Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: PERSON SEX (PATIENT) (1-100)			
VALIDITY EDITS			
1-100-01V	PERSON SEX (PATIENT) MUST =	F	FEMALE **OR**
		M	MALE **OR**
		Z	UNKNOWN
RELATIONAL EDITS			
	NONE		

ELEMENT NAME: PATIENT ZIP CODE (1-105)	
VALIDITY EDITS	
1-105-01V	MUST BE NINE DIGITS **OR** FIVE DIGITS WITH FOUR BLANKS
	MUST BE A VALID ZIP CODE (BASED ON ADMISSION DATE) IN THE GOVERNMENT PROVIDED ELECTRONIC ZIP CODE FILE **OR**
	MUST BE A THREE CHARACTER FOREIGN COUNTRY CODE (BASED ON THE COUNTRY CODES TABLE[1]) FOLLOWED BY SIX BLANKS
RELATIONAL EDITS	
	NONE

[1] WHEN FOREIGN COUNTRY CODES ARE SUBMITTED, THE FIRST THREE CHARACTERS WILL BE EDITED AGAINST ADDENDUM A.

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (1-110)			
	VALIDITY EDITS		
1-110-01V	MUST BE A VALID ENROLLMENT/HEALTH PLAN CODE (REFER TO SECTION 2.5).		
	RELATIONAL EDITS		
1-110-02R	IF ENROLLMENT/HEALTH PLAN CODE =	Y	CHCBP - STANDARD **OR**
		AA	CHCBP - EXTRA
	THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE CAN =	CL	CLINICAL TRIALS **OR**
		PF	ECHO
1-110-06R	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
1-110-09R	• TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001. WHEN BEGIN DATE OF CARE IS < 10/01/2001, THE OCCURRENCE/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
	AND TYPE OF INSTITUTION ≠	10	GENERAL MEDICAL AND SURGICAL
	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., MEDICARE 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 OCCURRENCE/LINE ITEM (EXCEPT FOR LINE CONTAINING REVENUE CODE 0001) 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**

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

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (1-110) (Continued)			
		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 NEWBORN **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
1-110-10R	• TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001 **UNLESS** THE BENEFICIARY IS AN INPATIENT AND THE ADMISSION DATE WAS PRIOR TO 10/01/2001, TFL WILL PAY FOR THE ENTIRE HOSPITAL STAY.		
	IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD
	AND TYPE OF INSTITUTION =	10	GENERAL MEDICAL AND SURGICAL
	THEN END DATE OF CARE ≥ 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., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) **OR**
		FS	TFL (SECOND PAYOR)
1-110-11R	• TFL CLAIMS: THE PATIENT MUST BE 64 YEARS AND 11 MONTHS OR GREATER. IF THE PATIENT IS LESS THAN THIS AGE THE OCCURRENCE/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
	THEN PATIENT AGE[1] MUST BE ≥ 64 YEARS AND 11 MONTHS		
	ELSE IF PATIENT AGE[1] IS < 64 YEARS AND 11 MONTHS		
	THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAILED OCCURRENCE/LINE ITEM (EXCEPT LINE CONTAINING REVENUE CODE 0001) 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**

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

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (1-110) (Continued)		
	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

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

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111)			
VALIDITY EDITS			
1-111-01V	MUST BE A VALID HCDP PLAN COVERAGE CODE LISTED IN ADDENDUM L.		
1-111-02V	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 OF ACTIVE DUTY DECEASED SPONSORS **OR**
		138	TRICARE USFHP DIRECT CARE INDIVUDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS **OR**
		139	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS
	THEN AMOUNT ALLOWED (TOTAL) MUST = ZERO		
RELATIONAL EDITS			
1-111-01R	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**
		413	TRS MEMBER-ONLY COVERAGE **OR**
		414	TRS MEMBER AND FAMILY COVERAGE

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111) (Continued)			
	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	SHCP-REFERRED CARE
1-111-02R	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
1-111-03R	IF HCDP PLAN COVERAGE CODE =	417	TCSRC
	THEN ENROLLMENT/HEALTH PLAN CODE MUST =	X	FOREIGN ADSM **OR**
		SR	SHCP - REFERRED CARE

ELEMENT NAME: REGION INDICATOR (1-112)			
	VALIDITY EDITS		
1-112-01V	MUST BE VALID REGION INDICATOR (REFER TO SECTION 2.8).		
1-112-02V	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
		SC	SOUTH CONTRACT **OR**
		WC	WEST CONTRACT
	THEN ADJUSTMENT KEY MUST =	0	BATCH **OR**
		5	VOUCHER
	RELATIONAL EDITS		
	NONE		

ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (1-115)			
	VALIDITY EDITS		
1-115-01V	MUST BE A VALID FOUR DIGIT PCM LOCATION DMIS-ID.		
1-115-03V	IF FILING DATE ≥ 09/01/2007		
	AND PCM LOCATION DMIS-ID =	0190	JOHNS HOPKINS MEDICAL SERVICES CORPORATION **OR**
		0191	BRIGHTON MARINE **OR**
		0192	CHRISTUS HEALTH/ST JOHN'S **OR**
		0193	ST VINCENTS CATHOLIC MEDICAL CENTERS OF NY **OR**
		0194	PACIFIC MEDICAL CLINICS **OR**
		0196	CHRISTUS HEALTH/ST JOSEPH'S **OR**
		0197	CHRISTUS HEALTH/ST MARY'S **OR**
		0198	MARTIN'S POINT HEALTH CARE **OR**
		0199	FAIRVIEW HEALTH SYSTEM
	THEN AMOUNT ALLOWED (TOTAL) MUST = ZERO		
	RELATIONAL EDITS		
	NONE		

ELEMENT NAME: AMOUNT BILLED (TOTAL) (1-120)			
	VALIDITY EDITS		
1-120-01V	MUST BE NUMERIC.		
	RELATIONAL EDITS		
1-120-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
	THEN AMOUNT BILLED (TOTAL) MUST BE > ZERO		
	UNLESS ANY OCCURRENCE/LINE ITEM REVENUE CODE = 0022 **OR** 0023		
	AND AMOUNT ALLOWED (TOTAL) = ZERO		
1-120-02R	AMOUNT BILLED (TOTAL) MUST = TOTAL CHARGE BY REVENUE CODE FOR REVENUE CODE 0001		

ELEMENT NAME: AMOUNT ALLOWED (TOTAL) (1-125)			
	VALIDITY EDITS		
1-125-01V	MUST BE NUMERIC.		
	RELATIONAL EDITS		
1-125-01R	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL
	THEN AMOUNT ALLOWED (TOTAL) MUST = ZERO		
	AND ALL OCCURRENCES/LINE ITEMS (EXCLUDING REVENUE CODE 0001) MUST CONTAIN A DENIAL CODE LISTED IN FIGURE 2.G-1 **OR** FIGURE 2.G-2		
1-125-02R	IF ALL DETAIL ADJUSTMENT/DENIAL REASON CODES CONTAIN A DENIAL CODE (REFER TO FIGURE 2.G-1 **OR** FIGURE 2.G-2)		
	AND TYPE OF SUBMISSION =	B	ADJUSTMENT NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN AMOUNT ALLOWED (TOTAL) MUST BE ≤ ZERO		
1-125-03R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
	THEN AMOUNT ALLOWED (TOTAL) MUST BE > ZERO		
	UNLESS ALL OCCURRENCES/LINE ITEMS (EXCLUDING REVENUE CODE 0001) CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN FIGURE 2.G-1 **OR** FIGURE 2.G-2		
	AND THE TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD **OR**
		3	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT BOTH EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD AND TO CORRECT CLAIM PROCESSING ERRORS OR UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION
1-125-04R	IF AMOUNT ALLOWED (TOTAL) = ZERO		
	THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST = ZERO		
	UNLESS TYPE OF SUBMISSION =	B	ADJUSTMENT NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

ELEMENT NAME: AMOUNT PAID BY OTHER HEALTH INSURANCE (1-130)			
	VALIDITY EDITS		
1-130-01V	MUST BE NUMERIC.		
	RELATIONAL EDITS		
1-130-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
	THEN AMOUNT OF OTHER HEALTH INSURANCE MUST BE ≥ ZERO		
1-130-03R	IF AMOUNT PAID BY OTHER HEALTH INSURANCE > ZERO		
	AND AMOUNT ALLOWED (TOTAL) > ZERO		
	AND AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) = ZERO		
	AND DATE ADJUSTMENT IDENTIFIER = ZEROES		
	THEN TYPE OF SUBMISSION MUST =	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
	UNLESS THE AMOUNT PATIENT COST-SHARE = THE AMOUNT ALLOWED (TOTAL) **OR** THE TED RECORD CORRECTION INDICATOR ≠ BLANK		

ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) TYPE CODE (1-131)			
	VALIDITY EDITS		
1-131-01V	MUST BE A VALID OGP TYPE CODE LISTING IN SECTION 2.6.		
	RELATIONAL EDITS		
1-131-01R	IF OGP TYPE CODE =	V	CHAMPVA
	THEN TYPE OF SUBMISSION MUST =	C	COMPLETE CANCELLATION **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) BEGIN REASON CODE (1-132)	
VALIDITY EDITS	
1-132-01V	MUST BE A VALID OGP BEGIN REASON CODE LISTING IN SECTION 2.6.
RELATIONAL EDITS	
	NONE

ELEMENT NAME: AMOUNT PATIENT COST-SHARE (1-135)			
	VALIDITY EDITS		
1-135-01V	MUST BE NUMERIC.		
	RELATIONAL EDITS		
1-135-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
	THEN AMOUNT PATIENT COST-SHARE MUST BE ≥ ZERO		
1-135-02R	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL
	THEN AMOUNT PATIENT COST-SHARE MUST BE = ZERO		

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) COPAYMENT FACTOR CODE (1-136)	
VALIDITY EDITS	
1-136-01V	MUST BE A VALID HCC COPAYMENT FACTOR CODE LISTING IN SECTION 2.5.
RELATIONAL EDITS	
	NONE

ELEMENT NAME: AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) (1-140)			
	VALIDITY EDITS		
1-140-01V	MUST BE NUMERIC.		
	RELATIONAL EDITS		
1-140-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		I	INITIAL SUBMISSION **OR**
		R	RESUBMISSION
	THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST BE ≥ ZERO		
1-140-02R	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL
	THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST = ZERO		

ELEMENT NAME: AMOUNT INTEREST PAYMENT (1-145)			
	VALIDITY EDITS		
1-145-01V	MUST BE NUMERIC.		
	RELATIONAL EDITS		
1-145-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		C	COMPLETE CANCELLATION **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
	THEN AMOUNT INTEREST PAYMENT MUST BE ≥ ZERO		
1-145-02R	IF AMOUNT INTEREST PAYMENT ≠ ZERO		
	THEN REASON FOR INTEREST PAYMENT MUST =	A	CLAIMS PENDED AT GOVERNMENT DIRECTION **OR**
		B	CLAIMS REQUIRING GOVERNMENT INTERVENTION **OR**
		C	CLAIMS REQUIRING DEVELOPMENT FOR POTENTIAL TPL **OR**
		D	CLAIMS REQUIRING AN ACTION/INTERFACE WITH ANOTHER PRIME CONTRACTOR **OR**
		E	CLAIMS RETAINED BY THE CONTRACTOR THAT DO NOT FALL INTO ONE OF THE ABOVE CATEGORIES
1-145-03R	IF FILING STATE/ COUNTRY CODE = A FOREIGN COUNTRY INCLUDING PUERTO RICO (PRI)		
	THEN AMOUNT INTEREST PAYMENT MUST = ZERO		

ELEMENT NAME: REASON FOR INTEREST PAYMENT (1-150)			
	VALIDITY EDITS		
1-150-01V	MUST BE A VALID REASON FOR INTEREST PAYMENT CODE (REFER TO SECTION 2.8).		
	RELATIONAL EDITS		
1-150-01R	IF REASON FOR INTEREST PAYMENT =	A	CLAIMS PENDED AT GOVERNMENT DIRECTION **OR**
		B	CLAIMS REQUIRING GOVERNMENT INTERVENTION **OR**
		C	CLAIMS REQUIRING DEVELOPMENT FOR POTENTIAL TPL **OR**
		D	CLAIMS REQUIRING AN ACTION/INTERFACE WITH ANOTHER PRIME CONTRACTOR **OR**
		E	CLAIMS RETAINED BY THE CONTRACTOR THAT DO NOT FALL INTO ONE OF THE ABOVE CATEGORIES
	THEN AMOUNT INTEREST PAYMENT MUST ≠ ZERO		

ELEMENT NAME: OVERRIDE CODE (1-160)			
	VALIDITY EDITS		
1-160-01V	OCCURRENCE NUMBER 1--MUST BE A VALID OVERRIDE CODE (REFER TO SECTION 2.6).		
1-160-02V	OCCURRENCE NUMBER 2--MUST BE A VALID OVERRIDE CODE (REFER TO SECTION 2.6).		
1-160-03V	OCCURRENCE NUMBER 3--MUST BE A VALID OVERRIDE CODE (REFER TO SECTION 2.6).		
1-160-04V	A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).		
1-160-05V	OVERRIDE CODE OCCURRENCES MUST BE LEFT JUSTIFIED.		
	RELATIONAL EDITS		
1-160-13R	IF ANY OCCURRENCE OF OVERRIDE CODE =	NC	NON-CERTIFIED PROVIDER (DOES NOT INCLUDE SANCTIONED/SUSPENDED PROVIDERS)
	THEN ANY OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AD	FOREIGN ACTIVE DUTY CLAIMS **OR**
		AN	SHCP - NON-MTF-REFERRED CARE **OR**
		AR	SHCP - REFERRED CARE **OR**
		CE	SHCP - CCEP **OR**
		EU	EMERGENCY SERVICES RENDERED BY AN UNAUTHORIZED PROVIDER **OR**
		GU	ADSM ENROLLED IN TPR **OR**
		MN	TSP - NETWORK **OR**
		MS	TSP - NON-NETWORK **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

ELEMENT NAME: TYPE OF SUBMISSION (1-165)			
	VALIDITY EDITS		
1-165-01V	VALUE MUST BE A VALID TYPE OF SUBMISSION.		
1-165-02V	IF TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN ADJUSTMENT KEY CANNOT =	0	BATCH **OR**
		5	VOUCHER
1-165-03V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		C	COMPLETE CANCELLATION **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN MATCH MUST BE FOUND ON THE TMA DATABASE		
	AND TYPE OF SUBMISSION ON THE EXISTING TMA DATABASE RECORD ≠	C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	UNLESS THE RECORD HAS PROVISIONAL ERRORS		
1-165-04V	IF TYPE OF SUBMISSION =	D	COMPLETE DENIAL **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
	THEN A TED RECORD MUST NOT BE PRESENT ON THE DATABASE WITH THE SAME TRI.		
1-165-06V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		C	COMPLETE CANCELLATION TO TED RECORD DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	AND CONTRACT NUMBER =	MDA906-02-C-0013 (TMOP) **OR**	
		MDA906-03-C-0009 (WEST) **OR**	
		MDA906-03-C-0010 (SOUTH) **OR**	
		MDA906-03-C-0011 (NORTH) **OR**	
		MDA906-03-C-0015 (TDEFIC) **OR**	
		MDA906-03-C-0019 (TRRx)	
	THEN TED RECORD CORRECTION INDICATOR MUST =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) **SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR**
		2	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT CLAIM PROCESSING ERRORS OR TO UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION **OR**

ELEMENT NAME: TYPE OF SUBMISSION (1-165) (Continued)			
		3	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT BOTH CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD
	RELATIONAL EDITS		
1-165-01R	IF TYPE OF SUBMISSION =	O	ZERO PAYMENT WITH 100% OHI/TPL
	THEN THE AMOUNT OF OHI MUST BE > ZERO		
	AND AMOUNT ALLOWED (TOTAL) MUST BE > ZERO		
	AND AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST BE = ZERO		
1-165-02R	IF ALL OCCURRENCES/LINE ITEMS (EXCLUDING REVENUE CODE 0001) CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN ADDENDUM G, FIGURE 2.G-1)		
	THEN TYPE OF SUBMISSION MUST =	C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	UNLESS THE TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD **OR**
		3	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT BOTH EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD AND TO CORRECT CLAIM PROCESSING ERRORS OR UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION
1-165-04R	IF BATCH/VOUCHER RESUBMISSION NUMBER = ZERO FOR THIS BATCH OR VOUCHER		
	THEN TYPE OF SUBMISSION MUST ≠	R	RESUBMISSION
1-165-05R	IF BATCH/VOUCHER RESUBMISSION NUMBER > ZERO FOR THIS BATCH OR VOUCHER		
	THEN TYPE OF SUBMISSION MUST BE ≠	I	INITIAL TED RECORD SUBMISSION
1-165-06R	IF TYPE OF SUBMISSION =	I	INITIAL SUBMISSION **OR**
		R	RESUBMISSION
	AND TYPE OF INSTITUTION ≠	70	HHA **OR**
		71	SNF
	AND SPECIAL PROCESSING CODE ≠	11	HOSPICE
	THEN AMOUNT BILLED (TOTAL), AMOUNT ALLOWED (TOTAL), COVERED DAYS, AND TOTAL CHARGE BY REVENUE CODE MUST BE > 0.		
1-165-07R	IF TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN BEGIN DATE OF CARE MUST BE < 10/01/2010		

ELEMENT NAME: CA/NAS NUMBER (1-170)			
	VALIDITY EDITS		
1-170-01V	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 ADMISSION DATE 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 - CCEP **OR**
		PF	ECHO **OR**
		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**
		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 ADMISSION DATE.
[2] MTF IS A 40 MILES CATCHMENT AREA.

ELEMENT NAME: CA/NAS NUMBER (1-170) (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 =	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**
		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**

[1] CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.
[2] MTF IS A 40 MILES CATCHMENT AREA.

ELEMENT NAME: CA/NAS NUMBER (1-170) (Continued)			
		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
1-170-02R	IF CA/NAS EXCEPTION REASON IS **NOT** BLANK		
	THEN CA/NAS NUMBER MUST = BLANK		
1-170-03R	IF CA/NAS EXCEPTION REASON = BLANK		
	AND PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316 (MENTAL HEALTH)		
	AND PATIENT ZIP CODE IS IN AN MTF[2] CATCHMENT AREA[1]		
	THEN CA/NAS NUMBER MUST BE CODED		
	UNLESS ANY OCCURRENCE OF OVERRIDE CODE =	C	GOOD FAITH PAYMENT
1-170-04R	IF CA/NAS NUMBER IS CODED		
	THEN CA/NAS EXCEPTION REASON MUST = BLANK		

[1] CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.
[2] MTF IS A 40 MILES CATCHMENT AREA.

ELEMENT NAME: CA/NAS REASON FOR ISSUANCE (1-175)	
VALIDITY EDITS	
1-175-01V	VALUE MUST BE A VALID CA/NAS REASON OF ISSUANCE.
RELATIONAL EDITS	
1-175-02R	IF CA/NAS NUMBER IS BLANK
	THEN CA/NAS REASON FOR ISSUANCE MUST = BLANK.

ELEMENT NAME: CA/NAS EXCEPTION REASON (1-180)			
	VALIDITY EDITS		
1-180-01V	VALUE MUST BE A VALID CA/NAS EXCEPTION REASON CODE OR BLANK (REFER TO SECTION 2.4).		
	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 ADMISSION DATE 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 - CCEP **OR**
		PF	ECHO **OR**
		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**
		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 ADMISSION DATE.
[2] MTF IS A 40 MILES CATCHMENT AREA.

ELEMENT NAME: CA/NAS EXCEPTION REASON (1-180) (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 =	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**

[1] CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.
[2] MTF IS A 40 MILES CATCHMENT AREA.

ELEMENT NAME: CA/NAS EXCEPTION REASON (1-180) (Continued)			
		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
1-180-03R	IF PATIENT ZIP CODE IS IN AN MTF[2] CATCHMENT AREA[1]		
	AND PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316 (MENTAL HEALTH)		
	AND CA/NAS NUMBER IS **NOT** CODED		
	THEN CA/NAS EXCEPTION REASON MUST BE CODED		
1-180-07R	IF CA/NAS EXCEPTION REASON =	5	RTC
	AND PATIENT ZIP CODE IS IN AN MTF[2] CATCHMENT AREA[1]		
	THEN TYPE OF INSTITUTION =	72	RTC
1-180-08R	IF CA/NAS EXCEPTION REASON =	S	HHA PPS
	THEN TYPE OF INSTITUTION MUST =	70	HHA
	AND ONE OCCURRENCE OF REVENUE CODE MUST =	0023	HHA PPS

[1] CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.
[2] MTF IS A 40 MILES CATCHMENT AREA.

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185)			
	VALIDITY EDITS		
1-185-01V	OCCURRENCE NUMBER 1--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8).		
1-185-02V	OCCURRENCE NUMBER 2--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8).		
1-185-03V	OCCURRENCE NUMBER 3--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8).		
1-185-04V	OCCURRENCE NUMBER 4--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8).		
1-185-05V	A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).		
1-185-06V	SPECIAL PROCESSING CODE OCCURRENCES MUST BE LEFT JUSTIFIED.		
1-185-07V	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		
1-185-08V	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		
1-185-10V	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		
1-185-11V	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		
1-185-14V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	ST	SPECIALIZED TREATMENT
	THEN BEGIN DATE OF CARE MUST BE < 10/01/2004		
	RELATIONAL EDITS		
1-185-08R	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
1-185-14R	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

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

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)			
	THEN ENROLLMENT/HEALTH PLAN CODE MUST =	SR	SHCP - REFERRED CARE **OR**
		SN	SHCP - NON-MTF REFERRED CARE **OR**
		SO	SHCP - NON-TRICARE ELIGIBLE **OR**
		ST	SHCP - TRICARE ELIGIBLE
1-185-32R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	E	HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP)
	THEN BEGIN DATE OF CARE IS ≥ 03/15/1999		
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	CM	ICMP
1-185-34R	• TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001. IF BEGIN DATE OF CARE IS < 10/01/2001, THE LINE ITEMS 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., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) **OR**
		FS	TFL (SECOND PAYOR)
	AND TYPE OF INSTITUTION ≠	10	GENERAL MEDICAL AND SURGICAL
	THEN BEGIN DATE OF CARE MUST BE ≥ 10/01/2001		
	AND ENROLLMENT/HEALTH PLAN CODE MUST =	FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD
	ELSE IF BEGIN DATE OF CARE IS < 10/01/2001		
	THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAILED LINE ITEM (EXCEPT LINE CONTAINING REVENUE CODE 0001) 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**

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

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)			
		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.
1-185-35R	• TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001 **UNLESS** THE BENEFICIARY IS AN INPATIENT AND THE ADMISSION DATE WAS PRIOR TO 10/01/2001, TFL WILL PAY FOR THE ENTIRE HOSPITAL STAY.		
	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., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) **OR**
		FS	TFL (SECOND PAYOR)
	AND TYPE OF INSTITUTION =	10	GENERAL MEDICAL AND SURGICAL
	THEN END DATE OF CARE MUST BE ≥ 10/01/2001		
	AND ENROLLMENT/HEALTH PLAN CODE MUST =	FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD
1-185-39R	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**
		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

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

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)			
1-185-49R	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[1] MUST BE ≥ 18 MONTHS		
1-185-50R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	49	HOSPITAL REIMBURSEMENT REDUCED BY MANUFACTURER CREDIT/REPLACEMENT OF DEVICE DURING WARRANTY PERIOD **OR**
		50	HOSPITAL REIMBURSEMENT REDUCED BY MANUFACTURER CREDIT/RECALLED DEVICE
	THEN DRG NUMBER MUST EQUAL A DRG SUBJECT TO THE REPLACEMENT DEVICE POLICY POSTED ON TRICARE'S DRG WEB PAGE AT HTTP://WWW.TRICARE.MIL/DRGRATES/.		
	AND DATE OF ADMISSION MUST BE ≥ THE DRG EFFECTIVE DATE AND ≤THE DRG TERMINATION DATE AS PER THE REPLACEMENT DEVICE POLICY POSTED ON TRICARE'S DRG WEB PAGE AT HTTP://WWW.TRICARE.MIL/DRGRATES/.		

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

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) SPECIAL ENTITLEMENT CODE (1-186)	
VALIDITY EDITS	
1-186-01V	MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE (REFER TO SECTION 2.5).
RELATIONAL EDITS	
	NONE

ELEMENT NAME: PRICING RATE CODE (1-190)			
	VALIDITY EDITS		
1-190-01V	VALUE MUST BE A VALID INSTITUTIONAL PRICING RATE CODE.		
	RELATIONAL EDITS		
1-190-01R	IF FILING STATE/COUNTRY CODE =	MD	MARYLAND
	THEN PRICING RATE CODE MUST ≠	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER **OR**
		I	TRICARE DRG REIMBURSEMENT WITH COST OUTLIER **OR**
		J	TRICARE DRG REIMBURSEMENT WITH NO OUTLIER
1-190-02R	IF DRG NUMBER IS CODED (OTHER THAN ZERO)		
	THEN PRICING RATE CODE MUST =	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER **OR**
		I	TRICARE DRG REIMBURSEMENT WITH COST OUTLIER **OR**
		J	TRICARE DRG REIMBURSEMENT WITH NO OUTLIER **OR**
		U	SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS **OR**
		V	MEDICARE REIMBURSEMENT RATE
1-190-03R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	11	HOSPICE
	THEN PRICING RATE CODE MUST =	D	DISCOUNT RATE AGREEMENT **OR**
		P	PER DIEM RATE AGREEMENT **OR**
		U	SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS **OR**
		V	MEDICARE REIMBURSEMENT RATE
	UNLESS TYPE OF SUBMISSION =	D	COMPLETE DENIAL
	OR AMOUNT ALLOWED (TOTAL) = ZERO		
1-190-04R	IF PRICING RATE CODE =	V	MEDICARE REIMBURSEMENT RATE
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) **AND** EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 **OR**
		FS	TFL (SECOND PAYOR) **OR**
		MN	TSP - NON-NETWORK **OR**
		MS	TSP - NETWORK
	OR TYPE OF INSTITUTION =	70	HHA **OR**
		76	SNF
1-190-05R	IF PRICING RATE CODE =	U	SHCP CLAIM OR ACTIVE DUTY MEMBER TPR CLAIM PAID OUTSIDE NORMAL LIMITS
	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**

ELEMENT NAME: PRICING RATE CODE (1-190) (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
1-190-06R	IF ANY OCCURRENCE OF REVENUE CODE =	0022	SNF - PPS
	THEN PRICING RATE CODE MUST =	D	DISCOUNT RATE AGREEMENT **OR**
		V	MEDICARE REIMBURSEMENT RATE
	UNLESS AMOUNT ALLOWED (TOTAL) = ZERO		
1-190-07R	IF ANY OCCURRENCE OF REVENUE CODE =	0023	HHA PPS
	THEN PRICING RATE CODE MUST =	D	DISCOUNT RATE AGREEMENT **OR**
		V	MEDICARE REIMBURSEMENT RATE
	UNLESS AMOUNT ALLOWED (TOTAL) = ZERO		
1-190-08R	IF PRICING RATE CODE =	CA	CAH REIMBURSEMENT
	THEN PROVIDER STATE OR COUNTRY CODE MUST =	AK	ALASKA
	AND DRG NUMBER MUST = BLANK		
	AND ADMISSION DATE MUST BE ≥ 07/01/2007		

ELEMENT NAME: PROVIDER STATE OR COUNTRY CODE (1-195)			
	VALIDITY EDITS		
1-195-01V	VALUE MUST BE A VALID STATE **OR** COUNTRY CODE (REFER TO ADDENDUM A OR ADDENDUM B)		
	RELATIONAL EDITS		
1-195-01R	PROVIDER STATE/COUNTRY CODE MUST MATCH THE CORRESPONDING RECORD[1] IN THE PROVIDER FILE.		
	UNLESS AMOUNT ALLOWED (TOTAL) ≤ ZERO		
	OR ADJUSTMENT/DENIAL REASON CODE =	38	SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS **OR**
		52	THE REFERRING/PRESCRIBING/RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/ PERFORM THE SERVICE BILLED **OR**
		B7	THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001
		FG	TFL (FIRST PAYOR - NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) **OR**
		FS	TFL (SECOND PAYOR) **OR**
		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
	THEN DO NOT CHECK FOR MATCH ON PROVIDER FILE		

[1] "CORRESPONDING RECORD" ON PROVIDER FILE IS BASED ON INSTITUTIONAL TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER ZIP CODE, AND TYPE OF INSTITUTION. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (1-200-02R).

- END -