

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PERSON SEX (PATIENT) (1-100)	
VALIDITY EDITS	
1-100-01V	MUST BE =
	F FEMALE OR
	M MALE OR
	Z NOT PROVIDED FROM DEERS
RELATIONAL EDITS	
	NONE
ELEMENT NAME: PATIENT ZIP CODE (1-105)	
VALIDITY EDITS	
1-105-01V	MUST BE 9 DIGITS OR 5 DIGITS WITH 4 BLANKS
	MUST BE A VALID ZIP CODE (BASED ON ADMISSION DATE) IN THE GOVERNMENT PROVIDED ELECTRONIC ZIP CODE FILE OR
	MUST BE A 3 CHARACTER FOREIGN COUNTRY CODE (BASED ON THE COUNTRY CODES TABLE ¹) FOLLOWED BY 6 BLANKS
RELATIONAL EDITS	
NO ERROR	IF ADMISSION DATE IS OLDER THAN 6 YEARS
	THEN DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA ⁴
1-105-01R	IF CA/NAS EXCEPTION REASON IS CODED
	THEN PATIENT ZIP CODE MUST BE WITHIN AN MTF ³ CATCHMENT AREA ⁴
¹ WHEN FOREIGN COUNTRY CODES ARE SUBMITTED, THE FIRST 3 CHARACTERS WILL BE EDITED AGAINST CHAPTER 2, ADDENDUM A . ² STSF IS A REGIONAL 200 MILES, 48 CONTIGUOUS STATES, OR MULTI-REGIONAL CATCHMENT AREA, DEPENDING ON TYPE OF STSF BEING PROCESSED. ³ MTF IS A 40 MILES CATCHMENT AREA. ⁴ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.	

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (1-110)	
VALIDITY EDITS	
1-110-01V	MUST BE A VALID ENROLLMENT/HEALTH PLAN CODE (REFER TO CHAPTER 2, SECTION 2.5)
1-110-02V	IF ENROLLMENT/HEALTH PLAN CODE =
	SO SHCP - NON-TRICARE ELIGIBLE OR
	ST SHCP - TRICARE ELIGIBLE
	THEN BEGIN DATE OF CARE MUST BE < 06/01/2004
1-110-03V	IF ENROLLMENT/HEALTH PLAN CODE =
	TS TSS
	THEN BEGIN DATE OF CARE MUST BE < 12/31/2002
1-110-04V	IF ENROLLMENT/HEALTH PLAN CODE =
	BB TSP
	THEN BEGIN DATE OF CARE MUST BE < 12/31/2001
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
1-110-03R	IF ENROLLMENT/HEALTH PLAN CODE =
	W TPR ADSM - USA
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =
	GU ADSM ENROLLED IN TPR
1-110-05R	IF ENROLLMENT/HEALTH PLAN CODE =
	BB TSP
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =
	MN TSP - NON-NETWORK OR
	MS TSP - NETWORK
1-110-06R	IF ENROLLMENT/HEALTH PLAN CODE =
	SN SHCP - NON-MTF-REFERRED CARE OR
	SO SHCP - NON-TRICARE ELIGIBLE OR
	SR SHCP - REFERRED CARE OR
	ST SHCP - TRICARE ELIGIBLE
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =
	AN SHCP - NON-MTF-REFERRED CARE OR
	AR SHCP - REFERRED CARE OR
	CE SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM 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)	
	SC SHCP - NON-TRICARE ELIGIBLE OR
	SE SHCP - TRICARE ELIGIBLE OR
	SM SHCP - EMERGENCY
1-110-07R	IF ENROLLMENT/HEALTH PLAN CODE = Z TRICARE PRIME, MTF/PCM
	THEN ADMISSION DATE MUST BE ≥ 10/01/1997
1-110-08R	IF ENROLLMENT/HEALTH PLAN CODE = TS TSS
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = SN TSS - NON-NETWORK OR
	SS TSS - NETWORK
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 LINE ITEMS 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 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
	30 PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING OR RESIDENCY REQUIREMENTS 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)

	31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED OR
	32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED OR
	33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE OR
	34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORN OR
	62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION OR
	141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE

1-110-10R • TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE $\geq 10/01/2001$ **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 • TFL CLAIMS: THE PATIENT MUST BE 64 YEARS AND 11 MONTHS OR GREATER. IF THE PATIENT IS LESS THAN THIS AGE THE LINE ITEMS 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 AGE¹ MUST BE ≥ 64 YEARS AND 11 MONTHS

ELSE IF PATIENT AGE¹ IS < 64 YEARS AND 11 MONTHS

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

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

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
	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
1-110-12R	IF ENROLLMENT/HEALTH PLAN CODE =	WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM

THEN BEGIN DATE OF CARE IS ≥ 09/01/2002

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

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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 [CHAPTER 2, ADDENDUM M](#).

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
	THEN ENROLLMENT/ HEALTH PLAN CODE MUST =	T	TRICARE STANDARD OR
		V	TRICARE EXTRA OR
		FE	TFL - EXTRA OR
		FS	TFL - STANDARD OR
		PS	TSRx OR
		SR	SHCP-REFERRED CARE

1-111-02R	IF HCDP PLAN COVERAGE CODE =	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
		405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111)	
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
<p>THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE CAN =</p>	
PF	ECHO

ELEMENT NAME: REGION INDICATOR (1-112)	
VALIDITY EDITS	
1-112-01V	MUST BE VALID REGION INDICATOR (REFER TO CHAPTER 2, 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
	SC SOUTH CONTRACT OR
	WC WEST CONTRACT
<p>THEN ADJUSTMENT KEY MUST =</p>	
	0 BATCH OR
	5 VOUCHER
RELATIONAL EDITS	
NONE	

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (1-115)

VALIDITY EDITS

1-115-01V	MUST BE A VALID 4 DIGIT PCM LOCATION DMIS-ID.		
1-115-02V	• REVISED FINANCING		
	IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE OR
		6	VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE
	AND ENROLLMENT/HEALTH PLAN CODE =	Z	TRICARE PRIME, MTF/CLINIC
	AND TYPE OF SUBMISSION ≠	B	ADJUTMENT NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN PCM LOCATION DMIS-ID MUST EQUAL A VALID MTF/CLINIC DMIS-ID ¹		
	AND CANNOT = 6501, 6901-6915, 6917-6919, 7901-7912, 7916 ² -7919, 8000-8099, OR BLANK		

RELATIONAL EDITS

NO ERROR	IF ANY OCCURRENCE OF OVERRIDE CODE =	S	ZIP CODE OVERRIDE TO BE USED WHEN A BENEFICIARY HAS MOVED OUT OF A REGION AND THE CONTRACTOR IS STILL RESPONSIBLE FOR THE CARE CLAIMED; OR IF A BENEFICIARY RESIDES IN A REGION DIFFERENT FROM THE REGION THEY ARE ENROLLED IN-- WITHIN THE SAME CONTRACT JURISDICTION
	THEN BYPASS ALL PCM LOCATION DMIS-ID RELATIONAL EDITING.		
1-115-01R	IF DATE OF ADMISSION ≥ 10/01/1997		
	AND ENROLLMENT/HEALTH PLAN CODE =	BB	TSP
	THEN PCM LOCATION DMIS-ID MUST BE A VALID MTF/CLINIC DMIS-ID ¹		
	AND CANNOT = 6501, 6901-6915, 6917-6919, 7901-7912, 7916 ² -7919, 8000-8099, OR BLANK.		
1-115-02R	IF DATE OF ADMISSION ≥ 10/01/1999		
	AND ENROLLMENT/HEALTH PLAN CODE =	SR	SHCP - REFERRED CARE
	THEN PCM LOCATION DMIS-ID MUST EQUAL A VALID MTF/CLINIC DMIS-ID ¹		
	AND CANNOT = 6501, 6901-6915, 6917-6919, 7901-7912, 7916 ² -7919, OR 8000-8099		
1-115-04R	IF DATE OF ADMISSION ≥ 10/01/1997 AND < 09/01/2002		
	AND ENROLLMENT/HEALTH PLAN CODE =	U	TRICARE PRIME, CIVILIAN PCM
	AND REGION INDICATOR =	B	BLANK OR
		NC	NORTH CONTRACT
	THEN DMIS-ID MUST = 6901, 6902, 6905, OR 8000-8099		

¹ A VALID MTF/CLINIC DMIS-ID MEANS ONE THAT MATCHES THE DOD DMIS-ID LISTING.

² 7916 IS THE DMIS-ID FOR ALASKA.

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ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (1-115) (CONTINUED)	
	OR REGION INDICATOR = h BLANK OR
	SC SOUTH CONTRACT
	THEN DMIS-ID MUST = 6903, 6904, 6906, 6913, 6914, OR 6915
	OR REGION INDICATOR = h BLANK OR
	WC WEST CONTRACT
	THEN DMIS-ID MUST = 6907, 6908, 6909, 6910, 6911, OR 6912
1-115-05R	IF DATE OF ADMISSION ≥ 10/01/1997 AND < 10/01/1999
	AND ENROLLMENT/HEALTH PLAN CODE =
	W TPR AD SM - USA
	AND REGION INDICATOR = h BLANK OR
	NC NORTH CONTRACT
	THEN DMIS-ID MUST = 7901, 7902, 7905, 8000-8099, OR BLANK
1-115-06R	IF DATE OF ADMISSION ≥ 10/01/1999 AND < 09/01/2002
	AND ENROLLMENT/HEALTH PLAN CODE =
	W TPR AD SM - USA
	AND REGION INDICATOR = h BLANK OR
	NC NORTH CONTRACT
	THEN DMIS-ID MUST = 7901, 7902, 7905, OR 8000-8099
	OR REGION INDICATOR = h BLANK OR
	SC SOUTH CONTRACT
	THEN DMIS-ID MUST = 7903, 7904, OR 7906
	OR REGION INDICATOR = h BLANK OR
	WC WEST CONTRACT
	THEN DMIS-ID MUST = 7907, 7908, 7909, 7910, 7911, 7912, OR 7916 ²
1-115-07R	IF DATE OF ADMISSION ≥ 10/01/1997
	AND ENROLLMENT/HEALTH PLAN CODE ≠
	U TRICARE PRIME, CIVILIAN PCM OR
	W TPR AD SM - USA OR
	X FOREIGN AD SM OR
	Z TRICARE PRIME, MTF/CLINIC OR
	BB TSP OR
	SN SHCP - NON-MTF REFERRED CARE OR
	SR SHCP - REFERRED CARE OR
	WA TPR FOREIGN AD SM OR
	WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE AD SM OR
	WO TPR FOREIGN ADFM OR
	XF FOREIGN ADFM
	THEN PCM LOCATION DMIS-ID MUST = h BLANK

¹ A VALID MTF/CLINIC DMIS-ID MEANS ONE THAT MATCHES THE DOD DMIS-ID LISTING.

² 7916 IS THE DMIS-ID FOR ALASKA.

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ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (1-115) (CONTINUED)

UNLESS HCDP PLAN COVERAGE CODE =	140	TRICARE PLUS WITH CHC COVERAGE FOR ADFM _s OR
	141	TRICARE PLUS COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	142	TRICARE PLUS WITH CHC COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	143	TRICARE PLUS COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	144	TRICARE PLUS WITH CHC COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	145	TRICARE PLUS COVERAGE FOR RETIRED SPONSORS, FAMILY MEMBERS AND MEDAL OF HONOR OR
	146	TRICARE PLUS WITH CHC COVERAGE FOR RETIRED SPONSORS, FAMILY MEMBERS AND MEDAL OF HONOR OR
	147	TRICARE PLUS WITH CHC COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/ RESERVE DECEASED SPONSORS OR
	148	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	149	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED OR
	150	TRICARE PLUS COVERAGE FOR ADFM _s OR
	151	TRICARE PLUS COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/ RESERVE DECEASED SPONSORS

1-115-08R	IF DATE OF ADMISSION ≥ 09/01/2002	
	AND ENROLLMENT/HEALTH PLAN CODE =	U TRICARE PRIME, CIVILIAN PCM
	AND REGION INDICATOR =	h BLANK OR
		NC NORTH CONTRACT
	THEN DMIS-ID MUST = 6901, 6902, 6905, 6917, 8007, OR 8009	
	OR REGION INDICATOR =	h BLANK OR
		SC SOUTH CONTRACT
	THEN DMIS-ID MUST = 6903, 6904, 6906, 6913, 6914, 6915, OR 6918	
	OR REGION INDICATOR =	h BLANK OR
		WC WEST CONTRACT
	THEN DMIS-ID MUST = 6907, 6908, 6909, 6910, 6911, 6912, OR 6919	

1-115-09R	IF DATE OF ADMISSION ≥ 09/01/2002	
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¹ A VALID MTF/CLINIC DMIS-ID MEANS ONE THAT MATCHES THE DOD DMIS-ID LISTING.

² 7916 IS THE DMIS-ID FOR ALASKA.

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ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (1-115) (CONTINUED)

AND ENROLLMENT/HEALTH PLAN CODE =	W	TPR ADSM - USA OR
	WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
AND REGION INDICATOR =	b	BLANK OR
	NC	NORTH CONTRACT
THEN DMIS-ID MUST =	7901, 7902, 7905, OR 7917	
OR REGION INDICATOR =	b	BLANK OR
	SC	SOUTH CONTRACT
THEN DMIS-ID MUST =	7903, 7904, 7906, OR 7918	
OR REGION INDICATOR =	b	BLANK OR
	WC	WEST CONTRACT
THEN DMIS-ID MUST =	7907, 7908, 7909, 7910, 7911, 7912, 7916 ² , OR 7919	

1-115-10R IF DATE OF ADMISSION ≥ 09/01/2003

AND ENROLLMENT/HEALTH PLAN CODE =	WA	TPR FOREIGN ADSM OR
	WO	TPR FOREIGN ADFM OR
	XF	FOREIGN ADFM
THEN DMIS-ID MUST ≠	BLANK	

¹ A VALID MTF/CLINIC DMIS-ID MEANS ONE THAT MATCHES THE DOD DMIS-ID LISTING.

² 7916 IS THE DMIS-ID FOR ALASKA.

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

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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 OCCURRENCE/LINE ITEMS (EXCLUDING REVENUE CODE 0001) MUST CONTAIN A DENIAL CODE LISTED IN CHAPTER 2, ADDENDUM H, FIGURE 2-H-1 OR FIGURE 2-H-2

1-125-02R IF ALL DETAIL ADJUSTMENT/DENIAL REASON CODES CONTAIN A DENIAL CODE (REFER TO FIGURE 2-H-1 OR FIGURE 2-H-2)

AND TYPE OF SUBMISSION = B ADJUSTMENT NON-TED RECORD (HCSR) DATA OR

E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

THEN AMOUNT ALLOWED (TOTAL) MUST BE ≤ZERO

1-125-03R IF TYPE OF SUBMISSION = A ADJUSTMENT OR

I INITIAL SUBMISSION OR

O ZERO PAYMENT WITH 100% OHI/TPL OR

R RESUBMISSION

THEN AMOUNT ALLOWED (TOTAL) MUST BE > ZERO

UNLESS ALL OCCURRENCE/LINE ITEMS (EXCLUDING REVENUE CODE 0001) CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN CHAPTER 2, ADDENDUM H, FIGURE 2-H-1 OR FIGURE 2-H-2

AND THE TED RECORD CORRECTION INDICATOR =

1 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR

3 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT BOTH EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD AND TO CORRECT CLAIM PROCESSING ERRORS OR UPDATE PRIOR DATA WITH MORE CURRENT/ ACCURATE INFORMATION

1-125-04R IF AMOUNT ALLOWED (TOTAL) = ZERO

THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST = ZERO

UNLESS TYPE OF SUBMISSION = B ADJUSTMENT NON-TED RECORD (HCSR) DATA OR

E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

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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

1-130-02R IF ONE OCCURRENCE OF
OVERRIDE CODE =

U	BENEFICIARY INDEMINIFICATION PAYMENT
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THEN AMOUNT OF OTHER HEALTH INSURANCE MUST = 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

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 [CHAPTER 2, SECTION 2.6](#).

RELATIONAL EDITS

1-131-01R IF OGP TYPE CODE =

V	CHAMPVA
---	---------

THEN TYPE OF SUBMISSION
MUST =

B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
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 [CHAPTER 2, SECTION 2.6](#).

RELATIONAL EDITS

NONE

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: AMOUNT INTEREST PAYMENT (1-145)

VALIDITY EDITS

1-145-01V MUST BE NUMERIC

RELATIONAL EDITS

1-145-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		C	COMPLETE CANCELLATION OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION

THEN AMOUNT INTEREST PAYMENT MUST BE ≥ ZERO

1-145-02R IF AMOUNT INTEREST PAYMENT ≠ ZERO

THEN REASON FOR INTEREST PAYMENT MUST =

A	CLAIMS PENDED AT GOVERNMENT DIRECTION OR
B	CLAIMS REQUIRING GOVERNMENT INTERVENTION OR
C	CLAIMS REQUIRING DEVELOPMENT FOR POTENTIAL TPL OR
D	CLAIMS REQUIRING AN ACTION/ INTERFACE WITH ANOTHER PRIME CONTRACTOR OR
E	CLAIMS RETAINED BY THE CONTRACTOR THAT DO NOT FALL INTO ONE OF THE ABOVE CATEGORIES

1-145-03R IF FILING STATE/ COUNTRY CODE = A FOREIGN COUNTRY INCLUDING PUERTO RICO (PRI)

THEN AMOUNT INTEREST PAYMENT MUST = ZERO

ELEMENT NAME: REASON FOR INTEREST PAYMENT (1-150)

VALIDITY EDITS

1-150-01V MUST BE A VALID REASON FOR INTEREST PAYMENT CODE (REFER TO [CHAPTER 2, 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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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: OVERRIDE CODE (1-160)

VALIDITY EDITS

1-160-01V	OCCURRENCE NUMBER 1--MUST BE A VALID OVERRIDE CODE ²
1-160-02V	OCCURRENCE NUMBER 2--MUST BE A VALID OVERRIDE CODE ²
1-160-03V	OCCURRENCE NUMBER 3--MUST BE A VALID OVERRIDE CODE ²
1-160-04V	A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).
1-160-05V	OVERRIDE CODE OCCURRENCES MUST BE LEFT JUSTIFIED.

RELATIONAL EDITS

1-160-03R	IF ANY OCCURRENCE OF OVERRIDE CODE =	B	PATIENT IS A SPOUSE UNDER 12 YEARS OF AGE
	THEN PATIENT AGE¹ MUST BE < 12		
	AND HCC MEMBER RELATIONSHIP CODE MUST =	B	SPOUSE OR
		G	SURVIVING SPOUSE
1-160-04R	IF ANY OCCURRENCE OF OVERRIDE CODE =	D	PATIENT IS FAMILY MEMBER 21 YEARS OF AGE OR OLDER
	THEN PATIENT AGE¹ MUST BE ≥ 21		
	AND HCC MEMBER RELATIONSHIP CODE MUST =	C	CHILD OR STEPCHILD OR
		D	WARD (NOT COURT ORDERED) OR
		E	WARD (COURT ORDERED)
1-160-05R	IF ANY OCCURRENCE OF OVERRIDE CODE =	I	PATIENT IS A FORMER SPOUSE UNDER 34 YEARS OF AGE
	THEN PATIENT AGE¹ MUST BE < 34		
	AND HCC MEMBER RELATIONSHIP CODE =	H	FORMER SPOUSE (20/20/20) OR
		I	FORMER SPOUSE (20/20/15) OR
		J	FORMER SPOUSE (10/20/10) OR
		K	FORMER SPOUSE (TRANSITIONAL ASSISTANCE (COMPOSITE))
	OR PATIENT AGE¹ MUST BE < 34		
	AND HCC MEMBER CATEGORY CODE =	W	FORMER SPOUSE
1-160-06R	IF ANY OCCURRENCE OF OVERRIDE CODE =	M	NATO
	THEN HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER

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

² AS STATED IN [CHAPTER 2, SECTION 2.6](#).

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: OVERRIDE CODE (1-160) (CONTINUED)			
1-160-07R	IF ANY OCCURRENCE OF OVERRIDE CODE =	E	DIAGNOSIS IS MATERNITY; PATIENT IS UNDER 12 YEARS OF AGE
	THEN PATIENT AGE¹ MUST BE < 12		
	AND AT LEAST ONE TREATMENT DIAGNOSIS MUST = MATERNITY (630-676 OR V22-V24 OR V270-V289)		
1-160-08R	IF ANY OCCURRENCE OF OVERRIDE CODE =	G	DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE
	THEN AT LEAST ONE OP/NSP OR DIAGNOSIS CODE MUST BE FOR FEMALE		
	AND PERSON SEX (PATIENT) MUST BE MALE.		
1-160-09R	IF ANY OCCURRENCE OF OVERRIDE CODE =	H	DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE
	THEN AT LEAST ONE OP/NSP OR DIAGNOSIS CODE MUST BE FOR MALE		
	AND PERSON SEX (PATIENT) MUST BE FEMALE		
1-160-10R	IF ANY OCCURRENCE OF OVERRIDE CODE =	N	RETROSPECTIVE PAYMENT-INPATIENT MENTAL HEALTH
	THEN PRICING RATE CODE MUST =	K	HOSPITAL-SPECIFIC PSYCH PER DIEM RATE OR
		L	REGION-SPECIFIC PSYCH PER DIEM RATE
	AND TYPE OF SUBMISSION MUST =	A	ADJUSTMENT OR
		B	ADJUSTMENT NON-TED RECORD (HCSR) DATA OR
		C	COMPLETE CANCELLATION OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
1-160-11R	IF ANY OCCURRENCE OF OVERRIDE CODE =	Y	NEWBORN IN MOTHER'S ROOM WITHOUT NURSERY CHARGES
	THEN PATIENT MUST BE NEWBORN (PERSON BIRTH CALENDAR DATE (PATIENT) EQUAL TO ADMISSION DATE)		
1-160-13R	IF ANY OCCURRENCE OF OVERRIDE CODE =	NC	NON-CERTIFIED PROVIDER (DOES NOT INCLUDE SANCTIONED/SUSPENDED PROVIDERS)
	THEN ANY OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AD	FOREIGN ACTIVE DUTY CLAIMS OR
		AN	SHCP - NON-MTF-REFERRED CARE OR
		AR	SHCP - REFERRED CARE OR

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

² AS STATED IN [CHAPTER 2, SECTION 2.6](#).

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: OVERRIDE CODE (1-160) (CONTINUED)

	CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
	EU	EMERGENCY SERVICES RENDERED BY AN UNAUTHORIZED PROVIDER OR
	GU	ADSM ENROLLED IN TPR OR
	MN	TSP - NETWORK OR
	MS	TSP - NON-NETWORK OR
	SC	SHCP - NON-TRICARE ELIGIBLE OR
	SE	SHCP - TRICARE ELIGIBLE OR
	SM	SHCP - EMERGENCY
		OR ENROLLMENT/ HEALTH PLAN CODE MUST =
	SN	SHCP - NON-MTF-REFERRED CARE OR
	SR	SHCP - REFERRED CARE
1-160-14R		IF ANY OCCURRENCE OF OVERRIDE CODE =
	Z	ENHANCED BENEFIT
		THEN ENROLLMENT/ HEALTH PLAN CODE MUST =
	U	TRICARE PRIME, CIVILIAN PCM OR
	Z	TRICARE PRIME, MTF/PCM

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

² AS STATED IN [CHAPTER 2, SECTION 2.6](#).

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: TYPE OF SUBMISSION (1-165)			
VALIDITY EDITS			
1-165-01V	VALUE MUST BE A VALID TYPE OF SUBMISSION.		
1-165-02V	IF TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN ADJUSTMENT KEY CANNOT =	0	BATCH OR
		5	VOUCHER
1-165-03V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		C	COMPLETE CANCELLATION OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN MATCH MUST BE FOUND ON THE TMA DATABASE		
	AND TYPE OF SUBMISSION ON THE EXISTING TMA DATABASE RECORD ≠	C	COMPLETE CANCELLATION OR
		D	COMPLETE DENIAL OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	UNLESS THE RECORD HAS PROVISIONAL ERRORS		
1-165-04V	IF TYPE OF SUBMISSION =	D	COMPLETE DENIAL OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION
	THEN A TED RECORD MUST NOT BE PRESENT ON THE DATABASE WITH THE SAME TED RECORD INDICATOR.		
1-165-05V	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 REGION INDICATOR MUST =	b	BLANK OR
		NC	NORTH CONTRACT OR
		SC	SOUTH CONTRACT OR
		WC	WEST CONTRACT
1-165-06V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME:		TYPE OF SUBMISSION (1-165) (CONTINUED)	
		C	COMPLETE CANCELLATION TO TED RECORD DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN TED RECORD CORRECTION INDICATOR MUST =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR
		2	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT CLAIM PROCESSING ERRORS OR TO UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION OR
		3	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT BOTH CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD
RELATIONAL EDITS			
1-165-01R	IF TYPE OF SUBMISSION =	O	ZERO PAYMENT WITH 100% OHI/TPL
	THEN THE AMOUNT OF OHI MUST BE > ZERO		
	AND AMOUNT ALLOWED (TOTAL) MUST BE > ZERO		
	AND AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST BE = ZERO		
1-165-02R	IF ALL OCCURRENCE/LINE ITEMS (EXCLUDING REVENUE CODE 0001) CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN CHAPTER 2, ADDENDUM H, FIGURE 2-H-1 OR FIGURE 2-H-2)		
	THEN TYPE OF SUBMISSION MUST =	C	COMPLETE CANCELLATION OR
		D	COMPLETE DENIAL OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	UNLESS THE TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR
		3	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT BOTH EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD AND TO CORRECT CLAIM PROCESSING ERRORS OR UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION
1-165-04R	IF RESUBMISSION NUMBER = ZERO FOR THIS BATCH OR VOUCHER		
	THEN TYPE OF SUBMISSION MUST ≠	R	RESUBMISSION
1-165-05R	IF RESUBMISSION NUMBER > ZERO FOR THIS BATCH OR VOUCHER		

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME:		TYPE OF SUBMISSION (1-165) (CONTINUED)	
	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	HOME HEALTH AGENCY OR
		71	SKILLED NURSING FACILITY
	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 CA/NAS NUMBER IS **NOT** BLANK **THEN** MUST BE **1 TO 11 OR 1 TO 15** ALPHANUMERIC CHARACTERS.

RELATIONAL EDITS

NO ERROR IF TYPE OF SUBMISSION = C COMPLETE CANCELLATION **OR**
D COMPLETE DENIAL

THEN BYPASS ALL CA/NAS NUMBER RELATIONAL EDITING.

NO ERROR IF ADMISSION DATE IS OLDER THAN 6 YEARS

THEN DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA

NO ERROR IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = R MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NOT A MEDICARE BENEFIT) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**

T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**

AN SHCP - NON-MTF-REFERRED CARE **OR**

AR SHCP - REFERRED CARE **OR**

CE SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM **OR**

PF ECHO **OR**

RS MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**

SC SHCP - NON-TRICARE ELIGIBLE **OR**

SE SHCP - TRICARE ELIGIBLE **OR**

SM SHCP - EMERGENCY **OR**

ST SPECIALIZED TREATMENT **OR**

WR MENTAL HEALTH WRAP AROUND

THEN BYPASS ALL CA/NAS NUMBER EDITING

NO ERROR IF ENROLLMENT/HEALTH PLAN CODE = U TRICARE PRIME, CIVILIAN PCM **OR**

W TPR ADSM - USA **OR**

X FOREIGN ADSM **OR**

Y CHCBP - STANDARD **OR**

Z TRICARE PRIME, MTF/PCM **OR**

AA CHCBP - EXTRA **OR**

BB TSP **OR**

FE TFL - EXTRA **OR**

FS TFL - STANDARD **OR**

¹ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.

² MTF IS A 40 MILES CATCHMENT AREA.

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

SN SHCP - NON-MTF-REFERRED CARE **OR**

SR SHCP - REFERRED CARE **OR**

WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE AD SM

THEN BYPASS ALL CA/NAS NUMBER EDITING

NO ERROR IF HCC MEMBER CATEGORY CODE = T FOREIGN MILITARY MEMBER

THEN BYPASS ALL CA/NAS NUMBER EDITING

NO ERROR IF ANY OCCURRENCE OF ADJUSTMENT/DENIAL REASON CODE = 15 PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER **OR**

26 EXPENSES INCURRED PRIOR TO COVERAGE **OR**

27 EXPENSES INCURRED AFTER COVERAGE TERMINATED **OR**

30 PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS **OR**

31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED **OR**

32 OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED **OR**

33 CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE **OR**

34 CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS **OR**

62 PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION **OR**

141 CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE

THEN BYPASS ALL CA/NAS NUMBER EDITING

NO ERROR IF AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO

THEN NO CA/NAS IS REQUIRED -- BYPASS ALL CA/NAS NUMBER EDITING.

NO ERROR IF HCDP PLAN COVERAGE CODE = 401 **TRS** TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) **OR**

402 **TRS** TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR**

¹ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.

² MTF IS A 40 MILES CATCHMENT AREA.

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

	405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRS SURVIVOR NEW FAMILY COVERAGE OR
	413	TRS MEMBER-ONLY COVERAGE OR
	414	TRS MEMBER AND FAMILY COVERAGE
1-170-02R	IF CA/NAS EXCEPTION REASON IS NOT BLANK THEN CA/NAS NUMBER MUST = BLANK	
1-170-03R	IF CA/NAS EXCEPTION REASON = BLANK AND PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316 (MENTAL HEALTH) AND PATIENT ZIP CODE IS IN AN MTF ² CATCHMENT AREA ¹ THEN CA/NAS NUMBER MUST BE CODED UNLESS ANY OCCURRENCE OF OVERRIDE CODE = C GOOD FAITH PAYMENT	
1-170-04R	IF CA/NAS NUMBER IS CODED THEN CA/NAS EXCEPTION REASON MUST = BLANK	
¹ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.		
² MTF IS A 40 MILES CATCHMENT AREA.		

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: CA/NAS REASON FOR ISSUANCE (1-175)	
VALIDITY EDITS	
1-175-01V	VALUE MUST BE A VALID CA/NAS REASON OF ISSUANCE.
RELATIONAL EDITS	
1-175-02R	IF CA/NAS NUMBER IS BLANK THEN CA/NAS REASON FOR ISSUANCE MUST = BLANK.
1-175-03R	IF CA/NAS REASON FOR ISSUANCE =
	7 ENROLLEE NETWORK CARE AUTHORIZATIONS/RESTRICTED CA/NAS OR
	8 ENROLLEE NON-NETWORK CARE AUTHORIZATIONS/RESTRICTED CA/NAS OR
	9 NOT ENROLLED, AUTHORIZED NETWORK CARE ONLY
	THEN ENROLLMENT/HEALTH PLAN CODE MUST =
	T TRICARE STANDARD OR
	U TRICARE PRIME, CIVILIAN PCM OR
	V TRICARE EXTRA OR
	Z TRICARE PRIME, MTF/PCM OR
	XF FOREIGN ADFM

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

VALIDITY EDITS

1-180-01V VALUE MUST BE A VALID CA/NAS EXCEPTION REASON CODE **OR** BLANK (REFER TO CHAPTER 2, SECTION 2.4)

RELATIONAL EDITS

NO ERROR IF TYPE OF SUBMISSION = C COMPLETE CANCELLATION **OR**
D COMPLETE DENIAL

THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING.

NO ERROR IF ADMISSION DATE IS OLDER THAN 6 YEARS

THEN DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA

NO ERROR IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = R MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NOT A MEDICARE BENEFIT) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**

T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**

AN SHCP - NON-MTF-REFERRED CARE **OR**

AR SHCP - REFERRED CARE **OR**

CE SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM **OR**

PF ECHO **OR**

RS MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**

SC SHCP - NON-TRICARE ELIGIBLE **OR**

SE SHCP - TRICARE ELIGIBLE **OR**

SM SHCP - EMERGENCY **OR**

ST SPECIALIZED TREATMENT **OR**

WR MENTAL HEALTH WRAP AROUND

THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING

NO ERROR IF ENROLLMENT/HEALTH PLAN CODE = U TRICARE PRIME, CIVILIAN PCM **OR**

W TPR ADSM - USA **OR**

X FOREIGN ADSM **OR**

Y CHCBP - STANDARD **OR**

Z TRICARE PRIME, MTF/PCM **OR**

AA CHCBP - EXTRA **OR**

BB TSP **OR**

FE TFL - EXTRA **OR**

FS TFL - STANDARD **OR**

¹ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.

² MTF IS A 40 MILES CATCHMENT AREA.

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: CA/NAS EXCEPTION REASON (1-180) (CONTINUED)	
	SN SHCP - NON-MTF-REFERRED CARE OR
	SR SHCP - REFERRED CARE OR
	WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING	
NO ERROR	IF HCC MEMBER CATEGORY CODE = T FOREIGN MILITARY MEMBER
THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING	
NO ERROR	IF ANY OCCURRENCE OF ADJUSTMENT/DENIAL REASON CODE =
	15 PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER OR
	26 EXPENSES INCURRED PRIOR TO COVERAGE OR
	27 EXPENSES INCURRED AFTER COVERAGE TERMINATED OR
	30 PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS OR
	31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED OR
	32 OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED OR
	33 CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE OR
	34 CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS OR
	62 PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION OR
	141 CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING	
NO ERROR	IF AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO
THEN NO CA/NAS IS REQUIRED -- BYPASS ALL CA/NAS EXCEPTION REASON EDITING.	
NO ERROR	IF HCDP PLAN COVERAGE CODE = 401 TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR

¹ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.

² MTF 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)	
	402 TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405 TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406 TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407 TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408 TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409 TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410 TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411 TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412 TRS SURVIVOR NEW FAMILY COVERAGE OR
	413 TRS MEMBER-ONLY COVERAGE OR
	414 TRS MEMBER AND FAMILY COVERAGE
1-180-01R	IF PATIENT ZIP CODE IS NOT IN AN MTF ² CATCHMENT AREA ¹ THEN CA/NAS EXCEPTION REASON MUST = BLANK
1-180-03R	IF PATIENT ZIP CODE IS IN AN MTF ² CATCHMENT AREA ¹ AND PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316 (MENTAL HEALTH) AND CA/NAS NUMBER IS NOT CODED THEN CA/NAS EXCEPTION REASON MUST BE CODED
1-180-07R	IF CA/NAS EXCEPTION REASON = 5 RTC AND PATIENT ZIP CODE IS IN AN MTF ² CATCHMENT AREA ¹ THEN TYPE OF INSTITUTION = 72 RTC
1-180-08R	IF CA/NAS EXCEPTION REASON = S HOME HEALTH AGENCY (HHA-PPS) THEN TYPE OF INSTITUTION MUST = 70 HOME HEALTH AGENCY AND ONE OCCURRENCE OF REVENUE CODE MUST = 0023 HOME HEALTH AGENCY (HHA-PPS)

¹ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.

² MTF IS A 40 MILES CATCHMENT AREA.

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (CONTINUED)		
	ELSE IF BEGIN DATE OF CARE (≥ 03/01/1997 AND ≤ 02/19/1998)	
	OR (≥ 09/01/1999 OR ≤ 05/31/2003)	
	AND PRINCIPAL/SECONDARY OP/NSP CODE IS 50.51 OR 50.59	
	THEN SPECIAL PROCESSING CODE MUST =	ST ¹ SPECIALIZED TREATMENT
1-185-06R	IF PRINCIPAL/SECONDARY OP/NSP CODE IS 37.5	
	THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST =	7 HEART TRANSPLANT
1-185-08R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PO TRICARE PRIME - POINT OF SERVICE
	THEN ENROLLMENT/HEALTH PLAN CODE MUST =	U TRICARE PRIME (CIVILIAN PCM) OR
		Z TRICARE PRIME, MTF/PCM OR
		WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM OR
		XF FOREIGN ADFM
1-185-09R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AD FOREIGN ACTIVE DUTY CLAIMS OR
		GU ADSM ENROLLED IN TPR
	THEN ENROLLMENT/HEALTH PLAN CODE MUST =	W TPR ADSM - USA
		X FOREIGN ADSM OR
		WA TPR FOREIGN ADSM
1-185-13R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	MN TSP - NON-NETWORK OR
		MS TSP - NETWORK
	THEN ENROLLMENT/HEALTH PLAN CODE MUST =	BB TSP
1-185-14R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AN SHCP - NON-MTF-REFERRED CARE OR
		AR SHCP - REFERRED CARE OR
		CE SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
		SC SHCP - NON-TRICARE ELIGIBLE OR
		SE SHCP - TRICARE ELIGIBLE OR
		SM SHCP - EMERGENCY
	THEN ENROLLMENT/HEALTH PLAN CODE MUST =	SR SHCP - REFERRED CARE OR
		SN SHCP - NON-MTF REFERRED CARE OR
		SO SHCP - NON-TRICARE ELIGIBLE OR
		ST SHCP - TRICARE ELIGIBLE
1-185-31R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	SN TSS - NON-NETWORK OR

¹ AS STATED IN CHAPTER 2, SECTION 2.8 OR BLANK.

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (CONTINUED)	
	SS TSS - NETWORK
	THEN ENROLLMENT/ HEALTH PLAN CODE MUST = TS TSS
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
1-185-33R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = GF TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADMS
	THEN BEGIN DATE OF CARE IS ≥ 10/30/2000 AND < 09/01/2002
	AND HCC MEMBER CATEGORY CODE MUST = A ACTIVE DUTY OR
	G NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	S RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE)
	AND HCC MEMBER RELATIONSHIP CODE MUST = B SPOUSE OR
	C CHILD OR STEPCHILD OR
	D WARD (NOT COURT ORDERED) OR
	E WARD (COURT ORDERED)
1-185-34R	• TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001. IF BEGIN DATE OF CARE IS < 10/01/2001, THE LINE ITEMS MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.
	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = FF TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) OR
	FG TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) OR
	FS TFL (SECOND PAYOR)
	AND TYPE OF INSTITUTION ≠ 10 GENERAL MEDICAL AND SURGICAL
	THEN BEGIN DATE OF CARE MUST BE ≥ 10/01/2001
	AND ENROLLMENT/ HEALTH PLAN CODE MUST = FE TFL - EXTRA OR
	FS TFL - STANDARD
	ELSE IF BEGIN DATE OF CARE IS < 10/01/2001
¹ AS STATED IN CHAPTER 2, SECTION 2.8 OR BLANK.	

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (CONTINUED)		
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
	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 \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 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 \geq 10/01/2001		
AND ENROLLMENT/HEALTH PLAN CODE MUST =	FE	TFL - EXTRA OR
	FS	TFL - STANDARD

¹ AS STATED IN CHAPTER 2, SECTION 2.8 OR BLANK.

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

1-185-38R	<ul style="list-style-type: none"> SPECIAL PROCESSING CODE 'V' IS USED FOR CARE PROVIDED WITHIN NORMAL LIMITS - WHILE SPECIAL PROCESSING CODE "W" IS USED FOR CARE OVER AND ABOVE THOSE NORMAL LIMITS
	IF BEGIN DATE OF CARE IS ≥ 12/28/2001
	AND ANY OCCURRENCE OF SPECIAL PROCESSING CODE = CT CCTP
	THEN AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =
	V FINANCIALLY UNDERWRITTEN PAYMENT BY CLAIMS PROCESSOR OR
	W NON-FINANCIALLY UNDERWRITTEN PAYMENT BY FINANCIALLY UNDERWRITTEN CLAIMS PROCESSOR
1-185-39R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = PF ECHO
	THEN HCDP PLAN COVERAGE CODE MUST ≠
	401 TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR
	402 TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	402 TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405 TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406 TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407 TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408 TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409 TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410 TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411 TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412 TRS SURVIVOR NEW FAMILY COVERAGE OR
	413 TRS MEMBER-ONLY COVERAGE OR
	414 TRS MEMBER AND FAMILY COVERAGE

¹ AS STATED IN CHAPTER 2, SECTION 2.8 OR BLANK.

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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 LISTING IN [CHAPTER 2, 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/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER OR
		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER
1-190-02R	IF DRG NUMBER IS CODED (OTHER THAN ZERO)		
	THEN PRICING RATE CODE MUST =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER OR
		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER OR
		U	SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS OR
		V	MEDICARE REIMBURSEMENT RATE
1-190-03R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	11	HOSPICE
	THEN PRICING RATE CODE MUST =	D	DISCOUNT RATE AGREEMENT OR
		P	PER DIEM RATE AGREEMENT OR
		U	SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS OR
		V	MEDICARE REIMBURSEMENT RATE
	UNLESS TYPE OF SUBMISSION =	D	COMPLETE DENIAL
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	HOME HEALTH AGENCY OR
		76	SKILLED NURSING FACILITY

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PRICING RATE CODE (1-190) (CONTINUED)			
1-190-05R	IF PRICING RATE CODE =	U	SHCP CLAIM OR ACTIVE DUTY MEMBER TPR CLAIM PAID OUTSIDE NORMAL LIMITS
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AN	SHCP - NON-MTF-REFERRED CARE OR
		AR	SHCP - REFERRED CARE OR
		CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
		GU	ADSM ENROLLED IN TPR OR
		SC	SHCP - NON-TRICARE ELIGIBLE OR
		SE	SHCP - TRICARE ELIGIBLE OR
		SM	SHCP - EMERGENCY
	OR ENROLLMENT/ HEALTH PLAN CODE MUST =	SN	SHCP - NON-MTF-REFERRED CARE OR
		SR	SHCP - REFERRED CARE
1-190-06R	IF ANY OCCURRENCE OF REVENUE CODE =	0022	SKILLED NURSING FACILITY CHARGE
	THEN PRICING RATE CODE MUST =	D	DISCOUNT RATE AGREEMENT OR
		V	MEDICARE REIMBURSEMENT RATE
1-190-07R	IF ANY OCCURRENCE OF REVENUE CODE =	0023	HOME HEALTH AGENCY (HHA-PPS)
	THEN PRICING RATE CODE MUST =	D	DISCOUNT RATE AGREEMENT OR
		V	MEDICARE REIMBURSEMENT RATE
1-190-08R	IF PRICING RATE CODE =	CA	CAH REIMBURSEMENT
	THEN PROVIDER STATE OR COUNTRY CODE MUST =	AK	ALASKA
	AND DRG NUMBER MUST = BLANK		
	AND ADMISSION DATE MUST BE ≥ 07/01/2007		

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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 CHAPTER 2, ADDENDUM A OR ADDENDUM B)

RELATIONAL EDITS

1-195-01R PROVIDER STATE/COUNTRY CODE MUST MATCH THE CORRESPONDING RECORD¹ 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 ZIP CODE, TYPE OF INSTITUTION, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (1-200-02R).

