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

DATA ELEMENT DEFINITION

ELEMENT NAME: NATIONAL DRUG CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-170	Up to 99	Yes[1]

PRIMARY PICTURE (FORMAT)	Eleven (11) alphanumeric characters.
DEFINITION	Number assigned to pharmaceutical products by the Food and Drug Administration (FDA).
CODE/VALUE SPECIFICATIONS	Unique number assigned to include pharmaceutical by the FDA.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **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.

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 and combining procedures does not conflict with other TED record requirements (i.e., Number of Services field size). For ambulance services, allergy testing, DME rental, or POV mileage for the Extended Care Health Option (ECHO), enter 01 for each service regardless of number of units or mileage. When multiple units are used in a single episode of care, such as one box of twelve syringes, code only one (1) supply or service. 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.

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

DATA ELEMENT DEFINITION

ELEMENT NAME: OPPS PAYMENT STATUS INDICATOR CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-331	Up to 99	Yes[1]

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.	
DEFINITION	Identifies how a service or procedure is paid under the Outpatient Prospective Payment System (OPPS).	
CODE/VALUE SPECIFICATIONS	A	Services paid under some payment method other than OPPS (i.e., DME, prosthetics, DMEPOS fee schedule, or CMAC).
	B	More appropriate code required for TRICARE OPPS.
	C	Inpatient services not paid under the OPPS.
	E	Items or services not covered by TRICARE.
	F	Acquisition of corneal tissue and certain CRNA services and Hepatitis B vaccines paid on an allowable charge basis.
	G	Drug, biological pass-through paid in separate APCs under the OPPS.
	H	Pass-through device categories, brachytherapy sources, and radiopharmaceutical agents allowed on a cost basis.
	K	Non-pass-through drugs and biologicals and blood and blood products paid in separate APCs under the OPPS.
	N	Incidental services, payment included in payment for another service or APC group.

NOTES AND SPECIAL INSTRUCTIONS:

[1] **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 OPPS Payment Status Indicator Codes. Must be left justified and blank filled.

DATA ELEMENT DEFINITION

ELEMENT NAME: OPPS PAYMENT STATUS INDICATOR CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	P	Services paid only in partial hospitalization programs.
	Q	Paid under OPPS; services either packaged or separately payable depending on the specific circumstances of the HCPCS billing. OCE logic will be applied in determining if the services will be packaged or separately payable.
	S	Significant procedures allowed under the OPPS but multiple procedure reduction does not apply.
	T	Surgical services allowed under the OPPS with multiple procedure payment reduction.
	V	Medical visits (including clinic or emergency department visits) allowed under the OPPS.
	W	Invalid HCPCS or invalid revenue code with blank HCPCS.
	X	Ancillary services allowed under the OPPS.
	Z	Valid revenue code with blank HCPCS and no other SI assigned.
ALGORITHM N/A		

SUBORDINATE AND/OR GROUP ELEMENTS	
SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **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 OPPS Payment Status Indicator Codes. Must be left justified and blank filled.

DATA ELEMENT DEFINITION

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

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-132	1	Yes[1]
Non-Institutional	2-192	Up to 99	Yes[1]

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.
DEFINITION	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.

CODE/VALUE SPECIFICATIONS		
	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.
	F	Eligibility for Medicare defaulted at age 65; verification not received from Center for Medicare and Medicaid Services (CMS). Applies to Medicare Part A only.

NOTES AND SPECIAL INSTRUCTIONS:

[1] **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) BEGIN REASON CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	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.
	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.
ALGORITHM N/A		

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **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

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.
DEFINITION	The code that represents what type of other government program the person has. Download field from DEERS.
CODE/VALUE SPECIFICATIONS	A Medicare Part 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; unless the DEERS response returns OGP TYPE CODE value 'D' then report 'H' 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.**
3. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A' and 'D' report a 'I' in the TED OGP TYPE CODE.**
4. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'B' and 'D' report a 'J' in the TED OGP TYPE CODE.**
5. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A', 'B', and 'D' report a 'L' in the TED OGP TYPE CODE.**
6. **If the DEERS response does not returns a OGP TYPE CODE segment report 'N' in the TED OGP TYPE CODE.**
7. **For Mail Order Pharmacy and Retail Pharmacy, the Medicare Coverage Type Code from the DEERS inquiry/response should be reported in the TED OGP TYPE CODE.**

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

On receipt of the claim, the TDEFIC 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)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	B	Medicare Part B
	C	Medicare Part A & B
	H	Medicare Part D
	I	Medicare Part A & D
	J	Medicare Part B & D
	L	Medicare Part A, B, & D
	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; unless the DEERS response returns OGP TYPE CODE value 'D' then report 'H' 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.**
3. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A' and 'D' report a 'I' in the TED OGP TYPE CODE.**
4. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'B' and 'D' report a 'J' in the TED OGP TYPE CODE.**
5. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A', 'B', and 'D' report a 'L' in the TED OGP TYPE CODE.**
6. **If the DEERS response does not returns a OGP TYPE CODE segment report 'N' in the TED OGP TYPE CODE.**
7. **For Mail Order Pharmacy and Retail Pharmacy, the Medicare Coverage Type Code from the DEERS inquiry/response should be reported in the TED OGP TYPE CODE.**

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

On receipt of the claim, the TDEFIC 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; unless the DEERS response returns OGP TYPE CODE value 'D' then report 'H' 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.**
3. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A' and 'D' report a 'I' in the TED OGP TYPE CODE.**
4. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'B' and 'D' report a 'J' in the TED OGP TYPE CODE.**
5. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A', 'B', and 'D' report a 'L' in the TED OGP TYPE CODE.**
6. **If the DEERS response does not returns a OGP TYPE CODE segment report 'N' in the TED OGP TYPE CODE.**
7. **For Mail Order Pharmacy and Retail Pharmacy, the Medicare Coverage Type Code from the DEERS inquiry/response should be reported in the TED OGP TYPE CODE.**

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

On receipt of the claim, the TDEFIC 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: OVERRIDE CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-160	3	Yes[1]
Non-Institutional	2-095	3	Yes[1]

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)

NOTES AND SPECIAL INSTRUCTIONS:

[1] **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.**

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.

Clarification on use of Override Codes 'H1' and 'H2":

Failure to group TED records under the correct voucher header impairs the government's ability to ensure adequate funding is available to meet government payment obligations. The funding availability validation is performed on initial submissions only based on amounts reported in the voucher header, therefore it is imperative that contractors group claims (benefit costs) under the correct BATCH/ VOUCHER CLIN/ASAP Account Number on the Initial Submission.

Many of the Financial Edits in Chapter 2, Section 8.1 try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/ VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any Chapter 2, Section 8.1 edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

Contractor must have prior government approval specific to error condition before code 'H2' can be used on TED records, usage will be monitored by TMA, CRM.

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	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)

NOTES AND SPECIAL INSTRUCTIONS:

[1] **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.**

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.

Clarification on use of Override Codes 'H1' and 'H2":

Failure to group TED records under the correct voucher header impairs the government's ability to ensure adequate funding is available to meet government payment obligations. The funding availability validation is performed on initial submissions only based on amounts reported in the voucher header, therefore it is imperative that contractors group claims (benefit costs) under the correct BATCH/ VOUCHER CLIN/ASAP Account Number on the Initial Submission.

Many of the Financial Edits in Chapter 2, Section 8.1 try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/ VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any Chapter 2, Section 8.1 edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

Contractor must have prior government approval specific to error condition before code 'H2' can be used on TED records, usage will be monitored by TMA, CRM.

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	B	Patient is a spouse under 12 years of age.
	C	Good faith claim; payment has been made.
	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.

NOTES AND SPECIAL INSTRUCTIONS:

[1] **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.**

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.

Clarification on use of Override Codes 'H1' and 'H2":

Failure to group TED records under the correct voucher header impairs the government's ability to ensure adequate funding is available to meet government payment obligations. The funding availability validation is performed on initial submissions only based on amounts reported in the voucher header, therefore it is imperative that contractors group claims (benefit costs) under the correct BATCH/ VOUCHER CLIN/ASAP Account Number on the Initial Submission.

Many of the Financial Edits in Chapter 2, Section 8.1 try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/ VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any Chapter 2, Section 8.1 edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

Contractor must have prior government approval specific to error condition before code 'H2' can be used on TED records, usage will be monitored by TMA, CRM.

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	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.

NOTES AND SPECIAL INSTRUCTIONS:

[1] **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.**

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.

Clarification on use of Override Codes 'H1' and 'H2":

Failure to group TED records under the correct voucher header impairs the government's ability to ensure adequate funding is available to meet government payment obligations. The funding availability validation is performed on initial submissions only based on amounts reported in the voucher header, therefore it is imperative that contractors group claims (benefit costs) under the correct BATCH/ VOUCHER CLIN/ASAP Account Number on the Initial Submission.

Many of the Financial Edits in Chapter 2, Section 8.1 try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/ VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any Chapter 2, Section 8.1 edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

Contractor must have prior government approval specific to error condition before code 'H2' can be used on TED records, usage will be monitored by TMA, CRM.

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	N	Retrospective payment - Inpatient Mental Health (Institutional Only)
	P	Reserved (to be used only with TMA authorization)
	Q	Former Spouse with Pre-Existing Condition
	R	Person birth calendar date (patient) is not consistent with diagnosis/ procedure code age restricting; procedure performed due to medical necessity.

NOTES AND SPECIAL INSTRUCTIONS:

[1] **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.**

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.

Clarification on use of Override Codes 'H1' and 'H2":

Failure to group TED records under the correct voucher header impairs the government's ability to ensure adequate funding is available to meet government payment obligations. The funding availability validation is performed on initial submissions only based on amounts reported in the voucher header, therefore it is imperative that contractors group claims (benefit costs) under the correct BATCH/ VOUCHER CLIN/ASAP Account Number on the Initial Submission.

Many of the Financial Edits in Chapter 2, Section 8.1 try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/ VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any Chapter 2, Section 8.1 edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

Contractor must have prior government approval specific to error condition before code 'H2' can be used on TED records, usage will be monitored by TMA, CRM.

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	S	Zip code override to be used when: **1.** A beneficiary has moved out of a region and the contractor is still responsible for the care claimed; or **2.** If a beneficiary resides in a region different from the region they are enrolled in, but are within the same contract jurisdiction.
	U	Beneficiary indemnification payment

NOTES AND SPECIAL INSTRUCTIONS:

[1] **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.**

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.

Clarification on use of Override Codes 'H1' and 'H2":

Failure to group TED records under the correct voucher header impairs the government's ability to ensure adequate funding is available to meet government payment obligations. The funding availability validation is performed on initial submissions only based on amounts reported in the voucher header, therefore it is imperative that contractors group claims (benefit costs) under the correct BATCH/ VOUCHER CLIN/ASAP Account Number on the Initial Submission.

Many of the Financial Edits in Chapter 2, Section 8.1 try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/ VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any Chapter 2, Section 8.1 edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

Contractor must have prior government approval specific to error condition before code 'H2' can be used on TED records, usage will be monitored by TMA, CRM.

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	V	Active Duty Family Member (ADFM), services provided in TRICARE Europe, Pacific or Latin America & Canada including the Caribbean Basin. (Effective 06/28/1996)
	Y	Newborn in mother's room without nursery charges. (Institutional Only)
	Z	Enhanced benefit
	H1[2]	Benefit payment made using incorrect BATCH/VOUCHER ASAP Number, contractor error.

NOTES AND SPECIAL INSTRUCTIONS:

[1] **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.**

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.

Clarification on use of Override Codes 'H1' and 'H2":

Failure to group TED records under the correct voucher header impairs the government's ability to ensure adequate funding is available to meet government payment obligations. The funding availability validation is performed on initial submissions only based on amounts reported in the voucher header, therefore it is imperative that contractors group claims (benefit costs) under the correct BATCH/ VOUCHER CLIN/ASAP Account Number on the Initial Submission.

Many of the Financial Edits in Chapter 2, Section 8.1 try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/ VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any Chapter 2, Section 8.1 edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

Contractor must have prior government approval specific to error condition before code 'H2' can be used on TED records, usage will be monitored by TMA, CRM.

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	H2[2]	Benefit payment made using incorrect BATCH/VOUCHER ASAP Number, Government caused error.
	NC	Non-Certified Providers (does not include sanctioned/suspended providers) (Effective 08/01/2003)
ALGORITHM N/A		

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	PROCESSING INFORMATION

NOTES AND SPECIAL INSTRUCTIONS:

[1] **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.**

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.

Clarification on use of Override Codes 'H1' and 'H2":

Failure to group TED records under the correct voucher header impairs the government's ability to ensure adequate funding is available to meet government payment obligations. The funding availability validation is performed on initial submissions only based on amounts reported in the voucher header, therefore it is imperative that contractors group claims (benefit costs) under the correct BATCH/ VOUCHER CLIN/ASAP Account Number on the Initial Submission.

Many of the Financial Edits in Chapter 2, Section 8.1 try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/ VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any Chapter 2, Section 8.1 edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

Contractor must have prior government approval specific to error condition before code 'H2' can be used on TED records, usage will be monitored by TMA, CRM.