

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: TYPE OF SUBMISSION (2-100)	
VALIDITY EDITS	
2-100-01V	VALUE MUST BE A VALID TYPE OF SUBMISSION.
2-100-02V	IF TYPE OF SUBMISSION =
	B ADJUSTMENT OF NON-TED RECORD (HCSR) DATA <b>OR</b>
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	<b>THEN ADJUSTMENT KEY CANNOT BE 0 OR 5</b>
	<b>AND REGION INDICATOR MUST = BLANK</b>
2-100-03V	IF TYPE OF SUBMISSION =
	A ADJUSTMENT <b>OR</b>
	B ADJUSTMENT OF NON-TED RECORD (HCSR) DATA <b>OR</b>
	C COMPLETE CANCELLATION <b>OR</b>
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	<b>THEN MATCH MUST BE FOUND ON THE TMA DATABASE</b>
	<b>AND TYPE OF SUBMISSION ON THE EXISTING TMA DATABASE RECORD ≠</b>
	C COMPLETE CANCELLATION <b>OR</b>
	D COMPLETE DENIAL <b>OR</b>
	E COMPLETE CANCELLATION NON-TED RECORD (HCSR) DATA
	<b>UNLESS THE RECORD HAS PROVISIONAL ERRORS</b>
2-100-04V	IF TYPE OF SUBMISSION =
	D COMPLETE DENIAL <b>OR</b>
	I INITIAL SUBMISSION <b>OR</b>
	O ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>
	R RESUBMISSION
	<b>THEN A TED RECORD MUST NOT BE PRESENT ON THE DATABASE WITH THE SAME TED RECORD INDICATOR</b>
2-100-05V	IF TYPE OF SUBMISSION =
	A ADJUSTMENT TO TED <b>OR</b>
	C COMPLETE CANCELLATION <b>OR</b>
	D COMPLETE DENIAL <b>OR</b>
	I INITIAL SUBMISSION <b>OR</b>
	O ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>
	R RESUBMISSION
	<b>THEN REGION INDICATOR MUST =</b>
	<del>B</del> BLANK <b>OR</b>

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ELEMENT NAME: TYPE OF SUBMISSION (2-100) (CONTINUED)	
	NC NORTH CONTRACT OR
	SC SOUTH CONTRACT OR
	WC WEST CONTRACT
RELATIONAL EDITS	
2-100-01R	IF TYPE OF SUBMISSION = O ZERO PAYMENT WITH 100% OHI/TPL THEN THE AMOUNT OF OHI MUST BE > ZERO AND THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE MUST > ZERO AND THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = 0
2-100-02R	IF ALL OCCURRENCE/LINE ITEMS ARE DENIED (REFER TO <a href="#">FIGURE 2-H-1</a> OR <a href="#">FIGURE 2-H-2</a> ) THEN TYPE OF SUBMISSION MUST = C COMPLETE CANCELLATION OR D COMPLETE DENIAL OR E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
2-100-04R	IF RESUBMISSION NUMBER = ZERO FOR THIS BATCH OR VOUCHER THEN TYPE OF SUBMISSION MUST ≠ R RESUBMISSION
2-100-05R	IF RESUBMISSION NUMBER > ZERO FOR THIS BATCH OR VOUCHER THEN TYPE OF SUBMISSION MUST ≠ I INITIAL TED RECORD SUBMISSION
2-100-06R	IF TYPE OF SUBMISSION = I INITIAL SUBMISSION OR R RESUBMISSION THEN THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT BILLED BY PROCEDURE CODE, AND THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE MUST BE > 0.
2-100-07R	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 < 10/01/2007
2-100-08R	IF DATE TED RECORD PROCESSED TO COMPLETION > 01/01/1996 AND SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) = X NOT APPLICABLE THEN TYPE OF SUBMISSION MUST = C COMPLETE CANCELLATION OR D COMPLETE DENIAL
2-100-09R	IF TYPE OF SUBMISSION = B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

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**ELEMENT NAME: TYPE OF SUBMISSION (2-100) (CONTINUED)**

THEN TYPE OF SERVICE  
(SECOND POSITION) MUST ≠ M MAIL ORDER PHARMACY DRUGS &  
SUPPLIES

**ELEMENT NAME: CLAIM FORM TYPE/EMC INDICATOR (2-105)**

**VALIDITY EDITS**

**2-105-01V** MUST BE A VALID TYPE/EMC INDICATOR.

**RELATIONAL EDITS**

**2-105-01R** IF CLAIM FORM TYPE/EMC  
INDICATOR = I ELECTRONIC DRUG CLAIM SUBMISSION

THEN TYPE OF SERVICE  
(SECOND POSITION) MUST = B RETAIL DRUGS & SUPPLIES **OR**

M MAIL ORDER PHARMACY DRUGS &  
SUPPLIES

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**ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (2-110)**

**VALIDITY EDITS**

**2-110-01V** MUST BE VALID DMIS-ID CODE.

**2-110-02V** • **REVISED FINANCING**

IF HEADER TYPE INDICATOR = 5 OR 6

AND ENROLLMENT/HEALTH  
PLAN CODE =

Z

TRICARE PRIME, MTF/CLINIC

AND TYPE OF SUBMISSION ≠

B

ADJUSTMENT NON-TED RECORD (HCSR)  
DATA OR

E

COMPLETE CANCELLATION OF NON-TED  
RECORD (HCSR) DATA

**THEN** PCM LOCATION DMIS-ID MUST = VALID CODE

**AND CANNOT** = 6501, 6901-6915, 7901-7912, 7916<sup>2</sup>, 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** (i.e., 2/5, 3/4,  
OR 9/10)

**THEN** BYPASS ALL PCM LOCATION DMIS-ID RELATIONAL EDITING.

**2-110-01R** IF BEGIN DATE OF CARE ≥ 10/01/1997

AND ENROLLMENT/HEALTH  
PLAN CODE =

BB

TSP

**THEN** PCM LOCATION DMIS-ID MUST BE A VALID MTF/CLINIC DMIS-ID<sup>1</sup>

**AND CANNOT** = 6501, 6901-6915, 7901-7912, 7916<sup>2</sup>, 8000-8099 OR BLANK

**2-110-02R** IF BEGIN DATE OF CARE ≥ 10/01/1999

AND ENROLLMENT/HEALTH  
PLAN CODE =

SN

SHCP - NON-MTF REFERRED CARE OR

SR

SHCP - REFERRED CARE

**THEN** PCM LOCATION DMIS-ID MUST BE A VALID MTF/CLINIC DMIS-ID<sup>1</sup>

**AND CANNOT** = 6501, 6901-6915, 7901-7912, 7916<sup>2</sup>, OR 8000-8099

**2-110-04R** IF BEGIN DATE OF CARE ≥ 10/01/1997 AND < 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 OR 8000-8099

OR REGION INDICATOR =

~~h~~

BLANK OR

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

<sup>2</sup> 7916 IS THE DMIS-ID FOR ALASKA.

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**ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (2-110) (CONTINUED)**

		SC	SOUTH CONTRACT
	THEN DMIS-ID MUST =	6903, 6904, 6906, 6913, 6914	OR 6915
	OR REGION INDICATOR =	<del>h</del>	BLANK OR
		WC	WEST CONTRACT
	THEN DMIS-ID MUST =	6907, 6908, 6909, 6910, 6911	OR 6912
<b>2-110-05R</b>	IF BEGIN DATE OF CARE ≥ 10/01/1997 AND < 10/01/1999		
	AND ENROLLMENT/HEALTH PLAN CODE =	W	TPR ACTIVE DUTY CLAIMS-USA
	AND REGION INDICATOR =	<del>h</del>	BLANK OR
		NC	NORTH CONTRACT
	THEN DMIS-ID MUST =	7901, 7902, 7905	OR 8000-8099 OR BLANK
	OR REGION INDICATOR =	<del>h</del>	BLANK OR
		WC	WEST CONTRACT
	THEN DMIS-ID MUST =	6911	OR BLANK
<b>2-110-06R</b>	IF BEGIN DATE OF CARE ≥ 10/01/1999 AND < 09/01/2002		
	AND ENROLLMENT/HEALTH PLAN CODE =	W	TPR ACTIVE DUTY CLAIMS-USA
	AND REGION INDICATOR =	<del>h</del>	BLANK OR
		NC	NORTH CONTRACT
	THEN DMIS-ID MUST =	7901, 7902, 7905	OR 8000-8099
	OR REGION INDICATOR =	<del>h</del>	BLANK OR
		SC	SOUTH CONTRACT
	THEN DMIS-ID MUST =	7903, 7904	OR 7906
	OR REGION INDICATOR =	<del>h</del>	BLANK OR
		WC	WEST CONTRACT
	THEN DMIS-ID MUST =	7907, 7908, 7909, 7910, 7911, 7912	OR 7916 <sup>2</sup>
<b>2-110-07R</b>	IF BEGIN DATE OF CARE ≥ 10/01/1997		
	AND ENROLLMENT/HEALTH PLAN CODE ≠	U	TRICARE PRIME, CIVILIAN PCM OR
		W	TPR ACTIVE DUTY CLAIMS-USA OR
		Z	TRICARE PRIME, MTF/CLINIC OR
		BB	TSP OR
		SR	SHCP - REFERRED CARE OR
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	THEN PCM LOCATION DMIS-ID MUST =		BLANK
<b>2-110-08R</b>	IF BEGIN DATE OF CARE ≥ 09/01/2002		
	AND ENROLLMENT/HEALTH PLAN CODE CODE =	U	TRICARE PRIME, CIVILIAN PCM
	AND REGION INDICATOR =	<del>h</del>	BLANK OR
		NC	NORTH CONTRACT

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

<sup>2</sup> 7916 IS THE DMIS-ID FOR ALASKA.

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<b>ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (2-110) (CONTINUED)</b>	
	THEN DMIS-ID MUST = 6901, 6902, 8007, 8009 OR 6905
OR REGION INDICATOR =	<del>h</del> BLANK OR
	SC SOUTH CONTRACT
	THEN DMIS-ID MUST = 6903, 6904, 6906, 6913, 6914 OR 6915
OR REGION INDICATOR =	<del>h</del> BLANK OR
	WC WEST CONTRACT
	THEN DMIS-ID MUST = 6907, 6908, 6909, 6910, 6911 OR 6912
<b>2-110-09R</b>	IF BEGIN DATE OF CARE ≥ 09/01/2002
	AND ENROLLMENT/HEALTH PLAN CODE CODE =
	W TPR ACTIVE DUTY CLAIMS - USA OR
	WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
AND REGION INDICATOR =	<del>h</del> BLANK OR
	NC NORTH CONTRACT
	THEN DMIS-ID MUST = 7901, 7902 OR 7905
OR REGION INDICATOR =	<del>h</del> BLANK OR
	SC SOUTH CONTRACT
	THEN DMIS-ID MUST = 7903, 7904, OR 7906
OR REGION INDICATOR =	<del>h</del> BLANK OR
	WC WEST CONTRACT
	THEN DMIS-ID MUST = 7907, 7908, 7909, 7910, 7911, 7912 OR 7916 <sup>2</sup>
<sup>1</sup> A VALID MTF/CLINIC DMIS-ID MEANS ONE THAT MATCHES THE DOD DMIS-ID LISTING.	
<sup>2</sup> 7916 IS THE DMIS-ID FOR ALASKA.	

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<b>ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS (2-115)</b>	
<b>VALIDITY EDITS</b>	
<b>2-115-01V</b>	MUST BE A VALID PRINCIPAL DIAGNOSIS CODE.
<b>RELATIONAL EDITS</b>	
<b>2-115-01R</b>	IF ANY PRINCIPAL TREATMENT DIAGNOSIS CODE IS FOR FEMALE AND PERSON SEX (PATIENT) IS MALE  THEN AT LEAST ONE OVERRIDE CODE MUST = G DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE
<b>2-115-02R</b>	IF ANY PRINCIPAL TREATMENT DIAGNOSIS CODE IS FOR MALE AND NOT FOR CIRCUMCISION (PROCEDURE CODE <sup>2</sup> 54150 OR 54160) AND SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY (REFER TO FIGURE 2-E-10) AND PERSON SEX (PATIENT) IS FEMALE  THEN AT LEAST ONE OVERRIDE CODE MUST = H DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE
<b>2-115-03R</b>	IF PRINCIPAL TREATMENT DIAGNOSIS CODE HAS AN AGE PARAMETER RESTRICTION THEN PATIENT'S AGE MUST BE CONSISTENT WITH RESTRICTIONS (i.e., NEWBORN (REFER TO FIGURE 2-E-8)  UNLESS AT LEAST ONE OVERRIDE CODE = R PERSON BIRTH CALENDAR DATE (PATIENT) IS NOT CONSISTENT WITH PROCEDURE/ DIAGNOSIS CODE AGE RESTRICTING; PROCEDURE PERFORMED DUE TO MEDICAL NECESSITY
<b>2-115-04R</b>	IF SECONDARY TREATMENT DIAGNOSIS = MATERNITY (630-676 OR V22-V24 OR V270- V289) AND PERSON BIRTH CALENDAR DATE (PATIENT) INDICATES AGE <sup>1</sup> < 12  THEN ONE OCCURRENCE OF OVERRIDE CODE MUST = E DIAGNOSIS IS MATERNITY; PATIENT IS UNDER 12 YEARS OF AGE
<b>2-115-05R</b>	IF PRINCIPAL TREATMENT DIAGNOSIS = 799.9 THEN CALCULATED AMOUNT BILLED (TOTAL) MUST > ZERO AND ≤\$200.00  AND TYPE OF SERVICE (FIRST POSITION) MUST = A AMBULATORY SURGERY COST-SHARED AS INPATIENT (ACTIVE DUTY FAMILY MEMBERS ONLY) OR  I INPATIENT OR  N OUTPATIENT COST-SHARED AS INPATIENT OR  O OUTPATIENT, EXCLUDING M, P, N

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

<sup>2</sup> CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2002 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS APPLY TO GOVERNMENT USE.

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<b>ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS (2-115) (CONTINUED)</b>	
	AND TYPE OF SERVICE (SECOND POSITION) MUST =
	4 DIAGNOSTIC/THERAPEUTIC X-RAY <b>OR</b>
	5 DIAGNOSTIC LABORATORY <b>OR</b>
	7 ANESTHESIA
	<b>UNLESS</b> TYPE OF SUBMISSION = D COMPLETE DENIAL
	<b>OR</b> ANY OCCURRENCE OF SPECIAL PROCESSING CODE = 1 MEDICAID
<b>2-115-06R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = PF PFPWD
	<b>THEN</b> PRINCIPAL DIAGNOSIS MUST <b>CANNOT</b> = 799.9
	<b>UNLESS</b> TYPE OF SUBMISSION = D COMPLETE DENIAL
	<b>OR</b> ANY OCCURRENCE OF SPECIAL PROCESSING CODE = 1 MEDICAID

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

<sup>2</sup> CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2002 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS APPLY TO GOVERNMENT USE.

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**ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS-1 - 4 (2-120 THROUGH 2-135)**

**VALIDITY EDITS**

**2-XXX-01V<sup>1</sup>** VALUE MUST BE VALID DIAGNOSIS CODE IF PRESENT, **OR** BLANK FILLED. ALL OCCURRENCES OF SECONDARY TREATMENT DIAGNOSIS MUST BE BLANK-FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK-FILLED SECONDARY TREATMENT DIAGNOSIS.

**RELATIONAL EDITS**

**2-XXX-01R<sup>1</sup>** IF ANY SECONDARY TREATMENT DIAGNOSIS CODE IS FOR FEMALE  
AND PERSON SEX (PATIENT) IS MALE

THEN AT LEAST ONE  
OVERRIDE CODE MUST = G DIAGNOSIS/PROCEDURAL CODE FOR  
FEMALE: SEX INDICATES MALE

**2-XXX-02R<sup>1</sup>** IF ANY SECONDARY TREATMENT DIAGNOSIS CODE IS FOR MALE  
AND NOT FOR CIRCUMCISION (PROCEDURE CODE<sup>3</sup> 54150 OR 54160)  
AND SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY (FIGURE 2-E-10)  
AND PERSON SEX (PATIENT) IS FEMALE

THEN AT LEAST ONE  
OVERRIDE CODE MUST = H DIAGNOSIS/PROCEDURAL CODE FOR  
MALE: SEX INDICATES FEMALE

**2-XXX-03R<sup>1</sup>** IF SECONDARY TREATMENT DIAGNOSIS CODE HAS AN AGE PARAMETER  
RESTRICTION

THEN PATIENT'S AGE MUST BE CONSISTENT WITH RESTRICTIONS (i.e., NEWBORN  
(REFER TO FIGURE 2-E-8)

UNLESS AT LEAST ONE  
OVERRIDE CODE = R PERSON BIRTH CALENDAR DATE (PATIENT)  
IS NOT CONSISTENT WITH PROCEDURE/  
DIAGNOSIS CODE AGE RESTRICTING;  
PROCEDURE PERFORMED DUE TO  
MEDICAL NECESSITY

**2-XXX-04R<sup>1</sup>** IF SECONDARY TREATMENT DIAGNOSIS = MATERNITY (630-676 OR V22-V24 OR V270-  
V289)

AND PERSON BIRTH CALENDAR DATE (PATIENT) INDICATES AGE<sup>2</sup> < 12

THEN ONE OCCURRENCE  
OF OVERRIDE CODE  
MUST = E DIAGNOSIS IS MATERNITY; PATIENT IS  
UNDER 12 YEARS OF AGE

<sup>1</sup> XXX EQUALS ELN (120 THROUGH 135) FOR EACH OCCURRENCE OF SECONDARY TREATMENT DIAGNOSIS.

<sup>2</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.

<sup>3</sup> CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2002 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS APPLY TO GOVERNMENT USE.

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**ELEMENT NAME: TOTAL OCCURRENCE/LINE ITEM COUNT (2-140)**

**VALIDITY EDITS**

2-140-01V VALUE MUST BE IN RANGE: 001-099

**AND MUST EQUAL THE PHYSICAL COUNT OF THE DETAIL LINE ITEMS ON THE TED RECORD.**

2-140-02V IF TYPE OF SUBMISSION = A ADJUSTMENT **OR**

B ADJUSTMENT OF NON-TED RECORD (HCSR) DATA **OR**

C COMPLETE CANCELLATION **OR**

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

**THEN TOTAL OCCURRENCE/LINE ITEM COUNT MUST BE  $\geq$  TOTAL OCCURRENCE/LINE ITEM COUNT FROM TMA DATABASE**

**RELATIONAL EDITS**

NONE

**ELEMENT NAME: OCCURRENCE/LINE ITEM NUMBER (2-145)**

**VALIDITY EDITS**

2-145-01V EACH VALUE MUST BE NUMERIC AND NOT EQUAL TO ZERO.

2-145-02V OCCURRENCE/LINE ITEM NUMBER MUST BE CODED FOR EACH NUMBER OF OCCURRENCES SPECIFIED BY THE TOTAL OCCURRENCE/LINE ITEM COUNT.

2-145-03V OCCURRENCE/LINE ITEM NUMBER MUST BE REPORTED IN ASCENDING CONSECUTIVE ORDER.

**RELATIONAL EDITS**

NONE

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**ELEMENT NAME: BEGIN DATE OF CARE (2-150)**

**VALIDITY EDITS**

2-150-01V MUST BE A VALID GREGORIAN DATE.

**RELATIONAL EDITS**

2-150-01R BEGIN DATE OF CARE MUST BE ≤END DATE OF CARE.

2-150-02R BEGIN DATE OF CARE MUST BE ≤FILING DATE.

2-150-03R BEGIN DATE OF CARE MUST BE ≤DATE TED RECORD PROCESSED TO COMPLETION.

2-150-04R BEGIN DATE OF CARE MUST BE ≥ PERSON BIRTH CALENDAR DATE (PATIENT).

2-150-05R IF TYPE OF SUBMISSION =

A	ADJUSTMENT <b>OR</b>
B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>
C	COMPLETE CANCELLATION <b>OR</b>
E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

THEN BEGIN DATE OF CARE MUST BE ≤DATE ADJUSTMENT IDENTIFIED.

UNLESS THE ADJUSTMENT IS TO CORRECT A PROVISIONALLY ACCEPTED RECORD

2-150-06R PROVIDER MUST BE "AUTHORIZED"<sup>1</sup> ON PROVIDER FILE FOR EACH BEGIN DATE OF CARE

<sup>1</sup> "AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER ZIP CODE, PROVIDER ACCEPTANCE AND TERMINATION DATES, AND PROVIDER RECORD EFFECTIVE DATE.

**ELEMENT NAME: END DATE OF CARE (2-155)**

**VALIDITY EDITS**

2-155-01V MUST BE A VALID GREGORIAN DATE.

**RELATIONAL EDITS**

2-155-01R END DATE OF CARE MUST BE ≥ BEGIN DATE OF CARE

2-155-02R END DATE OF CARE MUST BE ≤FILING DATE.

2-155-03R END DATE OF CARE MUST BE ≤DATE TED RECORD PROCESSED TO COMPLETION.

2-155-04R IF TYPE OF SUBMISSION =

A	ADJUSTMENT <b>OR</b>
B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>
C	COMPLETE CANCELLATION <b>OR</b>
E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

THEN END DATE OF CARE MUST BE ≤DATE ADJUSTMENT IDENTIFIED.

UNLESS THE ADJUSTMENT IS TO CORRECT A PROVISIONALLY ACCEPTED RECORD

2-155-05R PROVIDER MUST BE "AUTHORIZED"<sup>1</sup> ON PROVIDER FILE FOR EACH END DATE OF CARE

2-155-06R END DATE OF CARE MUST BE IN THE SAME FISCAL YEAR AS THE BEGIN DATE OF CARE

<sup>1</sup> "AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER ZIP CODE, PROVIDER ACCEPTANCE AND TERMINATION DATES, AND PROVIDER RECORD EFFECTIVE DATE.

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**ELEMENT NAME: PROCEDURE CODE (2-160)**

**VALIDITY EDITS**

**2-160-01V** MUST BE A VALID PROCEDURE CODE

**RELATIONAL EDITS**

**2-160-01R** IF PROCEDURE CODE DATABASE GOVERNMENT PAY CODE = 'Y' FOR THIS PROCEDURE CODE

**THEN** ON ONE OF THE RECORDS IN THE PROCEDURE CODE DATABASE THE DATED RECORD PROCESSED TO COMPLETION MUST BE ON **OR** AFTER THE PROCESSING EFFECTIVE DATE **AND** BEFORE THE PROCESSING TERMINATION DATE FOR THAT PROCEDURE CODE.

**AND** ON ONE OF THE RECORDS IN THE PROCEDURE CODE DATABASE THE BEGIN DATE OF CARE MUST BE ON OR AFTER THE CARE EFFECTIVE DATE **AND** BEFORE THE CARE TERMINATION DATE FOR THAT PROCEDURE CODE.

**ELSE**

IF PROCEDURE CODE DATABASE GOVERNMENT PAY CODE = 'N' FOR THIS PROCEDURE CODE

**THEN** AMOUNT ALLOWED BY PROCEDURE CODE MUST BE ≤ZERO

**UNLESS** 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**
- CL CLINICAL TRIALS **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** REGION INDICATOR =

**SC SOUTH CONTRACT**

**2-160-02R** IF ANY PROCEDURE CODE IS FOR FEMALE **AND** PERSON SEX (PATIENT) IS MALE

**THEN** AT LEAST ONE OVERRIDE CODE MUST = G DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE

**2-160-03R** IF ANY PROCEDURE CODE IS FOR MALE

**AND NOT** FOR CIRCUMCISION (PROCEDURE CODE<sup>1</sup> 54150 **OR** 54160)

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

<b>ELEMENT NAME: PROCEDURE CODE (2-160) (CONTINUED)</b>	
	AND SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY (FIGURE 2-E-10)
	AND PERSON SEX (PATIENT) IS FEMALE
	THEN AT LEAST ONE OVERRIDE CODE MUST = H DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE
<b>2-160-04R</b>	IF PROCEDURE CODE HAS AN AGE PARAMETER RESTRICTION THEN PATIENT'S AGE MUST BE CONSISTENT WITH RESTRICTIONS
	UNLESS AT LEAST ONE OVERRIDE CODE = R PERSON BIRTH CALENDAR DATE (PATIENT) IS NOT CONSISTENT WITH PROCEDURE/ DIAGNOSIS CODE AGE RESTRICTING; PROCEDURE PERFORMED DUE TO MEDICAL NECESSITY
<b>2-160-05R</b>	IF PROCEDURE CODE <sup>1</sup> = 06896, 98320, A0100, A0110, A0120, A0130, A0140, A0170, L3000- L3003, L3010, L3020, L3030, L3040, L3050, L3060, L3070, L3080, L3090, L3100, L3201-L3207, L3212-L3219, L3221-L3223, L3230, L3250-L3255, L3257, L3265, L3300, L3310, L3320, L3330, L3332, L3334, L3340, L3350, L3360, L3370, L3380, L3390, L3400, L3410, L3420, L3430, L3440, L3450, L3455, L3460, L3465, L3470, L3480, L3485, L3500, L3510, L3520, L3530, L3540, L3550, L3560, L3570, L3580, L3590, L3595, L3600, L3610, L3620, L3630, OR L3649
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = PF PFPWD
	UNLESS ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM IS A CODE LISTED IN FIGURE 2-H-1 OR FIGURE 2-H-2
	OR 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
	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 = X FOREIGN ADSM
<b>2-160-06R</b>	IF TYPE OF SERVICE (FIRST POSITION) = I INPATIENT
	THEN PROCEDURE CODE MUST NOT BE FOR OUTPATIENT ONLY CARE (REFER TO FIGURE 2-E-10).
<b>2-160-07R</b>	IF PROCEDURE CODE <sup>1</sup> = 90892-90898
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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

**ELEMENT NAME: PROCEDURE CODE (2-160) (CONTINUED)**

	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	WR	MENTAL HEALTH WRAPAROUND DEMONSTRATION
2-160-08R	IF PROCEDURE CODE <sup>1</sup> = 98800		
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS & SUPPLIES OR
		M	MAIL ORDER PHARMACY DRUGS & SUPPLIES
	AND NATIONAL DRUG CODE MUST ≠ BLANK		

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**ELEMENT NAME: PROCEDURE CODE MODIFIER (2-165)**

**VALIDITY EDITS**

2-165-01V	MUST BE A VALID PROCEDURE CODE MODIFIER AS DEFINED IN <a href="#">CHAPTER 2, SECTION 2.7</a>
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**RELATIONAL EDITS**

2-165-01R	IF PROCEDURE CODE <sup>1</sup> = 10040-69979 (SURGERY) THEN PROCEDURE CODE MODIFIER MUST = 20, 22, 23, 24, 25-27, 30, 32, 47, 50-59, 62, 66, 73-82, 90, 91, 99, E1-E4, F1-F9, FA, LC, LD, LT, P1-P5, RC, RT, QB, QU, T1-T9, TA, TC OR BLANK.
2-165-02R	IF PROCEDURE CODE <sup>1</sup> = 70010-79999 (RADIOLOGY) THEN PROCEDURE CODE MODIFIER MUST = 22, 26, 27, 32, 51-53, 58, 59, 62, 66, 76-80, 90, 99, QB, QU, TC OR BLANK.
2-165-03R	IF PROCEDURE CODE <sup>1</sup> = 80002-89399 (PATHOLOGY) THEN PROCEDURE CODE MODIFIER MUST = 22, 26, 32, 51-53, 59, 90, 91, QB, QU, TC OR BLANK.
2-165-04R	IF PROCEDURE CODE <sup>1</sup> = 90700-99199 (MEDICINE) THEN PROCEDURE CODE MODIFIER MUST = 22, 25-27, 32, 51-53, 55-59, 76-82, 90, 99, GT, QB, QU, TC OR BLANK.
2-165-05R	IF PROCEDURE CODE <sup>1</sup> = 99201-99499 (EVALUATION/MANAGEMENT) THEN PROCEDURE CODE MODIFIER MUST = 21, 22, 24, 25, 27, 32, 52, 53, 57, 59, GT, QB, QU, TC OR BLANK.
2-165-06R	IF PROCEDURE CODE = A0010-A0999 (TRANSPORTATION SERVICES) THEN PROCEDURE CODE MODIFIER MUST = D, E, G, H, I, J, N, P, R, S, X, AS, EE, EH, EM, EP, ER, ET, GM, HE, HH, HR, HT, PH, QB, QM, QN, QU, RA, RE, RH, SH, UC, XX OR BLANK.
2-165-07R	IF PROCEDURE CODE <sup>1</sup> = A4206-A6406 (MEDICAL AND SURGICAL SUPPLIES) THEN PROCEDURE CODE MODIFIER MUST = CC, LT, RT, QB, QU OR BLANK.
2-165-08R	IF PROCEDURE CODE = B4034-B9999 (ENTERAL & PARENTERAL THERAPY)

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

<b>ELEMENT NAME: PROCEDURE CODE MODIFIER (2-165) (CONTINUED)</b>	
	THEN PROCEDURE CODE MODIFIER MUST = CC, DD, QB, QU OR BLANK.
2-165-09R	IF PROCEDURE CODE = D0110-D9999 (DENTAL PROCEDURES)
	THEN PROCEDURE CODE MODIFIER MUST = CC, ET, LT, QB, QU, RT, TC OR BLANK.
2-165-10R	IF PROCEDURE CODE = E0100-E1830 (DURABLE MEDICAL EQUIPMENT)
	THEN PROCEDURE CODE MODIFIER MUST = CC, KH, KI, LL, LT, MS, NR, NU, QB, QE, QF, QG, QH, QT, QU, RP, RR, RT, TC, UE OR BLANK.
2-165-11R	IF PROCEDURE CODE = J0110-J8999 (DRUGS ADMINISTERED OTHER THAN ORAL METHOD)
	THEN PROCEDURE CODE MODIFIER MUST = AA, AB, AC, AD, AE, AF, AG, CC, QB, QR, QU, TC OR BLANK.
2-165-12R	IF PROCEDURE CODE = J9000-J9999 (CHEMOTHERAPY DRUGS)
	THEN PROCEDURE CODE MODIFIER MUST = CC, QB, QU, TC OR BLANK.
2-165-13R	IF PROCEDURE CODE = L0100-L9999 (ORTHOTIC/PROSTHETIC PROCEDURES)
	THEN PROCEDURE CODE MODIFIER MUST = CC, KO, LT, QB, QU, RT, TC OR BLANK.
2-165-14R	IF PROCEDURE CODE = M0005-M0900 (MEDICAL SERVICES)
	THEN PROCEDURE CODE MODIFIER MUST = AH, AJ, AN, CC, EJ, EM, EP, FP, QB, QC, QD, QT, QU, SF, TC OR BLANK.
2-165-15R	IF PROCEDURE CODE = P2028-P9615 (PATHOLOGY AND LABORATORY)
	THEN PROCEDURE CODE MODIFIER MUST = CC, LR, QB, QR, QU, TC OR BLANK.
2-165-16R	IF PROCEDURE CODE = Q0034-Q9940 (TEMPORARY CODES)
	THEN PROCEDURE CODE MODIFIER MUST = CC, LL, LR, QB, QC, QD, QE, QF, QG, QH, QT, QU, RP, RR, TC, UE OR BLANK.
2-165-17R	IF PROCEDURE CODE = R0070-R0076 (DIAGNOSTIC RADIOLOGY SERVICES)
	THEN PROCEDURE CODE MODIFIER MUST = CC, LT, QB, QU, RT, TC OR BLANK.
2-165-18R	IF PROCEDURE CODE = V2020-V2799 (VISION SERVICES)
	THEN PROCEDURE CODE MODIFIER MUST = AP, CC, LS, LT, PL, QB, QU, RT, SF, TC, VP OR BLANK.
2-165-19R	IF PROCEDURE CODE = V5008-V5364 (HEARING SERVICES)
	THEN PROCEDURE CODE MODIFIER MUST = CC, LT, QB, QU, RT, SF, TC OR BLANK.
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<b>ELEMENT NAME: NATIONAL DRUG CODE (2-170)</b>	
<b>VALIDITY EDITS</b>	
2-170-01V	MUST BE A VALID NATIONAL DRUG CODE OR BLANK
<b>RELATIONAL EDITS</b>	
2-170-01R	IF NATIONAL DRUG CODE = BLANK
	THEN TYPE OF SERVICE (SECOND POSITION) MUST ≠ B RETAIL DRUGS & SUPPLIES OR
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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

**ELEMENT NAME: NATIONAL DRUG CODE (2-170) (CONTINUED)**

M MAIL ORDER PHARMACY DRUGS & SUPPLIES

AND PROCEDURE CODE<sup>1</sup> MUST ≠ 98800

**2-170-02R** IF NATIONAL DRUG CODE ≠ BLANK

THEN TYPE OF SERVICE (SECOND POSITION) MUST =

B RETAIL DRUGS & SUPPLIES OR

M MAIL ORDER PHARMACY DRUGS & SUPPLIES

AND PROCEDURE CODE<sup>1</sup> MUST = 98800 FOR DRUGS

OR PROCEDURE CODE<sup>1</sup> MUST = 99070 FOR SUPPLIES

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**ELEMENT NAME: NUMBER OF SERVICES (2-175)**

**VALIDITY EDITS**

**2-175-01V** MUST BE NUMERIC.

**RELATIONAL EDITS**

**2-175-01R** 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 NUMBER OF SERVICES FOR EACH OCCURRENCE MUST BE > ZERO

**ELEMENT NAME: AMOUNT BILLED BY PROCEDURE CODE (2-180)**

**VALIDITY EDITS**

**2-180-01V** MUST BE NUMERIC.

**RELATIONAL EDITS**

**2-180-00R** IF TYPE OF SUBMISSION ≠

D COMPLETE DENIAL

THEN TOTAL OF ALL OCCURRENCES OF AMOUNT BILLED BY PROCEDURE CODE FOR THIS TED RECORD MUST NOT EXCEED TMA LIMIT OF \$1,000,000.00

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

<b>ELEMENT NAME: AMOUNT ALLOWED BY PROCEDURE CODE (2-185)</b>	
<b>VALIDITY EDITS</b>	
<b>2-185-01V</b>	MUST BE NUMERIC.
<b>RELATIONAL EDITS</b>	
<b>2-185-00R</b>	TOTAL OF ALL OCCURRENCES OF AMOUNT ALLOWED BY PROCEDURE CODE FOR THIS TED RECORD EXCEEDS TMA LIMIT OF \$1,000,000.00.
<b>2-185-01R</b>	IF TYPE OF SUBMISSION = C COMPLETE CANCELLATION <b>OR</b> D COMPLETE DENIAL  <b>THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO FOR ALL OCCURRENCE/LINE ITEM</b>
<b>2-185-02R</b>	IF PRICING RATE CODE = <del>h</del> NO SPECIAL RATE <b>OR</b> D DISCOUNT RATE <b>OR</b> V MEDICARE REIMBURSEMENT RATE  <b>AND TYPE OF SUBMISSION =</b> A ADJUSTMENT <b>OR</b> I INITIAL SUBMISSION <b>OR</b> O ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b> R RESUBMISSION  <b>THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE ≤AMOUNT BILLED BY PROCEDURE CODE FOR EACH OCCURRENCE/LINE ITEM</b>
<b>2-185-03R</b>	IF PRICING RATE CODE = 4 PAID AS BILLED  <b>AND TYPE OF SUBMISSION =</b> A ADJUSTMENT <b>OR</b> I INITIAL SUBMISSION <b>OR</b> O ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b> R RESUBMISSION  <b>THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE = AMOUNT BILLED BY PROCEDURE CODE</b>
<b>2-185-04R</b>	IF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO  <b>THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM MUST BE A CODE LISTED IN CHAPTER 2, ADDENDUM H, FIGURE 2-H-1 OR FIGURE 2-H-2</b>
<b>2-185-05R</b>	IF AMOUNT ALLOWED BY PROCEDURE CODE ≤ZERO  <b>THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM MUST BE A CODE LISTED IN CHAPTER 2, ADDENDUM H, FIGURE 2-H-1 OR FIGURE 2-H-2</b>  <b>AND TYPE OF SUBMISSION MUST =</b> B ADJUSTMENT NON-TED RECORD (HCSR) DATA <b>OR</b> E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
<b>2-185-06R</b>	IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO  <b>THEN TYPE OF SUBMISSION MUST =</b> A ADJUSTMENT <b>OR</b> I INITIAL SUBMISSION <b>OR</b> O ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b> R RESUBMISSION

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

**ELEMENT NAME: AMOUNT ALLOWED BY PROCEDURE CODE (2-185) (CONTINUED)**

<b>2-185-07R</b>	IF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO		
	<b>THEN</b> AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO		
	<b>UNLESS</b> TYPE OF SUBMISSION =	B	ADJUSTMENT NON-TED DATA (HCSR) DATA <b>OR</b>
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

**ELEMENT NAME: AMOUNT PAID BY OTHER HEALTH INSURANCE (2-190)**

**VALIDITY EDITS**

**2-190-01V** MUST BE NUMERIC.

**RELATIONAL EDITS**

**2-190-00R** TOTAL OF ALL OCCURRENCES OF AMOUNT PAID BY OTHER HEALTH INSURANCE FOR THIS TED RECORD EXCEEDS TMA LIMIT OF \$1,000,000.00.

<b>2-190-01R</b>	IF TYPE OF SUBMISSION =	A	ADJUSTMENT <b>OR</b>
		C	COMPLETE CANCELLATION <b>OR</b>
		D	COMPLETE DENIAL <b>OR</b>
		I	INITIAL SUBMISSION <b>OR</b>
		O	ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>
		R	RESUBMISSION

**THEN** AMOUNT PAID BY OTHER HEALTH INSURANCE MUST BE ≥ ZERO.

**2-190-02R** IF ANY OCCURRENCE OF OVERRIDE CODE = U BENEFICIARY INDEMNIFICATION PAYMENT

**THEN** AMOUNT PAID BY OTHER HEALTH INSURANCE MUST EQUAL ZERO.

**2-190-03R** IF THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT PAID BY OTHER HEALTH INSURANCE > 0

**AND** THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT ALLOWED (TOTAL) > 0

**AND** THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE = 0

**THEN** TYPE OF SUBMISSION MUST = O ZERO PAYMENT TED RECORD DUE TO 100% OHI

**ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) TYPE CODE (2-191)**

**VALIDITY EDITS**

**2-191-01V** MUST BE A VALID OGP TYPE CODE LISTING IN [SECTION 2.6](#).

**RELATIONAL EDITS**

NONE

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

**ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) BEGIN REASON CODE (2-192)**

**VALIDITY EDITS**

**2-192-01V** MUST BE A VALID OGP BEGIN REASON CODE LISTING IN [SECTION 2.6](#).

**RELATIONAL EDITS**

NONE

**ELEMENT NAME: AMOUNT APPLIED TOWARD DEDUCTIBLE (2-195)**

**VALIDITY EDITS**

**2-195-01V** MUST BE NUMERIC.

**RELATIONAL EDITS**

**2-195-00R** TOTAL OF ALL OCCURRENCES OF AMOUNT APPLIED TOWARD DEDUCTIBLE FOR THIS TED RECORD EXCEEDS TMA LIMIT OF \$1,000,000.00.

**2-195-01R** IF TYPE OF SUBMISSION =

A	ADJUSTMENT OR
I	INITIAL SUBMISSION OR
O	ZERO PAYMENT WITH 100% OHI/TPL OR
R	RESUBMISSION

THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST BE ≥ ZERO

**2-195-02R** IF TYPE OF SUBMISSION =

C	COMPLETE CANCELLATION OR
D	COMPLETE DENIAL

THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST BE = ZERO

