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 - CCEP **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**
		FS	TFL - STANDARD
[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 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		
2-301-03R	IF HCDP PLAN COVERAGE CODE =	417	TCSRC
	THEN ENROLLMENT/HEALTH PLAN CODE MUST =	X	FOREIGN ADSM **OR**
		SR	SHCP - REFERRED CARE
	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**

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (2-301) (Continued)			
		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 **OR**
		418	TRICARE RETIRED RESERVE (TRR) MEMBER-ONLY COVERAGE **OR**
		419	TRR MEMBER AND FAMILY COVERAGE **OR**
		420	TRR SURVIVOR INDIVIDUAL COVERAGE **OR**
		421	TRR SURVIVOR 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 **OR**
		418	TRR MEMBER-ONLY COVERAGE **OR**
		419	TRR MEMBER AND FAMILY COVERAGE **OR**
		420	TRR SURVIVOR INDIVIDUAL COVERAGE **OR**
		421	TRR SURVIVOR 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**

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ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)			
		RI	RESOURCE SHARING - INTERNAL
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 OUTLIER **OR**
		P3	OPPS WITH DISCOUNT
2-305-14R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PO	TRICARE PRIME - POS
	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 - CCEP **OR**
		SC	SHCP - NON-TRICARE ELIGIBLE **OR**
		SE	SHCP - TRICARE ELIGIBLE **OR**
		SM	SHCP - EMERGENCY

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ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)			
	THEN ENROLLMENT/HEALTH PLAN CODE MUST =	SN	SHCP - NON-MTF-REFERRED CARE **OR**
		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**

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ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)			
		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
	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 **OR**
		418	TRR MEMBER-ONLY COVERAGE **OR**
		419	TRR MEMBER AND FAMILY COVERAGE **OR**
		420	TRR SURVIVOR INDIVIDUAL COVERAGE **OR**
		421	TRR SURVIVOR FAMILY COVERAGE
2-305-31R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AU	AUTISM DEMONSTRATION
	THEN BEGIN DATE OF CARE MUST BE ≥ 03/15/2008		
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	PF	ECHO
	AND PATIENT AGE[2] MUST BE ≥ 18 MONTHS		
2-305-32R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	RB	RESPITE BENEFIT FOR ADSMs
	THEN BEGIN DATE OF CARE MUST BE ≥ 01/01/2008		
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	SE	SHCP - TRICARE ELIGIBLE

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ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)			
2-305-33R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PS	SPECIALTY PHARMACY SERVICES
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	AND PROCEDURE CODE MUST ≠	000MN	PRESCRIPTION MEDICAL NECESSITY REVIEWS **OR**
		000PA	PRESCRIPTION PRIOR AUTHORIZATIONS
2-305-34R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PV	RETAIL PHARMACY FOR DVA BENEFICIARIES
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	AND PROVIDER NETWORK STATUS INDICATOR MUST =	1	NETWORK PROVIDER
	AND PROCEDURE CODE MUST ≠	000MN	PRESCRIPTION MEDICAL NECESSITY REVIEWS **OR**
		000PA	PRESCRIPTION PRIOR AUTHORIZATIONS
2-305-35R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	EF	TRICARE RESERVE AND NATIONAL GUARD FAMILY MEMBER BENEFITS
	THEN BEGIN DATE OF CARE MUST BE ≥11/01/2009		
	AND ENROLLMENT/HEALTH PLAN CODE MUST =	T	TRICARE STANDARD PROGRAM **OR**
		V	TRICARE EXTRA
	AND HCDP SPECIAL ENTITLEMENT CODE MUST =	02	NOBLE EAGLE PARTICIPATION SPECIAL ENTITLEMENT **OR**
		03	ENDURING FREEDOM PARTICIPATION SPECIAL ENTITLEMENT
	AND AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO		
2-305-36R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	DE	TDRL PHYSICAL EXAMS
	THEN BEGIN DATE OF CARE MUST BE ≥ 03/30/2009		
	AND ENROLLMENT/HEALTH PLAN CODE MUST =	SR	SHCP - REFERRED CARE
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	SE	SHCP - TRICARE ELIGIBLE
2-305-37R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	DC	DCPE-DVA
	THEN BEGIN DATE OF CARE MUST BE ≥ 01/01/2011		
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	17	VA MEDICAL PROVIDER CLAIM

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ELEMENT NAME:	**SPECIAL PROCESSING CODE (2-305) (Continued)**		
	AND ENROLLMENT/HEALTH PLAN CODE MUST =	SR	SHCP - REFERRED CARE
	AND AT LEAST ONE PROCEDURE CODE[1] MUST = 99456		
2-305-38R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PH	PHILIPPINES DEMONSTRATION PROJECT
	THEN BEGIN DATE OF CARE MUST BE ≥ 01/01/2013		
	AND HCDP PLAN COVERAGE CODE MUST =	003	TRICARE STANDARD FOR ADFMS **OR**
		005	TRICARE STANDARD SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		007	TRICARE STANDARD TRANSITIONAL ASSISTANCE SPONSORS AND FAMILY MEMBERS **OR**
		009	TRICARE STANDARD RETIRED AND MOH SPONSORS AND FAMILY MEMBERS **OR**
		010	TRICARE STANDARD TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		015	TRICARE STANDARD TRANSITIONAL SURVIVORS OF NG/RESERVE DECEASED SPONSORS **OR**
		017	TRICARE STANDARD SURVIVORS OF NG/RESERVE DECEASED SPONSORS **OR**
		018	TFL RETIRED SPONSORS AND FAMILY MEMBERS AND MOH **OR**
		020	TFL TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		021	TFL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		022	TFL TRANSITIONAL SURVIVORS OF NG/RESERVE DECEASED SPONSORS **OR**
		023	TFL SURVIVORS OF NG/RESERVE DECEASED SPONSORS **OR**
		028	TRICARE STANDARD FOR MEDICALLY RETIRED SPONSORS AND FAMILY MEMBERS **OR**
		029	TFL FOR MEDICALLY RETIRED SPONSORS AND FAMILY MEMBERS **OR**
		409	TRS SURVIVOR CONTINUING INDIVIDUAL COVERAGE **OR**
		410	TRS SURVIVOR CONTINUING 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 **OR**
		418	TRR MEMBER-ONLY COVERAGE **OR**
		419	TRR MEMBER AND FAMILY COVERAGE **OR**

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ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)			
		420	TRR SURVIVOR INDIVIDUAL COVERAGE **OR**
		421	TRR SURVIVOR FAMILY COVERAGE **OR**
		422	TYA STANDARD FOR ADFMS **OR**
		423	TYA STANDARD FOR RETIRED AND MOH FAMILY MEMBERS **OR**
		424	TYA RESERVE SELECT **OR**
		425	TYA RETIRED RESERVE **OR**
		999	UNVERIFIED NEWBORN
	AND PATIENT ZIP CODE MUST =	PHL	PHILIPPINES
	AND PROVIDER STATE OR COUNTRY CODE MUST =	PHL	PHILIPPINES

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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 SIX YEARS		
	THEN DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA[1]		
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 - CCEP **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**
		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

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

ELEMENT NAME: CA/NAS NUMBER (2-310) (Continued)			
	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.		
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/ POA INDICATOR (POSITIONS 1-7) =	290-316 (MENTAL HEALTH, ICD-9-CM) **OR**	
		F01.50-F69 OR F99 (MENTAL HEALTH, ICD-10-CM)	
	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		

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

ELEMENT NAME: CA/NAS NUMBER (2-310) (Continued)	
	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 SIX 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 - CCEP **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**
[1] CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.			

ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320) (Continued)			
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	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		
2-320-04R	IF PATIENT ZIP CODE IS IN AN MTF CATCHMENT AREA[1]		
	AND TYPE OF SERVICE (FIRST POSITION) =	I	INPATIENT
	AND PRINCIPAL TREATMENT DIAGNOSIS/ POA INDICATOR (POSITIONS 1-7) =	290-316 (MENTAL HEALTH, ICD-9-CM) **OR**	
		F01.50-F69 OR F99 (MENTAL HEALTH, ICD-10-CM)	
	AND CA/NAS NUMBER NOT CODED		
	THEN CA/NAS EXCEPTION REASON MUST BE CODED		

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

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**
		CE	SHCP - CCEP **OR**

ELEMENT NAME: PRICING RATE CODE (2-325) (Continued)			
		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 =	NE	OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM DEMONSTRATION
	AND BEGIN DATE OF CARE ≥ 09/14/2001 **AND** < 11/01/2009		
	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 BEGIN DATE OF CARE MUST BE ≥ 12/01/2009		
	UNLESS PROVIDER STATE OR COUNTRY CODE =	AK	ALASKA
	THEN BEGIN DATE OF CARE MUST BE ≥ 07/01/2007		
2-325-10R	IF PRICING CODE =	W	PRICED OVER CMAC
	AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE =	EF	TRICARE RESERVE AND NATIONAL GUARD FAMILY MEMBER BENEFITS
	AND ENROLLMENT/HEALTH PLAN CODE =	T	TRICARE STANDARD PROGRAM
	THEN PROVIDER PARTICIPATING INDICATOR MUST =	N	NO

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 -