Non-Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300)			
	VALIDITY EDITS		
2-300-01V	MUST BE A VALID ENROLLMENT/HEALTH PLAN CODE (REFER TO SECTION 2.5)		
	RELATIONAL EDITS		
2-300-02R	IF ENROLLMENT/HEALTH PLAN CODE =	Y	CHCBP - STANDARD **OR**
		AA	CHCBP - EXTRA
	THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE =	CL	CLINICAL TRIALS **OR**
		PF	ECHO
2-300-07R	IF ENROLLMENT/HEALTH PLAN CODE =	SN	SHCP - NON-MTF-REFERRED CARE **OR**
		SO	SHCP - NON-TRICARE ELIGIBLE **OR**
		SR	SHCP - REFERRED CARE **OR**
		ST	SHCP - TRICARE ELIGIBLE
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AN	SHCP -NON-MTF-REFERRED CARE **OR**
		AR	SHCP - REFERRED CARE **OR**
		CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM **OR**
		SC	SHCP - NON-TRICARE ELIGIBLE **OR**
		SE	SHCP - TRICARE ELIGIBLE **OR**
		SM	SHCP - EMERGENCY
2-300-10R	IF ENROLLMENT/HEALTH PLAN CODE =	PS	TSRx
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS **OR**
		M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
2-300-11R	IF ENROLLMENT/HEALTH PLAN CODE =	PS	TSRx
	THEN BEGIN DATE OF CARE MUST BE ≥ 04/01/2001		
	AND NATIONAL DRUG CODE **CANNOT** BE BLANK.		
	UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	1	MEDICAID
2-300-12R	• TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001. FOR EACH LINE ITEM WHERE BEGIN DATE OF CARE IS < 10/01/2001, THE LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.		
	IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL - EXTRA **OR**
[1] PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.			

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (Continued)			
		FS	TFL - STANDARD
	THEN BEGIN DATE OF CARE MUST BE ≥ 10/01/2001		
	AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	FF	TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) **OR**
		FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) **OR**
		FS	TFL (SECOND PAYOR)
	ELSE IF BEGIN DATE OF CARE IS < 10/01/2001 (FOR THAT DETAILED LINE ITEM)		
	THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE MUST =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER **OR**
		26	EXPENSES INCURRED PRIOR TO COVERAGE **OR**
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED **OR**
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS **OR**
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED **OR**
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED **OR**
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE **OR**
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS **OR**
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION **OR**
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
2-300-13R	• TFL CLAIMS: THE PATIENT MUST BE 64 YEARS AND 11 MONTHS OR GREATER. IF THE PATIENT IS LESS THAN THIS AGE, THE LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.		
	IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD **OR**
		PS	TSRx
	AND TYPE OF SERVICE (SECOND POSITION) ≠	M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	THEN PATIENT AGE[1] MUST BE ≥ 64 YEARS AND 11 MONTHS		
	ELSE IF PATIENT AGE[1] IS < 64 YEARS AND 11 MONTHS		

[1] PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (Continued)			
	THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE MUST =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER **OR**
		26	EXPENSES INCURRED PRIOR TO COVERAGE **OR**
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED **OR**
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS **OR**
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED **OR**
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED **OR**
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE **OR**
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS **OR**
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION **OR**
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
2-300-15R	IF ENROLLMENT/HEALTH PLAN CODE =	SU	SCHP - REFERRAL DESIGNATION UNKNOWN
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS **OR**
		M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
2-300-16R	IF ENROLLMENT/HEALTH PLAN CODE =	SU	SCHP - REFERRAL DESIGNATION UNKNOWN
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	SC	SHCP - NON-TRICARE ELIGIBLE **OR**
		SE	SHCP - TRICARE ELIGIBLE
2-300-17R	• FOR TMOP ONLY: FOR TSRx, THE PATIENT MUST BE 64 YEARS AND 8 MONTHS OR GREATER. IF THE PATIENT IS LESS THAN THIS AGE, THE LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.		
	IF ENROLLMENT/HEALTH PLAN CODE =	PS	TSRx
	AND TYPE OF SERVICE (SECOND POSITION) =	M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	THEN PATIENT AGE[1] MUST BE ≥ 64 YEARS AND 8 MONTHS		
	ELSE IF PATIENT AGE[1] < 64 YEARS AND 8 MONTHS		

[1] PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (Continued)			
	THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE MUST =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER **OR**
		26	EXPENSES INCURRED PRIOR TO COVERAGE **OR**
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED **OR**
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS **OR**
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED **OR**
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED **OR**
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE **OR**
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS **OR**
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION **OR**
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
2-300-18R	IF ENROLLMENT/HEALTH PLAN CODE =	X	FOREIGN ADSM
	THEN HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF **OR**
		T	FOREIGN MILITARY MEMBER
	AND HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY **OR**
		G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) **OR**
		J	ACADEMY STUDENT **OR**
		N	NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) **OR**
		S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) **OR**
		V	RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS)

[1] PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (2-301)			
VALIDITY EDITS			
2-301-01V	MUST BE A VALID HCDP PLAN COVERAGE CODE LISTED IN ADDENDUM L.		
2-301-02V	IF FILING DATE ≥ 09/01/2007		
	AND HCDP PLAN COVERAGE CODE =	109	TRICARE USFHP DIRECT CARE COVERAGE FOR ADFMs **OR**
		114	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		115	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		118	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR RETIRED SPONSORS AND FAMILY MEMBERS **OR**
		119	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR RETIRED SPONSORS AND FAMILY MEMBERS **OR**
		133	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR TRANSITIONAL SURVIVORS OR ACTIVE DUTY DECEASED SPONSORS **OR**
		138	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS **OR**
		139	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS
	THEN THE TOTAL OF ALL OCCURRENCES/LINEITEMS OF AMOUNT ALLOWED BY PROCEDURE CODES MUST = ZERO		
RELATIONAL EDITS			
2-301-01R	IF HCDP PLAN COVERAGE CODE =	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
		406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
		407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) **OR**
		408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) **OR**
		409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE **OR**
		410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE **OR**
		411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR**
		412	TRS SURVIVOR NEW FAMILY COVERAGE **OR**

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (2-301) (Continued)			
		413	TRS MEMBER-ONLY COVERAGE **OR**
		414	TRS MEMBER AND FAMILY COVERAGE
	THEN ENROLLMENT/HEALTH PLAN CODE MUST =	T	TRICARE STANDARD **OR**
		V	TRICARE EXTRA **OR**
		FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD **OR**
		PS	TSRx **OR**
		SR	HCP-REFERRED CARE
2-301-02R	IF HCDP PLAN COVERAGE CODE =	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
		406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
		407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) **OR**
		408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) **OR**
		409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE **OR**
		410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE **OR**
		411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR**
		412	TRS SURVIVOR NEW FAMILY COVERAGE **OR**
		413	TRS MEMBER-ONLY COVERAGE **OR**
		414	TRS MEMBER AND FAMILY COVERAGE
	THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE CAN =	PF	ECHO

ELEMENT NAME: REGION INDICATOR (2-303)			
	VALIDITY EDITS		
2-303-01V	MUST BE A VALID REGION INDICATOR (REFER TO SECTION 2.8)		
2-303-02V	IF TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	AND REGION INDICATOR =	NC	NORTH CONTRACT **OR**
		OC	OVERSEAS CONTRACT **OR**
		SC	SOUTH CONTRACT **OR**
		WC	WEST CONTRACT
	THEN ADJUSTMENT KEY MUST =	0	BATCH **OR**
		5	VOUCHER
	RELATIONAL EDITS		
	NONE		

ELEMENT NAME: SPECIAL PROCESSING CODE (2-305)			
	VALIDITY EDITS		
2-305-01V	OCCURRENCE NUMBER 1--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8)		
2-305-02V	OCCURRENCE NUMBER 2--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8)		
2-305-03V	OCCURRENCE NUMBER 3--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8)		
2-305-04V	OCCURRENCE NUMBER 4--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8)		
2-305-05V	A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).		
2-305-06V	SPECIAL PROCESSING CODE OCCURRENCES MUST BE LEFT JUSTIFIED.		
2-305-07V	• SHCP REFERRED/NON-REFERRED		
	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AN	SHCP - NON-MTF-REFERRED CARE **OR**
		AR	SHCP - REFERRED CARE
	THEN BEGIN DATE OF CARE MUST BE < 06/01/2004		
2-305-08V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	GF	TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	THEN BEGIN DATE OF CARE MUST BE < 09/01/2002		
2-305-10V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	MN	TSP - NON-NETWORK **OR**
		MS	TSP - NETWORK
	THEN BEGIN DATE OF CARE MUST BE < 12/31/2001		
2-305-11V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	SN	TSS - NON-NETWORK **OR**
		SS	TSS - NETWORK
	THEN BEGIN DATE OF CARE MUST BE < 12/31/2002		
2-305-14V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	ST	SPECIALIZED TREATMENT
	THEN BEGIN DATE OF CARE MUST BE < 10/01/2004		
	RELATIONAL EDITS		
2-305-02R	IF CA/NAS EXCEPTION REASON =	6	RESOURCE SHARING
	THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST =	S	RESOURCE SHARING - EXTERNAL
2-305-08R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF	ECHO
	THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE =	6	HHC **OR**
		A	PARTNERSHIP PROGRAM **OR**
		E	HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP) **OR**
		S	RESOURCE SHARING - EXTERNAL **OR**
		CM	ICMP **OR**
		CT	CCTP **OR**
		RI	RESOURCE SHARING - INTERNAL

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ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)			
2-305-12R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	U	BRAC MEDICARE PHARMACY
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	AND BEGIN DATE OF CARE MUST BE < 04/01/2001		
2-305-13R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	16	AMBULATORY SURGERY FACILITY CHARGE
	THEN PRICING RATE CODE MUST =	0	PRICING NOT APPLICABLE (DENIED SERVICE/ SUPPLIES AND ALLOWED DRUGS) **OR**
		1	PRICED MANUALLY **OR**
		C	AMBULATORY SURGERY FACILITY PAYMENT RATE **OR**
		D	DISCOUNTED AMBULATORY SURGERY - FACILITY PAYMENT RATE **OR**
		E	AMBULATORY SURGERY-PAID AS BILLED **OR**
		P	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-FACILITY PAYMENT RATE **OR**
		Q	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, DISCOUNTED AMBULATORY SURGERY-FACILITY PAYMENT RATE **OR**
		R	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-PAID AS BILLED **OR**
		V	MEDICARE REIMBURSEMENT RATE **OR**
		P1	OPPS **OR**
		P2	OPPS WITH COST OUTLINER **OR**
		P3	OPPS WITH DISCOUNT
2-305-14R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PO	TRICARE PRIME - POINT OF SERVICE
	THEN ENROLLMENT/HEALTH PLAN CODE MUST =	U	TRICARE PRIME, CIVILIAN PCM **OR**
		Z	TRICARE PRIME, MTF/PCM **OR**
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM **OR**
		XF	FOREIGN ADFM
2-305-22R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AN	SHCP - NON-MTF-REFERRED CARE **OR**
		AR	SHCP - REFERRED CARE **OR**
		CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM **OR**
		SC	SHCP - NON-TRICARE ELIGIBLE **OR**
		SE	SHCP - TRICARE ELIGIBLE **OR**
		SM	SHCP - EMERGENCY
	THEN ENROLLMENT/HEALTH PLAN CODE MUST =	SN	SHCP - NON-MTF-REFERRED CARE **OR**

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ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)			
		SO	SHCP - NON-TRICARE ELIGIBLE **OR**
		SR	SHCP - REFERRED CARE **OR**
		ST	SHCP - TRICARE ELIGIBLE **OR**
		SU	SHCP - REFERRAL DESIGNATION UNKNOWN
2-305-24R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	E	HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP)
	THEN BEGIN DATE OF CARE MUST BE ≥ 03/15/1999		
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	CM	ICMP
2-305-26R	• TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001. FOR EACH OCCURRENCE/LINE ITEM WHERE DATE OF CARE IS < 10/01/2001, THE OCCURRENCE/LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.		
	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	FF	TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) **OR**
		FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) **OR**
		FS	TFL (SECOND PAYOR)
	ELSE IF BEGIN DATE OF CARE IS < 10/01/2001		
	THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAILED LINE MUST =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER **OR**
		26	EXPENSES INCURRED PRIOR TO COVERAGE **OR**
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED **OR**
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS **OR**
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED **OR**
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED **OR**
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE **OR**
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS **OR**
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION **OR**
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
2-305-30R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF	ECHO

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ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)		
THEN HCDP PLAN COVERAGE CODE MUST ≠	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) **OR**
	402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR**
	405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
	406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
	407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) **OR**
	408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) **OR**
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE **OR**
	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE **OR**
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR**
	412	TRS SURVIVOR NEW FAMILY COVERAGE **OR**
	413	TRS MEMBER-ONLY COVERAGE **OR**
	414	TRS MEMBER AND FAMILY COVERAGE

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ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) SPECIAL ENTITLEMENT CODE (2-306)			
	VALIDITY EDITS		
2-306-01V	MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE (REFER TO SECTION 2.5)		
	RELATIONAL EDITS		
	NONE		

ELEMENT NAME: CA/NAS NUMBER (2-310)			
	VALIDITY EDITS		
2-310-01V	IF CA/NAS NUMBER IS NOT BLANK **THEN** MUST BE 1 TO 11 **OR** 1 TO 15 ALPHANUMERIC CHARACTERS.		
	RELATIONAL EDITS		
NO ERROR	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL
	THEN BYPASS ALL CA/NAS NUMBER RELATIONAL EDITING.		
NO ERROR	IF BEGIN DATE OF CARE IS OLDER THAN 6 YEARS		
	THEN DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA		
NO ERROR	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	R	MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NOT A MEDICARE BENEFIT) AND BEGIN DATE OF CARE ≥ 10/01/2001 **OR**
		T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**
		AN	SHCP - NON-MTF-REFERRED CARE **OR**
		AR	SHCP - REFERRED CARE **OR**
		CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM **OR**
		PF	ECHO
		RS	MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**
		SC	SHCP - NON-TRICARE ELIGIBLE **OR**
		SE	SHCP - TRICARE ELIGIBLE **OR**
		SM	SHCP - EMERGENCY **OR**
		ST	SPECIALIZED TREATMENT **OR**
		WR	MENTAL HEALTH WRAP AROUND
	THEN BYPASS ALL CA/NAS NUMBER EDITING.		
NO ERROR	IF ENROLLMENT/HEALTH PLAN CODE =	U	TRICARE PRIME, CIVILIAN PCM **OR**
		W	TPR ADSM - USA **OR**
		X	FOREIGN ADSM **OR**
		Y	CHCBP - STANDARD **OR**
		Z	TRICARE PRIME, MTF/PCM **OR**
		AA	CHCBP - EXTRA **OR**
		BB	TSP **OR**
[1] CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.			

ELEMENT NAME: CA/NAS NUMBER (2-310) (Continued)			
		FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD **OR**
		PS	TSRx **OR**
		SN	SHCP - NON-MTF-REFERRED CARE **OR**
		SR	SHCP - REFERRED CARE **OR**
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	THEN BYPASS ALL CA/NAS NUMBER EDITING.		
NO ERROR	IF HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER
	THEN BYPASS ALL CA/NAS NUMBER EDITING.		
NO ERROR	IF ANY OCCURRENCE OF ADJUSTMENT/ DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER **OR**
		26	EXPENSES INCURRED PRIOR TO COVERAGE **OR**
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED **OR**
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS **OR**
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED **OR**
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED **OR**
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE **OR**
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS **OR**
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION **OR**
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
	THEN BYPASS ALL CA/NAS NUMBER EDITING		
NO ERROR	IF AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO		
	THEN NO CA/NAS IS REQUIRED -- BYPASS ALL CA/NAS NUMBER EDITING.		
NO ERROR	IF HCDP PLAN COVERAGE CODE =	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
		406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**

[1] CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.

ELEMENT NAME: CA/NAS NUMBER (2-310) (Continued)			
		407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) **OR**
		408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) **OR**
		409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE **OR**
		410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE **OR**
		411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR**
		412	TRS SURVIVOR NEW FAMILY COVERAGE **OR**
		413	TRS MEMBER-ONLY COVERAGE **OR**
		414	TRS MEMBER AND FAMILY COVERAGE
2-310-02R	IF CA/NAS EXCEPTION REASON ≠ BLANK		
	THEN CA/NAS NUMBER MUST = BLANK		
2-310-03R	• MENTAL HEALTH CHECK		
	IF CA/NAS EXCEPTION REASON = BLANK		
	AND TYPE OF SERVICE (FIRST POSITION) =	I	INPATIENT
	AND PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316		
	AND PATIENT ZIP CODE IS IN AN MTF CATCHMENT AREA[1]		
	THEN CA/NAS NUMBER MUST BE CODED		
	UNLESS ANY OCCURRENCE OF OVERRIDE CODE =	C	GOOD FAITH PAYMENT
	THEN CA/NAS NUMBER MUST = BLANK		
2-310-04R	IF CA/NAS NUMBER IS CODED		
	THEN CA/NAS EXCEPTION REASON MUST = BLANK		
[1] CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.			

ELEMENT NAME: CA/NAS REASON FOR ISSUANCE (2-315)	
VALIDITY EDITS	
2-315-01V	VALUE MUST A VALID CA/NAS REASON FOR ISSUANCE.
RELATIONAL EDITS	
2-315-02R	IF CA/NAS NUMBER = BLANK
	THEN CA/NAS REASON FOR ISSUANCE MUST = BLANK.

ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320)			
	VALIDITY EDITS		
2-320-01V	VALUE MUST BE A VALID CA/NAS EXCEPTION REASON.		
	RELATIONAL EDITS		
NO ERROR	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL
	THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING.		
NO ERROR	IF BEGIN DATE OF CARE IS OLDER THAN 6 YEARS		
	THEN DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA		
NO ERROR	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	R	MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NOT A MEDICARE BENEFIT) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**
		T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR-NOT A MEDICARE BENEFIT) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**
		AN	SHCP - NON-MTF-REFERRED CARE **OR**
		AR	SHCP - REFERRED CARE **OR**
		CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM **OR**
		PF	ECHO
		RS	MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**
		SC	SHCP - NON-TRICARE ELIGIBLE **OR**
		SE	SHCP - TRICARE ELIGIBLE **OR**
		SM	SHCP - EMERGENCY **OR**
		ST	SPECIALIZED TREATMENT **OR**
		WR	MENTAL HEALTH WRAP AROUND
	THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING.		
NO ERROR	IF ENROLLMENT/HEALTH PLAN CODE =	U	TRICARE PRIME, CIVILIAN PCM **OR**
		W	TPR ADSM - USA **OR**
		X	FOREIGN ADSM **OR**
		Y	CHCBP - STANDARD **OR**
		Z	TRICARE PRIME, MTF/PCM **OR**
		AA	CHCBP - EXTRA **OR**
		BB	TSP **OR**
		FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD **OR**
		PS	TSRx **OR**
		SN	SHCP - NON-MTF-REFERRED CARE **OR**
		SR	SHCP - REFERRED CARE **OR**
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM

ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320) (Continued)			
	THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING.		
NO ERROR	IF HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER
	THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING.		
NO ERROR	IF ANY OCCURRENCE OF ADJUSTMENT/ DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER **OR**
		26	EXPENSES INCURRED PRIOR TO COVERAGE **OR**
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED **OR**
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS **OR**
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED **OR**
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED **OR**
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE **OR**
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS **OR**
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION **OR**
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
	THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING		
NO ERROR	IF AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO		
	THEN NO CA/NAS IS REQUIRED -- BYPASS ALL CA/NAS EXCEPTION REASON EDITING		
NO ERROR	IF HCDP PLAN COVERAGE CODE =	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
		406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
		407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) **OR**
		408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) **OR**
		409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE **OR**
		410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE **OR**
		411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR**

ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320) (Continued)			
		412	TRS SURVIVOR NEW FAMILY COVERAGE **OR**
		413	TRS MEMBER-ONLY COVERAGE **OR**
		414	TRS MEMBER AND FAMILY COVERAGE
2-320-04R	IF PATIENT ZIP CODE IS IN AN MTF CATCHMENT AREA		
	AND TYPE OF SERVICE (FIRST POSITION) =	I	INPATIENT
	AND PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316		
	AND CA/NAS NUMBER NOT CODED		
	THEN CA/NAS EXCEPTION REASON MUST BE CODED		

ELEMENT NAME: PRICING RATE CODE (2-325)			
	VALIDITY EDITS		
2-325-01V	VALUE MUST A VALID NON-INSTITUTIONAL PRICING RATE CODE.		
	RELATIONAL EDITS		
2-325-01R	IF PRICING RATE CODE =	C	AMBULATORY SURGERY FACILITY PAYMENT RATE **OR**
		D	DISCOUNTED AMBULATORY SURGERY FACILITY PAYMENT RATE **OR**
		E	AMBULATORY SURGERY-PAID AS BILLED **OR**
		P	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-FACILITY PAYMENT RATE **OR**
		Q	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, DISCOUNTED AMBULATORY SURGERY-FACILITY PAYMENT RATE **OR**
		R	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-PAID AS BILLED
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	16	AMBULATORY SURGERY FACILITY CHARGE
2-325-02R	IF ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM IS A CODE LISTED IN ADDENDUM G, FIGURE 2.G-1.		
	THEN PRICING RATE CODE MUST =	0	PRICING NOT APPLICABLE (DENIED SERVICE/ SUPPLIES AND ALLOWED DRUGS)
2-325-03R	IF PRICING RATE CODE FOR THAT OCCURRENCE/LINE ITEM =	0	PRICING NOT APPLICABLE (DENIED SERVICE/ SUPPLIES AND ALLOWED DRUGS)
	THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO		
	UNLESS TYPE OF SERVICE (SECOND POSITION) =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS **OR**
		M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR)
2-325-04R	IF PRICING RATE CODE =	V	MEDICARE REIMBURSEMENT RATE
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	16	AMBULATORY SURGERY FACILITY CHARGE **OR**
		T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**
		FS	TFL (SECOND PAYOR) **OR**
		MN	TSP - NON-NETWORK **OR**
		MS	TSP - NETWORK
2-325-05R	IF PRICING RATE CODE =	U	SHCP CLAIM OR ACTIVE DUTY MEMBER TPR PAID OUTSIDE NORMAL LIMITS
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AR	SHCP - REFERRED CARE **OR**
		AN	SHCP - NON-MTF-REFERRED CARE **OR**

ELEMENT NAME: PRICING RATE CODE (2-325) (Continued)			
		CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM **OR**
		GU	ADSM ENROLLED IN TPR **OR**
		SC	SHCP - NON-TRICARE ELIGIBLE **OR**
		SE	SHCP - TRICARE ELIGIBLE **OR**
		SM	SHCP - EMERGENCY
	OR ENROLLMENT/HEALTH PLAN CODE MUST =	SN	SHCP - NON-MTF-REFERRED CARE **OR**
		SR	SHCP - REFERRED CARE
2-325-06R	IF PRICING CODE =	W	PRICED OVER CMAC
	AND ENROLLMENT/HEALTH PLAN CODE =	T	TRICARE STANDARD PROGRAM
	AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	NE	OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM
	AND BEGIN DATE OF CARE ≥ 09/14/2001 **AND** < 11/01/2007		
	THEN PROVIDER PARTICIPATING INDICATOR MUST =	N	NO
2-325-08R	IF PRICING RATE CODE =	P1	OPPS **OR**
		P2	OPPS WITH COST OUTLIER **OR**
		P3	OPPS WITH DISCOUNT **OR**
		P5	PARTIAL HOSPITALIZATION - PAID AS OPPS
	THEN APC CODE MUST ≠ BLANK **OR** ZEROES.		
2-325-09R	IF PRICING RATE CODE =	CA	CAH REIMBURSEMENT
	THEN PROVIDER STATE OR COUNTRY CODE MUST =	AK	ALASKA
	AND BEGIN DATE OF CARE MUST BE ≥ 07/01/2007		

ELEMENT NAME: AMBULATORY PAYMENT CLASSIFICATION (APC) CODE (2-330)			
	VALIDITY EDITS		
2-330-01V	MUST BE A VALID APC CODE AS LISTED ON TMA'S OPPS WEB SITE AT HTTP://WWW.TRICARE.MIL/OPPS, BLANK, **OR** ALL ZEROES		
	UNLESS AMOUNT ALLOWED BY PROCEDURE CODE = ZERO		
	RELATIONAL EDITS		
2-330-01R	IF APC CODE = BLANK **OR** ZEROES.		
	THEN PRICING RATE CODE ≠	P1	OPPS **OR**
		P2	OPPS WITH COST OUTLIER **OR**
		P3	OPPS WITH DISCOUNT **OR**
		P5	PARTIAL HOSPITALIZATION - PAID AS OPPS

ELEMENT NAME: OPPS PAYMENT STATUS INDICATOR CODE (2-331)			
	VALIDITY EDITS		
2-331-01V	MUST BE A VALID OPPS PAYMENT STATUS INDICATOR CODE (REFER TO SECTION 2.6) **OR** BLANK.		
	RELATIONAL EDITS		
2-331-01R	IF OPPS PAYMENT STATUS INDICATOR CODE = BLANK		
	THEN APC CODE MUST = ALL ZEROES **OR** BLANK.		

ELEMENT NAME: AMOUNT NETWORK PROVIDER DISCOUNT (2-335)			
	VALIDITY EDITS		
2-335-01V	MUST BE NUMERIC AND ≥ ZERO		
	RELATIONAL EDITS		
2-335-01R	IF TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED (HCSR) DATA **OR**
		C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA **OR**
		O	ZERO GOVERNMENT TED RECORD DUE TO 100% OHI
	THEN AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO		
2-335-02R	IF PROVIDER NETWORK STATUS INDICATOR =	2	NON-NETWORK PROVIDER
	THEN AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO		
2-335-03R	IF REGION INDICATOR =		BLANK **OR**
		OC	OVERSEAS CONTRACT
	THEN AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO		

- END -