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 FDA.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] Only required for Outpatient Drug claims. Blank fill for non-pharmacy TED records.

This data element must be present for Mail Order Pharmacy (MOP) 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 ECHO, enter 01 for each service regardless of number of units or mileage. When multiple units are used in a single Episode Of Care (EOC), 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. Report the number of prescriptions (not pills or day's supply) for 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.
For a list of maximum number of services allowed for a procedure code per day, refer to the Maximum Number of Services by Procedure Code list on TMA's web site at http://www.tricare.mil/tma/Rates.aspx. These values conform to CMS' Medically Unlikely Edits (MUE) program for CPT/HCPCS codes that have been assigned a limit by CMS. Any CPT/HCPCS code not assigned a limit by CMS have been assigned a limit deemed reasonable by TRICARE. The edits for MUE program are published on the CMS web site at http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp.

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. Occurrence/line item number 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 OPPS.	
CODE/VALUE SPECIFICATIONS	A	Services paid under some payment method other than OPPS (e.g., payment for non-implantable prosthetic and orthotic devices, DME, ambulance services, and individual professional services).
	B	More appropriate code required for TRICARE OPPS.
	C	Inpatient services.
	E	Items or services not covered by TRICARE.
	F	Acquisition of corneal tissue and certain CRNA services and Hepatitis B vaccines.
	G	Pass-through drugs and biologicals.
	H	**1.** Pass-through device categories. **2.** Therapeutic radiopharmaceuticals.
	K	Non-pass-through drugs and biologicals.
	N	Items and services packaged into APC rates.
	P	Partial hospitalization service.
	Q	Packaged services subject to separate payment based on payment criteria. See codes Q1 through Q3 listed below.
	R	Blood and blood products.
	S	Significant procedures not subject to multiple procedure discounting.
	T	Significant procedures subject to multiple procedure discounting.
	U	Brachytherapy sources.
	V	Clinic or ED visits.
	W	Invalid HCPCS or invalid revenue code with blank HCPCS.
	X	Ancillary services.
	Z	Valid revenue code with blank HCPCS and no other SI assigned.
	TB	TRICARE reimbursement not allowed for CPT/HCPCS code submitted.
	Q1	STVX-packaged codes.

NOTES AND SPECIAL INSTRUCTIONS:

[1] Required on all TED records reimbursed under OPPS.

Refer to the TRM for additional information and more complete definitions of the OPPS Payment SI Codes. Must be left justified and blank filled.

The list of Payment SIs For Hospital OPPS and OPPS Payment Status can be found at http://www.tricare.mil/opps.

DATA ELEMENT DEFINITION

ELEMENT NAME: OPPS PAYMENT STATUS INDICATOR CODE (Continued)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	Q2	T-packaged codes.
	Q3	Codes that may be paid through a composite APC.
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 OPPS.

Refer to the TRM for additional information and more complete definitions of the OPPS Payment SI Codes. Must be left justified and blank filled.

The list of Payment SIs For Hospital OPPS and OPPS Payment Status can be found at http://www.tricare.mil/opps.

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 OGP began. The OGP begin reason code only applies to OGP type codes of 'A' or 'B' only. 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, C or D; over or under age 65. Medicare Part B can only be obtained by payment of monthly premiums. This value applies to Medicare Part B, C or D.
	D	Eligible for Medicare 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.
	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 because of end-stage renal disease. This value applies to Medicare Part A.
	V	Eligible for the 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 MOP use the data element Medicare 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
	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
ALGORITHM	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 MOP 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 TDEFIC contractor when the DEERS response shows a Health Care Delivery Plan Code of 018, 020, 021, or 022, indicating TFL 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 contractor when the DEERS response carries a Medicare Begin Reason Code indicating the patient has Medicare Part A.

On receipt of the claim, the TDEFIC 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)

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 MOP 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 TDEFIC contractor when the DEERS response shows a Health Care Delivery Plan Code of 018, 020, 021, or 022, indicating TFL 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 contractor when the DEERS response carries a Medicare Begin Reason Code indicating the patient has Medicare Part A.

On receipt of the claim, the TDEFIC 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: 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	A code which indicates 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.
	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, SSN not applicable.
	N	Retrospective payment - Inpatient Mental Health (Institutional Only)

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.

[2] Override codes 'H1' and 'H2' can only be reported by the following contracts: MDA906-02-C-0013, MDA906-03-C-0009, MDA906-03-C-0010, MDA906-03-C-0011, MDA906-03-C-0015, and MDA906-03-C-0019.

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (Continued)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	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.
	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
	V	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.
	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)
	NS	Contractor has determined that number of services is medically necessary.
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.

[2] Override codes 'H1' and 'H2' can only be reported by the following contracts: MDA906-02-C-0013, MDA906-03-C-0009, MDA906-03-C-0010, MDA906-03-C-0011, MDA906-03-C-0015, and MDA906-03-C-0019.

- END -