

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL  
 RECORD DATA ELEMENTS (M - O)

DATA ELEMENT DEFINITION

|   |                 |                    |                  |
|---|-----------------|--------------------|------------------|
| <b>ELEMENT NAME: NATIONAL DRUG CODE</b>   |                 |                    |                  |
| <b>RECORDS/LOCATOR NUMBERS</b>  |                 |                    |                  |
| <b>RECORD NAME</b>  | <b>LOCATOR#</b> | <b>OCCURRENCES</b> | <b>REQUIRED</b>  |
| Non-Institutional   | 2-170           | Up to 99           | Yes <sup>1</sup> |
| <b>PRIMARY PICTURE (FORMAT)</b> Eleven (11) alphanumeric characters.                                    |                 |                    |                  |
| <b>DEFINITION</b> Number assigned to pharmaceutical products by the Food and Drug Administration (FDA). |                 |                    |                  |
| <b>CODE/VALUE SPECIFICATIONS</b> Unique number assigned to include pharmaceutical by the FDA.           |                 |                    |                  |
| <b>ALGORITHM</b> N/A  |                 |                    |                  |
| <b>SUBORDINATE AND/OR GROUP ELEMENTS</b>  |                 |                    |                  |
| <b>SUBORDINATE</b>  |                 | <b>GROUP</b>       |                  |
| N/A   |                 | N/A                |                  |

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> Only required for Outpatient Drug claim. For non-pharmacy claims blank fill.

This data element must be present for Mail Order Pharmacy **and Retail Pharmacy.**

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DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (M - O)

DATA ELEMENT DEFINITION

**ELEMENT NAME: NUMBER OF SERVICES**

RECORDS/LOCATOR NUMBERS

| RECORD NAME       | LOCATOR# | OCCURRENCES | REQUIRED |
|-------------------|----------|-------------|----------|
| Non-Institutional | 2-175    | Up to 99    | Yes      |

**PRIMARY PICTURE (FORMAT)** Three (3) signed numeric digits.

**DEFINITION** Number of procedures performed/services or supplies rendered for medical, dental, and mental health care.

**CODE/VALUE SPECIFICATIONS** N/A

**ALGORITHM** Identical procedures must be combined when performed by the same provider, with the same charge for each, and within the same calendar month, provided the reason for allowance/denial is the same for each charge. For ambulance services, allergy testing, DME rental, POV mileage for **the Extended Care Health Option (ECHO)**, or anesthesiology, enter 01 for each service regardless of length of time, number of base units or mileage. Allowed prescription drugs must be combined separately from disallowed prescription drugs. For prescriptions report the number of prescriptions.

SUBORDINATE AND/OR GROUP ELEMENTS

| SUBORDINATE | GROUP |
|-------------|-------|
| N/A         | N/A   |

**NOTES AND SPECIAL INSTRUCTIONS:**

Number of Services should be reported as 999 for HCPCS J-codes when the actual quantity of the services on the claim form exceeds 999.

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**DATA ELEMENT DEFINITION**

**ELEMENT NAME:** OCCURRENCE/LINE ITEM NUMBER

**RECORDS/LOCATOR NUMBERS**

| RECORD NAME       | LOCATOR# | OCCURRENCES | REQUIRED |
|-------------------|----------|-------------|----------|
| Institutional     | 1-380    | Up to 450   | Yes      |
| Non-Institutional | 2-145    | Up to 99    | Yes      |

**PRIMARY PICTURE (FORMAT)** Three (3) numeric digits.

**DEFINITION** A unique number for each utilization/revenue data occurrence within the TED Record. Line item must be assigned in sequential ascending order.

**CODE/VALUE SPECIFICATIONS** N/A

**ALGORITHM** N/A

**SUBORDINATE AND/OR GROUP ELEMENTS**

| SUBORDINATE | GROUP |
|-------------|-------|
| N/A         | N/A   |

**NOTES AND SPECIAL INSTRUCTIONS:**

N/A

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DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (M - O)

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: OPPTS PAYMENT STATUS INDICATOR CODE**

**RECORDS/LOCATOR NUMBERS**

| <b>RECORD NAME</b>  | <b>LOCATOR#</b> | <b>OCCURRENCES</b>  | <b>REQUIRED</b>  |
|---|-----------------|---|------------------|
| Non-Institutional   | 2-331           | Up to 99  | Yes <sup>1</sup> |
| <b>PRIMARY PICTURE (FORMAT)</b> Two (2) alphanumeric characters.  |                 |   |                  |
| <b>DEFINITION</b> Identifies how a service or procedure is paid under the Outpatient Prospective Payment System (OPPS). |                 |   |                  |
| <b>CODE/VALUE SPECIFICATIONS</b>  | A               | Services paid under some payment method other than OPPTS (i.e., DME, prosthetics, DMEPOS fee schedule, or CMAC).  |                  |
|   | C               | Inpatient services not paid under the OPPTS.  |                  |
|   | E               | Items or services not covered by TRICARE or codes not recognized by TRICARE.  |                  |
|   | F               | Acquisition of corneal tissue and certain CRNA services paid on an allowable charge basis.  |                  |
|   | G               | Drug, biological or radiopharmaceutical agent paid under transitional pass-through.   |                  |
|   | H               | Devices paid under the OPPTS transitional pass-through rules and brachytherapy sources that are paid on an allowable charge basis.  |                  |
|   | K               | Drugs, biologicals (including blood and blood products) and certain radiopharmaceuticals agents that are paid in separate APCs under the OPPTS, but not paid under OPPTS transitional pass-through rules. |                  |
|   | N               | Incidental services, payment included in payment for another service or APC group.  |                  |

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> Required on all TED records reimbursed under Outpatient Prospective Payment System (OPPTS).

Refer to the TRICARE Reimbursement Manual, [Chapter 13, Section 3](#) for additional information and more complete definitions of the OPPTS Payment Status Indicator Codes. Must be left justified and blank filled.

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DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (M - O)

**DATA ELEMENT DEFINITION**

| <b>ELEMENT NAME: OPPTS PAYMENT STATUS INDICATOR CODE (CONTINUED)</b> |              |   |
|--|--------------|---|
| <b>CODE/VALUE SPECIFICATIONS<br/>(CONTINUED)</b>                     | P            | Services paid only in partial hospitalization programs.   |
|  | S            | Significant procedures allowed under the OPPTS but multiple procedure reduction does not apply. |
|  | T            | Surgical services allowed under the OPPTS with multiple procedure payment reduction.            |
|  | V            | Medical visits (including clinic or emergency department visits) allowed under the OPPTS.       |
|  | X            | Ancillary services allowed under the OPPTS.   |
| <b>ALGORITHM N/A</b>   |              |   |
| <b>SUBORDINATE AND/OR GROUP ELEMENTS</b>                             |              |   |
| <b>SUBORDINATE</b>   | <b>GROUP</b> |   |
| N/A  | N/A          |   |

**NOTES AND SPECIAL INSTRUCTIONS:**  
<sup>1</sup> Required on all TED records reimbursed under Outpatient Prospective Payment System (OPPS).  
  
Refer to the TRICARE Reimbursement Manual, Chapter 13, Section 3 for additional information and more complete definitions of the OPPTS Payment Status Indicator Codes. Must be left justified and blank filled.

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DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (M - O)

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) BEGIN REASON CODE**

**RECORDS/LOCATOR NUMBERS**

| <b>RECORD NAME</b>  | <b>LOCATOR#</b> | <b>OCCURRENCES</b>  | <b>REQUIRED</b>  |
|---|-----------------|---|------------------|
| Institutional   | 1-132           | 1   | Yes <sup>1</sup> |
| Non-Institutional   | 2-192           | Up to 99  | Yes <sup>1</sup> |
| <b>PRIMARY PICTURE (FORMAT)</b> One (1) alphanumeric character.   |                 |   |                  |
| <b>DEFINITION</b> The code that indicates the reason that the person's period of eligibility for a non-DoD Other Government Program began. Download field from DEERS. |                 |   |                  |
| <b>CODE/VALUE SPECIFICATIONS</b>  | A               | Eligible for Medicare. Eligibility began after age 65 (the person did not have enough quarters of Social Security contributions to qualify at age 65). This value applies to Medicare Part A.   |                  |
|   | B               | Enrollment in Medicare Part B; over or under age 65. Medicare Part B can only be obtained by payment of monthly premiums. This value applies to Medicare Part B.  |                  |
|   | D               | Eligible for Medicare under age 65 because of disability. This value applies to Medicare Part A.  |                  |
|   | E               | Eligible for Medicare at age 65. This value applies to Medicare Part A.   |                  |
|   | N               | Not eligible for Medicare. Under age 65 this is the default value. At age 65 this indicates eligibility could not begin because the person did not have enough quarters of Social Security contributions to qualify. This value applies to Medicare Part A. |                  |

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> If the DEERS response does not contain an OGP BEGIN REASON CODE, report 'W' in this field.

If person not on DEERS but claim is payable (i.e., government liability), report 'W' in this field.

**NOTE:** For Mail Order Pharmacy use the data element Medicare A Begin Reason Code from the DEERS inquiry/response to report this information. If the DEERS response does not contain an OGP BEGIN REASON CODE, report 'W' in this field.

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**DATA ELEMENT DEFINITION**

| <b>ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) BEGIN REASON CODE (CONTINUED)</b> |   |  |
|---|---|--|
| <b>CODE/VALUE SPECIFICATIONS (CONTINUED)</b>                                      |   |  |
|   | P | Eligible for Medicare at or after 65 because of purchase. This value applies to Medicare Part A.                         |
|   | R | Eligible for Medicare under age 65 because of end-stage renal disease. This value applies to Medicare Part A and Part B. |
|   | V | Eligible for the Civilian Health and Medical Program of the Department of Veteran's Affairs (CHAMPVA).                   |
|   | W | Not applicable.  |
| <b>ALGORITHM N/A</b>  |   |  |
| <b>SUBORDINATE AND/OR GROUP ELEMENTS</b>  |   |  |
| <b>SUBORDINATE</b>  |   | <b>GROUP</b>   |
| N/A   |   | N/A  |

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> If the DEERS response does not contain an OGP BEGIN REASON CODE, report 'W' in this field.

If person not on DEERS but claim is payable (i.e., government liability), report 'W' in this field.

**NOTE:** For Mail Order Pharmacy use the data element Medicare A Begin Reason Code from the DEERS inquiry/response to report this information. If the DEERS response does not contain an OGP BEGIN REASON CODE, report 'W' in this field.

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) TYPE CODE**

**RECORDS/LOCATOR NUMBERS**

| RECORD NAME   | LOCATOR# | OCCURRENCES | REQUIRED            |
|---|----------|-------------|---------------------|
| Institutional   | 1-131    | 1           | Yes                 |
| Non-Institutional   | 2-191    | Up to 99    | Yes                 |
| <b>PRIMARY PICTURE (FORMAT)</b> One (1) alphanumeric character.   |          |             |                     |
| <b>DEFINITION</b> The code that represents what type of other government program the person has. Download field from DEERS. |          |             |                     |
| <b>CODE/VALUE SPECIFICATIONS</b>  |          | A           | Medicare Part A     |
|   |          | B           | Medicare Part B     |
|   |          | C           | Medicare Part A & B |
|   |          | H           | Medicare HMO        |
|   |          | N           | No Medicare         |
|   |          | V           | CHAMPVA             |

**NOTES AND SPECIAL INSTRUCTIONS:**

**Instructions to submit the TED OGP TYPE CODE:**

1. If the DEERS response returns only one OGP TYPE CODE segment report the DEERS OGP TYPE CODE in the TED OGP TYPE CODE;
2. If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A' and "B" report a 'C' in the TED OGP TYPE CODE; or
3. If the DEERS response does not returns a OGP TYPE CODE segment report 'N' in the TED OGP TYPE CODE.
4. For Mail Order Pharmacy use the data element Medicare Coverage Type Code from DEERS inquiry/response to report this information. If DEERS response does not contain an OGP BEGIN REASON CODE, report 'N' in this field.

Contractors shall forward claims for beneficiaries who are age 65 or older to the TRICARE Dual Eligible Fiscal Intermediary Contractor when the DEERS response shows a Health Care Delivery Plan Code of 018, 020, 021, or 022, indicating TRICARE For Life or the response carries a Medicare Begin Reason Code of A, D, E, or R, indicating the patient has Medicare Part A.

Contractors shall forward claims for beneficiaries who are under 65 to the TRICARE Dual Eligible Fiscal Intermediary Contractor when the DEERS response carries a Medicare Begin Reason Code indicating the patient has Medicare Part A.

On receipt of the claim, the TRICARE Dual Eligible Fiscal Intermediary Contractor shall determine if a benefit exists. The forwarding regional MCSCs shall determine if a dual eligible benefit exists.

If person not on DEERS but claim is payable (i.e., government liability), report 'N' in this field.

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) TYPE CODE (CONTINUED)**

**ALGORITHM** N/A

**SUBORDINATE AND/OR GROUP ELEMENTS**

| SUBORDINATE | GROUP |
|-------------|-------|
| N/A         | N/A   |

**NOTES AND SPECIAL INSTRUCTIONS:**

Instructions to submit the TED OGP TYPE CODE:

1. If the DEERS response returns only one OGP TYPE CODE segment report the DEERS OGP TYPE CODE in the TED OGP TYPE CODE;
2. If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A' and "B" report a 'C' in the TED OGP TYPE CODE; or
3. If the DEERS response does not returns a OGP TYPE CODE segment report 'N' in the TED OGP TYPE CODE.
4. For Mail Order Pharmacy use the data element Medicare Coverage Type Code from DEERS inquiry/response to report this information. If DEERS response does not contain an OGP BEGIN REASON CODE, report 'N' in this field.

Contractors shall forward claims for beneficiaries who are age 65 or older to the TRICARE Dual Eligible Fiscal Intermediary Contractor when the DEERS response shows a Health Care Delivery Plan Code of 018, 020, 021, or 022, indicating TRICARE For Life or the response carries a Medicare Begin Reason Code of A, D, E, or R, indicating the patient has Medicare Part A.

Contractors shall forward claims for beneficiaries who are under 65 to the TRICARE Dual Eligible Fiscal Intermediary Contractor when the DEERS response carries a Medicare Begin Reason Code indicating the patient has Medicare Part A.

On receipt of the claim, the TRICARE Dual Eligible Fiscal Intermediary Contractor shall determine if a benefit exists. The forwarding regional MCSCs shall determine if a dual eligible benefit exists.

If person not on DEERS but claim is payable (i.e., government liability), report 'N' in this field.

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DATA ELEMENT DEFINITION

ELEMENT NAME: **VERRIDE CODE**

RECORDS/LOCATOR NUMBERS

| RECORD NAME       | LOCATOR# | OCCURRENCES | REQUIRED         |
|-------------------|----------|-------------|------------------|
| Institutional     | 1-160    | 3           | Yes <sup>1</sup> |
| Non-Institutional | 2-095    | 3           | Yes <sup>1</sup> |

**PRIMARY PICTURE (FORMAT)** Six (6) alphanumeric characters.

**DEFINITION** The group of three codes which indicate that certain questionable data has been identified and approved by the contractor and the normal editing and processing rules should be bypassed for this record.

| CODE/VALUE SPECIFICATIONS |    |  |
|---------------------------|----|--|
|                           | 11 | Claims retained by the contractor for development (information not available from in-house sources). (Effective 02/01/2000)  |
|                           | 12 | TPL claims requiring development. (Effective 02/01/2000)   |
|                           | 13 | Government intervention claims - pended up to 60 calendar days. (Benefit Changes, CMAC updates, etc.) (Effective 02/01/2000) |
|                           | 14 | Claims requiring intervention by another contractor. (Effective 02/01/2000)  |
|                           | 15 | Claims pended at government direction 60 calendar days and over. (Effective 02/01/2000)                                      |
|                           | A  | Patient is over 65. (Terminated 06/01/2003)  |
|                           | B  | Patient is a spouse under 12 years of age.   |
|                           | C  | Good faith claim; payment has been made.   |

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> Required if override code is applicable to override TMA edit checking. Each occurrence is two characters, left justify and blank fill each. Can report 1 to 3 codes, do not duplicate.

<sup>2</sup> Override codes 'H1' and 'H2' are only valid for [Chapter 2, Section 8.1](#) edits. Override codes 'H1' and 'H2' are to be submitted on adjustment TED records only to allow financial edit errors to clear when payment is made from the wrong Batch/Voucher ASAP Account Number.

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**DATA ELEMENT DEFINITION**

| <b>ELEMENT NAME: OVERRIDE CODE (CONTINUED)</b>   |   |   |
|--|---|---|
| <b>CODE/VALUE SPECIFICATIONS<br/>(CONTINUED)</b> | D | Patient is family member 21 years or older and over 18 for VA (over 18 for VA is no longer effective after 01/01/1996).                                     |
|  | E | Diagnosis is maternity; patient is under 12 years of age.   |
|  | F | Claim was filed after the filing deadline.  |
|  | G | Diagnosis/procedure code for female; sex indicates male.  |
|  | H | Diagnosis/procedure code for male, sex indicates female.  |
|  | I | Patient is a former spouse under 34 years of age.   |
|  | J | Successive admission (patient is family member of an active duty sponsor and cost-share is based on both current and prior admission). (Institutional Only) |
|  | K | Catastrophic loss protection limit reached, patient cost-share and deductible rules do not apply.   |
|  | M | NATO, Social Security Number not applicable.  |
|  | N | Retrospective payment - Inpatient Mental Health (Institutional Only)  |
|  | P | Reserved (to be used only with TMA authorization)   |
|  | Q | Former Spouse with Pre-Existing Condition   |

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> Required if override code is applicable to override TMA edit checking. Each occurrence is two characters, left justify and blank fill each. Can report 1 to 3 codes, do not duplicate.

<sup>2</sup> Override codes 'H1' and 'H2' are only valid for [Chapter 2, Section 8.1](#) edits. Override codes 'H1' and 'H2' are to be submitted on adjustment TED records only to allow financial edit errors to clear when payment is made from the wrong Batch/Voucher ASAP Account Number.

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DATA ELEMENT DEFINITION

| ELEMENT NAME: OVERRIDE CODE (CONTINUED)  |  |
|--|--|
| CODE/VALUE SPECIFICATIONS<br>(CONTINUED) | R<br>Person birth calendar date (patient) is not consistent with diagnosis/ procedure code age restricting; procedure performed due to medical necessity.  |
|  | S<br>Zip code override to be used when:<br><br>1. A beneficiary has moved out of a region and the contractor is still responsible for the care claimed; or<br><br>2. If a beneficiary resides in a region different from the region they are enrolled in, but are within the same contract jurisdiction. |
|  | U<br>Beneficiary indemnification payment   |
|  | V<br>Active Duty Family Member (ADFM), services provided in TRICARE Europe, Pacific or Latin America & Canada including the Caribbean Basin. (Effective 06/28/1996)  |
|  | Y<br>Newborn in mother's room without nursery charges. (Institutional Only)  |
|  | Z<br>Enhanced benefit  |
|  | H1 <sup>2</sup><br>Benefit payment made using incorrect BATCH/VOUCHER ASAP Number, contractor error.   |
|  | H2 <sup>2</sup><br>Benefit payment made using incorrect BATCH/VOUCHER ASAP Number, Government caused error.  |

NOTES AND SPECIAL INSTRUCTIONS:

<sup>1</sup> Required if override code is applicable to override TMA edit checking. Each occurrence is two characters, left justify and blank fill each. Can report 1 to 3 codes, do not duplicate.

<sup>2</sup> Override codes 'H1' and 'H2' are only valid for [Chapter 2, Section 8.1](#) edits. Override codes 'H1' and 'H2' are to be submitted on adjustment TED records only to allow financial edit errors to clear when payment is made from the wrong Batch/Voucher ASAP Account Number.

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**DATA ELEMENT DEFINITION**

|  |    |  |
|--|----|--|
| <b>ELEMENT NAME: OVERRIDE CODE (CONTINUED)</b> |    |  |
| <b>CODE/VALUE SPECIFICATIONS (CONTINUED)</b>   | NC | Non-Certified Providers (does not include sanctioned/suspended providers) (Effective 08/01/2003) |
| <b>ALGORITHM</b> N/A                           |    |  |
| <b>SUBORDINATE AND/OR GROUP ELEMENTS</b>       |    |  |
| <b>SUBORDINATE</b>                             |    | <b>GROUP</b>   |
| N/A  |    | PROCESSING INFORMATION   |

**NOTES AND SPECIAL INSTRUCTIONS:**

- <sup>1</sup> Required if override code is applicable to override TMA edit checking. Each occurrence is two characters, left justify and blank fill each. Can report 1 to 3 codes, do not duplicate.
- <sup>2</sup> Override codes 'H1' and 'H2' are only valid for [Chapter 2, Section 8.1](#) edits. Override codes 'H1' and 'H2' are to be submitted on adjustment TED records only to allow financial edit errors to clear when payment is made from the wrong Batch/Voucher ASAP Account Number.

