of not meeting criteria are deleted visits that were never sent before and incomplete in hospital visits.
Skipped visits because of an error	11	9	Y		Number of visits not exported due to errors.
Skipped visits due to DEMO,PATIENT	12	9	Y		Total number of visits skipped because they were for a patient whose name begins with DEMO,PATIENT
Export filename	13	14	Y		Export filename. E.g. AAPC000101.34

1.2 Record AD1

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
Record Code	1	3	Y		Will always be AD1.
RECORD CODE	2	2	Y		Will always be 00.
SEQUENCE #	3	1	Y		Will always be 1.
UNIQUE VISIT RECORD ID	4	16	Y		Unique ID for this visit. Static ASUFAC_IEN of the visit. IEN of visit is left zero filled to 10 digits.
ASUFAC_HRN	5	12	Y		Use ASUFAC and HRN at location of encounter, if one exists. Otherwise, ASUFAC_HRN at DUZ(2). Chart number is left zero filled.
DOB	6	8	Y		DOB in format YYYYMMDD
SEX	7	1	Y		Sex. M or F.
SSN	8	9	Y		SSN of patient or 9 blanks. No dashes.
PRIMARY TRIBE	9	3	Y		Tribe code from standard code book.
COMMUNITY OF RESIDENCE	10	7	Y		STCTYCOM code of patient's residence. Taken from the current community field.
CLASSIFICATION/BENEFICIARY	11	2	Y		Beneficiary code from standard codebook.
ELIGIBILITY	12	1	Y		Eligibility status from standard codebook.
MEDICAID ELIG ON VISIT DATE	13	1	Y		Y or N. If patient was Medicaid eligible on the visit date, this is set to Y; if not, N.
MEDICARE ELIG ON VISIT DATE	14	1	Y		Y or N. If patient was Medicare eligible on the visit date, this is set to Y; if not, N.
PRIVATE INSURANCE ELIGIBILITY ON VISIT DATE	15	1	Y		Y or N. If patient was Private Insurance eligible on the visit date, this is set to Y; if not, N.
VISIT/ADMISSION DATE	16	8	Y		Date of Visit in YYYYMMDD format.
TIME OF DAY	17	4	Y		Time of day in internal FileMan format; e.g., 1000, 1310, 0805
DAY OF WEEK	18	1	Y		DOW in APC record definition format.
LOCATION OF ENCOUNTER	19	6	Y		ASUFAC of location of encounter.
TYPE	20	1	Y		Type of Visit; e.g., C, I, O, 6, T, U, V, S, etc.
SERVICE CATEGORY	21	2	Y		Service Category; e.g., A, H, I, C, T, etc.
CLINIC	22	2	N		Clinic of visit. Standard 2-digit code.
EVALUATION AND MANAGEMENT CPT CODE	23	5	N		CPT code from evaluation and management field of visit file.
LEVEL OF SERVICE	24	1	N		Level of Service code from PCC form.
EDUCATION DONE OF THIS	25	1	N		Was an education topic provided on this visit? Y or N

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
VISIT					
EXAMS DONE ON THIS VISITQ	26	1	N		Were one or more exams done on this visit? Y or N
# OF LAB TESTS DONE	27	3	N		# of lab tests done.
# OF RX'S	28	2	N		# of prescriptions filled.
ANY MEASURMENTS DONE?	29	1	N		Were any measurements taken on this visit? Y or N
PRIMARY PROV AFFILIATION/ DISCIPLINE	30	3	Y		Primary provider's affiliation and discipline; e.g., 101.
OTHER PROVIDER AFFILIATION/ DISCIPLINE	31	3	N		First secondary provider affiliation/discipline.
OTHER PROVIDER AFFILIATION/ DISCIPLINE	32	3	N		2nd secondary provider affiliation/discipline
OTHER PROVIDER AFFILIATION/ DISCIPLINE	33	3	N		3rd secondary provider affiliation/discipline.
OTHER PROVIDER AFFILIATION/ DISCIPLINE	34	3	N		4th secondary provider affiliation/discipline.
PRIMARY ICD DX	35	6	Y		Primary ICD Dx. If this is a non-hospitalization visit, it is the 1st diagnosis entered.
APC CODE 1	36	3	Y		Blank.
CAUSE OF DX 1	37	1	N		1-Hospital acquired, 2-alcohol-related, 3-battered child, 4- employment-related for Diagnosis 1
CAUSE OF INJURY	38	6	N		Valid ICD9 E code for an injury. If Diagnosis 1 is an injury 800-999.9.
PLACE OF INJURY	39	1	N		PCC place of injury code for Diagnosis 1 if Diagnosis 1 is an injury.
DIAGNOSIS 2	40	6	Y		ICD Dx 2. If this is a non-hospitalization visit, it is the 2nd diagnosis entered.
APC CODE 2	41	3	Y		Blank.
CAUSE OF DX 2	42	1	N		1-Hospital-acquired, 2-alcohol-related, 3-battered child, 4- employment-related for Diagnosis 2
CAUSE OF INJURY	43	6	N		Valid ICD9 E code for an injury. If Diagnosis 2 is an injury 800-999.9.
PLACE OF INJURY	44	1	N		PCC place of injury code for Diagnosis 2 if Diagnosis 2 is an injury.
DIAGNOSIS 3	45	6	Y		ICD Dx 3. If this is a non-hospitalization visit, it is the 3rd diagnosis entered.
APC CODE 3	46	3	Y		Blank.
CAUSE OF DX 3	47	1	N		1-Hospital-acquired, 2-alcohol-related, 3-battered child, 4- employment-related for Diagnosis 3
CAUSE OF	48	6	N		Valid ICD9 E code for an injury. If Diagnosis 3 is

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
INJURY					an injury 800-999.9.
PLACE OF INJURY	49	1	N		PCC place of injury code for Diagnosis 3 if Diagnosis 3 is an injury.
DIAGNOSIS 4	50	6	Y		ICD Dx 4. If this is a non-hospitalization visit, it is the 4th diagnosis entered.
APC CODE 4	51	3	Y		Blank.
CAUSE OF DX 4	52	1	N		1-Hospital-acquired, 2-alcohol-related, 3-battered child, 4- employment-related for Diagnosis 4
CAUSE OF INJURY	53	6	N		Valid ICD9 E code for an injury. If Diagnosis 4 is an injury 800-999.9.
PLACE OF INJURY	54	1	N		PCC place of injury code for Diagnosis 4 if Diagnosis 4 is an injury.
DIAGNOSIS 5	55	6	Y		ICD Dx 5. If this is a non-hospitalization visit, it is the 5th diagnosis entered.
APC CODE 5	56	3	Y		Blank.
CAUSE OF DX 5	57	1	N		1-Hospital-acquired, 2-alcohol-related, 3-battered child, 4- employment-related for Diagnosis 5
CAUSE OF INJURY	58	6	N		Valid ICD9 E code for an injury. If Diagnosis 5 is an injury 800-999.9.
PLACE OF INJURY	59	1	N		PCC place of injury code for Diagnosis 5 if Diagnosis 5 is an injury.
DIAGNOSIS 6	60	6	Y		ICD Dx 6. If this is a non-hospitalization visit, it is the 6th diagnosis entered.
APC CODE 6	61	3	Y		Blank.
CAUSE OF DX 6	62	1	N		1-Hospital-acquired, 2-alcohol-related, 3-battered child, 4- employment-related for Diagnosis 6
CAUSE OF INJURY	63	6	N		Valid ICD9 E code for an injury. If Diagnosis 6 is an injury 800-999.9.
PLACE OF INJURY	64	1	N		PCC place of injury code for Diagnosis 6 if Diagnosis 6 is an injury.
DIAGNOSIS 7	65	6	Y		ICD Dx 7. If this is a non-hospitalization visit, it is the 7th diagnosis entered.
APC CODE 7	66	3	Y		Blank.
CAUSE OF DX 7	67	1	N		1-Hospital-acquired, 2-alcohol-related 3-battered child, 4- employment-related for Diagnosis 7
CAUSE OF INJURY 7	68	6	N		Valid ICD9 E code for an injury. If Diagnosis 7 is an injury 800-999.9.
PLACE OF INJURY 7	69	1	N		PCC place of injury code for Diagnosis 7 if Diagnosis 7 is an injury.

1.3 Record AD2

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
AIB Record Code	1	3	Y		Will always be AD2.
RECORD CODE	2	2	Y		Will always be 00.
SEQUENCE #	3	1	Y		Will always be 2.
UNIQUE VISIT RECORD ID	4	16	Y		Unique ID for this visit. Static ASUFAC_IEN of the visit. IEN of visit is left zero filled to 10 digits.
ASUFAC_HRN	5	12	Y		Use ASUFAC and HRN at location of encounter, if one exists. Otherwise, ASUFAC_HRN at DUZ(2). Chart number is left zero filled.
DIAGNOSIS 8	6	6	Y		ICD Dx 8. If this is a non-hospitalization visit, it is the 8th diagnosis entered.
APC CODE 8	7	3	Y		Blank.
CAUSE OF DX 8	8	1	N		1-Hospital-acquired, 2-alcohol- related, 3-battered child, 4- employment-related for Diagnosis 8.
CAUSE OF INJURY	9	6	N		Valid ICD9 E code for an injury. If Diagnosis 8 is an injury 800-999.9.
PLACE OF INJURY	10	1	N		PCC place of injury code for Diagnosis 8 if Diagnosis 8 is an injury.
DIAGNOSIS 9	11	6	Y		ICD Dx 9. If this is a non-hospitalization visit, it is the 9th diagnosis entered.
APC CODE 9	12	3	Y		Blank.
CAUSE OF DX 9	13	1	N		1-Hospital-acquired, 2-alcohol- related, 3-battered child, 4- employment-related for Diagnosis 9.
CAUSE OF INJURY	14	6	N		Valid ICD9 E code for an injury. If Diagnosis 9 is an injury 800-999.9.
ICD PROC CODE (1)	15	5	N		ICD operation code.
PROC DATE (1)	16	8	N		YYYYMMDD format of date of procedure.
INFECTION (1)	17	1	N		Y-Yes, N-No.
PROC PROV AFF/DISC(1)	18	3	N		Operating provider's affiliation/discipline code.
CPT CODE (1)	19	5	N		CPT code for this procedure.
DX DONE FOR (1)	20	2	N		The number (1-9) of the diagnosis that this procedure was done for.
ICD PROC CODE (2)	21	5	N		ICD operation code.
PROC DATE (2)	22	8	N		YYYYMMDD format of date of procedure.
INFECTION (2)	23	1	N		Y-Yes, N-No.
PROC PROV AFF/DISC(2)	24	3	N		Operating provider's affiliation/discipline code.
CPT CODE (2)	25	5	N		CPT code for this procedure.
DX DONE FOR (2)	26	2	N		The number (1-9) of the diagnosis that this procedure was done for.
ICD PROC CODE (3)	27	5	N		ICD operation code.
PROC DATE (3)	28	8	N		YYYYMMDD format of date of procedure.

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
INFECTION (3)	29	1	N		Y-Yes, N-No.
PROC PROV AFF/DISC(3)	30	3	N		Operating provider's affiliation/discipline code.
CPT CODE (3)	31	5	N		CPT code for this procedure.
DX DONE FOR (3)	32	2	N		The number (1-9) of the diagnosis that this procedure was done for.
IMMUNIZATION CODE	33	2	N		Immunization given, from standard codes.
IMMUNIZATION SERIES	34	1	N		Set of codes.
IMMUNIZATION CODE	35	2	N		Immunization given, from standard codes.
IMMUNIZATION SERIES	36	1	N		Set of codes.
IMMUNIZATION CODE	37	2	N		Immunization given, from standard codes.
IMMUNIZATION SERIES	38	1	N		Set of codes.
ADA CODE (1)	39	4	N		ADA code
ADA UNITS (1)	40	2	N		# of units
ADA CODE (2)	41	4	N		ADA code
ADA UNITS (2)	42	2	N		# of units
ADA CODE (3)	43	4	N		ADA code
ADA UNITS (3)	44	2	N		# of units
ADA CODE (4)	45	4	N		ADA code
ADA UNITS (4)	46	2	N		# of units
ADA CODE (5)	47	4	N		ADA code
ADA UNITS (5)	48	2	N		# of units
ADA CODE (6)	49	4	N		ADA code
ADA UNITS (6)	50	2	N		# of units
ADMISSION DATE	51	8	N		Admission date in YYYYMMDD format.
ADMISSION SERVICE	52	2	N		Admitting service (2-digit IHS code).
ADMISSION TYPE	53	1	N		Admission type.
ATTENDING PHYSICIAN	54	6	N		Affiliation/discipline code.
CAUSE OF DEATH	55	6	N		ICD code.
# OF CONSULTS	56	3	N		Number of consults during an inpatient stay.
DISCHARGE DATE	57	8	N		YYYYMMDD format of discharge date.
DISCHARGE SERVICE	58	2	N		From Standard Treating Specialty table.
DISCHARGE TYPE	59	1	N		IHS standard code for discharge type.
FACILITY TRANSFER TO (ASUFAC)	60	6	N		From Location table.
LENGTH OF	61	3	N		Length of stay.

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
STAY					
MIDWIFERY	62	1	N		1 if midwife was a provider.
ACTIVITY TIME	63	4	N		Minutes.
TRAVEL TIME	64	4	N		Minutes.
CHS COST	65	9	N		For CHS visits, total cost information.

1.4 Record AD3

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
AIB Record Code	1	3	Y		Will always be AD3.
RECORD CODE	2	2	Y		Will always be 00.
SEQUENCE #	3	1	Y		Will always be 3.
UNIQUE VISIT RECORD ID	4	16	Y		Unique ID for this visit. Static ASUFAC_IEN of the visit. IEN of visit is left zero filled to 10 digits.
ASUFAC_HRN	5	12	Y		Use ASUFAC and HRN at location of encounter, if one exists. Otherwise, ASUFAC_HRN at DUZ(2). Chart number is left zero filled.
LMP	6	8	Y		Last LMP on file. Note: this may not be current. Check against date noted.
DATE LMP NOTED	7	8	Y		Date LMP noted. Format: 19960209
IMMUNIZATION CODE (4^{TH})	8	2	N		Immunization given, from standard codes.
IMUNIZATION SERIES (4^{th})	9	2	N		Series for this immunization.
HGB A1C value	10	6	N		If done, HGB A1C result
HTN DOCUMENTED EVER (Y/N)	11	1	N		If HTN was ever documented as a POV, Y, otherwise N or blank
DATE HTN LAST DOCUMENTED	12	8	N		Date HTN last documented as a POV
BLOOD PRESSURE SYSTOLIC	13	3	N		Systolic Blood Pressure result
BLOOD PRESSURE DIASTOLIC	14	3	N		Diastolic Blood Pressure result
WAS AN ACE INHIBITOR FILLED (Y/N)	15	1	N		Was an ACE INHIBITOR filled at our pharmacy for this patient, this visit
%RECOMMENDED WEIGHT	16	6	N		%RW as a number.
DM NUTRITION EDUCATION DONE? Y/N	17	1	N		Was DM-Nutrition education done? Y or N
DISPOSITION ON ER VISITS	18	1	N		If this is an ER visit, what was the disposition? Set of Codes
V EXAM CODE1	19	2	N		V Exam #1 this visit
V EXAM CODE2	20	2	N		V Exam #2 this visit
V EXAM CODE3	21	2	N		V Exam #3 this visit
V EXAM CODE4	22	2	N		V Exam #4 this visit
V EXAM CODE5	23	2	N		V Exam #5 this visit
PATIENT EDUCATION CODE #1	24	12	N		Patient Education Topic #1
PATIENT EDUCATION CODE #2	25	12	N		Patient Education Topic #2

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
PATIENT EDUCATION CODE #3	26	12	N		Patient Education Topic #3
PATIENT EDUCATION CODE #4	27	12	N		Patient Education Topic #4
PATIENT EDUCATION CODE #5	28	12	N		Patient Education Topic #5

1.5 Record AD4

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
AIB Record Code	1	3	Y		Will always be AD4.
RECORD CODE	2	2	Y		Will always be 00.
SEQUENCE #	3	1	Y		Will always be 4.
UNIQUE VISIT RECORD ID	4	16	Y		Unique ID for this visit. Static ASUFAC_IEN of the visit. IEN of visit is left zero filled to 10 digits.
ASUFAC_HRN	5	12	Y		Use ASUFAC and HRN at location of encounter, if one exists. Otherwise, ASUFAC_HRN at DUZ(2). Chart number is left zero filled.
Unique Registration ID	6	16	Y		Unique Registration ID. Static ASUFAC concatenated with the patient's internal entry number left zero filled to 10 digits.
PLACE OF INJURY 9	7	1	N		PCC place of injury code for Diagnosis 9 f Diagnosis 9is an injury.
DIAGNOSIS 10	8	6	Y		ICD Dx 10. If this is a non-hospitalization visit, it is the 10th diagnosis entered.
APC CODE 10	9	3	N		Blank
CAUSE OF DX 10	10	1	N		1-Hospital-acquired, 2-alcohol-related, 3-battered child, 4- employment-related for Diagnosis 10
CAUSE OF INJURY 10	11	6	N		Valid ICD9 E code for an injury. If Diagnosis 10 is an injury 800-999.9.
PLACE OF INJURY 10	12	1	N		PCC place of injury code for Diagnosis 4 if Diagnosis 10 is an injury.
DIAGNOSIS 11	13	6	Y		ICD Dx 11. If this is a non-hospitalization visit, it is the 11th diagnosis entered.
APC CODE 11	14	3	N		Blank.
CAUSE OF DX 11	15	1	N		1-Hospital-acquired, 2-alcohol-related, 3-battered child, 4- employment-related for Diagnosis 11
CAUSE OF INJURY 11	16	6	N		Valid ICD9 E code for an injury. If Diagnosis 11 is an injury 800-999.9.
PLACE OF INJURY 11	17	1	N		PCC place of injury code for Diagnosis 11 if Diagnosis 11 is an injury.
DIAGNOSIS 12	18	6	Y		ICD Dx 12. If this is a non-hospitalization visit, it is the 12th diagnosis entered.
APC CODE 12	19	3	N		Blank.
CAUSE OF DX 12	20	1	N		1-Hospital-acquired, 2-alcohol-related, 3-battered child, 4- employment-related for Diagnosis 12
CAUSE OF INJURY 12	21	6	N		Valid ICD9 E code for an injury. If Diagnosis 12 is an injury 800-999.9.
PLACE OF INJURY 12	22	1	N		PCC place of injury code for Diagnosis 12 if Diagnosis 12 is an injury.
DIAGNOSIS 13	23	6	Y		ICD Dx 13. If this is a non-hospitalization visit, it is the 13th diagnosis entered.
APC CODE 13	24	6	N		Blank.
CAUSE OF DX 13	25	1	N		1-Hospital-acquired, 2-alcohol-related 3-battered child, 4- employment-related for Diagnosis 13
CAUSE OF INJURY 13	26	6	N		Valid ICD9 E code for an injury. If Diagnosis 13 is an injury 800-999.9.
PLACE OF INJURY 13	27	1	N		PCC place of injury code for Diagnosis 13 if Diagnosis 13 is an injury.

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
DIAGNOSIS 14	28	6	Y		ICD Dx 14. If this is a non-hospitalization visit, it is the 14th diagnosis entered.
APC CODE 14	29	3	N		Blank.
CAUSE OF DX 14	30	1	N		1-Hospital-acquired, 2-alcohol-related 3-battered child, 4- employment-related for Diagnosis 14
CAUSE OF INJURY 14	31	6	N		Valid ICD9 E code for an injury. If Diagnosis 14 is an injury 800-999.9.
PLACE OF INJURY 14	32	1	N		PCC place of injury code for Diagnosis 14 if Diagnosis 14 is an injury.
Pap Lab Test	33	1	N	Y	Y/N was Pap lab test documented in V LAB?
Glucose Value	34	15	N	Y	Value of Glucose test done on this visit.
HDL Cholesterol Test	35	1	N	Y	Y/N was HDL Cholesterol test performed?
HDL Cholesterol Value	36	15	N	Y	Value of HDL Cholesterol test.
LDL Cholesterol Test	37	1	N	Y	Y/N was LDL Cholesterol test performed?
LDL Cholesterol Value	38	15	N	Y	Value of LDL Cholesterol test.
Triglyceride Test	39	1	N	Y	Y/N was test performed?
Triglyceride Value	40	15	N	Y	Value of Triglyceride test
Urine Protein Test	41	1	N	Y	Y/N was test performed?
Urine Protein Value	42	15	N	Y	Value of Urine Protein test
Microalbuminuria Test	43	1	N	Y	Y/N was test performed?
Microalbuminuria Value	44	15	N	Y	Value of Microalbuminuria test
Prenatal Risk Health Factor	45	1	N	Y	Was prenatal risk factor documented on the visit (Y/N)
Smoking Health Factor	46	40	N	Y	Smoking Health factor that was documented
PSA Lab Test	47	1	N	Y	Y/N was PSA Test done?
Fecal Occult Blood Lab	48	1	N	Y	Y/N was Fecal Occult Blood Test done
Physical Activity Health Factor	49	40	N	Y	Name of Physical Activity Health factor if documented on this visit
Immunization Code 5	50	2	N	Y	IHS code for 5th immunization
Immunization Series 5	51	1	N	Y	5 Immunization series
Immunization Code 6	52	2	N	Y	IHS code for 6th immunization
Immunization Series 6	53	1	N	Y	6 Immunization series
Immunization Code 7	54	2	N	Y	IHS code for 7th immunization
Immunization Series 7	55	1	N	Y	7 Immunization series
Immunization Code 8	56	2	N	Y	IHS code for 8th immunization

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
Immunization Series 8	57	1	N	Y	8 Immunization series
Immunization Code 9	58	2	N	Y	IHS code for 9th immunization
Immunization Series 9	59	1	N	Y	9 Immunization series
Imm 1 HL7 code	60	3	N	Y	HL7 code
Imm 2 HL7 code	61	3	N	Y	HL7 code
Imm 3 HL7 code	62	3	N	Y	HL7 code
Imm 4 HL7 code	63	3	N	Y	HL7 code
Imm 5 HL7 code	64	3	N	Y	HL7 code
Imm 6 HL7 code	65	3	N	Y	HL7 code
Imm 7 HL7 code	66	3	N	Y	HL7 code
Imm 8 HL7 code	67	3	N	Y	HL7 code
Imm 9 HL7 code	68	3	N	Y	HL7 code

1.6 Record AD5

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
AIB Record Code	1	3	Y		Will always be AD5.
RECORD CODE	2	2	Y		Will always be 00.
SEQUENCE #	3	1	Y		Will always be 5.
UNIQUE VISIT RECORD ID	4	16	Y		Unique ID for this visit. Static ASUFAC_IEN of the visit. IEN of visit is left zero filled to 10 digits.
ASUFAC_HRN	5	12	Y		Use ASUFAC and HRN at location of encounter, if one exists. Otherwise, ASUFAC_HRN at DUZ(2). Chart number is left zero filled.
PHN Activity Code	6	2	N	Y	PHN Activity Code
PHN Level of Intervention	7	1	N	Y	Level of Intervention
Weight	8	5	N	Y	Weight if taken on this visit.
Height	9	4	N	Y	Height if taken on this visit
Vendor Type	10	2	N		Vendor type
Dentist's SSN	11	9	N		SSN of dentist
Visit Export Date	12	8	N		Date visit exported
Delivery Mode	13	1	N		K or D
Dental Total Cost	14	7	N		0-9999999. Rounded to nearest dollar.
ADA Code 1 Fee	15	5	N		Fee.
ADA Code 2 Fee	16	5	N		Fee.
ADA Code 3 Fee	17	5	N		Fee.
ADA Code 4 Fee	18	5	N		Fee.
ADA Code 5 Fee	19	5	N		Fee.
ADA Code 6 Fee	20	5	N		Fee.
ADA Code 7	21	4	N		ADA Code 7
ADA Units 7	22	2	N		ADA Units 7
ADA Fee 7	23	5	N		ADA Fee 7
ADA Code 8	24	4	N		ADA Code 8
ADA Units 8	25	2	N		ADA Units 8
ADA Fee 8	26	5	N		ADA Fee 8
ADA Code 9	27	4	N		ADA Code 9
ADA Units 9	28	2	N		ADA Units 9
ADA Fee 9	29	5	N		ADA Fee 9
ADA Code 10	30	4	N		ADA Code 10
ADA Units 10	31	2	N		ADA Units 10
ADA Fee 10	32	5	N		ADA Fee 10
ADA Code 11	33	4	N		ADA Code 11
ADA Units 11	34	2	N		ADA Units 11
ADA Fee 11	35	5	N		ADA Fee 11
ADA Code 12	36	4	N		ADA Code 12
ADA Units 12	37	2	N		ADA Units 12
ADA Fee 12	38	5	N		ADA Fee 12
ADA Code 13	39	4	N		ADA Code 13
ADA Units 13	40	2	N		ADA Units 13
ADA Fee 13	41	5	N		ADA Fee 13
ADA Code 14	42	4	N		ADA Code 14

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
ADA Units 14	43	2	N		ADA Units 14
ADA Fee 14	44	5	N		ADA Fee 14
ADA Code 15	45	4	N		ADA Code 15
ADA Units 15	46	2	N		ADA Units 15
ADA Fee 15	47	5	N		ADA Fee 15
ADA Code 16	48	4	N		ADA Code 16
ADA Units 16	49	2	N		ADA Units 16
ADA Fee 16	50	5	N		ADA Fee 16
ADA Code 17	51	4	N		ADA Code 17
ADA Units 17	52	2	N		ADA Units 17
ADA Fee 17	53	5	N		ADA Fee 17
ADA Code 18	54	4	N		ADA Code 18
ADA Units 18	55	2	N		ADA Units 18
ADA Fee 18	56	5	N		ADA Fee 18
ADA Code 19	57	4	N		ADA Code 19
ADA Units 19	58	2	N		ADA Units 19
ADA Fee 19	59	5	N		ADA Fee 19
ADA Code 20	60	4	N		ADA Code 20
ADA Units 20	61	2	N		ADA Units 20
ADA Fee 20	62	5	N		ADA Fee 20
Zip Code	63	10	Y		Zip Code of patient
Initials of Primary Provider	64	3	N		Initials of Primary Provider
Delete Record Flag	65	1	N		If this visit has been deleted since last exported.
Data Entry Creation Date	66	8	Y		Date this visit was created in PCC.
Date Visit Last Modified	67	8	Y		Date this visit was last modified in PCC.
# of CPT records (AD6's)	68	2	Y		Total number of cpt records on this visit.
PCC Export Log #	69	6	Y		Log number from the PCC DATA TRANSMISSION LOG that this record was a part of.
Export File name	70	14	Y		Export filename created by XBGSAVE. Static "AAPC"_static ASUFAC_ ."_julian date. Date is the date when the file was written. E.g. AAPC000101.34
DIAGNOSIS 15	71	6	Y		ICD Dx 15. If this is a non-hospitalization visit, it is the 15th diagnosis entered.
APC CODE 15	72	3	N		Blank.
CAUSE OF DX 15	73	1	N		1-Hospital-acquired, 2-alcohol-related 3-battered child, 4- employment-related for Diagnosis 15
CAUSE OF INJURY 15	74	6	N		Valid ICD9 E code for an injury. If Diagnosis 15 is an injury 800-999.9.
PLACE OF INJURY 15	75	1	N		PCC place of injury code for Diagnosis 15 if Diagnosis 15 is an injury.

1.7 Record AD6

There may be more than 1 of these records per visit, depending on the number of cpt codes entered. Each will be record code 00, sequence # 6 and the field order # will be 1-n. There are 25 CPT codes on each record. If a visit has 26 cpt codes there will be 2 records of this type for that visit. The first is order #1, the second is order #2

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
AIB Record Code	1	3	Y		Will always be AD6.
RECORD CODE	2	2	Y		Will always be 00.
SEQUENCE #	3	1	Y		Will always be 6.
UNIQUE VISIT RECORD ID	4	16	Y		Static Unique ID for this visit. Static ASUFAC_IEN of the visit. IEN of visit is left zero filled to 10 digits.
ASUFAC_HRN	5	12	Y		Use ASUFAC and HRN at location of encounter, if one exists. Otherwise, ASUFAC_HRN at DUZ(2). Chart number is left zero filled.
RECORD ORDER	6	2	Y		1,2,3 indicating how many of this type of record there is.
CPT 1	7	5	N		CPT 1
CPT QUANTITY 1	8	2	N		CPT Quantity 1
CPT 2	9	5	N		2nd CPT
CPT QUANTITY 2	10	2	N		CPT Quantity for 2nd CPT
CPT 3	11	5	N		CPT 2
CPT QUANTITY 3	12	2	N		CPT Quantity 3
CPT 4	13	5	N		CPT 4
CPT QUANTITY 4	14	2	N		CPT Quantity for 4th CPT
CPT 5	15	5	N		CPT 5
CPT QUANTITY 5	16	2	N		CPT QUANTITY 5
CPT 6	17	5	N		CPT 6
CPT QUANTITY 6	18	2	N		CPT QUANTITY 6
CPT 7	19	5	N		CPT 7
CPT QUANTITY 7	20	2	N		CPT QUANTITY 7
CPT 8	21	5	N		CPT 8
CPT QUANTITY 8	22	2	N		CPT QUANTITY 8
CPT 9	23	5	N		CPT9
CPT QUANTITY 9	24	2	N		CPT QUANTITY 9
CPT 10	25	5	N		CPT 10
CPT QUANTITY	26	2	N		CPT QUANTITY 10

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
10					
CPT 11	27	5	N		CPT 11
CPT QUANTITY 11	28	2	N		CPT QUANTITY 11
CPT 12	29	5	N		CPT 12
CPT QUANTITY 12	30	2	N		CPT QUANTITY 12
CPT 13	31	5	N		CPT 13
CPT QUANTITY 13	32	2	N		CPT QUANTITY 13
CPT 14	33	5	N		CPT 14
CPT QUANTITY 14	34	2	N		CPT QUANTITY 14
CPT 15	35	5	N		CPT 15
CPT QUANTITY 15	36	2	N		CPT QUANTITY 15
CPT 16	37	5	N		CPT 16
CPT QUANTITY 16	38	2	N		CPT QUANTITY 16
CPT 17	39	5	N		CPT 17
CPT QUANTITY 17	40	2	N		CPT QUANTITY 17
CPT 18	41	5	N		CPT 18
CPT QUANTITY 18	42	2	N		CPT QUANTITY 18
CPT 19	43	5	N		CPT 19
CPT QUANTITY1 9	44	2	N		CPT QUANTITY 19
CPT 20	45	5	N		CPT 20
CPT QUANTITY 20	46	2	N		CPT QUANTITY 20
CPT 21	47	5	N		CPT 21
CPT QUANTITY 21	48	2	N		CPT QUANTITY 21
CPT 22	49	5	N		CPT 22
CPT QUANTITY 22	50	2	N		CPT QUANTITY 22
CPT 23	51	5	N		CPT 23
CPT QUANTITY 23	52	2	N		CPT QUANTITY 23
CPT 24	53	5	N		CPT 24
CPT QUANTITY 24	54	2	N		CPT QUANTITY 24
CPT 25	55	5	N		CPT 25
CPT QUANTITY 25	56	2	N		CPT QUANTITY 25

1.8 Record AD7

There may be more than 1 of these records per visit, depending on the number of MEDICATIONS entered. Each will be record code 00, sequence #7 and the field order # will be 1-n. There 1 medication on each record. If a visit has 3 medications there will be 3 records of this type for that visit. The first is order #1, the second is order #2, etc.

Item	^ piece	Max Leng	Req	Oryx/ GPRA	Description of Item
AIB Record Code	1	3	Y		Will always be AD7.
RECORD CODE	2	2	Y		Will always be 00.
SEQUENCE #	3	1	Y		Will always be 7.
UNIQUE VISIT RECORD ID	4	16	Y		Static Unique ID for this visit. Static ASUFAC_IEN of the visit. IEN of visit is left zero filled to 10 digits.
ASUFAC_HRN	5	12	Y		Use ASUFAC and HRN at location of encounter, if one exists. Otherwise, ASUFAC_HRN at DUZ(2). Chart number is left zero filled.
RECORD ORDER	6	2	Y	Y	1,2,3 indicating how many of this type of record there is.
DRUG NAME	7	40	Y	Y	Name of Drug from the Drug file.
NDC Code	8	20	N	Y	NDC code for this drug, if known
VA Drug Class	9	5	N	Y	VA Drug Class, if known. Will be 2 alpha and 3 numbers like AA000.
Quantity	10	11	N	Y	Quantity. A number up to 9999999.999

2.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the ITSC Help Desk by:

Phone: (505) 248-4371 or
(888) 830-7280

Fax: (505) 248-4199

Web: http://www.rpms.ihs.gov/TechSupp.asp

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