

Institutional Edit Requirements (ELN 100 - 199)

Revision:



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 .	

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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/eMSM-REFERRED CARE OR SO SHCP - NON-TRICARE ELIGIBLE OR SR SHCP - MTF/eMSM REFERRED CARE OR ST SHCP - TRICARE ELIGIBLE
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AN SHCP - NON-MTF/eMSM-REFERRED CARE OR AR SHCP - MTF/eMSM REFERRED CARE OR CE SHCP - CCEP OR SC SHCP - NON-TRICARE ELIGIBLE OR SE SHCP - TRICARE ELIGIBLE OR SM SHCP - EMERGENCY
1-110-09R	<ul style="list-style-type: none"> 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.		

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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 O
	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		<ul style="list-style-type: none"> TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE \geq 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 \geq 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		<ul style="list-style-type: none"> 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 \geq 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.		

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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.	

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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 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 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 OR

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

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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 OR
		SC	SOUTH CONTRACT OR
		WC	WEST CONTRACT OR
		E7	EAST CONTRACT 2017 OR
		W7	WEST CONTRACT 2017
	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			

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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 ADDENDUM G, 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 ADDENDUM G, 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
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

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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 \geq 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 \neq 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

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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 \geq 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 \geq 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	

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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
1-145-04R	IF TYPE OF SUBMISSION =
	D COMPLETE DENIAL
THEN AMOUNT INTEREST PAYMENT MUST BE = 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	

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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	ALL OCCURRENCES OF OVERRIDE CODE MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED OVERRIDE CODE.		
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/eMSM-REFERRED CARE OR
		AR	SHCP - MTF/eMSM REFERRED CARE OR
		CE	SHCP - CCEP OR
		EU	EMERGENCY SERVICES RENDERED BY AN UNAUTHORIZED PROVIDER OR
		GU	SERVICE MEMBER 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/eMSM-REFERRED CARE OR
		SR	SHCP - MTF/eMSM REFERRED CARE

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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 DHA DATABASE		
	AND TYPE OF SUBMISSION ON THE EXISTING DHA 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.		
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
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

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ELEMENT NAME: TYPE OF SUBMISSION (1-165) (Continued)		
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	

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Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: CA/NAS NUMBER (1-170)	
VALIDITY EDITS	
1-170-01V	IF BEGIN DATE OF CARE ≥ 03/28/2013
	THEN CA/NAS NUMBER MUST BE BLANK
	ELSE 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 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) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
	AN SHCP - NON-MTF/eMSM-REFERRED CARE OR
	AR SHCP - MTF/eMSM 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 SERVICE MEMBER - USA OR
	X FOREIGN SERVICE MEMBER OR
	Y CHCBP - STANDARD OR
	Z TRICARE PRIME, MTF/eMSM/PCM OR
	AA CHCBP - EXTRA OR
	BB TSP OR
	FE TFL - EXTRA OR
	FS TFL - STANDARD OR
	SN SHCP - NON-MTF/eMSM-REFERRED CARE OR
¹ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.	
² MTF/eMSM IS A 40 MILES CATCHMENT AREA.	

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Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: CA/NAS NUMBER (1-170) (Continued)			
		SR	SHCP - MTF/eMSM REFERRED CARE OR
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE SERVICE MEMBER
	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.		
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/ 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/eMSM ² CATCHMENT AREA ¹		
	AND BEGIN DATE OF CARE IS < 03/28/2013		
	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		
¹ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.			
² MTF/eMSM IS A 40 MILES CATCHMENT AREA.			

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

THEN CA/NAS EXCEPTION REASON MUST = BLANK

¹ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.

² MTF/eMSM IS A 40 MILES CATCHMENT AREA.

ELEMENT NAME: CA/NAS REASON FOR ISSUANCE (1-175)

VALIDITY EDITS

1-175-01V IF BEGIN DATE OF CARE ≥ 03/28/2013

THEN CA/NAS REASON FOR ISSUANCE MUST BE BLANK

ELSE VALUE MUST BE A VALID CA/NAS REASON OF ISSUANCE **OR** BLANK.

RELATIONAL EDITS

1-175-02R IF CA/NAS NUMBER IS BLANK

THEN CA/NAS REASON FOR ISSUANCE MUST = BLANK.

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ELEMENT NAME: CA/NAS EXCEPTION REASON (1-180)	
VALIDITY EDITS	
1-180-01V	IF BEGIN DATE OF CARE ≥ 03/28/2013
	THEN CA/NAS EXCEPTION REASON MUST BE BLANK
	ELSE 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 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) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
	AN SHCP - NON-MTF/eMSM-REFERRED CARE OR
	AR SHCP - MTF/eMSM 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 SERVICE MEMBER - USA OR
	X FOREIGN SERVICE MEMBER OR
	Y CHCBP - STANDARD OR
	Z TRICARE PRIME, MTF/eMSM/PCM OR
	AA CHCBP - EXTRA OR
	BB TSP OR
	FE TFL - EXTRA OR
	FS TFL - STANDARD OR
	SN SHCP - NON-MTF/eMSM-REFERRED CARE OR
	SR SHCP - MTF/eMSM REFERRED CARE OR
¹ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.	
² MTF/eMSM IS A 40 MILES CATCHMENT AREA.	

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Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: CA/NAS EXCEPTION REASON (1-180) (Continued)		
	WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE SERVICE MEMBER
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.		
1-180-03R	IF PATIENT ZIP CODE IS IN AN MTF/eMSM ² CATCHMENT AREA ¹	
	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 IS NOT CODED	
	AND BEGIN DATE OF CARE IS < 03/28/2013	
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/eMSM 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
¹ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.		
² MTF/eMSM IS A 40 MILES CATCHMENT AREA.		

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ELEMENT NAME: CA/NAS EXCEPTION REASON (1-180) (Continued)	
AND ONE OCCURRENCE OF REVENUE	
CODE MUST =	0023 HHA PPS
¹ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.	
² MTF/eMSM IS A 40 MILES CATCHMENT AREA.	

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Institutional Edit Requirements (ELN 100 - 199)

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	ALL OCCURRENCES OF SPECIAL PROCESSING CODE MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED SPECIAL PROCESSING CODE.
1-185-07V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	AN SHCP - NON-MTF/eMSM-REFERRED CARE OR
	AR SHCP - MTF/eMSM 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 SERVICE MEMBER
	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/eMSM/PCM OR
	WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE SERVICE MEMBER OR
	XF FOREIGN ADFM
1-185-14R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	AN SHCP - NON-MTF/eMSM-REFERRED CARE OR
	AR SHCP - MTF/eMSM 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.	

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Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)		
THEN ENROLLMENT/HEALTH PLAN CODE MUST =	SR	SHCP - MTF/eMSM REFERRED CARE OR
	SN	SHCP - NON-MTF/eMSM 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	<ul style="list-style-type: none"> 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.		

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Institutional Edit Requirements (ELN 100 - 199)

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		<ul style="list-style-type: none"> 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
	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
¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.		

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Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)		
	420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
	421	TRR SURVIVOR FAMILY COVERAGE
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 IF END DATE OF CARE < 10/01/2014	
	THEN 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/ .	
	ELSE END DATE OF CARE MUST BE ≥ THE DRG EFFECTIVE DATE AND ≤ THE DRG TERMINATION DATE	
1-185-51R	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
¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.		

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ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)	
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
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
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	

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Institutional Edit Requirements (ELN 100 - 199)

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 OR
		DD	DISCOUNTED DRG
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 OR
		DD	DISCOUNTED DRG
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/eMSM-REFERRED CARE OR
		AR	SHCP - MTF/eMSM REFERRED CARE OR

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ELEMENT NAME: PRICING RATE CODE (1-190) (Continued)			
		CE	SHCP - CCEP OR
		GU	SERVICE MEMBER 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/eMSM-REFERRED CARE OR
		SR	SHCP - MTF/eMSM 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 ADMISSION DATE MUST BE ≥ 12/01/2009		
	UNLESS PROVIDER STATE OR COUNTRY CODE =	AK	ALASKA
	THEN ADMISSION DATE MUST BE ≥ 07/01/2007		
1-190-09R	IF PRICING RATE CODE =	CR	CCR
	THEN ADMISSION DATE MUST BE ≥ 01/01/2014.		
1-190-10R	IF PRICING RATE CODE =	CA	CAH REIMBURSEMENT
	AND ADMISSION DATE ≥ 01/01/2014.		
	THEN TYPE OF INSTITUTION MUST =	93	CAH

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Institutional Edit Requirements (ELN 100 - 199)

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 ADDENDUMS A OR 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 -