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MANAGEMENT ACTIVITY

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FOR
TRICARE SYSTEMS MANUAL (TSM)

The TRICARE Management Activity has authorized the following addition(s)/
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CHANGE TITLE: TSM CHANGE CHAPTER 2

PAGE CHANGE(S): See pages 2 and 3.

SUMMARY OF CHANGE(S): The change consists of new TED edits, changes to
current edits and updates to valid value tables. This file also contains name changes
from DITSCAP to DIACAP.

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Officer.

A handwritten signature in black ink that reads "Evie Lammle".

Evie Lammle
Director, Program Requirements Division

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WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

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GENERAL ADP REQUIREMENTS

1.0. GENERAL

1.1. The TRICARE Systems Manual defines the contractor's responsibilities related to automated processing of health care information and transmission of relevant data between the contractor and TRICARE Management Activity (TMA). It covers three major categories of information flowing among the contractor and TMA/Defense Enrollment Eligibility Reporting System (DEERS): health care coverage information; provider information; and pricing information. For each of these categories it presents specifics of submission, record and data element specifications, editing requirements, and TMA reporting of detected errors to the contractor.

1.2. This chapter addresses major administrative, functional and technical requirements related to the flow of health care related Automated Data Processing (ADP) information between the contractor and TMA. TRICARE Encounter Data (TED) records as well as provider and pricing information shall be submitted to TMA in electronic media. This information is essential to both the accounting and statistical needs of TMA in management of the TRICARE program and in required reports to Department of Defense, Congress, other governmental entities, and to the public. Technical requirements for the transmission of data between the contractor and TMA are presented in this section. The requirements for submission of TRICARE Encounter Data records and resubmission of records are outlined in [Chapter 2, Section 1.1](#), the TMA requirements related to submission and updating of provider information are outlined in [Chapter 2, Section 1.2](#) and the TMA requirements related to submission and updating of pricing information are outlined in [Chapter 2, Section 1.3](#).

1.3. For the purposes of this contract, DoD/TMA data includes any information provided to the contractor for the purposes of determining eligibility, enrollment, disenrollment, capitation, fees, patient health information, protected as defined by DoD 6025.18-R, or any other information for which the source is the Government. Any information received by a contractor or other functionary or system(s), whether Government owned or contractor owned, in the course of performing government business is also DoD/TMA data. DoD/TMA data means any information, regardless of form or the media on which it may be recorded.

1.4. The ADP requirements shall incorporate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated standards where required.

2.0. ADP REQUIREMENTS

It is the responsibility of the contractor to employ adequate hardware, software, personnel, procedures, controls, contingency plans, and documentation to satisfy TMA data processing and reporting requirements. Items requiring special attention are listed below.

2.1. Continuity of Operations Plan (COOP)

2.1.1. The contractor shall develop a plan to ensure the continuous operation of their information technologies (IT) systems and data support of TRICARE. The COOP shall ensure the availability of the system and associated data in the event of hardware, software and/or communications failures. The contractor shall develop a COOP that will enable compliance with all processing standards as defined in the TRICARE Operations Manual, [Chapter 1, Section 3](#).

2.1.2. The contractor shall conduct a test of the backup system within the first quarter of the initial health care delivery period and shall continue to assure backup capabilities by testing or reviewing the availability and capability of the backup ADP system to process the TRICARE data and produce the expected results. The contractor's testing of the backup system shall be done at least once a year.

2.1.3. Annual disaster recovery tests shall involve a total of 400 claims and be performed in two parts. Contractors shall perform claims and catastrophic inquiries for 200 claims against production DEERS and the production Catastrophic Cap and Deductible Database (CCDD) on DEERS. This test will demonstrate the ability to connect to production DEERS and the CCDD from the recovery site and the ability to successfully submit claims inquiries and receive DEERS claims responses and Catastrophic Cap Inquiries and responses. Contractors shall not perform catastrophic cap updates in the CCDD and DEERS production regions for these 200 test claims.

2.1.4. To successfully demonstrate the ability to perform catastrophic cap updates and to create newborn placeholder records on DEERS the contractor shall process an additional 200 claims using the DEERS and CCDD contractor test region. Contractors shall coordinate connectivity to the DEERS and the CCDD production and contractor test regions with DMDC at least 30 days prior to the test. In all cases, the results of the review and/or test results shall be reported to the TMA, Contract Management Division within 15 days of conclusion of the review or test.

2.2. DoD Information Assurance Certification And Accreditation Process (DIACAP) Requirements

Contractor Information Systems (IS)/networks involved in the operation of systems of records in support of the DoD Military Health System requires obtaining, maintaining, and using sensitive and personal information strictly in accordance with controlling laws, regulations, and DoD policy.

2.2.1. The contractor's IS/networks involved in the operation of DoD systems of records shall be safeguarded through the use of a mixture of administrative, procedural, physical, communications, emanations, computer and personnel security measures that

together achieve the same requisite level of security established for DoD IS/networks for the protection of information referred to as "Sensitive Information" (SI) and/or "Controlled Unclassified Information." The contractor shall provide a level of trust which encompasses trustworthiness of systems/networks, people and buildings that ensure the effective safeguarding of SI against unauthorized modifications, disclosure, destruction and denial of service.

2.2.2. Information System (IS)/Networks Certification and Accreditation (C&A)

The DoD Information Assurance Certification and Accreditation Process (DIACAP) dated July 6, 2006, was established for the authorization of the operation of DoD information systems consistent with the Federal Information Security Management Act (FISMA), Section 3541 of title 44, United States Code, DoD Directive 8500.1, "Information Assurance (IA)," October 24, 2002, and DoD Directive (DoDD) 8100.1, "Global Information Grid (GIG) Overarching Policy," September 19, 2002. This process supersedes DoD Instruction (DoDI) 5200.40, "DoD Information Technology Security Certification and Accreditation Process (DITSCAP)," December 30, 1997 and DoD 8510.1-M, DoD Information Technology Security Certification and Accreditation Process (DITSCAP) Application Manual," July 2000.

The contractor's IS/networks shall comply with the C&A process established under the DIACAP for safeguarding DoD SI accessed, maintained and used in the operation of systems of records under this contract. Although the DITSCAP has been superseded by the DIACAP, it should be noted there are no differences in the evaluation criteria. The difference between the processes is specific to reporting requirements by the Information Assurance evaluation team.

Accreditation is the formal approval by the government for the contractors' IS' to operate in a particular security mode using a prescribed set of safeguards at an acceptable level of risk. In addition, accreditation allows IS' to operate within the given operational environment with stated interconnections; and with appropriate levels of information assurance security controls.

2.2.3. Certification And Accreditation (C&A) Process

The C&A process ensures that the trust requirement is met for systems and networks. Certification is the determination of the appropriate level of protection required for IS/networks. Certification also includes a comprehensive evaluation of the technical and nontechnical security features and countermeasures required for each system/network. Accreditation is the formal approval by the government to operate the contractor's IS/networks in a particular security mode using a prescribed set of safeguards at an acceptable level of risk. In addition, accreditation allows IS/networks to operate within the given operational environment with stated interconnections; and with appropriate level of protection for the specified period. The C&A requirements apply to all DoD IS/networks and contractor's IS/networks that access, manage, store, or manipulate electronic DoD SI data.

2.3. The DIACAP is the standardized approach to the certification and accreditation (C&A) process within DoD. Each IS/network that undergoes DIACAP must have required security controls in place, must have documented the security components and operation of

the IS/network and must successfully complete testing of the required security controls. The contractor shall ensure **DIACAP** documentation is available for review and is accurate. The contractor shall also implement an information assurance vulnerability management program providing mitigation from known vulnerabilities. The contractor, as part of that program, shall provide a primary and secondary point of contact for the MHS Information Assurance Vulnerability Alert (IAVA) Monitor. The point of contact shall provide, upon receipt of a vulnerability message, an acknowledgment of receipt. The contractor shall mitigate the vulnerability, and upon mitigation, report compliance. Receipt and compliance messages to the government shall occur within the stipulated window, as stated in the vulnerability message, and be directed to the MHS IAVA Monitor. Mitigation compliance for IA vulnerabilities shall be assessed on an annual basis.

The contractor shall execute the **DIACAP** process by providing, for receipt by the Contracting Officer within **60 days** following contract award, the required documentation necessary to receive an Approval to Operate (ATO), and making their IS/networks available for testing and **initiate testing 120 days in advance of accessing DoD data or interconnecting with DoD IS**. The contractor shall ensure the proper contractor support staff is available to participate in all phases of the C&A process. They include, but are not limited to: (a) attending and supporting C&A meetings with the government; (b) supporting/conducting the vulnerability mitigation process; and (c) supporting the C&A Team during system security testing. Contractors must confirm that their system baseline configuration remains static during the initial testing.

Confirmation of system baseline configuration shall be agreed upon during the definition of the C&A boundary and be signed by the government and the contractor and documented as part of the System Identification Profile (SIP) and artifacts.

During the actual baseline and mitigation assessment scans, the information system must remain frozen. The freeze is only in place during the actual testing periods. Changes between baseline testing and mitigation testing must be coordinated and approved by the MHS IA Program Office prior to implementation. Any reconfiguration or changes in the system during the C&A testing process may require a rebaselining of the system and documentation of system changes. This could result in a negative impact to the C&A timeline.

The contractor shall be required to mitigate the vulnerabilities identified for correction during the **C&A** process. The above requirements shall be met before interconnecting with any DoD IS/network or **electronic access to DoD SI** is authorized. The contractor shall comply with the Military Health System (MHS) **DIACAP** Checklist. Reference material and **DIACAP** tools can be obtained at http://www.tricare.osd.mil/tmis_new/ia.htm.

After contract award date, and an ATO is granted to the contractor, reaccreditation is required every three years or when significant changes occur that impact the security posture of the contractors' information system. An annual review shall be conducted by the TRICARE Management Activity Information Assurance Office that comprehensively evaluates existing contractor system security posture in accordance with FISMA.

2.3.1. Disposing of Electronic Media

Contractors shall follow the DoD standards, procedures and use approved products to dispose of unclassified hard drives and other electronic media, as appropriate, in accordance with DoD Memorandum, "Disposition of Unclassified Computer Hard Drives," June 4, 2001. DoD guidance on sanitization of other internal and external media components are found in DoDI 8500.2, "Information Assurance (IA) Implementation," February 6, 2003 (see PECS-1 in Enclosure 4, Attachment 5) and DoD 5220.22-M, "Industrial Security Program Operating Manual (NISPOM)," Chapter 8).

3.0. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The contractor shall be compliant with the Health Insurance Portability and Accountability Act (HIPAA) as implemented by the Department of Health and Human Services (DHHS) final rule on Health Insurance Reform: Security Standards (45 Code of Federal Regulations, Parts 160, 162, and 164), effective April 21, 2003. Although the compliance date established by the DHHS final rule is April 21, 2005, the contractor shall be in compliance with the requirements of the final rule at the start-work date of this contract.

4.0. PHYSICAL SECURITY REQUIREMENTS

The contractor shall employ physical security safeguards for IS/networks involved in the operation of its systems of records to prevent the unauthorized access, disclosure, modification, destruction, use, etc., of DoD SI and to otherwise protect the confidentiality and ensure the authorized use of SI. In addition, the contractor shall support a Physical Security Assessment performed by the government of its internal information management infrastructure using the criteria from the Physical Security Assessment Matrix. The contractor shall correct any deficiencies identified by the government of its physical security posture. The Physical Security Audit Matrix can be accessed via the Policy and Guidance/ Security Matrices section at http://www.tricare.osd.mil/tmis_new/ia.htm.

5.0. PERSONNEL SECURITY ADP/IT REQUIREMENTS

5.1. Policy References

Personnel to be assigned to an ADP/IT position must undergo a successful security screening before being provided access to DoD information technology (IT) resources. Prior to an employee being granted interim access to DoD sensitive information, the organization must receive notification that the Office of Personnel Management (OPM) has scheduled the employee's investigation. The references and specific guidance below provided to TMA by the Under Secretary of Defense for Intelligence (USDI) and OPM safeguard against inappropriate use and disclosure.

- Privacy Act of 1974
- Health Insurance Portability and Accountability Act (HIPAA) of 1996
- DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 2003
- DoD 5200.2-R, "Personnel Security Program," (January 1987)"

- DoD 5220.22-M, “National Industrial Security Program Operating Manual” (NISPOM), January 1995 (Change 2, May 1, 2000)
- DoDI 8500.1, “Information Assurance (IA) (October 24, 2002).”

The requirement above must be met by contractors, subcontractors and others who have access to information systems containing information protected by the Privacy Act of 1974 and protected health information under HIPAA. Background checks are required for all ADP/IT personnel who receive, process, store, display, or transmit sensitive information (SI).

5.2. Formal Designations Required

All contractor personnel in positions requiring access to DoD IS/networks or COCO IS/networks interconnected with DoD IS/networks must be designated as ADP/IT-I, ADP/IT-II, or ADP/IT-III. Only TRICARE contractors are permitted to submit ADP/IT background checks in accordance with this policy. Military Service and Military Treatment Facility contractors are not to use this guidance.

5.3. Special Access Requirements

All contractor personnel accessing the Defense Enrollment Eligibility Reporting System (DEERS) database or the Business to Business (B2B) Gateway must have an ADP/IT-II Trustworthiness Determination. Contractor personnel currently working in DEERS with an ADP/IT-III or an interim ADP/IT-III Trustworthiness Determination must upgrade to an ADP/IT-II or interim ADP/IT-II Trustworthiness Determination no later than October 1, 2004. DEERS access for contractor personnel with ADP/IT-III Trustworthiness Determinations will no longer be granted after October 1, 2004.

New employees hired by contractors are granted interim access for six months upon submission of the SF 85P and fingerprint cards to the Office of Personnel Management. Contractors must notify the TMA Privacy Office of the submission of SF 85Ps for new hires and the date submitted. In addition, Contractors are required to respond timely to the Office of Personnel Management for requests for additional information required for the processing of the SF 85P. Failure to respond timely to the Office of Personnel Management will result in the revocation of interim access by the TMA Privacy Office.

Contractors are required to ensure personnel viewing data obtained from DEERS or the B2B Gateway or viewing Privacy Act protected data follow contractor established procedures as required by the TRICARE Operations Manual, [Chapter 1, Section 4, paragraph 3.0.](#), to assure confidentiality of all beneficiary and provider information. The contractor is required to assure the rights of the individual are protected in accordance with the provisions of the Privacy Act, HIPAA and HHS Privacy regulation and to prevent the unauthorized use of TMA files.

5.4. ADP/IT Category Guidance

In establishing the categories of positions, a combination of factors may affect the determination. Unique characteristics of the system or the safeguards protecting the system

permit position category placement based on the agency's judgement. Guidance on ADP/IT categories is:

ADP/IT-I - Critical Sensitive Position. A position where the individual is responsible for the development and administration of MHS IS/network security programs and the direction and control of risk analysis and/or threat assessment. The required investigation is equivalent to a Single-Scope Background Investigation (SSBI). Responsibilities include:

- Significant involvement in life-critical or mission-critical systems.
- Responsibility for the preparation or approval of data for input into a system, which does not necessarily involve personal access to the system, but with relatively high risk for effecting severe damage to persons, properties or systems, or realizing significant personal gain.
- Relatively high risk assignments associated with or directly involving the accounting, disbursement, or authorization for disbursement from systems of (1) dollar amounts of \$10 million per year or greater; (2) lesser amounts if the activities of the individuals are not subject to technical review by higher authority in the ADP/IT-I category to insure the integrity of the system.
- Positions involving major responsibility for the direction, planning, design, testing, maintenance, operation, monitoring and or management of systems hardware and software.
- Other positions as designated by the DAA that involve a relatively high risk for causing severe damage to persons, property or systems, or potential for realizing a significant personal gain.

ADP/IT-II - Non-critical-Sensitive Position. A position where an individual is responsible for systems design, operation, testing, maintenance and/or monitoring that is carried out under technical review of higher authority in the ADP/IT-I category, includes but is not limited to: (1) access to and/or processing of proprietary data, information requiring protection under the Privacy Act of 1974, or Government-developed privileged information involving the award of contracts; (2) accounting, disbursement, or authorization for disbursement from systems of dollar amounts less than \$10 million per year.

Other positions are designated by the DAA that involve a degree of access to a system that creates a significant potential for damage or personal gain less than that in ADP/IT-I positions. The required investigation is equivalent to a National Agency Check with Law Enforcement and Credit (NACLCL).

ADP/ITs submitted as a NAC to DSS prior to 2000 were approved as ADP/IT-II/III. Effective 2000, OPM took over the investigation process for TMA. The submission requirements for ADP/IT levels were upgraded as follows: ADP/IT-III is a NACLCL; ADP/IT-II is a NACLCL and; an ADP/IT-I is a SSBI. Investigations submitted before 2000 for a NACLCL (ADP/IT-II/III) will need to submit a new SF85P User Form and fingerprint card for a NACLCL to be upgraded to an ADP/IT-II.

ADP/IT-III - Non-sensitive Position. All other positions involved in Federal computer activities. The required investigation is equivalent to a National Agency Check (NAC).

5.5. Additional ADP/IT Level Designation Guidance

All TMA contractors requiring ADP/IT-I Trustworthiness Determinations for their personnel are required to submit a written request for approval to the TMA Privacy Office prior to submitting applications to OPM. The justification will be submitted to the TMA Privacy Officer, Skyline Five, 5111 Leesburg Pike, Suite 810, Falls Church, Virginia, 20041, on the letterhead of the applicant's contracting company. The request letter must be signed by, at a minimum, the company security officer or other appropriate executive, include contact information for the security officer or other appropriate executive, and a thorough job description which justifies the need for the ADP/IT-I Trustworthiness Determination. Contractors shall not apply for an ADP/IT-I Trustworthiness Determination unless specifically authorized by the TMA Privacy Officer.

5.5.1. Required Forms

Each contractor shall be required to complete and submit the necessary standard forms, fingerprint forms, and other documentation as may be required by the Office of Personnel Management (OPM) to open and complete investigations. Additional information may be requested while the investigation is in progress. This information must be provided in the designated timeframe or the investigation may be closed. All contractor employees that are prior military should include Copy 4 of the DD214 (certificate of Release or Discharge from Active Duty) with their original submission. Forms and guidance can be found at <http://www.opm.gov/extra/investigate>.

NOTE: The appropriate billing code will be provided following contract award. Contractors should contact the TMA Privacy Office to obtain the PIPS Form 12 when applying for a Submitting Office Number (SON). The application and billing information must be requested from the TMA Privacy Office. Each contracting company or subcontracting company must contact the TMA Privacy Office individually for this information.

5.5.2. Interim Assignment: (U.S. Citizens Working In The U.S. Only)

Contractor personnel who are U.S. Citizens will receive an OPM Investigation Schedule Notice (ISN) from the TMA Privacy Office once the Office of Personnel Management (OPM) has scheduled the investigation. TMA sends the ISN to the contracting security officer as validation for interim access. The contractor security officer may use receipt of the ISN as their authority to grant interim access to DoD IS/networks until a Trustworthiness Determination is made.

Contractor personnel undergoing the process to upgrade their current Trustworthiness Determination level (e.g., ADP/IT-III to ADP/IT-II) who maintain continuous employment with the contractor, or have had no lapse in employment with the contractor of greater than 24 months, shall continue to have the current access level during the upgrade process.

5.5.3. Temporary Assignments (U.S. Citizens Only)

Temporary employees include intermittent, volunteers, and seasonal workers. Efforts shall be taken to obtain an approved ADP/IT-II or ADP/IT-III Trustworthiness Determination for those positions requiring access to DoD sensitive information. Interim access is allowed as outlined in [paragraph 5.5.2.](#) above.

5.5.4. Preferred/Partnership Providers At OCONUS MHS Facilities (U.S. Citizens Only)

To obtain an ADP Trustworthiness Determination for a preferred/partnership provider the Security Officer of the MTF will contact the TMA Privacy Officer for instructions and guidance on completing and submitting the SF85P User Form, fingerprint cards and system access. The TMA Privacy Officer will provide guidance on system access upon contact by the Security Officer of the MTF.

5.5.5. ADP/IT Level Trustworthiness Determination Upgrades

Contact the TMA Privacy Office if a higher ADP/IT level is required than what was submitted for an employee. In addition, the contractor's security officer must contact the OPM Federal Investigations Processing Center to determine the status of the investigation. OPM can upgrade the level of investigation only if the investigation has not been closed/completed. If the NAC is pending, you may fax a request to upgrade the NAC to a NACLIC in writing to OPM, Attention: Corrections Technician. You must provide the name, SSN, and Case Number on your request (Case Number can be found on the ISN). If the SF85P User Form is missing information, the Correction Technician will call the requester for missing information. Addresses for each organization are shown below.

- TMA Privacy Office, Skyline Five, 5111 Leesburg Pike, Suite 810, Falls Church, Virginia, 22041
- OPM Federal Investigations Processing Center, P.O. Box 618, Boyers, Pennsylvania, 16018-0618
- OPM Corrections Department, Federal Investigations Processing Center, P.O. Box 618, Boyers, Pennsylvania, 16018-0618

If the investigation has been closed/completed, the original SF85P Agency User Form (coversheet) must be submitted for the higher ADP/IT level. The SF85P may be re-used within 120 days of the case closed date, with corrected ADP level code (ADP/IT-II=O8B). The letter "I" must be inserted in the Codes box located above C and D on the SF85P Agency User Form and no fingerprint card is needed. The contractor's Security Officer must update the SF85P Agency User Form, re-sign and re-date the form in Block P. The individual must line through any obsolete information, replacing it with corrected information and initial all changes made to the SF85P. The individual must re-sign and re-date the certification section of the form.

If it is beyond the 120 day period, the old SF85P may be used if all the information is updated and the certification part of the form is re-dated, and re-signed by the individual. A new SF85P Agency User Form (coversheet) showing the correct ADP/IT (O8B) level code

is required at this time. Each correction/change made to the form must be initialed and dated by the individual. Fingerprint cards must be submitted if the case has been closed for more than 120 days.

5.6. Assignment Of Non-U.S. Citizens

5.6.1. Policy

Interim Access at CONUS locations for Non-U.S. Citizens is Not Authorized. Non-U.S. citizen contractor employees are not being adjudicated for any Trustworthiness positions.

5.6.2. Grandfathering Of Non-U.S. Citizens

Earlier guidance authorized the grandfathering (continuation) of certain CONUS non-U.S. Citizens who previously were working on a TMA contract. Grandfathered contractor personnel are authorized to continue working under the existing contract until contract expiration date. This provision is not applicable to contractor employees who opt to transition employment from a contractor holding a legacy TRICARE contract to a contractor awarded a contract under the TRICARE Next Generation series of contracts.

5.6.3. End Date Of CONUS Non-U.S. Citizen Access

Access to DoD IS/networks or data will end on December 31, 2004 for all CONUS non-U.S. Citizen contractor personnel, or in accordance with the guidance provided in [paragraph 5.6.2.](#)

5.6.4. Non-U.S. Citizens/Foreign Nationals Working At OCONUS MHS Facilities

Non-U.S. Citizens/Foreign Nationals employed by DoD organizations overseas, whose duties do not require access to classified information, shall be the subject of record checks that include host-government law enforcement and security agency checks at the city, state (province), and national level, whenever permissible by the laws of the host government, initiated by the appropriate Military Department investigative organization prior to employment.

5.7. Transfers Between Contractor Organizations

5.7.1. When contractor employees transfer employment from one government contractor to another, while their investigation for ADP/IT Trustworthiness Determination is in process, the investigation being conducted for the previous employer may be applied to the new employing contractor. The new contracting company will send an Excel spreadsheet to the TMA Privacy Office to provide notification of the addition of the new employee from a previous TRICARE contractor. The spreadsheet must contain the following:

- Name
- Social Security Number
- Name of the former employing contractor
- ADP/IT level applied for

- Effective date of the transfer/employment

TMA will verify the status of the Trustworthiness Determination/scheduled investigation for the employee(s) being transferred. If the investigation has not been completed, the TMA Privacy Office will notify OPM to transfer the investigation from the old SON (submitting office number) to the new SON. If the investigation has been completed, OPM cannot affect the transfer. If the Trustworthiness Determination has been approved, TMA will verify the approval of the Trustworthiness Determination and send a copy to the new employing contractor's office.

5.8. New Contractor Personnel With Recent Secret Clearance

New contractor personnel who have had an active secret clearance within the last two years do not need to submit a SF85P User Form. The contracting company will need to send a copy of the Letter of Consent (LOC) to the TMA Privacy Office for verification.

5.9. Notification Of Submittal And Termination

Contracting companies must notify the TMA Privacy Office when the Security Officer has submitted the SF85P User Form to OPM for new employees. Upon termination of a contractor employee from the TRICARE Contract, contracting companies must notify the TMA Privacy Office and OPM of the action, including the termination date.

5.10. Exception Or Extensions

Exceptions to or extensions beyond any end date or other requirement will be granted (if approved) only by the Director, TRICARE or the Deputy Director, TRICARE. Any exception or extension, if provided, will be in response to a written request, and based upon appropriate health program interests.

6.0. PUBLIC KEY INFRASTRUCTURE (PKI)

The DoD has initiated a Public Key Infrastructure policy to enhance the identification and authentication of users and systems within DoD. The PKI program is in its initial stage and is evolving. The following paragraphs provide current DoD PKI requirements. Additional guidance as it applies to this contract will be provided as the policy and implementation guidance is finalized within DoD.

The contractor is required to obtain PKI certificates for individuals who will be directly accessing any DoD applications which reside either on a DoD Local Area Network or a DoD private (restricted access, e.g., username/password) Web server including, but not limited to, the following:

- The Defense Online Enrollment System (DOES) [DEERS client/server application]
- The General Inquiry of DEERS (GIQD) application [DEERS Web application]
- The TRICARE Duplicate Claims System [TMA Web application]

- The Enterprise Wide Referral and Authorization System (EWRAS) [Web application]
- Civilian PCM Panel Reassignment [DEERS Client/Server application]
- Catastrophic Cap and Deductible/Fee Research [DEERS Web application]
- PCM Research [DEERS Web application]
- DEERS Security Web Application [Web application]
- OHI/SIT [DEERS Web application]
- Direct Care PCM Panel Reassignment [Web application]
- Purchased Care [Web application]

Contractor personnel who access these systems from a .mil domain will be eligible to receive their certificates from the government. PKI certificates for contractor personnel that access the above listed systems from non-.mil domains may be purchased through DoD approved External Certification Authorities (ECAs).

Additionally the contractor is required to obtain DoD acceptable PKI server certificates for identity and authentication of the servers involved in the following system-to-system or host-to-host interfaces. These interfaces include, but are not limited to, the following:

- Contractor systems for claims eligibility inquiries and responses and DEERS
- Contractor systems and the TRICARE Encounter Data (TED) Processing Center

7.0. TELECOMMUNICATIONS

7.1. MHS Demilitarized Zone (DMZ) Managed Partner Care Business To Business (B2B) Gateway

7.1.1. All contractor systems that will communicate with DoD systems will interconnect through the established MHS B2B gateway. For all Web applications, contractors will connect to a DISA-established Web DMZ.

7.1.2. In accordance with contract requirements, MCS contractors will connect to the B2B gateway via a contractor procured Internet Service Provider (ISP) connection. Contractors will assume all responsibilities for establishing and maintaining their connectivity to the B2B Gateway. This will include acquiring and maintaining the circuit to the B2B Gateway and acquiring a Virtual Private Network (VPN) device compatible with the MHS VPN device.

7.1.3. It is anticipated that modifications will also allow provisioning of dedicated point-to-point commercial circuits to the B2B gateway. The DISA B2B Gateway is a redundant service that is provisioned at two locations. If contractors require high availability, they may acquire redundant circuits to both locations.

7.1.4. Contractors will comply with DoD guidance regarding allowable ports, protocols and risk mitigation strategies.

7.2. Contractor Provided IT Infrastructure

7.2.1. Platforms shall support HTTP, HTTPS, Web derived Java Applets, client/server, FTP, secure FTP, and all software that the contractor proposes to use to interconnect with DoD facilities.

NOTE: The DoD is phasing out the use of FTP. Upon notification from the government, the contractor shall cease using FTP and begin utilizing the FTP alternative stipulated by the government.

7.2.2. Contractors shall configure their networks to support access to government systems (e.g., configure ports and protocols for access).

7.2.3. Contractors shall provide full time connections to a TIER 1 or TIER 2 ISP. Dial-up ISP connections are not acceptable.

7.3. Defense Information System Agency (DISA) Form 41 Submission

All contractors that use the DoD gateways to access government systems must submit a DISA Form 41 or equivalent in accordance with Contracting Officer guidance. In addition, Form 41s are required for each system administrator responsible for each host-to-host interface. Contractors shall complete and submit to TMA one Form 41 for their organization, attached to which shall be a listing of those individuals for whom background checks have been completed or for whom requests/applications for background checks have been completed, submitted to the Office of Personnel Management (OPM), and acknowledgements have been received from OPM that the applications are complete and are pending action by OPM. The request must clearly delineate the ports and protocols used for each IP address. The contractor shall complete the form and submit it to the government for final processing.

7.4. MHS Systems Telecommunications

7.4.1. The primary communication links shall be via Secure Internet Protocol (IPSEC) virtual private network (VPN) tunnels between the contractor's primary site and the MHS B2B Gateway.

7.4.2. The contractor shall place the VPN appliance device outside the contractor's firewalls and shall allow full management access to this device (e.g., in router access control lists) to allow Central VPN Management services provided by the Defense Information Systems Agency (DISA) or other source of service as designated by the MHS to remotely manage, configure, and support this VPN device as part of the MHS VPN domain.

7.4.3. For backup purposes, an auxiliary VPN device for contractor locations shall also be procured and configured for operation to minimize any downtime associated with problems of the primary VPN.

7.4.4. The MHS VPN management authority (e.g., DISA) will remotely configure the VPN once installed by the contractor.

7.4.5. Maintenance and repair of contractor procured VPN equipment shall be the responsibility of the contractor. Troubleshooting of VPN equipment shall be the responsibility of the government.

7.5. Contractors Located On Military Treatment Facilities (MTFs)

7.5.1. If the contractor plans to locate personnel on a military facility, the contractor must coordinate with the Base/Post/Camp communications office and the MTF.

7.5.2. Contractors located on military facilities who require direct access to government systems shall coordinate/obtain these connections with the local MTF and Base/Post/Camp communication personnel. These connections will be furnished by the government.

7.5.3. Contractors located on military facilities that require direct connections to their networks shall either:

- Coordinate their network connections to the respective military infrastructure and through the MHS B2B Gateway.
- If the contractor requires a direct connection back to the contractor's network, they shall provide an isolated IT infrastructure, coordinate with the Base/Post/Camp communications personnel and the MTF in order to get approval for a contractor procured circuit to be installed and to ensure the contractor is within compliance with the respective organizational security policies, guidance and protocols. Note: In some cases, the contractor may not be allowed to establish these connections due to local administrative/security requirements.

7.5.4. The contractor shall be responsible for all security certification documentation as required to support DoD Information Assurance requirements for network interconnections. Further, the contractor shall provide, on request, detailed network configuration diagrams to support **DIACAP** accreditation requirements. The contractor shall comply with **DIACAP** accreditation requirements. All network traffic shall be via TCP/IP using ports and protocols in accordance with current Service security policy. All traffic that traverses MHS, DMDC, and/or military Service Base/Post/Camp security infrastructure is subject to monitoring by security staff using Intrusion Detection Systems.

7.6. DEERS

7.6.1. Primary Site

7.6.1.1. The DEERS primary site is located in Auburn Hills, Michigan and the backup site is located in Seaside, California.

7.6.1.2. The contractor shall communicate with DEERS through the MHS B2B Gateway.

7.6.2. PCs/Hardware

The contractor is responsible for all systems and operating system software needed internally to support the DOES.

7.7. TMA/TRICARE Encounter Data

7.7.1. Primary Site

The TRICARE Encounter Data (TED) primary site is currently located in Denver, Colorado, and operated by the Defense Enterprise Computing Center (DECC), Denver Detachment for the DISA. Note: The location of the primary site may be changed. The contractor shall be advised should this occur.

7.7.2. General

The common means of administrative communication between Government representatives and the contractor is via telephone and e-mail. An alternate method may be approved by TMA, as validated and authorized by TMA. Each contractor on the telecommunication network is responsible for furnishing to TMA at the start-up planning meeting (and update when a change occurs), the name, address, and telephone number of the person who will serve as the technical point of contact. Contractors shall also furnish a separate computer center (Help Desk) number to TMA which the TMA computer operator can use for resolution of problems related to data transmissions.

7.7.3. TED-Specific Data Communications Technical Requirements

7.7.3.1. Systems Interface Requirements

The contractor shall communicate with the government's Data Center through the MHS B2B Gateway.

7.7.3.2. Communication Protocol Requirements

7.7.3.2.1. File transfer software shall be used to support communications with the TED Data Processing Center. CONNECT:Direct is the current communications software standard for TED transmissions. The contractor is expected to upgrade/comply with any changes to this software. The contractor shall provide this product and a platform capable of supporting this product with the TCP/IP option included. Details on this product can be obtained from:

Sterling Commerce
4600 Lakehurst Court
P.O. Box 8000
Dublin, OH 43016-2000 USA
<http://www.sterlingcommerce.com/solutions/products/ebi/connect/direct.html>
Phone: 614-793-7000
Fax: 614-793-4040

7.7.3.2.2. For Ports and Protocol support, TCP/IP communications software incorporating the TN3270 emulation shall be provided by the contractor.

7.7.3.2.3. Transmission size is limited to any combination of 250,000 records at one time.

7.7.3.2.4. “As Required” Transfers

Ad hoc movement of data files shall be coordinated through and executed by the network administrator or designated representative at the source file site. Generally speaking, the requestor needs only to provide the point of contact at the remote site, and the source file name. Destination file names shall be obtained from the network administrator at the site receiving the data. Compliance with naming conventions used for recurring automated transfers is not required. Other site specific requirements, such as security constraints and pool names are generally known to the network administrators.

7.7.3.2.5. File Naming Convention

7.7.3.2.5.1. All files received by and sent from the TMA data processing site shall comply with the following standard when using CONNECT:Direct:

POSITION(S)	CONTENT
1 - 2	'TD'
3 - 8	YYMMDD Date of transmission
9 - 10	Contractor number
11 - 12	Sequence number of the file sent on a particular day. Ranges from 01 to 99. Reset with the first file transmission the next day.

7.7.3.2.5.2. All files sent from the TMA data processing site shall be named after coordination with receiving entities in order to accommodate specific communication requirements for the receivers.

7.7.3.2.5.3. Timing

Telecommunication transfers during normal business hours may be adversely affected by normal processing. Therefore, every attempt shall be made to maximize utilization of telecommunications lines by deferring transfers to night-time operation. Ideally, a single file will be transmitted at night. However, there are no restrictions on the number of files that may be transmitted. Under most circumstances, the source file site shall initiate automated processes to cause transmission to occur. With considerations for timing and frequency, activation of transfers for each application shall be addressed on a case by case basis.

7.7.3.2.5.4. Alternate Transmission

Should the contractor not be able to transmit their files through the normal operating means, the contractor should notify TMA (EL/DS Operations) that they will be sending their files by tape via overnight delivery.

7.8. TMA/MHS Referral And Authorization System

7.8.1. Primary Site

The MHS Referral and Authorization System primary site is to be determined.

7.8.2. PCs/Hardware

The contractor is responsible for all systems and operating system software needed internally to support the MHS Referral and Authorization System.

7.9. TMA/TRICARE Duplicate Claims System

7.9.1. Primary Site

The TRICARE Duplicate Claims System (DCS) primary site is located in Aurora, Colorado.

7.9.2. Contractor Connection With TMA For The Duplicate Claims System (DCS)

The DCS is planned to operate as a web application. The contractor is responsible for providing internal connectivity to the public Internet. The contractor is responsible for all systems and operating system software needed internally to support the DCS. (See the TRICARE Operations Manual, [Chapters 9](#) and [10](#) for DCS Specifications.)

TRICARE ENCOUNTER DATA (TED)

SECTION	SUBJECT
1.1	DATA REPORTING - TRICARE ENCOUNTER DATA RECORD SUBMISSION
	1.0. General
	2.0. Initial Submission Of TED Records
	3.0. Submission Of Adjustment/Cancellation TED Records
	4.0. Resubmission of TED Batch/Vouchers and TED Records
	5.0. Assignment of TED Records to the Accrual Fund
	6.0. Batch/Voucher CLIN /ASAP Account Number Selection Criteria For Regional Contractors
	7.0. Interim Institutional Payments
	8.0. Process for Reporting Resource Sharing and Capitated Treatment Encounters to TMA
	9.0. Process for Reporting Blood Clotting Factor Data to TMA
1.2	DATA REPORTING - PROVIDER FILE RECORD SUBMISSION
	1.0. General
	2.0. Provider File Record Maintenance
	3.0. Resubmission of Provider Batches and Provider Records
1.3	DATA REPORTING - PRICING FILE RECORD SUBMISSION
	1.0. General
2.1	DATA REQUIREMENTS - OVERVIEW
2.2	DATA REQUIREMENTS - DATA ELEMENT LAYOUT
	1.0. Batch/Voucher Header Data Element
	2.0. Institutional data element
	3.0. Non-institutional data element
	4.0. Provider File Record
	5.0. Transmission Records
	6.0. Print/Report Transmissions
2.3	DATA REQUIREMENTS - HEADER RECORD DATA
2.4	DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (A - D)
2.5	DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (E - L)
2.6	DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (M - O)
2.7	DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (P)

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SECTION	SUBJECT
2.8	DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (Q - S)
2.9	DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (T - Z)
2.10	DATA REQUIREMENTS - PROVIDER RECORD DATA
3.1	GENERAL EDIT REQUIREMENTS - OVERVIEW 1.0. TMA Editing System 2.0. TMA Error Messages 3.0. Relational Error Codes 4.0. Relational Error Messages 5.0. No Government Cost Edit Revisions
4.1	HEADER EDIT REQUIREMENTS (ELN 000 - 099)
5.1	INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)
5.2	INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)
5.3	INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)
5.4	INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)
5.5	INSTITUTIONAL EDIT REQUIREMENTS (ELN 400 - 499)
6.1	NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)
6.2	NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)
6.3	NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)
6.4	NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)
7.1	PROVIDER EDIT REQUIREMENTS (ELN 000 - 099)
7.2	PROVIDER EDIT REQUIREMENTS (ELN 100 - 199)
8.1	FINANCIAL EDIT REQUIREMENTS
ADDENDUM A	DATA REQUIREMENTS - COUNTRY AND/OR ISLANDS CODES
ADDENDUM B	DATA REQUIREMENTS - STATE CODES FIGURE 2-B-1 State Codes FIGURE 2-B-2 Medicare State Codes
ADDENDUM C	DATA REQUIREMENTS - PROVIDER'S MAJOR SPECIALTY CODES FIGURE 2-C-1 Provider Major Specialty Codes FIGURE 2-C-2 Provider Major Specialty Codes For Use On Non-Institutional TED Records For Outpatient Hospital Care
ADDENDUM D	DATA REQUIREMENTS - TYPE OF INSTITUTION CODES FIGURE 2-D-1 Type Of Institution

TED RECORD NEGATIVE ADJUSTMENT (CONTINUED)

EFFECT AT TMA	
Amount Billed	500.00
Amount Allowed	500.00
Patient Cost-Share	0
Amount Paid	500.00
Covered Days	5
CANCELLATION TED RECORD	
Amount Billed	0
Amount Allowed	-500.00
Patient Cost-Share	0
Amount Paid	-500.00
Covered Days	-5
EFFECT AT TMA	
Amount Billed	500.00
Amount Allowed	0
Patient Cost-Share	0
Amount Paid	0
Covered Days	0

4.0. RESUBMISSION OF TED BATCH/VOUCHERS AND TED RECORDS

4.1. Batches/vouchers that fail any edits at the header record level will be rejected and returned to the contractor for correction. Header level rejections require the resubmission of the entire batch/voucher with the appropriate data corrections. The RESUBMISSION NUMBER must not be incremented from what was reported on the prior submission.

4.2. Institutional and Non-Institutional Records which fail only relational edits will be “provisionally” accepted on the TMA TED database, and returned to the contractor for correction. Provisionally accepted records must be corrected and resubmitted as an adjustment, in a new voucher/batch. Refer to [paragraph 3.0.](#) for requirements on correction of TED Records with provisional errors.

4.3. Institutional and Non-Institutional Records which fail validity edits will be rejected and returned to the contractor for correction and resubmission. All returned records which fail the validity edits within a **voucher** must be returned by the contractor at the same time and balance to the outstanding TOTAL AMOUNT PAID and number of outstanding records at TMA. All returned records which fail the validity edits within a **batch** must be returned by the contractor at the same time and balance to the outstanding number of records. Upon resubmission, the records will again be processed through the TMA editing system. Resubmission batch/vouchers are identified by the BATCH/VOUCHER RESUBMISSION NUMBER in the Header Record. Resubmission applies to all Institutional and Non-Institutional TED Records which have failed to pass the TMA validity edits, whether or not the TED Records incur relational edits as well.

4.4. TED Record resubmissions must be reported using the TED RECORD INDICATOR reported on the initial or adjustment TED Record, regardless of the number of times the TED Record is resubmitted.

4.5. All data as reported on the initial or adjustment TED Record must be resubmitted except for that data changed in order to correct the error(s).

4.6. If a TED Record with TYPE OF SUBMISSION = 'I' (initial) is rejected for validity errors, report the correction TED Record with TYPE OF SUBMISSION = 'R' (resubmission).

All other TED Records rejected for validity errors must retain their original TYPE OF SUBMISSION code throughout the validity error resubmission process.

4.7. To liquidate or "clear" a voucher, both TOTAL AMOUNT PAID and the number of outstanding TED Records must zero out. When a TED Record passes editing (including provisionally accepted records), the TOTAL NUMBER OF RECORDS and the TOTAL AMOUNT PAID submitted on the original voucher are decremented on the TMA database by the corresponding amount. A voucher "clears" when both totals reach zero and the TMA database reflects no outstanding record or paid amounts.

4.8. To liquidate or "clear" a batch, the number of outstanding records must zeroed out.

4.9. If TMA edits identify that the dollar amounts on the voucher are incorrect, the contractor must correct the related monetary data to balance to the AMOUNT PAID BY GOVERNMENT CONTRACTOR reported on the TED Record. **Do not change the AMOUNT PAID BY THE GOVERNMENT CONTRACTOR on the TED record.** Correction of the payment error will be reflected through the contractor's processing and subsequent submission of the adjustment/cancellation TED Record.

5.0. ASSIGNMENT OF TED RECORDS TO THE ACCRUAL FUND

5.1. All contractors that are required to separate costs between Automated Standard Application for Payment (ASAP) accounts (appropriated funds and accrual funds) shall use the algorithm below to determine the appropriate ASAP account to use when paying a claim.

5.2. When ASAP accounts are assigned to a contractor, the government will specify the appropriate fund that the ASAP account shall be linked to. All claims grouped to the Accrual Fund shall use the algorithm specified below. All claims that do not group with the Accrual Fund shall be grouped with the Appropriated Fund ASAP account.

ACCRUAL FUND ALGORITHM FOR RETIRED SPONSORS, FAMILY MEMBERS OF RETIRED SPONSORS, AND SURVIVORS OF RETIRED DECEASED SPONSORS

IF OTHER GOVERNMENT PROGRAM TYPE CODE =	A	MEDICARE PART A OR
	C	MEDICARE PART A & B OR
	H	MEDICARE HMO
AND HEALTH CARE DELIVERY PROGRAM PLAN COVERAGE CODE =	005	TRICARE STANDARD FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR

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ACCRUAL FUND ALGORITHM FOR RETIRED SPONSORS, FAMILY MEMBERS OF RETIRED SPONSORS, AND SURVIVORS OF RETIRED DECEASED SPONSORS (CONTINUED)

010	TRICARE STANDARD FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
015	TRICARE STANDARD FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
017	TRICARE STANDARD FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
020	TFL FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
021	TFL FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
022	TFL FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
023	TFL FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
110	TRICARE PRIME FOR INDIVIDUAL COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
111	TRICARE PRIME FAMILY COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
131	TRICARE PRIME INDIVIDUAL COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
132	TRICARE PRIME FAMILY COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
134	TRICARE PRIME INDIVIDUAL COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
135	TRICARE PRIME FAMILY COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
136	TRICARE PRIME INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
137	TRICARE PRIME FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS 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

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ACCRUAL FUND ALGORITHM FOR RETIRED SPONSORS, FAMILY MEMBERS OF RETIRED SPONSORS, AND SURVIVORS OF RETIRED DECEASED SPONSORS (CONTINUED)

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
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 WITH CHC FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
151	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS

THEN TED RECORD IS TO BE GROUPED ON THE ACCRUAL VOUCHER

ACCRUAL FUND ALGORITHM FOR RETIRED SPONSORS, FAMILY MEMBERS OF RETIRED SPONSORS, AND SURVIVORS OF RETIRED DECEASED SPONSORS

IF OTHER GOVERNMENT PROGRAM TYPE CODE =	A	MEDICARE PART A OR
	C	MEDICARE PART A & B
AND HEALTH CARE COVERAGE (HCC) MEMBER CATEGORY CODE =	F	FORMER MEMBER OR
	H	MEDAL OF HONOR RECIPIENT OR
	R	RETIRED MILITARY MEMBER ELIGIBLE FOR RETIRED PAY OR
	W	FORMER SPOUSE

THEN TED RECORD IS TO BE GROUPED ON THE ACCRUAL VOUCHER

NOTE: THIS ALGORITHM IS BASED ON THE SUPPOSITION THAT CHILDREN OF RETIRED DECEASED SPONSORS ARE INCLUDED IN ONE OF THE LISTED VALUES UNDER HEALTH CARE COVERAGE MEMBER RELATIONSHIP CODE. VERIFICATION IS PENDING FROM DEERS.

6.0. BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER SELECTION CRITERIA FOR REGIONAL CONTRACTORS¹

The following process is only to be used by contractors submitting both financially underwritten & non-financially underwritten claims to TMA.

6.1. Batches

For all data submissions sent to TMA using the Batch process, the contractor shall zero fill the BATCH/VOUCHER ASAP Account Number.

¹ These guidelines apply only to the benefit CLINS, they DO NOT apply to the Administrative CLINS.

6.2. Vouchers

For all data submissions sent to TMA using the Voucher process, the contractor must use one of the BATCH/VOUCHER **CLIN**/ASAP Numbers assigned to them by TMA, CRM in accordance with the TRICARE Operations Manual (TOM), [Chapter 3, Section 2](#). TMA, CRM shall assign two types of BATCH/VOUCHER **CLIN**/ASAP Account Numbers to the contractor's non-financially underwritten ASAP Accounts (formerly known as not-at-risk bank accounts) and financially underwritten **CLIN** Accounts. Financially underwritten **CLIN** Account Numbers are comprised of the contract CLIN plus the fiscal year (position 7) plus the Region (position 8). CLINs that are only four digits long will have 00 to fill positions 5 and 6 in this field. Non-financially underwritten ASAP Accounts are usually issued on a federal fiscal year basis by TMA, CRM. Financially underwritten CLIN ASAP Accounts are usually issued twice a year, at the change of each federal fiscal year and when an Option Period is exercised. The contractor should use the procedures outlined below in order to properly group claims under the correct BATCH/VOUCHER **CLIN**/ASAP Account Number.

6.2.1. Criteria For Selecting TMA Foreign Non-Financially Underwritten ASAP Accounts (South Contract Only)

All claims submitted using the foreign vouchering process (South Contract only) shall be submitted to TMA, CRM using the non-financially underwritten ASAP Account Numbers with a '3', '4', '5', or '6' in position 8. The BATCH/VOUCHER **CLIN**/ASAP Account Number with a '3' in position 8 shall be used for all appropriated fund foreign benefit payments - excluding Navy/Marine deployed claims covered by TRICARE Global Remote Overseas. The BATCH/VOUCHER **CLIN**/ASAP Account Number with a '4' in position 8 shall be used for all Accrual/Trust fund foreign benefit payments. The BATCH/VOUCHER **CLIN**/ASAP Account Number with a '5' in position 8 shall be used for all Navy deployed claims covered by TRICARE Global Remote Overseas. The BATCH/VOUCHER **CLIN**/ASAP Account Number with a '6' in position 8 shall be used for all Marine deployed claims covered by TRICARE Global Remote Overseas.

6.2.2. Criteria For Selecting The TMA Domestic Non-Financially Underwritten ASAP Account (excludes claims that meet criteria specified under 6.2.1. above)

All domestic non-financially underwritten claims shall be submitted to TMA, CRM using the non-financially underwritten ASAP Account Number with a '1' in position 8. Exception: All Resource Sharing claims must follow the procedures as indicated in [paragraph 6.2.3](#).

6.2.3. Criteria For Selecting Financially Underwritten CLINs (excludes claims that meet criteria specified under 6.2.1. and 6.2.2. above)

All financially underwritten benefit payments and all Resource Sharing claims must use the BATCH/VOUCHER **CLIN**/ASAP Account Number containing the TMA Benefit CLIN (positions 1 through 6 of ASAP).

6.2.4. Criteria For Selecting BATCH/VOUCHER CLIN/ASAP Account Number based on 'Active' Dates (Fiscal Year & Option Period)

All BATCH/VOUCHER CLIN/ASAP Account Numbers assigned by TMA, CRM shall have an 'active' date range assigned. The BATCH/VOUCHER CLIN/ASAP Account Number's 'active' dates shall not overlap across Option Periods (CLIN type account numbers only) or Fiscal Year (ASAP & CLIN type account numbers). The BATCH/VOUCHER Date (0-030) is the field TMA shall use when editing for proper selection of BATCH/VOUCHER CLIN/ASAP Account Number based on date. All disbursements shall be made using a currently 'active' BATCH/VOUCHER CLIN/ASAP Account Number. All credits where reported disbursements did not occur (stale dated checks, voids, etc.) shall be credited back to the BATCH/VOUCHER CLIN/ASAP Account Number originally used to report the disbursement. All collections (credits) of funds where the disbursement was originally reported using a CLIN Type BATCH/VOUCHER CLIN/ASAP Account Numbers shall be credited back to the BATCH/VOUCHER CLIN/ASAP Account Number originally used to report the disbursement. All collections (credits) of funds where the disbursement was originally reported to TMA using a ASAP Type BATCH/VOUCHER CLIN/ASAP Account Numbers (BATCH/VOUCHER CLIN/ASAP Account Number with a '1' or '3' or '4' or '5' or '6' in position 8) shall be credited to TMA using currently 'active' BATCH/VOUCHER CLIN/ASAP Account Number.

Note: These guidelines apply only to benefit CLINs. They DO NOT apply to administrative CLINs.

7.0. INTERIM INSTITUTIONAL PAYMENTS

In certain cases, providers can submit interim bills for institutional claims. All TED Records for interim (interim or final) institutional bills must be submitted as an adjustment using the same ICN as the initial submission.

8.0. PROCESS FOR REPORTING RESOURCE SHARING AND CAPITATED TREATMENT ENCOUNTERS TO TMA

The following process is to be used by claims processors to submit data to TMA which relates to Resource Sharing or Capitated Treatment Encounters.

8.1. Special Processing Code

For Resource Sharing and/or Capitated claims/encounters, submit a TED Record which includes the appropriate SPECIAL PROCESSING CODE, as defined in [Chapter 2, Section 2.8](#), for each patient encounter.

8.2. "Amount" Field Reporting

The "amount" fields must contain the following:

8.2.1. Amount Billed/Amount Billed By Procedure Code

The AMOUNT BILLED/AMOUNT BILLED BY PROCEDURE CODE fields shall be the amount (institutional or noninstitutional charges) that the capitated provider would charge a patient on a capitated basis. If a Resource Sharing provider is being reimbursed on a fee-for-service basis with negotiated/discounted rates, report these amounts.

8.2.2. Amount Allowed/Amount Allowed By Procedure Code

The AMOUNT ALLOWED/AMOUNT ALLOWED BY PROCEDURE CODE fields must contain the appropriate DRG or per diem for institutional services, the CHAMPUS Maximum Allowable Charge (CMAC) for noninstitutional services, or negotiated/discounted rates for both institutional and noninstitutional services.

8.2.3. Amount Paid By Government Contractor

The AMOUNT PAID BY GOVERNMENT CONTRACTOR field must equal the “lesser” of the amount allowed minus (PATIENT COST-SHARE plus AMOUNT APPLIED TOWARD DEDUCTIBLE) or AMOUNT ALLOWED minus amount of OHI. If the “Lesser” computed amount is negative, AMOUNT PAID BY GOVERNMENT CONTRACTOR must = \$0.00.

9.0. PROCESS FOR REPORTING BLOOD CLOTTING FACTOR DATA TO TMA

The following process is to be used by claims processors to report claim-related data to TMA which contain charges for blood clotting factor.

9.1. Blood Clotting Factor

Data is to be reported on the Institutional TED Record, even though they are to be reimbursed separately from the DRG methodology.

9.2. Calculation of Charge

Charges will be calculated in a two-step process, as described below.

9.2.1. First Step

The DRG-reimbursable hospital charges will be calculated in the normal way. All related financial data will be stored for later use (see below).

9.2.2. Second Step

The blood clotting factor financial data will be calculated based on the reimbursement methodology described in the TRICARE Policy Manual. All related financial data will be stored for later use. Revenue Code 0636 (Drugs Requiring Detailed Coding) is to be reported for blood clotting factor only. All other drugs are to be reported using the appropriate Revenue Codes in the 025X series.

9.2.2.1. The number to be coded in the UNITS OF SERVICE field is the number of units billed on the claim, not the number of payment units (which is 100 times the number of units billed).

9.2.2.2. The billed charges for blood clotting factor are to be reported in the TOTAL CHARGE BY REVENUE CODE field of the payment record.

NOTE: While blood clotting factor charges will be priced separately, the ADJUSTMENT DENIAL REASON CODE cannot indicate DRG non-reimbursables.

9.2.3. Data Reporting

From the two steps above, merge the financial data as follows, and enter them into the appropriate cost fields:

9.2.3.1. Amount Billed

This is the sum of all billed charges **including** those for blood clotting factor.

9.2.3.2. Amount Allowed

This is the sum of the two separate amounts allowed resulting from the calculations in step 2 above.

9.2.3.3. Amount of Other Health Insurance

This is the amount paid by other primary sources of reimbursement, if applicable.

9.2.3.4. Patient Cost-Share

Enter in the appropriate field based on the Category of Beneficiary:

9.2.3.4.1. Patient Cost-Share (For Other Than Family Members of Active Duty)

This is the amount based on either 25% of the billed charges (including those for blood clotting factor) or the per diem amount times the number of days in the hospital stay.

9.2.3.4.2. Patient Cost-Share (For Family Members of Active Duty)

This is the amount based on the inpatient hospital daily rate times the number of days in the hospital stay.

9.2.3.4.3. Amount Paid By Government Contractor

This is the sum of the two separate amounts resulting from the calculations in step 2 above.

DATA REQUIREMENTS - DATA ELEMENT LAYOUT

1.0. BATCH/VOUCHER HEADER DATA ELEMENT

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
0-001	HEADER TYPE INDICATOR	X	1	1
0-005	CONTRACT IDENTIFIER		2	34
0-010	CONTRACT NUMBER	X(13)	2	14
0-015	BATCH/VOUCHER IDENTIFIER	X	15	15
0-020	BATCH/VOUCHER NUMBER		16	34
0-025	BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER	X(8)	16	23
0-030	BATCH/VOUCHER DATE	YYYYDDD	24	30
0-035	BATCH/VOUCHER SEQUENCE NUMBER	X(2)	31	32
0-040	BATCH/VOUCHER RESUBMISSION NUMBER	X(2)	33	34
0-045	TOTAL NUMBER OF RECORDS	9(7)	35	41
0-050	TOTAL AMOUNT PAID	S9(10)V99	42	53
0-055	INITIAL TRANSMISSION DATE (TMA DERIVED)	YYYYMMDD	54	61
0-060	TMA BATCH/VOUCHER PROCESSING DATE (TMA DERIVED)	YYYYMMDD	62	69
0-065	FUND ACCOUNTING	S9(8)V99	70	79

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DATA REQUIREMENTS - DATA ELEMENT LAYOUT

2.0. INSTITUTIONAL DATA ELEMENT

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
1-001	RECORD TYPE INDICATOR	X	1	1
1-005	TED RECORD INDICATOR		2	25
1-010	INTERNAL CONTROL NUMBER (ICN)		2	18
1-015	FILING DATE	YYYYDDD	2	8
1-020	FILING STATE/COUNTRY CODE	X(3)	9	11
1-025	SEQUENCE NUMBER	X(7)	12	18
1-030	TIME STAMP	X(6)	19	24
1-035	ADJUSTMENT KEY	X	25	25
1-040	DATE TED RECORD PROCESSED TO COMPLETION	YYYYMMDD	26	33
1-045	DATE ADJUSTMENT IDENTIFIED	YYYYMMDD	34	41
1-050	PERSON IDENTIFIER (SPONSOR)	X(9)	42	50
1-051	PERSON IDENTIFIER TYPE CODE (SPONSOR)	X	51	51
1-056	PAY GRADE CODE (SPONSOR)	X(2)	52	53
1-057	PAY PLAN CODE (SPONSOR)	X(5)	54	58
1-060	SERVICE BRANCH CLASSIFICATION CODE (SPONSOR)	X	59	59
1-065	AGR SERVICE LEGAL AUTHORITY CODE	X	60	60
1-066	HEALTH CARE COVERAGE MEMBER CATEGORY CODE	X	61	61
1-070	HEALTH CARE COVERAGE MEMBER RELATIONSHIP CODE	X	62	62
1-075	PERSON NAME (PATIENT)		63	157
1-076	PERSON LAST NAME (PATIENT)	X(35)	63	97
1-077	PERSON FIRST NAME (PATIENT)	X(25)	98	122
1-078	PERSON MIDDLE NAME (PATIENT)	X(25)	123	147
1-079	PERSON CADENCY NAME (PATIENT)	X(10)	148	157
1-080	PERSON IDENTIFIER (PATIENT)	X(9)	158	166
1-081	PERSON IDENTIFIER TYPE CODE (PATIENT)	X	167	167
1-085	PERSON BIRTH CALENDAR DATE (PATIENT)	YYYYMMDD	168	175
1-095	PATIENT IDENTIFIER (DOD)	X(10)	176	185
1-097	DEERS IDENTIFIER (PATIENT)	X(11)	186	196
1-100	PERSON SEX (PATIENT)	X	197	197
1-105	PATIENT ZIP CODE	X(9)	198	206
1-110	ENROLLMENT/HEALTH PLAN CODE	X(2)	207	208
1-111	HEALTH CARE DELIVERY PROGRAM PLAN COVERAGE CODE	X(3)	209	211
1-112	REGION INDICATOR	X(2)	212	213
1-115	PCM LOCATION DMIS-ID (ENROLLMENT) CODE	X(4)	214	217
1-120	AMOUNT BILLED (TOTAL)	S9(7)V99	218	226
1-125	AMOUNT ALLOWED (TOTAL)	S9(7)V99	227	235
1-130	AMOUNT PAID BY OTHER HEALTH INSURANCE	S9(7)V99	236	244
1-131	OTHER GOVERNMENT PROGRAM TYPE CODE	X	245	245

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DATA REQUIREMENTS - DATA ELEMENT LAYOUT

5.3. Appended to the end of each transmission to TMA, whether by teleprocessing or magnetic tape, will be a transmission trailer record. The format for the transmission trailer record follows:

TRANSMISSION TRAILER RECORD FORMAT

POSITION(S)	DESCRIPTION	CONTENT	COMMENT
1	Alpha	Record ID	Must be "@" sign.
2-3	Alphanumeric	Contractor Number	TMA-assigned Contractor number.
4-10	Alphanumeric	Transmission Date	Enter in YYYYDDD format.
11-14	Numeric	Batch Count	Number of batches and/or vouchers in the transmission.
15-20	Numeric	Record Count	Includes the total number of batch/voucher header records, provider, pricing and variable length TED records. Excludes transmission header and transmission trailer.
21-80	Blank	Reserved	Must be HEX 40.

5.4. Transmissions will be returned to the contractor, with appropriate error codes appended, if any of the following occur:

ERROR CODE	ERROR TYPE	VALIDATION RULE
1200	Transmission header record not found	First record of the file must be a Transmission Header (1st position is 'T').
1201	No records found in Transmission file	Byte count of the file = 0.
1202	Data Type is incorrect	Data Type must be "TED Data" - upper/lower case as shown is required. Cannot be all lower or all upper case.
1203	Second transmission header found	2nd Transmission Header (1st position is 'T') must not be found.
1207	Value of MAXRLN in transmission header is not possible	MAXRLN must be a valid value based on the combinations of record lengths included. Compare against all possible record lengths for Header (1), Inst (450), Non-Inst (99), and Provider (1) records.
1210	Transmission trailer record not found	A record must be found with 1st position = '@'.
1220	Second record was not a batch or voucher header record)	Second record of the transmission must be batch/voucher record (record type = 0 or 5).

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DATA REQUIREMENTS - DATA ELEMENT LAYOUT

ERROR CODE	ERROR TYPE	VALIDATION RULE
1240	Header record error in FSIZE, Record Type, or MAXRLLEN fields)	'FSIZE', 'RTYPEV' and 'MAXRLLEN' literals must be found in Transmission Header record and value of MAXRLLEN must be > 0 and < 25535.
1250	Record type other than 0, 1, 2, 3, 4,5, T, or @ is invalid)	Record Type (1st position of the record) must be 0, 1, 2, 3, 4, 5, 6, 9, T, or @.
1260	Extraneous data found after transmission trailer record	No record should be found after Trailer Record of the transmission file.
1290	Count of batch/voucher headers on trailer not equal headers read	Count of batch/voucher headers on trailer must match count of batch/vouchers.
1291	Batch/voucher Identifier code invalid	Batch/voucher identifier must be = 3, 4, or 5.
1295	Total record count on transmission trailer record not in balance.	Record count of transmission trailer must match total record count (except transmission header and trailer) of the file.
1299	Transmission header file-size not in possible in file	Transmission Header file size (FSIZE) must match total record count (except transmission header) of the file.
1850	Duplicate Transmission file	Transmission is a duplicate within this cycle.
1999	Invalid character	Transmission file must not contain invalid characters (e.g., binary values, >, <, :, ;, \, ", , etc.). The only acceptable characters are A-Z (uppercase only), 0-9, ', @, *, #, and blank.
2000	Invalid data case	Non-numeric data must be upper case.

6.0. PRINT/REPORT TRANSMISSIONS

6.1. All errors in TED Records detected by the TMA editing system will be reported to the contractor in 133-byte record print image format. Except for special situations, these records will be teleprocessed to the contractor the day following processing. The format of the error records returned to the contractor will be:

ERROR RECORDS RETURNED FORMAT

DESCRIPTION	POSITION	
	FROM	THRU
Number of errors on this TED record	1	3
TED data as submitted	4	Variable
Error code number (occurs 1 to 500 times based on number of errors above)	Variable	Variable

DATA REQUIREMENTS - HEADER RECORD DATA

DATA ELEMENT DEFINITION

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER			
RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Header	0-025	1	Yes ¹
PRIMARY PICTURE (FORMAT) Eight (8) alphanumeric characters.			
DEFINITION	This field is used to identify the Automated Standard Application for Payment (ASAP) Account ² Number the voucher will be drawn from. Each year when new non-financially underwritten bank account(s) are setup by the contractor (per the TRICARE Operations Manual, Chapter 3, Section 2), TMA will assign an 8 digit CLIN/ASAP Account Number to draw funds from as checks clear the non-financially underwritten bank account(s).		
CODE/VALUE SPECIFICATIONS N/A			
ALGORITHM	Chapter 2, Section 1.1, paragraph 5.0 . provides instructions on how to assign TED Records to the Accrual Fund.		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE	GROUP		
N/A	VOUCHER NUMBER		
NOTES AND SPECIAL INSTRUCTIONS:			
¹ For Header Type Indicator '0' or '9', Batch/Voucher CLIN/ASAP Account Number can only be zero filled.			
² For Header Type Indicator '5' or '6', contractor must have "opened" CLIN/ASAP Accounts with TMA, Contract Resource Management (CRM) per TRICARE Operations Manual (TOM), Chapter 3, Section 2 .			
CLIN based CLIN/ASAP Account Numbers are used for Invoicing (via the TED Record) the Cost Reimbursement Benefit CLINS (positions 1 thru 6 of the CLIN/ASAP Account Number shall equal the benefit contract CLIN or sub-CLIN you are invoicing), ASAP based CLIN/ASAP Account Numbers are used for the reporting of 'pass thru' costs.			

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DATA REQUIREMENTS - HEADER RECORD DATA

DATA ELEMENT DEFINITION

ELEMENT NAME: BATCH/VOUCHER DATE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Header	0-030	1	Yes

PRIMARY PICTURE (FORMAT) Seven (7) alphanumeric characters, YYYYDDD.

DEFINITION Date the contractor first created the batch/voucher for transmission to TMA. This date will not change through the resubmission process.

CODE/VALUE SPECIFICATIONS	YYY	4 digit calendar year
	DDD	3 digit Julian date

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	BATCH/VOUCHER NUMBER

NOTES AND SPECIAL INSTRUCTIONS:

N/A

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DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (A - D)

DATA ELEMENT DEFINITION

ELEMENT NAME: DEERS DEPENDENT SUFFIX

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-075	1	No

PRIMARY PICTURE (FORMAT) Two (2) alphanumeric characters.

DEFINITION Code maintained on DEERS database that uniquely identifies the patient within the family. Download field from DEERS.

CODE/VALUE SPECIFICATIONS

Blank (not reported)

01-19	Eligible Dependent Children
20	Sponsor
30-39	Spouse of Sponsor
40-44	Mother of Sponsor
45-49	Father of Sponsor
50-54	Mother-in-law of Sponsor
55-59	Father-in-law of Sponsor
60-69	Other Eligible Family Members (including former spouse)
70-74	Unknown by DEERS
75	Pseudo DDS - Unknown by Contractor
98	Service Secretary Designee

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

This data element CAN ONLY be used for TYPE OF SERVICE (SECOND POSITION) = 'M' (Mail Order Pharmacy Drugs, Supplies, Prescription Authorizations, and Reviews) and for TYPE OF SUBMISSION 'B' (ADJUSTMENT OF NON-TED REORD (HCSR) DATA) AND 'E' (COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA).

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CHAPTER 2, SECTION 2.4

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (A - D)

DATA ELEMENT DEFINITION

ELEMENT NAME: DEERS IDENTIFIER (PATIENT)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-097	1	Yes
Non-Institutional	2-082	1	Yes

PRIMARY PICTURE (FORMAT) Eleven (11) alphanumeric characters.

DEFINITION A DEERS identifier created from the combination of the DEERS assigned 9-digit DEERS Family identifier and 2-digit DEERS Beneficiary Identifier. Download from DEERS.

CODE/VALUE SPECIFICATIONS Positions 1 through 9 = DEERS Family Identifier

ALGORITHM Positions 10 and 11 = DEERS Beneficiary Identifier (Valid Values are 00 through 99).

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

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

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CHAPTER 2, SECTION 2.6

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

DATA ELEMENT DEFINITION

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

NOTES AND SPECIAL INSTRUCTIONS:

¹ Required on all TED records reimbursed under Outpatient Prospective Payment System (OPPS).

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

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CHAPTER 2, SECTION 2.6

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

DATA ELEMENT DEFINITION

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

RECORDS/LOCATOR NUMBERS

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

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

DEFINITION The code that indicates the reason that the person's period of eligibility for a non-DoD Other Government Program began. Download field from DEERS.

CODE/VALUE SPECIFICATIONS		
	A	Eligible for Medicare. Eligibility began after age 65 (the person did not have enough quarters of Social Security contributions to qualify at age 65). This value applies to Medicare Part A.
	B	Enrollment in Medicare Part B; over or under age 65. Medicare Part B can only be obtained by payment of monthly premiums. This value applies to Medicare Part B.
	D	Eligible for Medicare under age 65 because of disability. This value applies to Medicare Part A.
	E	Eligible for Medicare at age 65. This value applies to Medicare Part A.
	F	Eligibility for Medicare defaulted at age 65; verification not received from Center for Medicare and Medicaid Services (CMS). Applies to Medicare Part A only.

NOTES AND SPECIAL INSTRUCTIONS:

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

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

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

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

DATA ELEMENT DEFINITION

ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) BEGIN REASON CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)		
	N	Not eligible for Medicare. Under age 65 this is the default value. At age 65 this indicates eligibility could not begin because the person did not have enough quarters of Social Security contributions to qualify. This value applies to Medicare Part A.
	P	Eligible for Medicare at or after 65 because of purchase. This value applies to Medicare Part A.
	R	Eligible for Medicare under age 65 because of end-stage renal disease. This value applies to Medicare Part A and Part B.
	V	Eligible for the Civilian Health and Medical Program of the Department of Veteran's Affairs (CHAMPVA).
	W	Not applicable.
ALGORITHM N/A		
SUBORDINATE AND/OR GROUP ELEMENTS		
SUBORDINATE		GROUP
N/A		N/A

NOTES AND SPECIAL INSTRUCTIONS:

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

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

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

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

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 HMO
		N	No Medicare
		V	CHAMPVA

NOTES AND SPECIAL INSTRUCTIONS:

Instructions to submit the TED OGP TYPE CODE:

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

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

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

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

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

DATA ELEMENT DEFINITION

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

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

Instructions to submit the TED OGP TYPE CODE:

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

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

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

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

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

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE			
RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-160	3	Yes ¹
Non-Institutional	2-095	3	Yes ¹
PRIMARY PICTURE (FORMAT) Six (6) alphanumeric characters.			
DEFINITION The group of three codes which indicate that certain questionable data has been identified and approved by the contractor and the normal editing and processing rules should be bypassed for this record.			
CODE/VALUE SPECIFICATIONS	11	Claims retained by the contractor for development (information not available from in-house sources). (Effective 02/01/2000)	

NOTES AND SPECIAL INSTRUCTIONS:

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

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

Clarification on use of Override Codes 'H1' & 'H2':

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

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

Use of Override Code 'H2':

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

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 2.6

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

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	12	TPL claims requiring development. (Effective 02/01/2000)
	13	Government intervention claims - pending 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 pending at government direction 60 calendar days and over. (Effective 02/01/2000)
	A	Patient is over 65. (Terminated 06/01/2003)

NOTES AND SPECIAL INSTRUCTIONS:

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

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

Clarification on use of Override Codes 'H1' & 'H2':

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

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

Use of Override Code 'H2':

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

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	B	Patient is a spouse under 12 years of age.
	C	Good faith claim; payment has been made.
	D	Patient is family member 21 years or older and over 18 for VA (over 18 for VA is no longer effective after 01/01/1996).
	E	Diagnosis is maternity; patient is under 12 years of age.
	F	Claim was filed after the filing deadline.
	G	Diagnosis/procedure code for female; sex indicates male.

NOTES AND SPECIAL INSTRUCTIONS:

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

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

Clarification on use of Override Codes 'H1' & 'H2':

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

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

Use of Override Code 'H2':

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

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	H	Diagnosis/procedure code for male, sex indicates female.
	I	Patient is a former spouse under 34 years of age.
	J	Successive admission (patient is family member of an active duty sponsor and cost-share is based on both current and prior admission). (Institutional Only)
	K	Catastrophic loss protection limit reached, patient cost-share and deductible rules do not apply.
	M	NATO, Social Security Number not applicable.

NOTES AND SPECIAL INSTRUCTIONS:

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

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

Clarification on use of Override Codes 'H1' & 'H2':

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

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

Use of Override Code 'H2':

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

DATA ELEMENT DEFINITION

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

NOTES AND SPECIAL INSTRUCTIONS:

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

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

Clarification on use of Override Codes 'H1' & 'H2':

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

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

Use of Override Code 'H2':

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

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	S	Zip code override to be used when: <ol style="list-style-type: none"> 1. A beneficiary has moved out of a region and the contractor is still responsible for the care claimed; or 2. If a beneficiary resides in a region different from the region they are enrolled in, but are within the same contract jurisdiction.
	U	Beneficiary indemnification payment

NOTES AND SPECIAL INSTRUCTIONS:

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

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

Clarification on use of Override Codes 'H1' & 'H2':

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

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

Use of Override Code 'H2':

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

DATA ELEMENT DEFINITION

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

NOTES AND SPECIAL INSTRUCTIONS:

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

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

Clarification on use of Override Codes 'H1' & 'H2':

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

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

Use of Override Code 'H2':

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

DATA ELEMENT DEFINITION

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

NOTES AND SPECIAL INSTRUCTIONS:

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

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

Clarification on use of Override Codes 'H1' & 'H2':

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

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

Use of Override Code 'H2':

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

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 2.7

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (P)

DATA ELEMENT DEFINITION

ELEMENT NAME: PROCEDURE CODE MODIFIER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-165	4/Up to 99	No

PRIMARY PICTURE (FORMAT) Four occurrences of two (2) alphanumeric characters per line item for non-institutional.

DEFINITION Two digit code which provides the means by which the health care professional can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. (Refer to Physician's Current Procedure Terminology¹ (CPT-4), or HCPCS National Level II Medicare Codes)

CODE/VALUE SPECIFICATIONS Must be 21-27, 32, 47, 50-59, 62, 63, 66, 73-82, 90, 91, 99, 0A-0P, 0Z, 1A-1J, 1Z, 2A-2O, 2Q-2T, 2Z, 3A-3I, 3K, 3Z, 4A-4O, 4Z, 5A-5O, 5Z, 6A-6F, 6Z, 7A-7F, 7Z, 8A, 8B, 8Z, 9A-9D, 9L-9Q, 9Z, A1-A9, AA, AD-AH, AJ, AK, AM, AP-AX, BA, BL, BO-BR, BU, CA-CG, CR, DE, DG, DI, DJ, DN, DR, DS, DX, E1-E4, ED, EG-EJ, EM, EN, EP, ER-ET, EX, EY, F1-F9, FA, FB, FP, G1-G9, GA-GT, GV-GZ, H9, HA-HZ, ID, IE, IG, IH, IJ, IN, IR, IS, IX, J1-J3, JD, JE, JG-JL, JN, JR, JS, JW, JX, K0-K4, KA-KD, KF, KH-KJ, KM-KS, KX, KZ, LC, LD, LL, LR-LT, MS, MR, ND, NE, NG-NJ, NN, NP, NR-NU, P1-P6, PL, PN, Q2-Q9, QA-QH, QJ-QZ, RC-RE, RG-RJ, RN, RP-RT, RX, SA-SN, SQ-SY, T1-T9, TA, TC-TK, TL-TN, TP-TW, U1-U9, UA-UH, UJ-UK, UN, UP-US, VP, XD, XE, XG-XJ, XN, XR, XS, or blank.

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

¹ CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

NOTE: Can report from 0 to 4 codes. Left justify and blank fill. Do not duplicate. Each occurrence consists of two (2) characters left justify and blank fill to right.

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 2.7

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (P)

DATA ELEMENT DEFINITION

ELEMENT NAME: PROCESSING INFORMATION

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-155	1	Yes ¹

PRIMARY PICTURE (FORMAT) Group

DEFINITION Field containing multiple elements that describe processing related to the TED Record.

CODE/VALUE SPECIFICATIONS N/A

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
OVERRIDE CODE TYPE OF SUBMISSION CA/NAS NUMBER CA/NAS REASON FOR ISSUANCE CA/NAS EXCEPTION REASON SPECIAL PROCESSING CODE PRICING RATE CODE	N/A

NOTES AND SPECIAL INSTRUCTIONS:

¹ Required if applicable to TED Record conditions.

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CHAPTER 2, SECTION 2.8

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (Q - S)

DATA ELEMENT DEFINITION

ELEMENT NAME: SOURCE OF ADMISSION (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	A Transfer from a Critical Access Hospital (CAH)	The patient was admitted to this facility as a transfer from a Critical Access Hospital where he or she was an inpatient.
	B Transfer from Another HHA	The patient was admitted to this home health agency as a transfer from another home health agency.
	C Readmission to the Same Home Health Agency	The patient was readmitted to this home health agency within the existing 60 day payment.
	D Transfer from Hospital Inpatient	Transfer from Hospital Inpatient in same facility resulting in a separate claim to the payer.
CODE STRUCTURE FOR NEWBORN¹		
	1 Normal Delivery	A baby delivered without complications.
	2 Premature Delivery	A baby delivered with time and/or weight factors qualifying it for premature status.
	3 Sick Baby	A baby delivered with medical complications, other than those relating to premature status.
	4 Extramural Birth	A newborn born in a non-sterile environment.
ALGORITHM N/A		
SUBORDINATE AND/OR GROUP ELEMENTS		
SUBORDINATE	GROUP	
N/A	N/A	
NOTES AND SPECIAL INSTRUCTIONS:		
¹ Use this coding structure when the TYPE OF ADMISSION = '4' (newborn).		

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 2.8

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (Q - S)

DATA ELEMENT DEFINITION

ELEMENT NAME: SPECIAL PROCESSING CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-185	4	Yes ¹
Non-Institutional	2-305	4/Up to 99	Yes ¹
PRIMARY PICTURE (FORMAT) Four occurrences of two (2) alphanumeric characters per line items for non-institutional.			
DEFINITION Code indicating care that requires special processing.			
CODE/VALUE SPECIFICATIONS	0	Hospice non-affiliated provider	
	1	Medicaid	
	3	Allogeneic bone marrow recipient (Wilford Hall referred only prior to 10/01/1997 and PCM/HCF referred after 12/31/2002)	
	4	Allogeneic bone marrow donor (Wilford Hall referred only prior to 10/01/1997 and PCM/HCF referred after 12/31/2002)	
	5	Liver transplant (effective for care before 03/01/1997, or between 02/20/1998 and 08/31/1999 and after 05/31/2003)	
	6	Home Health Care (non-institutional only)	
	7	Heart Transplant	
	10	Active duty cost-share ambulatory surgery taken from professional claim	
	11	Hospice	
	12	Capitated Arrangements	
	14	Bone marrow transplants - TMA approved	
	16	Ambulatory Surgery Facility charge	
	17	VA medical provider claim (care rendered by a VA provider)	

NOTES AND SPECIAL INSTRUCTIONS:

¹ Required if TED Record processing is applicable to special processing conditions. Can report from 0 to 4 codes, left justify and blank fill. Do not duplicate. Each occurrence consists of two (2) characters. Left justify and blank fill.

² Whenever SPECIAL PROCESSING CODE = 'E' (grandfathered HHC claims) is coded, SPECIAL PROCESSING CODE 'CM' must be present.

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CHAPTER 2, SECTION 2.9

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (T - Z)

DATA ELEMENT DEFINITION

ELEMENT NAME: TIME STAMP			
RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-030	1	Yes ¹
Non-Institutional	2-030	1	Yes ¹
PRIMARY PICTURE (FORMAT) Six (6) alphanumeric characters.			
DEFINITION Unique system time assigned by the claims processor's computer system when issuing an initial TED Record record. Used as part of the TED RECORD INDICATOR field for unique key definition.			
CODE/VALUE SPECIFICATIONS Issued in MMSSH (Minutes, Seconds, Hundredths)			
ALGORITHM N/A			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		GROUP	
N/A		TED RECORD INDICATOR	

NOTES AND SPECIAL INSTRUCTIONS:
¹ **TYPE OF SUBMISSION A and C** TED Records should be submitted using the same **TIME STAMP** value as the initial TED Record. **TYPE OF SUBMISSION B and E** TED Record should be submitted with **the same TIME STAMP** value as the original non-TED record (HCSR).

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CHAPTER 2, SECTION 2.9

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (T - Z)

DATA ELEMENT DEFINITION

ELEMENT NAME: TOTAL CHARGE BY REVENUE CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-395	Up to 450	Yes

PRIMARY PICTURE (FORMAT) Nine (9) signed numeric digits including two (2) decimal places.

DEFINITION Amount billed for this revenue code.

CODE/VALUE SPECIFICATIONS Must be equal to or less than 999,999.99 unless Revenue Code 0001 which must be equal to or less than 9,999,999.99.

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

N/A

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CHAPTER 2, SECTION 2.9

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (T - Z)

DATA ELEMENT DEFINITION

ELEMENT NAME: TOTAL OCCURRENCE/LINE ITEM COUNT

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-375	1	Yes
Non-Institutional	2-140	1	Yes

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

DEFINITION Institutional: The number of sets of revenue codes and related data elements that occur on the record.

Non-Institutional: The number of sets of procedure codes and related utilization data elements that occur on the record.

CODE/VALUE SPECIFICATIONS Institutional: Must be greater than 0 and not more than 450.

Non-Institutional: Must be greater than 0 and not more than 99.

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

N/A

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 2.9

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (T - Z)

DATA ELEMENT DEFINITION

ELEMENT NAME: TYPE OF ADMISSION											
RECORDS/LOCATOR NUMBERS											
RECORD NAME	LOCATOR# OCCURRENCES REQUIRED										
Institutional	1-255 1 Yes										
PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.										
DEFINITION	A code indicating the type of this admission.										
CODE/VALUE SPECIFICATIONS	<table border="1"> <tr> <td>1 Emergency</td> <td>The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.</td> </tr> <tr> <td>2 Urgent</td> <td>The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.</td> </tr> <tr> <td>3 Elective</td> <td>The patient's condition permits adequate time to schedule the availability of a suitable accommodation.</td> </tr> <tr> <td>4 Newborn</td> <td>Use of this code necessitates the use of special SOURCE OF ADMISSION codes (1 through 4). Must not be used for the mother.</td> </tr> <tr> <td>5 Trauma Center</td> <td>Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation.</td> </tr> </table>	1 Emergency	The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.	2 Urgent	The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.	3 Elective	The patient's condition permits adequate time to schedule the availability of a suitable accommodation.	4 Newborn	Use of this code necessitates the use of special SOURCE OF ADMISSION codes (1 through 4). Must not be used for the mother.	5 Trauma Center	Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation.
1 Emergency	The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.										
2 Urgent	The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.										
3 Elective	The patient's condition permits adequate time to schedule the availability of a suitable accommodation.										
4 Newborn	Use of this code necessitates the use of special SOURCE OF ADMISSION codes (1 through 4). Must not be used for the mother.										
5 Trauma Center	Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation.										
ALGORITHM	N/A										
SUBORDINATE AND/OR GROUP ELEMENTS											
SUBORDINATE	GROUP										
N/A	TYPE OF BILL										
NOTES AND SPECIAL INSTRUCTIONS:											
N/A											

HEADER EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: HEADER TYPE INDICATOR (0-001)		VALIDITY EDITS		
0-001-01V	HEADER TYPE INDICATOR MUST =	0	BATCH HEADER (USED ON ALL PROVIDER, PRICING BATCHES, AND FOR INSTITUTIONAL/NON-INSTITUTIONAL FINANCIALLY UNDERWRITTEN NON-ADMIN CLAIM RATE ELIGIBLE TED RECORDS) OR	
		5	VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE OR	
		6	VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE OR	
		9	BATCH HEADER (INSTITUTIONAL/NON-INSTITUTIONAL FINANCIALLY UNDERWRITTEN ADMIN CLAIM RATE ELIGIBLE TED RECORDS)	
RELATIONAL EDITS				
0-001-01R	IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE OR	
		6	VOUCHER HEADER ADMIN CLAIM RATE-ELIGIBLE OR	
		9	BATCH HEADER (INSTITUTIONAL/NON-INSTITUTIONAL FINANCIALLY UNDERWRITTEN ADMIN CLAIM RATE ELIGIBLE TED RECORDS)	
	THEN BATCH/VOUCHER IDENTIFIER MUST =	5	INSTITUTIONAL/NON-INSTITUTIONAL (BATCH/VOUCHER)	
0-001-02R	IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE OR	
		6	VOUCHER HEADER ADMIN CLAIM RATE-ELIGIBLE	
		AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
			E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN ADJUSTMENT KEY MUST =	5	VOUCHER	

IF THE FIRST POSITION OF EACH BATCH/VOUCHER HEADER RECORD IS NOT A '0', '5', '6', OR '9' THEN THE ENTIRE BATCH/VOUCHER WILL BE REJECTED.

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CHAPTER 2, SECTION 4.1

HEADER EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: HEADER TYPE INDICATOR (0-001) (CONTINUED)			
0-001-03R	IF HEADER TYPE INDICATOR =	0	BATCH HEADER (USED ON ALL PROVIDER, PRICING BATCHES, AND FOR INSTITUTIONAL/NON-INSTITUTIONAL AT-RISK NON-ADMIN CLAIM RATE ELIGIBLE TED RECORDS) OR
		9	BATCH HEADER (INSTITUTIONAL/NON-INSTITUTIONAL AT-RISK ADMIN CLAIM RATE ELIGIBLE RED RECORDS)
	AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	AND BATCH/VOUCHER IDENTIFIER =	5	INSTITUTIONAL/NON-INSTITUTIONAL
	THEN ADJUSTMENT KEY MUST =	0	BATCH

0-001-04R	IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE OR
		6	VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE
	AND TYPE OF SUBMISSION =	D	COMPLETE DENIAL OR
		O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
	THEN AMOUNT INTEREST PAYMENT MUST =	ZERO	
	AND FOR INSTITUTIONAL RECORDS AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST =	ZERO	
	FOR NON-INSTITUTIONAL RECORDS THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST =	ZERO	

IF THE FIRST POSITION OF EACH BATCH/VOUCHER HEADER RECORD IS NOT A '0', '5', '6', OR '9' THEN THE ENTIRE BATCH/VOUCHER WILL BE REJECTED.

ELEMENT NAME: CONTRACT NUMBER (0-010)	
VALIDITY EDITS	
0-010-01V	MUST BE A VALID VALUE FOUND ON THE TMA DATABASE.
RELATIONAL EDITST	
	NONE

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CHAPTER 2, SECTION 4.1

HEADER EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: BATCH/VOUCHER ASAP ACCOUNT NUMBER (0-025)

VALIDITY EDITS

0-025-01V MUST BE ALPHANUMERIC.

RELATIONAL EDITS

0-025-01R IF HEADER TYPE INDICATOR = 0 BATCH HEADER (USED ON ALL PROVIDER, PRICING BATCHES, AND FOR INSTITUTIONAL/NON-INSTITUTIONAL FINANCIALLY UNDERWRITTEN NON-ADMIN CLAIM RATE ELIGIBLE TED RECORDS) **OR**

9 BATCH HEADER (INSTITUTIONAL/NON-INSTITUTIONAL FINANCIALLY UNDERWRITTEN ADMIN CLAIM RATE ELIGIBLE TED RECORDS)

THEN BATCH/VOUCHER ASAP ACCOUNT NUMBER MUST BE ZERO.

0-025-02R IF HEADER TYPE INDICATOR = 5 VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE **OR**

6 VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE

AND BATCH/VOUCHER RESUBMISSION NUMBER = ZERO

THEN ASAP ACCOUNT NUMBER MUST BE VALID¹ AND ACTIVE FOR THE CONTRACT NUMBER ON THE TED BATCH/VOUCHER RECORD.

¹ TMA DATABASE.

ELEMENT NAME: BATCH/VOUCHER DATE (0-030)

VALIDITY EDITS

0-030-01V MUST BE A VALID JULIAN DATE **AND CANNOT BE > TMA CURRENT SYSTEM DATE.**

0-030-02V BATCH/VOUCHER DATE MUST BE ≥ CONTRACT BEGIN DATE¹

AND BATCH/VOUCHER DATE MUST BE ≤ CONTRACT END DATE¹

RELATIONAL EDITS

0-030-01R IF HEADER TYPE INDICATOR = 5 VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE **OR**

6 VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE

AND BATCH/VOUCHER RESUBMISSION NUMBER = 00

AND TYPE OF SUBMISSION = D COMPLETE DENIAL **OR**

I INITIAL SUBMISSION **OR**

O ZERO PAYMENT WITH 100% OHI/TPL **OR**

R RESUBMISSION

¹ CONTRACT DATES ON THE TMA DATABASE. THESE DATES ARE TAKEN FROM THE TMA CONTRACTS.

² DEFINED IN THE TRICARE OPERATIONS MANUAL (TOM), **CHAPTER 3. IF CONTRACTOR REQUIRES THE ABILITY TO SUBMIT 'INITIAL SUBMISSIONS' ON A CLOSED BATCH/VOUCHER CLIN/ASAP ACCOUNT, THEN CONTACT TMA, CRM FOR INSTRUCTIONS ON HOW TO PROCEED.**

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 4.1

HEADER EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: BATCH/VOUCHER DATE (0-030) (CONTINUED)

THEN BATCH/VOUCHER DATE IN HEADER MUST BE EQUAL TO OR WITHIN ASAP BEGIN AND END DATES ON THE TMA DATABASE²

0-030-02R IF HEADER TYPE INDICATOR = 5 VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE **OR**

6 VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE

THEN BATCH/VOUCHER DATE IN HEADER MUST NOT BE LESS THAN THE ASAP BEGIN DATE ON THE TMA DATABASE.

0-030-03R IF BATCH/VOUCHER RESUBMISSION NUMBER = 00

THEN BATCH/VOUCHER DATE MUST ≠ 09/29/XXXX **OR**

09/30/XXXX

UNLESS BATCH/VOUCHER IDENTIFIER = 3 PROVIDER (BATCH ONLY)

0-030-04R IF BATCH/VOUCHER RESUBMISSION NUMBER = 00

THEN BATCH/VOUCHER DATE MUST NOT BE < 10/01/2005

UNLESS BATCH/VOUCHER NUMBER = MDA90603C001518D9565220052700100 **OR**

MDA90603C001518D9565220052700200 **OR**

MDA90603C001518D9565220052700300 **OR**

MDA90603C001518D9565220052700600 **OR**

MDA90603C001518D9565220052700700 **OR**

MDA90603C001518D9565220052700800 **OR**

MDA90603C001518D9565220052690800 **OR**

MDA90603C00100208AD5S20052650200 **OR**

MDA90603C00100208AD5S20052690100 **OR**

MDA90603C0013MIPR502A20052690300

OR BATCH/VOUCHER IDENTIFIER = PROVIDER (BATCH)

¹ CONTRACT DATES ON THE TMA DATABASE. THESE DATES ARE TAKEN FROM THE TMA CONTRACTS.

² DEFINED IN THE TRICARE OPERATIONS MANUAL (TOM), CHAPTER 3. IF CONTRACTOR REQUIRES THE ABILITY TO SUBMIT 'INITIAL SUBMISSIONS' ON A CLOSED BATCH/VOUCHER CLIN/ASAP ACCOUNT, THEN CONTACT TMA, CRM FOR INSTRUCTIONS ON HOW TO PROCEED.

ELEMENT NAME: BATCH/VOUCHER SEQUENCE NUMBER (0-035)

VALIDITY EDITS

0-035-01V MUST BE NUMERIC AND > ZERO.

RELATIONAL EDITS

NONE

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 4.1

HEADER EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: BATCH/VOUCHER RESUBMISSION NUMBER (0-040)

VALIDITY EDITS

0-040-01V MUST BE NUMERIC

AND IF BATCH/VOUCHER
IDENTIFIER =

5

INSTITUTIONAL/NON-INSTITUTIONAL

THEN MUST BE 1 GREATER THAN THE PRIOR SUBMISSION NUMBER UNDER THE
SAME CONTRACT IDENTIFIER¹

RELATIONAL EDITS

NONE

¹ TMA DATABASE.

ELEMENT NAME: TOTAL NUMBER OF RECORDS (0-045)

VALIDITY EDITS

0-045-01V MUST BE NUMERIC.

0-045-02V MUST EQUAL NUMBER OF TED RECORDS IN THE BATCH/VOUCHER.

0-045-03V TOTAL RECORDS MUST > 0

RELATIONAL EDITS

0-045-01R IF BATCH/VOUCHER
IDENTIFIER =

5

INSTITUTIONAL/NON-INSTITUTIONAL

AND BATCH/VOUCHER RESUBMISSION NUMBER > ZERO

THEN NUMBER OF RECORDS IN THE BATCH/VOUCHER MUST = NUMBER
OUTSTANDING RECORDS¹.

¹ TMA DATABASE.

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CHAPTER 2, SECTION 4.1

HEADER EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: TOTAL AMOUNT PAID (0-050)	
VALIDITY EDITS	
0-050-01V	MUST BE NUMERIC.
RELATIONAL EDITS	
0-050-01R	IF BATCH/VOUCHER IDENTIFIER = 5 INSTITUTIONAL/NON-INSTITUTIONAL THEN TOTAL AMOUNT PAID MUST = THE ACCUMULATED TOTAL OF AMOUNTS PAID BY GOVERNMENT CONTRACTOR AND AMOUNT OF INTEREST PAYMENT FOR ALL TED RECORDS IN THE BATCH/VOUCHER.
0-050-02R	IF BATCH/VOUCHER IDENTIFIER = 3 PROVIDER OR 4 PRICING THEN TOTAL AMOUNT PAID MUST EQUAL ZERO.
0-050-03R	IF HEADER TYPE INDICATOR = 5 VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE OR 6 VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE AND BATCH/VOUCHER IDENTIFIER = 5 INSTITUTIONAL/NON-INSTITUTIONAL AND BATCH/VOUCHER RESUBMISSION NUMBER > ZERO THEN TOTAL AMOUNT PAID MUST BE EQUAL TO THE VOUCHER BALANCE.
¹ TMA DATABASE (EXCLUDES TMOP).	

ELEMENT NAME: INITIAL TRANSMISSION DATE (TMA DERIVED) (0-055)	
VALIDITY EDITS	
NONE	
RELATIONAL EDITS	
NONE	

ELEMENT NAME: TMA BATCH/VOUCHER PROCESSING DATE (TMA DERIVED) (0-060)	
VALIDITY EDITS	
NONE	
RELATIONAL EDITS	
NONE	

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CHAPTER 2, SECTION 4.1

HEADER EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: FUND ACCOUNTING (0-065)

VALIDITY EDITS

0-065-01V MUST BE NUMERIC.

RELATIONAL EDITS

0-065-01R IF CONTRACT NUMBER = MDA90602C0013 (MAIL ORDER PHARMACY)

AND BATCH/VOUCHER IDENTIFIER = 5 INSTITUTIONAL/NON-INSTITUTIONAL

THEN THE FUND ACCOUNTING MUST = THE ACCUMULATED TOTALS OF AMOUNT ALLOWED BY PROCEDURE CODE MINUS AMOUNT BILLED BY PROCEDURE CODE FOR ALL TED RECORDS IN THIS VOUCHER.

0-065-02R IF CONTRACT NUMBER = MDA90602C0013 (MAIL ORDER PHARMACY)

AND HEADER TYPE INDICATOR = 5 VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE OR

6 VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE

AND BATCH/VOUCHER IDENTIFIER = 5 INSTITUTIONAL/NON-INSTITUTIONAL

AND BATCH/VOUCHER RESUBMISSION NUMBER > ZERO

THEN THE FUND ACCOUNTING MUST BE EQUAL TO THE VOUCHER BALANCE¹.

¹ TMA DATABASE (TMOP ONLY).

INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: RECORD TYPE INDICATOR (1-001)	
VALIDITY EDITS	
1-001-01V	RECORD TYPE INDICATOR MUST = 1 INSTITUTIONAL
RELATIONAL EDITS	
1-001-01R	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
AND MATCH IS FOUND ON THE TMA DATABASE	
THEN THE RECORD TYPE FOR THE TED ON THE DATABASE MUST EQUAL THE RECORD TYPE ON THE ADJUSTMENT/CANCELLATION TED BEING SUBMITTED.	

ELEMENT NAME: FILING DATE (1-015)	
VALIDITY EDITS	
1-015-01V	MUST BE A VALID JULIAN DATE AND CANNOT BE > TMA CURRENT SYSTEM DATE.
RELATIONAL EDITS	
1-015-01R	FILING DATE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION
1-015-02R	END DATE OF CARE PLUS ONE YEAR MUST BE > FILING DATE UNLESS ONE OCCURRENCE OF OVERRIDE CODE = F CLAIM FILED AFTER DEADLINE
1-015-03R	IF ONE OCCURRENCE OF OVERRIDE CODE = F CLAIM FILED AFTER DEADLINE THEN BEGIN DATE OF CARE PLUS SIX YEARS MUST BE > FILING DATE

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: FILING STATE/COUNTRY CODE (1-020)

VALIDITY EDITS

1-020-01V MUST BE A VALID STATE/COUNTRY CODE. (REFER TO [CHAPTER 2, ADDENDUM A](#) AND [ADDENDUM B](#)).

RELATIONAL EDITS

1-020-01R	IF PRICING RATE CODE =	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

THEN FILING STATE/COUNTRY CODE MUST **NOT** BE A FOREIGN COUNTRY EXCEPT FOR PUERTO RICO (PRI)

ELEMENT NAME: SEQUENCE NUMBER (1-025)

VALIDITY EDITS

1-025-01V THE FIRST 5 CHARACTERS MUST BE A COMBINATION OF ALPHABETIC OR NUMERIC CHARACTERS THE LAST 2 CHARACTERS MUST = BLANK.

NOTE: THE FIRST 5 CHARACTERS CANNOT BE SPACES OR SPECIAL CHARACTERS.

RELATIONAL EDITS

NONE

ELEMENT NAME: TIME STAMP (1-030)

VALIDITY EDITS

1-030-01V MUST BE NUMERIC

RELATIONAL EDITS

1-030-01R IF FILING DATE IS \geq 02/01/1995
THEN TIME STAMP MUST BE > ZERO

ELEMENT NAME: ADJUSTMENT KEY (1-035)

VALIDITY EDITS

1-035-01V MUST BE ALPHA, '0', OR '5'

RELATIONAL EDITS

NONE

ELEMENT NAME: DATE TED RECORD PROCESSED TO COMPLETION (1-040)

VALIDITY EDITS

1-040-01V MUST BE VALID GREGORIAN DATE **AND CANNOT BE > TMA CURRENT SYSTEM DATE.**

RELATIONAL EDITS

1-040-01R DATE TED RECORD PROCESSED TO COMPLETION MUST BE \leq BATCH/VOUCHER DATE.
1-040-02R DATE TED RECORD PROCESSED TO COMPLETION MUST BE < CURRENT SYSTEM DATE.

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CHAPTER 2, SECTION 5.1

INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: DATE ADJUSTMENT IDENTIFIED (1-045)

VALIDITY EDITS

1-045-01V MUST BE VALID GREGORIAN DATE OR ALL ZEROES **AND CANNOT BE > TMA CURRENT SYSTEM DATE.**

1-045-02V	IF TYPE OF SUBMISSION =	D	CONTRACTOR DENIAL OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION

THEN DATE ADJUSTMENT IDENTIFIED MUST BE ALL ZEROES.

1-045-03V	IF TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD
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AND THE TYPE OF SUBMISSION ON THE CORRESPONDING PROVISIONALLY ACCEPTED TED RECORD ON THE TMA DATABASE =

		D	CONTRACTOR DENIAL OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION

THEN DATE ADJUSTMENT IDENTIFIED MUST = ZEROES.

1-045-04V	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 DATE ADJUSTMENT IDENTIFIED MUST BE A VALID GREGORIAN DATE

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

AND DATE ADJUSTMENT IDENTIFIED ON TMA DATABASE = ZEROES.

RELATIONAL EDITS

1-045-03R	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 DATE ADJUSTMENT IDENTIFIED MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION AND ≥ FILING DATE

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CHAPTER 2, SECTION 5.1

INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: DATE ADJUSTMENT IDENTIFIED (1-045) (CONTINUED)

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

AND DATE ADJUSTMENT IDENTIFIED ON TMA DATABASE = ZEROES.

ELEMENT NAME: PERSON IDENTIFIER (SPONSOR) (1-050)

VALIDITY EDITS

1-050-01V MUST BE 9 NUMERIC DIGITS (CANNOT BE ALL ZEROES, ALL NINES, OR ALL BLANKS).

RELATIONAL EDITS

NONE

ELEMENT NAME: PERSON IDENTIFIER TYPE CODE (SPONSOR) (1-051)

VALIDITY EDITS

1-051-01V MUST BE A VALID VALUE LOCATED IN [CHAPTER 2, SECTION 2.7](#).

RELATIONAL EDITS

NONE

ELEMENT NAME: PAY GRADE CODE (SPONSOR) (1-056)

VALIDITY EDITS

1-056-01V MUST BE A VALID PAY GRADE CODE (SPONSOR) (REFER TO [CHAPTER 2, SECTION 2.7](#))

RELATIONAL EDITS

NONE

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CHAPTER 2, SECTION 5.1

INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: PERSON BIRTH CALENDAR DATE (PATIENT) (1-085)

VALIDITY EDITS

1-085-01V MUST BE A VALID GREGORIAN DATE **AND CANNOT BE > TMA CURRENT SYSTEM DATE.**

RELATIONAL EDITS

1-085-01R PATIENT AGE¹ MUST BE < 125 YEARS

1-085-02R PERSON BIRTH CALENDAR DATE (PATIENT) ≤ BEGIN DATE OF CARE

1-085-03R PERSON BIRTH CALENDAR DATE (PATIENT) ≤ ADMISSION DATE

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

ELEMENT NAME: PATIENT IDENTIFIER (DoD) (1-095)

VALIDITY EDITS

1-095-01V MUST NOT BE BLANK FILLED.

1-095-02V MUST NOT EQUAL ALL ZEROS

UNLESS TYPE OF SUBMISSION = D COMPLETE DENIAL INITIAL TED RECORD DATA

OR
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

RELATIONAL EDITS

NONE

ELEMENT NAME: DEERS IDENTIFIER (PATIENT) (1-097)

VALIDITY EDITS

1-097-01V POSITIONS 10 AND 11 MUST BE NUMERIC.

RELATIONAL EDITS

NONE

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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 ≥ ZERO

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

U	BENEFICIARY INDEMINIFICATION PAYMENT
---	---

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 ≠ 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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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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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 ADSM
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 TRICARE RESERVE SELECT 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 NUMBER (1-170) (CONTINUED)	
402	TRICARE RESERVE SELECT TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
405	TRICARE RESERVE SELECT TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
406	TRICARE RESERVE SELECT TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
407	TRICARE RESERVE SELECT TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
408	TRICARE RESERVE SELECT TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
409	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
410	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
411	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW INDIVIDUAL COVERAGE OR
412	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW 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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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 TRICARE RESERVE SELECT 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	TRICARE RESERVE SELECT TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
405	TRICARE RESERVE SELECT TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
406	TRICARE RESERVE SELECT TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
407	TRICARE RESERVE SELECT TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
408	TRICARE RESERVE SELECT TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
409	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
410	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
411	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW INDIVIDUAL COVERAGE OR
412	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW 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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CHAPTER 2, SECTION 5.2

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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CHAPTER 2, SECTION 5.2

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: 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).

INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: PROVIDER TAXPAYER NUMBER (1-200)	
VALIDITY EDITS	
1-200-01V	MUST BE NUMERIC
	OR (FIRST 3 POSITIONS MUST BE A VALID STATE/COUNTRY CODE AND LAST 6 POSITIONS MUST BE NUMERIC)
	OR (FIRST 3 POSITIONS MUST BE A VALID STATE/COUNTRY CODE AND FOURTH POSITION MUST BE = 'A' AND LAST 5 POSITIONS MUST BE NUMERIC)
RELATIONAL EDITS	
NO ERROR	IF 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
	THEN DO NOT CHECK PROVIDER FILE
NO ERROR	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
	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 PROVIDER FILE
NO ERROR	IF AMOUNT ALLOWED (TOTAL) ≤ ZERO
	THEN DO NOT CHECK PROVIDER FILE
¹ ONLY THE FIRST 5 DIGITS OF THE PROVIDER ZIP CODE IS USED IN THE MATCH.	

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: PROVIDER TAXPAYER NUMBER (1-200) (CONTINUED)

1-200-02R IF ANY OCCURRENCE OF
OVERRIDE CODE = NC NON-CERTIFIED PROVIDER

THEN THE NON-CERTIFIED PROVIDER MUST MATCH THE PROVIDER ON THE
PROVIDER FILE USING THE FOLLOWING:
INSTITUTIONAL PROVIDER TAXPAYER NUMBER
AND TYPE OF INSTITUTION
AND PROVIDER ZIP CODE¹
AND PROVIDER SUB-IDENTIFIER
AND ACCEPTANCE AND TERMINATION DATES MUST = ZEROES
AND PROVIDER CONTRACT AFFILIATION CODE MUST = '5' (NON-CERTIFIED
PROVIDER)

IF NO OCCURRENCE OF
OVERRIDE CODE = NC NON-CERTIFIED PROVIDER

THEN CERTIFIED PROVIDER MUST MATCH THE PROVIDER ON THE PROVIDER FILE
USING THE FOLLOWING:
INSTITUTIONAL PROVIDER TAXPAYER NUMBER
AND TYPE OF INSTITUTION
AND PROVIDER ZIP CODE¹
AND PROVIDER SUB-IDENTIFIER

AND PROVIDER MUST BE CERTIFIED TO PROVIDE SERVICES ON THE CLAIM DATE(S) OF
CARE.

¹ ONLY THE FIRST 5 DIGITS OF THE PROVIDER ZIP CODE IS USED IN THE MATCH.

ELEMENT NAME: PROVIDER SUB-IDENTIFIER (1-205)

VALIDITY EDITS

1-205-01V MUST BE ALPHA OR NUMERIC--NO BLANKS

RELATIONAL EDITS

NONE

ELEMENT NAME: PROVIDER INDIVIDUAL NPI NUMBER (RESERVED) (1-210)

VALIDITY EDITS

1-210-01V MUST BE BLANK FILLED.

RELATIONAL EDITS

NONE

ELEMENT NAME: PROVIDER GROUP NPI NUMBER (RESERVED) (1-215)

VALIDITY EDITS

1-215-01V MUST BE BLANK FILLED.

RELATIONAL EDITS

NONE

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: PROVIDER ZIP CODE (1-220)	
VALIDITY EDITS	
1-220-01V	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	
NONE	
¹ WHEN FOREIGN COUNTRY CODES ARE SUBMITTED, THE FIRST 3 CHARACTERS WILL BE EDITED AGAINST CHAPTER 2, ADDENDUM A.	

ELEMENT NAME: PROVIDER PARTICIPATION INDICATOR (1-225)	
VALIDITY EDITS	
1-225-01V	MUST BE A VALID PROVIDER PARTICIPATION INDICATOR.
RELATIONAL EDITS	
1-225-01R	IF PRICING RATE CODE =
	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
	THEN PROVIDER PARTICIPATION INDICATOR MUST =
	Y YES
1-225-02R	IF THERE IS A MEDICARE NUMBER PRESENT ON THE CORRESPONDING RECORD¹ IN THE PROVIDER FILE
	THEN THE PROVIDER PARTICIPATION INDICATOR ON TED MUST =
	Y YES
¹ "CORRESPONDING RECORD" ON PROVIDER FILE IS BASED ON THE PROVIDER MATCH OBTAINED IN EDIT 1-200-02R.	

ELEMENT NAME: PROVIDER NETWORK STATUS INDICATOR (1-230)	
VALIDITY EDITS	
1-230-01V	MUST BE ONE OF THE FOLLOWING VALUES
	1 NETWORK PROVIDER OR
	2 NON-NETWORK PROVIDER
RELATIONAL EDITS	
NONE	

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: TYPE OF INSTITUTION (1-235)

VALIDITY EDITS

1-235-01V VALUE MUST BE A VALID TYPE OF INSTITUTION CODE.

RELATIONAL EDITS

1-235-01R IF TYPE OF INSTITUTION = 72 RTC
 AND PATIENT ZIP CODE IS IN AN MTF CATCHMENT AREA

THEN CA/NAS
 EXCEPTION REASON
 MUST = 5 RTC

1-235-02R IF PRICING RATE CODE = K HOSPITAL-SPECIFIC PSYCHIATRIC PER
 DIEM RATE OR
 L REGION SPECIFIC PSYCHIATRIC PER DIEM
 RATE

THEN TYPE OF INSTITUTION
 MUST = 22 PSYCHIATRIC HOSPITAL/UNIT OR
 52 CHILDREN'S PSYCHIATRIC HOSPITAL/
 UNIT

1-235-03R IF TYPE OF INSTITUTION = 70 HOME HEALTH AGENCY
 AND BEGIN DATE OF CARE ≥ 06/01/2004

THEN ONE OCCURRENCE
 OF REVENUE CODE
 MUST = 0023 HOME HEALTH AGENCY (HHA-PPS)

ELEMENT NAME: CLAIM FORM TYPE/EMC INDICATOR (1-240)

VALIDITY EDITS

1-240-01V VALUE MUST BE A VALID CLAIM FORM TYPE/EMC INDICATOR.

RELATIONAL EDITS

NONE

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: FREQUENCY CODE (1-250)

VALIDITY EDITS

1-250-01V MUST BE A VALID FREQUENCY CODE AND MUST = THE VALUES IN THE FOLLOWING TABLE **IF FREQUENCY CODE ≠ 0, 7, 8 OR 9:**

FREQUENCY CODE	PREVIOUS TED RECORD FREQUENCY CODE
1	= 1 OR NO PREVIOUS TED RECORD
2	= 2 OR NO PREVIOUS TED RECORD
3	= 2 OR 3 (PREVIOUS TED RECORD MUST EXIST)
4	= 2, 3 OR 4 (PREVIOUS TED RECORD MUST EXIST)

RELATIONAL EDITS

1-250-01R	IF PATIENT STATUS =	30	STILL A PATIENT
	THEN FREQUENCY CODE MUST =	2	INTERIM-INITIAL OR
		3	INTERIM-INTERIM
	UNLESS TYPE OF INSTITUTION =	70	HOME HEALTH AGENCY
	THEN FREQUENCY CODE MUST =	2	INTERIM-INITIAL OR
		3	INTERIM-INTERIM OR
		7	REPLACEMENT OF PRIOR CLAIM OR
		8	VOID/CANCEL OF PRIOR CLAIM OR
		9	FINAL CLAIM FOR HOME HEALTH AGENCY EPISODE
1-250-02R	IF PATIENT STATUS =	01	DISCHARGED OR
		02	TRANSFERRED OR
		20	EXPIRED
	THEN FREQUENCY CODE MUST =	0	NON-PAYMENT/ZERO CLAIM OR
		1	ADMIT THRU DISCHARGE OR
		4	INTERIM-FINAL OR
		7	REPLACEMENT OF PRIOR CLAIM OR
		8	VOID/CANCELLATION OF PRIOR CLAIM OR
		9	FINAL CLAIM FOR HOME HEALTH AGENCY (HHA-PPS) EPISODE
1-250-03R	IF PRICING RATE CODE =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER
	THEN FREQUENCY CODE MUST =	1	ADMIT THRU DISCHARGE
1-250-05R	IF FREQUENCY CODE =	0	NON-PAYMENT/ZERO CLAIM
	THEN TYPE OF INSTITUTION MUST =	70	HOME HEALTH AGENCY OR
		76	SKILLED NURSING FACILITY

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: TYPE OF ADMISSION (1-255)

VALIDITY EDITS

1-255-01V VALUE MUST BE A VALID TYPE OF ADMISSIONS CODE.

**UNLESS REVENUE CODE ON ANY
OF THE OCCURRENCES/LINE
ITEMS =**

0023 HOME HEALTH AGENCY

THEN VALUE MUST BE BLANK OR A VALID TYPE OF ADMISSIONS CODE

RELATIONAL EDITS

1-255-02R IF CA/NAS EXCEPTION REASON = 2 EMERGENCY

**THEN TYPE OF ADMISSION
MUST =**

1 EMERGENCY OR

4 NEWBORN

1-255-03R IF TYPE OF ADMISSION = 4 NEWBORN

**THEN PRINCIPAL DIAGNOSIS MUST BE A NEWBORN DIAGNOSIS (REFER TO
CHAPTER 2, ADDENDUM E, FIGURE 2-E-1).**

ELEMENT NAME: SOURCE OF ADMISSION (1-260)

VALIDITY EDITS

1-260-01V VALUE MUST BE A VALID SOURCE OF ADMISSION.

RELATIONAL EDITS

1-260-01R IF TYPE OF ADMISSION = 4 NEWBORN

**THEN SOURCE OF ADMISSION
MUST =**

1 NORMAL DELIVERY OR

2 PREMATURE DELIVERY OR

3 SICK BABY OR

4 EXTRAMURAL BIRTH

**AND PRINCIPAL DIAGNOSIS MUST BE A NEWBORN DIAGNOSIS (REFER TO
CHAPTER 2, ADDENDUM E, FIGURE 2-E-1).**

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: PATIENT STATUS (1-270)

VALIDITY EDITS

1-270-01V VALUE MUST BE A VALID PATIENT STATUS CODE.

RELATIONAL EDITS

1-270-01R	IF FREQUENCY CODE =	2	INTERIM-INITIAL OR
		3	INTERIM-INTERIM
	THEN PATIENT STATUS MUST =	30	STILL A PATIENT
1-270-02R	IF FREQUENCY CODE =	1	ADMIT THRU DISCHARGE
	THEN PATIENT STATUS MUST =	01	DISCHARGED OR
		02	TRANSFERRED OR
		03	DISCHARGED/TRANSFERRED TO SKILLED NURSING FACILITY (SNF) OR
		04	DISCHARGED/TRANSFERRED TO INTERMEDIATE CARE FACILITY (ICF) OR
		05	DISCHARGED/TRANSFERRED TO ANOTHER TYPE OF INSTITUTION FOR INPATIENT CARE, OR REFERRED FOR OUTPATIENT CARE TO ANOTHER INSTITUTION OR
		06	DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF ORGANIZED HOME HEALTH SERVICE ORGANIZATION OR
		07	LEFT AGAINST MEDICAL ADVICE OR DISCONTINUED CARE OR
		08	DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF A HOME IV PROVIDER OR
		20	EXPIRED OR
		40	DIED AT HOME OR
		41	DIED IN MEDICAL FACILITY, SUCH AS HOSPITAL, SNF OR FREE-STANDING HOSPICE OR
		42	PLACE OF DEATH UNKNOWN OR
		43	DISCHARGED/TRANSFERRED TO A FEDERAL HOSPITAL OR
		50	HOSPICE-HOME OR
		51	HOSPICE-MEDICAL FACILITY OR
		61	DISCHARGED/TRANSFERRED WITHIN THIS INSTITUTION TO A HOSPITAL-BASED MEDICARE APPROVED SWING BED OR
		62	DISCHARGED/TRANSFERRED TO ANOTHER REHABILITATION FACILITY INCLUDING REHABILITATION DISTINCT PART UNITS OF A HOSPITAL OR
		63	DISCHARGED/TRANSFERRED TO A LONG TERM CARE HOSPITAL OR

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: PATIENT STATUS (1-270) (CONTINUED)			
		64	DISCHARGED/TRANSFERRED TO A NURSING FACILITY CERTIFIED UNDER MEDICAID BUT NOT CERTIFIED UNDER MEDICARE OR
		65	DISCHARGED/TRANSFERRED TO A PSYCHIATRIC HOSPITAL OR PSYCHIATRIC DISTINCT PART OF A HOSPITAL OR
		66	DISCHARGED/TRANSFERRED TO A CRITICAL ACCESS HOSPITAL
1-270-03R	IF PRICING RATE CODE =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER
	THEN PATIENT STATUS MUST ≠	30	STILL A PATIENT

ELEMENT NAME: BEGIN DATE OF CARE (1-275)			
VALIDITY EDITS			
1-275-01V	MUST BE A VALID GREGORIAN DATE AND CANNOT BE > TMA CURRENT SYSTEM DATE.		
1-275-02V	CANNOT BE MORE THAN 10 YEARS PRIOR TO TMA CURRENT SYSTEM DATE.		
1-275-03V	BEGIN DATE OF CARE MUST BE ≤ END DATE OF CARE.		
RELATIONAL EDITS			
1-275-02R	BEGIN DATE OF CARE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION		
1-275-03R	BEGIN DATE OF CARE MUST BE ≥ PERSON BIRTH CALENDAR DATE (PATIENT)		
1-275-04R	BEGIN DATE OF CARE MUST BE ≥ ADMISSION DATE		
1-275-05R	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 BEGIN DATE OF CARE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED		
	UNLESS TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD
	AND DATE ADJUSTMENT IDENTIFIED ON TMA DATABASE = ZEROES.		
1-275-06R	PROVIDER MUST BE "AUTHORIZED" ¹ ON PROVIDER FILE FOR THIS BEGIN DATE OF CARE		

¹ "AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON **INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, 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).**

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: BEGIN DATE OF CARE (1-275) (CONTINUED)

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 **OR**

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 PROVIDER FILE

¹ **"AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, 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).**

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CHAPTER 2, SECTION 5.3

INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: END DATE OF CARE (1-280)	
VALIDITY EDITS	
1-280-01V	MUST BE A VALID GREGORIAN DATE AND CANNOT BE > TMA CURRENT SYSTEM DATE.
1-280-02V	CANNOT BE MORE THAN 10 YEARS PRIOR TO TMA CURRENT SYSTEM DATE.
1-280-03V	END DATE OF CARE MUST BE ≥ BEGIN DATE OF CARE.
RELATIONAL EDITS	
1-280-01R	END DATE OF CARE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION
1-280-02R	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 END DATE OF CARE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED	
UNLESS TED RECORD CORRECTION INDICATOR =	
	1 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD
AND DATE ADJUSTMENT IDENTIFIED ON TMA DATABASE = ZEROES.	
1-280-03R	PROVIDER MUST BE "AUTHORIZED" ¹ ON PROVIDER FILE FOR THIS END DATE OF CARE
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 OR
	FG TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) OR
	FS TFL (SECOND PAYOR) OR
¹ "AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, 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).	

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: END DATE OF CARE (1-280) (CONTINUED)

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 PROVIDER FILE

¹ "AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, 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).

ELEMENT NAME: ADMINISTRATIVE CLIN (1-283)

VALIDITY EDITS

1-283-01V MUST BE BLANKS OR A VALID CLIN FOR THE CONTRACT NUMBER ON THE TMA DATABASE.

1-283-02V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		B	HCSR ADJUSTMENT OR
		C	COMPLETE CANCELLATION OR
		E	HCSR CANCELLATION

AND ADMINISTRATIVE CLAIM COUNT CODE (TMA DERIVED FIELD) ON TMA FILE =

1 CLAIM RATE HAS BEEN PAID

THEN ADMINISTRATIVE CLIN ON THE ADJUSTMENT MUST = ADMINISTRATIVE CLIN ON TMA DATABASE¹

RELATIONAL EDITS

REFER TO CHAPTER 2, SECTION 8.1.

¹ THIS EDIT IS CHECKED DURING THE MATCH AND MARRY PROCESS.

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: COVERED DAYS (1-285)			
VALIDITY EDITS			
1-285-01V	MUST BE NUMERIC.		
RELATIONAL EDITS			
NO ERROR	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	11	HOSPICE
	THEN BYPASS ALL COVERED DAYS		
1-285-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION
	AND TYPE OF INSTITUTION ≠	70	HOME HEALTH AGENCY
	THEN COVERED DAYS 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 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
1-285-02R	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION OR
		D	COMPLETE DENIAL
	OR 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 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
	THEN COVERED DAYS MUST = ZERO		
1-285-03R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		I	INITIAL SUBMISSION OR

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME:		COVERED DAYS (1-285) (CONTINUED)	
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION
<p>THEN COVERED DAYS MUST BE ≤SUM OF UNITS OF SERVICE BY REVENUE CODE FOR REVENUE CODES THAT INDICATE THAT A ROOM WAS USED (010X-018X, 020X-021X, 0724, OR 0762)</p>			
1-285-04R	IF TYPE OF INSTITUTION =	70	HOME HEALTH AGENCY
	AND TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT TED RECORD DUE 100% OHI OR
		R	RESUBMISSION OF ERROR REJECT
<p>THEN COVERED DAYS MUST = ZERO</p>			

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: DRG NUMBER (1-290) (CONTINUED)

		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER
		AND DATE OF ADMISSION ≥ 10/01/2004 AND < 10/01/2005	
		THEN DRG NUMBER MUST = 001-111, 113-213, 216-220, 223-384, 391-433, 439-455, 461-471, 473, 475-482, 484-513, 515-543, 600-619, 621-624, 626-628, 630-636, 900-901.	
1-290-28R	IF PRICING RATE CODE =	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
		AND DATE OF ADMISSION ≥ 10/01/2005 AND < 10/01/2006	
		THEN DRG NUMBER MUST = 001-003, 006-106, 108, 110-111, 113-114, 117-208, 210-213, 216-220, 223-230, 232-384, 391-399, 401-433, 439-455, 461-471, 473, 475-477, 479-482, 484-513, 515, 518-525, 528-559, 600-619, 621-624, 626-628, 630-636, 900-901.	
1-290-29R	IF PRICING RATE CODE =	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
		AND DATE OF ADMISSION ≥ 10/01/2006	
		THEN DRG NUMBER MUST = 001-003, 006-019, 021-023, 026-106, 108, 110-111, 113-114, 117-147, 149-153, 155-208, 210-213, 216-220, 223-230, 232-384, 391-399, 401-414, 417-433, 439-455, 461-471, 473, 476-477, 479-482, 484-513, 515, 518-522, 524-525, 528-579, 600-619, 621-624, 626-628, 630-636, 900-901.	

ELEMENT NAME: HIPPS CODE (1-292)

VALIDITY EDITS

1-292-01V MUST BE VALID HIPPS CODES REFER TO [CHAPTER 2, SECTION 2.8](#)

RELATIONAL EDITS

1-292-01R	IF HIPPS CODE = BLANK		
	THEN NO OCCURRENCE OF REVENUE CODE CAN =	0022	SKILLED NURSING FACILITY OR
		0023	HOME HEALTH AGENCY

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: ADMISSION DIAGNOSIS (1-295)

VALIDITY EDITS

1-295-01V FOR FILING DATE PRIOR TO 10/01/2004 VALUE MUST BE VALID DIAGNOSIS CODE, EXCLUDING E800.0-E999.1.

UNLESS REVENUE CODE ON ANY OF THE OCCURRENCES/LINE ITEMS =

0023 HOME HEALTH AGENCY

THEN VALUE MUST BE BLANK OR A VALID DIAGNOSIS CODE, EXCLUDING E800.0-E999.1

1-295-02V FOR FILING DATE ON OR AFTER 10/01/2004 VALUE MUST BE VALID DIAGNOSIS CODE, EXCLUDING E800.0-E999.1.

AND BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE

OR END DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE

UNLESS REVENUE CODE ON ANY OF THE OCCURRENCES/LINE ITEMS =

0023 HOME HEALTH AGENCY

THEN VALUE MUST BE BLANK **OR** VALUE MUST BE A VALID DIAGNOSIS CODE, EXCLUDING E800.0-E999.1

AND BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE

OR END DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE

RELATIONAL EDITS

NONE

INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS (1-300)	
VALIDITY EDITS	
1-300-01V	FOR FILING DATE PRIOR TO 10/01/2004 VALUE MUST BE A VALID DIAGNOSIS CODE, EXCLUDING E800.0-E999.1.
1-300-02V	FOR FILING DATE ON OR AFTER 10/01/2004 VALUE MUST BE A VALID DIAGNOSIS CODE, EXCLUDING E800.0-E999.1
	AND BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE
	OR END DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE
RELATIONAL EDITS	
1-300-01R	IF PRINCIPAL TREATMENT DIAGNOSIS = 799.9
	THEN TYPE OF SUBMISSION MUST = D COMPLETE DENIAL
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE = 1 MEDICAID
1-300-02R	IF ANY PRINCIPAL TREATMENT DIAGNOSIS CODE IS FOR FEMALE
	AND PERSON SEX (PATIENT) = MALE
	THEN AT LEAST ONE OVERRIDE CODE MUST = G DIAGNOSIS/PROCEDURE CODE FOR FEMALE: SEX INDICATES MALE
1-300-03R	IF ANY PRINCIPAL TREATMENT DIAGNOSIS CODE IS FOR MALE
	AND NOT FOR CIRCUMCISION (V50.2)
	AND SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-3)
	AND PERSON SEX (PATIENT) = FEMALE
	THEN AT LEAST ONE OVERRIDE CODE MUST = H DIAGNOSIS/PROCEDURE CODE FOR MALE: SEX INDICATES FEMALE
1-300-04R	IF PRINCIPAL TREATMENT DIAGNOSIS CODE HAS AN AGE PARAMETER RESTRICTION
	THEN PATIENT'S AGE MUST BE CONSISTENT WITH RESTRICTIONS
¹ PATIENT AGE IS CALCULATED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN CARE DATE.	

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS (1-300) (CONTINUED)

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

1-300-05R IF OP/NSP CODE IS CESAREAN SECTION OR REMOVAL OF FETUS (74.2, 74.0-74.99)

THEN DIAGNOSIS CODE MUST BE 640 THROUGH 676.

1-300-06R IF OP/NSP CODE IS ECTOPIC (74.3)

THEN DIAGNOSIS CODE MUST BE 633.0-633.9.

1-300-07R IF TYPE OF INSTITUTION = 72 RTC

THEN PRINCIPAL TREATMENT DIAGNOSIS CODE MUST = 290-316

AND PATIENT AGE¹ MUST BE < 21

UNLESS AMOUNT ALLOWED (TOTAL) = 0

1-300-08R IF PRINCIPAL TREATMENT DIAGNOSIS = MATERNITY (630-676 OR V22-V24 OR V270-V289)

AND PATIENT AGE¹ < 12

THEN ONE OCCURRENCE
OF OVERRIDE CODE
MUST =

E DIAGNOSIS IS MATERNITY; PATIENT IS
UNDER 12 YEARS OF AGE

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

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS - 1-11 (1-305 THROUGH 1-342)

VALIDITY EDITS

1-XXX-01V¹ FOR FILING DATES PRIOR TO 10/01/2004 VALUE IF PRESENT MUST BE A VALID DIAGNOSIS CODE IF PRESENT OR BLANK FILLED.

1-XXX-02V¹ FOR FILING DATE ON OR AFTER 10/01/2004 VALUE IF PRESENT MUST BE A VALID DIAGNOSIS CODE OR BLANK FILLED

AND BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE.

OR END DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE

1-XXX-03V¹ ALL OCCURRENCES OF SECONDARY TREATMENT DIAGNOSIS MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED SECONDARY TREATMENT DIAGNOSIS.

RELATIONAL EDITS

1-XXX-01R¹ IF ANY SECONDARY TREATMENT DIAGNOSIS CODE IS FOR FEMALE
AND PERSON SEX (PATIENT) = MALE

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

1-XXX-02R¹ IF ANY SECONDARY TREATMENT DIAGNOSIS CODE IS FOR MALE
AND NOT FOR CIRCUMCISION (V50.2)

AND SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-3)

AND PERSON SEX (PATIENT) = FEMALE

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

1-XXX-03R¹ IF SECONDARY TREATMENT DIAGNOSIS CODE HAS AN AGE PARAMETER RESTRICTION

THEN PATIENT'S AGE MUST BE CONSISTENT WITH RESTRICTIONS (i.e., NEWBORN) (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-1).

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

1-XXX-04R¹ IF SECONDARY TREATMENT DIAGNOSIS = MATERNITY (630-676 OR V22-V24 OR V270-V289)

AND PATIENT AGE² < 12

¹ XXX EQUALS ELN (305 THROUGH 342) FOR EACH OCCURRENCE OF SECONDARY TREATMENT DIAGNOSIS.

² PATIENT AGE IS CALCULATED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

**ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS - 1-11 (1-305 THROUGH 1-342)
(CONTINUED)**

THEN ONE OCCURRENCE
OF OVERRIDE CODE
MUST =

E DIAGNOSIS IS MATERNITY; PATIENT IS
UNDER 12 YEARS OF AGE

¹ XXX EQUALS ELN (305 THROUGH 342) FOR EACH OCCURRENCE OF SECONDARY TREATMENT
DIAGNOSIS.

² PATIENT AGE IS CALCULATED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN
DATE OF CARE.

ELEMENT NAME: PRINCIPAL OPERATION/NON-SURGICAL PROCEDURE CODE (1-345)

VALIDITY EDITS

1-345-01V FOR FILING DATE PRIOR TO 10/01/2004 VALUE MUST BE A VALID OP/NSP CODE IF
PRESENT OR BLANK FILLED.

1-345-02V FOR FILING DATE ON OR AFTER 10/01/2004 VALUE MUST BE A VALID OP/NSP CODE IF
PRESENT OR BLANK FILLED

AND BEGIN DATE OF CARE MUST BE ON OR AFTER THE OP/NSP EFFECTIVE DATE
AND NOT LATER THAN THE OP/NSP TERMINATION DATE ON THE OP/NSP
REFERENCE TABLE

OR END DATE OF CARE MUST BE ON OR AFTER THE OP/NSP EFFECTIVE DATE
AND NOT LATER THAN THE OP/NSP TERMINATION DATE ON THE OP/NSP
REFERENCE TABLE

RELATIONAL EDITS

1-345-01R IF ANY OCCURRENCE OF REVENUE CODE = 036X OR 0722
THEN PRINCIPAL OP/NSP PROCEDURE CODE IS REQUIRED.
UNLESS DRG NUMBER = BLANK

1-345-02R IF DIAGNOSIS CODE FOR MATERNITY/OBSTETRICS (630-676)
EXCLUDING PRENATAL AND POSTPARTUM (REFER TO CHAPTER 2, ADDENDUM E,
FIGURE 2-E-4)
THEN PRINCIPAL OP/NSP PROCEDURE CODE MUST = 54.21, 65.0-75.99, 87.81, 88.03,
88.46, 88.78, OR 92.17.

ELSE IF THE DIAGNOSIS CODE IS FOR DELIVERY (640-669)
THEN CIRCUMCISION (OP/NSP CODE 64.0) IS ALLOWED

1-345-04R IF PERSON SEX (PATIENT) IS MALE
THEN PRINCIPAL OP/NSP PROCEDURE CODE CANNOT BE FEMALE (RANGE 65.0-
75.99 (OPERATIONS ON FEMALE GENITAL ORGANS/OBSTETRICS))

UNLESS ONE OCCURRENCE OF
OVERRIDE CODE = G DIAGNOSIS/PROCEDURAL CODE FOR
FEMALE: SEX INDICATES MALE

1-345-05R IF PERSON SEX (PATIENT) IS FEMALE
THEN PRINCIPAL OP/NSP PROCEDURE CODE CANNOT BE MALE (RANGE 60.0-64.99
(OPERATIONS ON MALE GENITAL ORGAN))

UNLESS ONE OCCURRENCE OF
OVERRIDE CODE = H DIAGNOSIS/PROCEDURAL CODE FOR
MALE: SEX INDICATES FEMALE

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE 1-11 (1-350 THROUGH 1-373)

VALIDITY EDITS

1-XXX-01V¹ FOR FILING DATE PRIOR TO 10/01/2004 VALUE MUST BE A VALID OP/NSP CODE IF PRESENT OR BLANK FILLED.

1-XXX-02V¹ FOR FILING DATE ON OR AFTER 10/01/2004 VALUE MUST BE VALID OP/NSP CODE IF PRESENT OR BLANK FILLED

AND BEGIN DATE OF CARE MUST BE ON OR AFTER THE OP/NSP EFFECTIVE DATE AND NOT LATER THAN THE OP/NSP TERMINATION DATE ON THE OP/NSP REFERENCE TABLE

OR DATE OF CARE MUST BE ON OR AFTER THE OP/NSP EFFECTIVE DATE AND NOT LATER THAN THE OP/NSP TERMINATION DATE ON THE OP/NSP REFERENCE TABLE

1-XXX-03V¹ ALL OCCURRENCES OF SECONDARY OP/NSP CODE FIELD MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED SECONDARY OP/NSP CODE.

RELATIONAL EDITS

1-XXX-01R¹ IF PRICING RATE CODE = 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

AND DATE OF ADMISSIONS < 10/01/1998

THEN SECONDARY OP/NSP PROCEDURE CODE

CANNOT = 37.5 HEART TRANSPLANT OR

50.59 LIVER TRANSPLANT

1-XXX-02R¹ IF PERSON SEX (PATIENT) IS MALE

THEN SECONDARY OP/NSP PROCEDURE CODE CANNOT BE FEMALE (RANGE 65.0 - 75.99 (OPERATIONS ON FEMALE GENITAL ORGANS/OBSTETRICS))

UNLESS ONE OVERRIDE CODE = G DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE

1-XXX-03R¹ IF PERSON SEX (PATIENT) IS FEMALE

THEN SECONDARY OP/NSP PROCEDURE CODE CANNOT BE MALE (RANGE 60.0 - 64.99 (OPERATIONS ON MALE GENITAL ORGAN))

UNLESS ONE OVERRIDE CODE = H DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE

¹ XXX EQUALS ELN (350 THROUGH 373) FOR EACH OCCURRENCE OF SECONDARY OPERATION/ NON-SURGICAL PROCEDURE CODE.

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CHAPTER 2, SECTION 5.4

INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: TED RECORD CORRECTION INDICATOR (1-374)

VALIDITY EDITS

1-374-01V	VALUE MUST BE A VALID TED RECORD CORRECTION INDICATOR		
1-374-02V	IF TED RECORD CORRECTION INDICATOR =	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. (NOT TO BE USED TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD) 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
	THEN TYPE OF SUBMISSION MUST =	A	ADJUSTMENT OR
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		C	COMPLETE CANCELLATION OF TED RECORD DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
1-374-03V	IF TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OR 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 CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD
	THEN A MATCH TO A PROVISIONALLY ACCEPTED TED RECORD MUST BE PRESENT ON THE TMA DATABASE.		
1-374-04V	IF TED RECORD CORRECTION INDICATOR =	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
	THEN A CORRESPONDING PROVISIONALLY ACCEPTED TED RECORD MUST NOT BE PRESENT ON THE TMA DATABASE.		

RELATIONAL EDITS

NONE

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CHAPTER 2, SECTION 5.4

INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: TOTAL OCCURRENCE/LINE ITEM COUNT (1-375)	
VALIDITY EDITS	
1-375-01V	VALUE MUST BE IN RANGE 001-450. AND MUST EQUAL THE PHYSICAL COUNT OF THE DETAIL LINE ITEMS ON THE TED RECORD
1-375-02V	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 TOTAL OCCURRENCE/LINE ITEM COUNT MUST BE ≥ TOTAL OCCURRENCE/LINE ITEM COUNT FROM TMA DATABASE

RELATIONAL EDITS	
NONE	

ELEMENT NAME: OCCURRENCE/LINE ITEM NUMBER (1-380)	
VALIDITY EDITS	
1-380-01V	EACH VALUE MUST BE NUMERIC.
1-380-02V	OCCURRENCE/LINE ITEM NUMBER MUST BE CODED FOR EACH NUMBER OF OCCURRENCES SPECIFIED BY THE TOTAL OCCURRENCE/LINE ITEM COUNT.
1-380-03V	OCCURRENCE/LINE ITEM NUMBER MUST BE REPORTED IN ASCENDING CONSECUTIVE ORDER.

RELATIONAL EDITS	
NONE	

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CHAPTER 2, SECTION 5.4

INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: REVENUE CODE (1-385)

VALIDITY EDITS

1-385-01V VALUE MUST BE A VALID REVENUE CODE.
UNLESS ADJUSTMENT/DENIAL REASON CODE IS A DENIAL REASON CODE LISTING IN [CHAPTER 2, ADDENDUM H, FIGURE 2-H-1](#) **OR** [FIGURE 2-H-2](#)
 NOTE: THE FOLLOWING VALID OUTPATIENT REVENUE CODES ARE ALLOWED ON AN INSTITUTIONAL TED RECORD ONLY **WHEN** BEING DENIED
 049X, 051X-054X, 0630-0635, 064X, 0661, 0662, 082X-085X, 0882, **AND** 310X.

1-385-02V FIRST DETAILED LINE MUST CONTAIN REVENUE CODE 0001.

RELATIONAL EDITS

1-385-01R ONLY ONE OCCURRENCE OF REVENUE CODE MUST = 0001.

1-385-02R AT LEAST ONE OCCURRENCE OF REVENUE CODE FOR ROOM ACCOMMODATION CHARGES MUST = 010X-021X **OR** 0724

UNLESS ONE OCCURRENCE OF
 OVERRIDE CODE = Y NEWBORN IN MOTHER'S ROOM WITHOUT NURSERY CHARGES

OR ANY OCCURRENCE OF
 SPECIAL PROCESSING CODE = 11 HOSPICE

OR ANY OCCURRENCE OF REVENUE CODE = 0023

1-385-03R IF PRICING RATE CODE = 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

THEN PROFESSIONAL SERVICE REVENUE CODES = 0901, 0914-0918, **OR** 096X-098X
AND ORGAN CODES (081X) MUST BE DENIED.

1-385-04R IF ANY REVENUE CODE = 0723
THEN PERSON SEX (PATIENT) MUST = MALE.

1-385-05R IF ANY REVENUE CODE = 072X BUT **NOT** 0723
THEN PERSON SEX (PATIENT) MUST = FEMALE

1-385-06R IF TYPE OF SUBMISSION = A ADJUSTMENT **OR**
 C COMPLETE CANCELLATION

THEN REVENUE CODES MUST OCCUR IN THE SAME ORDER
AND ON THE SAME OCCURRENCE/LINE ITEM NUMBER AS TMA DATABASE.

1-385-07R IF REVENUE CODE = 0022 SKILLED NURSING FACILITY CHARGE
THEN ADMISSION DATE ≥ 08/01/2003

AND TYPE OF
 INSTITUTION MUST = 76 SKILLED NURSING FACILITY

AND HIPPS CODE ≠ BLANK

UNLESS PATIENT AGE IS < 10 YEARS OF AGE ON DATE OF ADMISSION

1-385-08R IF ANY REVENUE CODE = 0655 INPATIENT RESPITE CARE **OR**
 0656 GENERAL INPATIENT CARE - NON-RESPITE

THEN TYPE OF INSTITUTION
 MUST = 79 HOSPITAL BASED HOSPICE

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CHAPTER 2, SECTION 5.4

INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: REVENUE CODE (1-385) (CONTINUED)	
1-385-09R	IF ANY REVENUE CODE =
	0650 GENERAL CLASSIFICATION OR
	0651 ROUTINE HOME CARE OR
	0652 CONTINUOUS HOME CARE OR
	0657 PHYSICIAN SERVICES OR
	0659 OTHER HOSPICE
	THEN TYPE OF INSTITUTION MUST =
	78 NON-HOSPITAL BASED HOSPICE
1-385-11R	IF REVENUE CODE =
	0023 HOME HEALTH AGENCY (HHA-PPS)
	AND BEGIN DATE OF CARE ≥ 06/01/2004
	THEN TYPE OF INSTIUTION MUST =
	70 HOME HEALTH AGENCY

ELEMENT NAME: UNITS OF SERVICE BY REVENUE CODE (1-390)

VALIDITY EDITS

1-390-01V	VALUE MUST BE SIGNED NUMERIC, 0 TO 9,999,999.
	UNLESS TYPE OF SUBMISSION =
	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN VALUE MUST BE SIGNED NUMERIC, - 9,999,999 TO 9,999,999

RELATIONAL EDITS

1-390-01R	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 UNITS OF SERVICE BY REVENUE CODE MUST BE > ZERO FOR ALL OCCURRENCE/LINE ITEMS

EXCLUDING REVENUE CODE 0001.

1-390-02R	IF UNITS OF SERVICE BY REVENUE CODE = 0
	AND TYPE OF SUBMISSION ≠
	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

THEN TOTAL CHARGE BY REVENUE CODE MUST ALSO = 0 (FOR THAT OCCURRENCE)

EXCEPT FOR REVENUE CODE 0001 OR 0022

1-390-03R	IF UNITS OF SERVICE BY REVENUE CODE > 0
	AND 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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INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: UNITS OF SERVICE BY REVENUE CODE (1-390) (CONTINUED)

THEN TOTAL CHARGE BY REVENUE CODE MUST ALSO > 0 (FOR THAT OCCURRENCE)

UNLESS REVENUE CODE = 0022 SKILLED NURSING FACILITY

OR REVENUE CODE = 0023 HOME HEALTH AGENCY

AND THE OCCURRENCE/LINE ITEM CONTAINS AN ADJUSTMENT/DENIAL REASON CODE LISTED IN CHAPTER 2, ADDENDUM H, FIGURE 2-H-1 OR FIGURE 2-H-2.

1-390-04R IF REVENUE CODE 0001

THEN UNITS OF SERVICE BY REVENUE CODE MUST = ZERO.

1-390-05R IF REVENUE CODE = 0023 HOME HEALTH AGENCY (HHA-PPS)

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

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

THEN UNITS OF SERVICE BY REVENUE CODE MUST = 1

UNLESS THE OCCURRENCE/LINE ITEM CONTAINS AN ADJUSTMENT/DENIAL REASON CODE LISTED IN CHAPTER 2, ADDENDUM H, FIGURE 2-H-1 OR FIGURE 2-H-2.

THEN UNITS OF SERVICE BY REVENUE CODE MUST = 0

ELEMENT NAME: TOTAL CHARGE BY REVENUE CODE (1-395)

VALIDITY EDITS

1-395-01V IF TYPE OF SUBMISSION = B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR

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

THEN MUST BE - 999,999.99 TO 999,999.99

UNLESS REVENUE CODE = 0001

THEN MUST BE - 9,999,999.99 TO 9,999,999.99

ELSE MUST BE 0 TO 999,999.99

UNLESS REVENUE CODE = 0001

THEN MUST BE 0 TO 9,999,999.99

RELATIONAL EDITS

1-395-01R 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 TOTAL CHARGE BY REVENUE CODE MUST BE > ZERO ON EACH OCCURRENCE/LINE ITEM (EXCLUDING REVENUE CODE 0022 AND 0023)

1-395-02R THE SUM OF ALL TOTAL CHARGE BY REVENUE CODE FOR REVENUE CODES OTHER THAN 0001 MUST EQUAL THE TOTAL CHARGE BY REVENUE CODE FOR REVENUE CODE 0001.

INSTITUTIONAL EDIT REQUIREMENTS (ELN 400 - 499)

ELEMENT NAME: ADJUSTMENT/DENIAL REASON CODE (1-400)	
VALIDITY EDITS	
1-400-01V	VALUE MUST BE A VALID ADJUSTMENT/DENIAL REASON CODE (REFER TO CHAPTER 2, ADDENDUM H) OR BLANK.
RELATIONAL EDITS	
1-400-01R	IF AMOUNT ALLOWED (TOTAL) = ZERO
	THEN ALL OCCURRENCE/LINE ITEMS (EXCLUDING REVENUE CODE 0001) MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE (REFER TO FIGURE 2-H-1 OR FIGURE 2-H-2)
	UNLESS TYPE OF SUBMISSION =
	B ADJUSTMENT OF NON-TED RECORD (HCSR) DATA OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
1-400-02R	IF TYPE OF SUBMISSION =
	C COMPLETE CANCELLATION OR
	D COMPLETE DENIAL
	THEN ALL OCCURRENCE/LINE ITEMS (EXCLUDING REVENUE CODE 0001) MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE (REFER TO FIGURE 2-H-1 OR FIGURE 2-H-2)
1-400-03R	IF FREQUENCY CODE =
	1 ADMIT THRU DISCHARGE
	AND PRICING RATE CODE =
	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
	THEN NO OCCURRENCE OF ADJUSTMENT/DENIAL REASON MAY =
	135 CLAIM DENIED. INTERIM BILLS CANNOT BE PROCESSED
1-400-04R	IF PRICING RATE CODE =
	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
	AND REVENUE CODE = 0901, 0914-0918, 096X-098X (PROFESSIONAL SERVICES), OR 081X (ORGAN ACQUISITION)
	THEN ADJUSTMENT/DENIAL REASON CODE MUST BE A CODE LISTED IN FIGURE 2-H-1 OR FIGURE 2-H-2

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CHAPTER 2, SECTION 5.5

INSTITUTIONAL EDIT REQUIREMENTS (ELN 400 - 499)

ELEMENT NAME: ADJUSTMENT/DENIAL REASON CODE (1-400) (CONTINUED)

1-400-05R IF ANY OCCURRENCE OF
ADJUSTMENT/DENIAL REASON
CODE = 135 CLAIM DENIED. INTERIM BILLS CANNOT BE
PROCESSED

THEN ALL OCCURRENCE/LINE ITEMS (EXCLUDING REVENUE CODE 0001) MUST BE DENIED (ADJUSTMENT/DENIAL REASON CODE MUST BE A CODE LISTED IN CHAPTER 2, ADDENDUM H, FIGURE 2-H-1 OR FIGURE 2-H-2).

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: RECORD TYPE INDICATOR (2-001)			
VALIDITY EDITS			
2-001-01V	MUST =	2	NON-INSTITUTIONAL
RELATIONAL EDITS			
2-001-01R	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
AND A MATCH IS FOUND ON THE TMA DATABASE			
THEN THE RECORD TYPE FOR THE TED ON THE DATABASE MUST = THE RECORD TYPE ON THE ADJUSTMENT/CANCELLATION TED BEING SUBMITTED.			

ELEMENT NAME: FILING DATE (2-015)			
VALIDITY EDITS			
2-015-01V	MUST BE A VALID JULIAN DATE	AND CANNOT BE > TMA CURRENT SYSTEM DATE.	
RELATIONAL EDITS			
2-015-01R	FILING DATE MUST BE	≤ DATE TED RECORD PROCESSED TO COMPLETION	
2-015-02R	END DATE OF CARE PLUS ONE YEAR MUST BE > FILING DATE		
	UNLESS ONE OCCURRENCE OF OVERRIDE CODE =	F	CLAIM FILED AFTER DEADLINE
2-015-03R	IF ONE OCCURRENCE OF OVERRIDE CODE =	F	CLAIM FILED AFTER DEADLINE
THEN BEGIN DATE OF CARE PLUS SIX YEARS MUST BE > FILING DATE			

ELEMENT NAME: FILING STATE/COUNTRY CODE (2-020)			
VALIDITY EDITS			
2-020-01V	MUST BE A VALID STATE/COUNTRY CODE (REFER TO	CHAPTER 2, ADDENDUM A AND ADDENDUM B.)	
RELATIONAL EDITS			
NONE			

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CHAPTER 2, SECTION 6.1

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: SEQUENCE NUMBER (2-025)

VALIDITY EDITS

2-025-01V THE FIRST 5 CHARACTERS MUST BE A COMBINATION OF ALPHABETIC OR NUMERIC CHARACTERS LAST 2 CHARACTERS MUST BE BLANK.

NOTE: THE FIRST 5 CHARACTERS CANNOT BE SPACES OR SPECIAL CHARACTERS.

RELATIONAL EDITS

NONE

ELEMENT NAME: TIME STAMP (2-030)

VALIDITY EDITS

2-030-01V MUST BE NUMERIC.

RELATIONAL EDITS

2-030-01R IF FILING DATE IS \geq 02/01/1995

THEN TIME STAMP MUST BE $>$ ZERO

ELEMENT NAME: ADJUSTMENT KEY (2-035)

VALIDITY EDITS

2-035-01V MUST BE ALPHA, '0', OR '5'

RELATIONAL EDITS

NONE

ELEMENT NAME: DATE TED RECORD PROCESSED TO COMPLETION (2-040)

VALIDITY EDITS

2-040-01V MUST BE A VALID GREGORIAN DATE AND CANNOT BE $>$ TMA CURRENT SYSTEM DATE.

RELATIONAL EDITS

2-040-01R DATE TED RECORD PROCESSED TO COMPLETION MUST BE \leq BATCH/VOUCHER DATE

2-040-02R DATE TED RECORD PROCESSED TO COMPLETION MUST BE $<$ CURRENT SYSTEM DATE

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CHAPTER 2, SECTION 6.1

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: DATE ADJUSTMENT IDENTIFIED (2-045)

VALIDITY EDITS

2-045-01V MUST BE A VALID GREGORIAN DATE OR ALL ZEROES AND CANNOT BE > TMA CURRENT SYSTEM DATE.

2-045-02V IF TYPE OF SUBMISSION =

D	DENIAL OR
I	INITIAL SUBMISSION OR
O	ZERO PAYMENT WITH 100% OHI/TPL OR
R	RESUBMISSION

THEN DATE ADJUSTMENT IDENTIFIED MUST BE ALL ZEROES.

2-045-03V IF TED RECORD CORRECTION INDICATOR =

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

AND THE TYPE OF SUBMISSION ON THE CORRESPONDING PROVISIONALLY ACCEPTED TED RECORD ON THE TMA DATABASE =

D	CONTRACTOR DENIAL OR
I	INITIAL SUBMISSION OR
O	ZERO PAYMENT WITH 100% OHI/TPL OR
R	RESUBMISSION

THEN DATE ADJUSTMENT IDENTIFIED MUST = ZEROES.

2-045-04V 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 DATE OF ADJUSTMENT IDENTIFIED MUST BE A VALID GREGORIAN DATE

UNLESS TED RECORD CORRECTION INDICATOR =

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

AND DATE ADJUSTMENT IDENTIFIED ON TMA DATABASE = ZEROES

RELATIONAL EDITS

2-045-03R 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 DATE ADJUSTMENT IDENTIFIED MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION AND ≥ FILING DATE

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CHAPTER 2, SECTION 6.1

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: DATE ADJUSTMENT IDENTIFIED (2-045) (CONTINUED)

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

AND DATE ADJUSTMENT IDENTIFIED ON TMA DATABASE = ZEROES

ELEMENT NAME: PERSON IDENTIFIER (SPONSOR) (2-050)

VALIDITY EDITS

2-050-01V MUST BE 9 NUMERIC DIGITS (CANNOT BE ALL ZEROES, ALL NINES, OR ALL BLANKS)

RELATIONAL EDITS

NONE

ELEMENT NAME: PERSON IDENTIFIER TYPE CODE (SPONSOR) (2-051)

VALIDITY EDITS

2-051-01V MUST BE A VALID VALUE LOCATED IN [CHAPTER 2, SECTION 2.7](#)

RELATIONAL EDITS

NONE

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055)

VALIDITY EDITS

2-055-01V MUST BE A VALID SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (REFER TO
[CHAPTER 2, SECTION 2.8](#))

RELATIONAL EDITS

REFER TO [CHAPTER 2, SECTION 8.1](#)

ELEMENT NAME: AGR SERVICE LEGAL AUTHORITY CODE (2-056)

VALIDITY EDITS

2-056-01V MUST BE VALID AGR SERVICE LEGAL AUTHORITY CODE (REFER TO [CHAPTER 2,](#)
[SECTION 2.4](#))

RELATIONAL EDITS

REFER TO [CHAPTER 2, SECTION 8.1](#)

ELEMENT NAME: PERSON LAST NAME (PATIENT) (2-061)

VALIDITY EDITS

2-061-01V MUST BE AT LEAST 1 CHARACTER (LEFT-JUSTIFIED).

RELATIONAL EDITS

NONE

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CHAPTER 2, SECTION 6.1

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: PERSON FIRST NAME (PATIENT) (2-062)	
VALIDITY EDITS	
NONE	
RELATIONAL EDITS	
NONE	
ELEMENT NAME: PERSON MIDDLE NAME (PATIENT) (2-063)	
VALIDITY EDITS	
NONE	
RELATIONAL EDITS	
NONE	
ELEMENT NAME: PERSON CADENCY NAME (PATIENT) (2-064)	
VALIDITY EDITS	
NONE	
RELATIONAL EDITS	
NONE	
ELEMENT NAME: PERSON IDENTIFIER (PATIENT) (2-065)	
VALIDITY EDITS	
2-065-01V	MUST BE 9 NUMERIC DIGITS AND CANNOT EQUAL ALL BLANKS.
RELATIONAL EDITS	
NONE	
ELEMENT NAME: PERSON IDENTIFIER TYPE CODE (PATIENT) (2-066)	
VALIDITY EDITS	
2-066-01V	MUST BE A VALID VALUE LISTED IN CHAPTER 2, SECTION 2.7
RELATIONAL EDITS	
NONE	
ELEMENT NAME: PERSON BIRTH CALENDAR DATE (PATIENT) (2-070)	
VALIDITY EDITS	
2-070-01V	MUST BE VALID GREGORIAN DATE AND CANNOT BE > TMA CURRENT SYSTEM DATE.
RELATIONAL EDITS	
2-070-01R	PATIENT AGE ¹ MUST BE < 125 YEARS
2-070-02R	PERSON BIRTH CALENDAR DATE (PATIENT) ≤ BEGIN DATE OF CARE.
¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.	

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CHAPTER 2, SECTION 6.1

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: DEERS DEPENDENT SUFFIX (2-075)

VALIDITY EDITS

2-075-01V	IF TYPE OF SERVICE (SECOND POSITION) =	M	(MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS)
	OR TYPE OF SUBMISSION =	B	ADJUSTMENT OF NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN MUST BE A VALID DEERS DEPENDENT SUFFIX OR BLANK (REFER TO CHAPTER 2, SECTION 2.4) OTHERWISE MUST BE BLANK			

RELATIONAL EDITS

NO ERROR	IF DEERS DEPENDENT SUFFIX = BLANK	THEN BYPASS ALL DEERS DEPENDENT SUFFIX RELATIONAL EDITING	
2-075-01R	IF PATIENT AGE ¹ < 17		
	THEN DEERS DEPENDENT SUFFIX MUST ≠	20	SPONSOR
2-075-02R	IF PATIENT AGE ¹ ≥ 21		
	AND PERSON BIRTH CALENDAR DATE (PATIENT) ≠ 19111111		
	THEN DEERS DEPENDENT SUFFIX MUST ≠	01-19	CHILDREN
	UNLESS ONE OCCURRENCE OF OVERRIDE CODE =	D	PATIENT IS FAMILY MEMBER 21 YEARS OF AGE OR OLDER
2-075-03R	IF PATIENT AGE ¹ < 12		
	THEN DEERS DEPENDENT SUFFIX MUST ≠	30-39	SPOUSE
	UNLESS ONE OCCURRENCE OF OVERRIDE CODE =	B	PATIENT IS A SPOUSE UNDER 12 YEARS OF AGE
2-075-04R	IF DEERS DEPENDENT SUFFIX =	20	SPONSOR
	THEN HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
		Z	UNKNOWN
2-075-05R	IF DEERS DEPENDENT SUFFIX =	01-19	CHILDREN OR
		60-69	OTHER ELIGIBLE DEPENDENTS (INCLUDING FORMER SPOUSE) OR
		70-75	UNKNOWN
	THEN HCC MEMBER RELATIONSHIP CODE MUST =	C	CHILD OR STEP CHILD OR
		D	PRE-ADOPTIVE CHILD OR
		E	WARD (COURT ORDERED)
2-075-07R	IF DEERS DEPENDENT SUFFIX =	30-39	SPOUSE OR

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

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CHAPTER 2, SECTION 6.1

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: DEERS DEPENDENT SUFFIX (2-075) (CONTINUED)	
	60-69 OTHER ELIGIBLE DEPENDENTS
THEN HCC MEMBER RELATIONSHIP CODE MUST =	B SPOUSE OR
	G SURVIVING SPOUSE OR
	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
	Z UNKNOWN
2-075-08R IF HCC MEMBER CATEGORY CODE =	T FOREIGN MILITARY MEMBER
AND DEERS DEPENDENT SUFFIX ≠	20 SPONSOR
THEN DEERS DEPENDENT SUFFIX MUST =	01-19 CHILDREN OR
	30-39 SPOUSE
IF HCC MEMBER CATEGORY CODE =	T FOREIGN MILITARY MEMBER
AND HCC MEMBER RELATIONSHIP CODE =	A SELF
THEN ANY OCCURRENCE OF SPECIAL PROCESSING CODE MUST	AN SHCP - NON-REFERRED CARE OR
	AR SHCP - REFERRED CARE OR
	SC SHCP - NON-TRICARE ELIGIBLE OR
	SM SHCP - EMERGENCY
OR ENROLLMENT/ HEALTH PLAN CODE CODE MUST =	SO SHCP - NON-TRICARE ELIGIBLE OR
	SN SHCP - NON-MTF REFERRED OR
	SR SHCP - REFERRED OR
	SU SHCP - REFERRED DESIGNATION UNKNOWN
UNLESS TYPE OF SUBMISSION =	D COMPLETE DENIAL OF INITIAL TED
THEN BYPASS THIS EDIT	
2-075-09R IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF ECHO
THEN DEERS DEPENDENT SUFFIX MUST =	01-19 CHILDREN OR
	30-39 SPOUSE
2-075-10R IF DEERS DEPENDENT SUFFIX =	70-74 UNKNOWN
AND PATIENT AGE¹ > 2 YEARS	

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

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: DEERS DEPENDENT SUFFIX (2-075) (CONTINUED)

AND PERSON BIRTH CALENDAR DATE (PATIENT) ≠ 19111111

THEN TYPE OF
SUBMISSION = D COMPLETE DENIAL

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

ELEMENT NAME: PATIENT IDENTIFIER (DoD) (2-080)

VALIDITY EDITS

2-080-01V MUST NOT BE BLANK FILLED

2-080-02V MUST NOT EQUAL ALL ZEROES

UNLESS TYPE OF SUBMISSION = D COMPLETE DENIAL TED RECORD DATA

OR ALL OCCURRENCE/LINE ITEMS 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

RELATIONAL EDITS

NONE

ELEMENT NAME: DEERS IDENTIFIER (PATIENT) (2-082)

VALIDITY EDITS

2-082-01V POSITIONS 10 AND 11 MUST BE NUMERIC

RELATIONAL EDITS

NONE

ELEMENT NAME: PERSON SEX (PATIENT) (2-085)

VALIDITY EDITS

2-085-01V MUST BE = F FEMALE OR

M MALE OR

Z NOT PROVIDER FROM DEERS

RELATIONAL EDITS

NONE

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: PATIENT ZIP CODE (2-090)

VALIDITY EDITS

2-090-01V MUST BE 9 DIGITS OR 5 DIGITS WITH 4 BLANKS

MUST BE A VALID ZIP CODE (BASED ON BEGIN DATE OF CARE) IN THE GOVERNMENT PROVIDED ELECTRONIC ZIP CODE FILE OR

MUST BE A 3 CHARACTER FOREIGN COUNTRY CODE (BASED ON THE COUNTRY CODES TABLE¹) FOLLOWED BY 6 BLANKS

RELATIONAL EDITS

NO ERROR IF BEGIN DATE OF CARE IS OLDER THAN 6 YEARS

THEN DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA³

2-090-01R IF CA/NAS EXCEPTION REASON IS CODED

THEN PATIENT ZIP CODE MUST BE WITHIN AN MTF² CATCHMENT AREA³

¹ WHEN FOREIGN COUNTRY CODES ARE SUBMITTED, THE FIRST 3 CHARACTERS WILL BE EDITED AGAINST [CHAPTER 2, ADDENDUM A](#).

² MTF IS A 40 MILES CATCHMENT AREA.

³ CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: OVERRIDE CODE (2-095)

VALIDITY EDITS

2-095-01V	OCCURRENCE NUMBER 1--MUST BE A VALID OVERRIDE CODE ²
2-095-02V	OCCURRENCE NUMBER 2--MUST BE A VALID OVERRIDE CODE ²
2-095-03V	OCCURRENCE NUMBER 3--MUST BE A VALID OVERRIDE CODE ²
2-095-04V	A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).
2-095-05V	OVERRIDE CODE OCCURRENCES MUST BE LEFT JUSTIFIED

RELATIONAL EDITS

2-095-03R	IF ANY OCCURRENCE OF OVERRIDE CODE =	B	PATIENT IS A SPOUSE UNDER 12 YEARS OF AGE
	THEN PATIENT AGE MUST BE < 12		
	AND HCC MEMBER RELATIONSHIP CODE =	B	SPOUSE OR
		G	SURVIVING SPOUSE
2-095-04R	IF ANY OCCURRENCE OF OVERRIDE CODE =	D	PATIENT IS DEPENDENT 21 YEARS OF AGE OR OLDER
	THEN FOR EACH LINE OCCURRENCE		PATIENT AGE ¹ MUST BE ≥ 21
	AND HCC MEMBER RELATIONSHIP CODE =	C	CHILD OR STEPCHILD OR
		D	PRE-ADOPTIVE CHILD OR
		E	WARD (COURT ORDERED) OR
		Z	UNKNOWN
	UNLESS AMOUNT ALLOWED BY PROCEDURE CODE FOR THAT OCCURRENCE = 0		
2-095-05R	IF ANY OCCURRENCE OF OVERRIDE CODE =	I	PATIENT IS A FORMER SPOUSE UNDER 34 YEARS OF AGE
	THEN PATIENT AGE ¹ 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 AGE ¹ MUST BE < 34		
	AND HCC MEMBER CATEGORY CODE =	W	FORMER SPOUSE

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

² AS STATED IN CHAPTER 2, SECTION 2.6.

³ CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2005 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS APPLY TO GOVERNMENT USE.

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: OVERRIDE CODE (2-095) (CONTINUED)	
2-095-06R	IF ANY OCCURRENCE OF OVERRIDE CODE = M NATO
	THEN HCC MEMBER CATEGORY CODE MUST = T FOREIGN MILITARY MEMBER
2-095-07R	IF ANY OCCURRENCE OF OVERRIDE CODE = E DIAGNOSIS IS MATERNITY; PATIENT IS UNDER 12 YEARS OF AGE
	THEN PATIENT AGE ¹ MUST BE < 12
	AND AT LEAST ONE TREATMENT DIAGNOSIS MUST = MATERNITY
2-095-08R	IF ANY OCCURRENCE OF OVERRIDE CODE = G DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE
	THEN AT LEAST ONE PROCEDURE OR DIAGNOSIS CODE MUST BE FOR FEMALE
	AND PERSON SEX (PATIENT) MUST BE MALE.
2-095-09R	IF ANY OCCURRENCE OF OVERRIDE CODE = H DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE
	THEN AT LEAST ONE PROCEDURE OR DIAGNOSIS CODE MUST BE FOR MALE
	AND NOT FOR CIRCUMCISION (PROCEDURE CODE ³ 54150 OR 54160)
	AND PRINCIPAL/SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-3)
	AND PERSON SEX (PATIENT) MUST BE FEMALE.
2-095-11R	IF ANY OCCURRENCE OF OVERRIDE CODE = NC NON-CERTIFIED PROVIDER (DOES NOT INCLUDE SANCTIONED/SUSPENDED PROVIDERS)
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =
	AD FOREIGN ACTIVE DUTY CLAIMS OR
	AN SHCP - NON-MTF REFERRED CARE OR
	AR SHCP - REFERRED CARE OR
	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

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

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

³ CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2005 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS APPLY TO GOVERNMENT USE.

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: OVERRIDE CODE (2-095) (CONTINUED)	
	OR ENROLLMENT/ HEALTH PLAN CODE MUST =
	SN SHCP - NON-MTF-REFERRED CARE OR
	SR SHCP - REFERRED CARE OR
	SU SHCP - REFERRAL DESIGNATION UNKNOWN
2-095-12R	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 CARE DATES.

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

³ CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2005 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS APPLY TO GOVERNMENT USE.

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 OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN ADJUSTMENT KEY CANNOT =	0	BATCH OR
		5	VOUCHER
	AND REGION INDICATOR MUST = BLANK		
2-100-03V	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 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 NON-TED RECORD (HCSR) DATA
	UNLESS THE RECORD HAS PROVISIONAL ERRORS		
2-100-04V	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		
2-100-05V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT TO TED OR
		C	COMPLETE CANCELLATION OR
		D	COMPLETE DENIAL OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

	THEN REGION INDICATOR MUST =	↳	BLANK OR
		NC	NORTH CONTRACT OR
		SC	SOUTH CONTRACT OR
		WC	WEST CONTRACT
2-100-06V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		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

2-100-01R	IF TYPE OF SUBMISSION =	O	ZERO PAYMENT WITH 100% OHI/TPL
	THEN THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF 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 = ZERO		
2-100-02R	IF ALL OCCURRENCE/LINE ITEMS ARE DENIED (REFER TO CHAPTER 2, ADDENDUM H, FIGURE 2-H-1)		
	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 INDICATION =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: TYPE OF SUBMISSION (2-100) (CONTINUED)	
	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
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 < 10/01/2010
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 THEN TYPE OF SERVICE (SECOND POSITION) MUST ≠ M MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
2-100-10R	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) BY PROCEDURE CODE > 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 UNLESS THE SUM OF THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT PATIENT COST-SHARE AND THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT APPLIED TOWARD DEDUCTIBLE > THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE OR THE TED RECORD CORRECTION INDICATOR ≠ BLANK

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

VALIDITY EDITS

2-105-01V MUST BE A VALID CLAIM FORM 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, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS **OR**

M MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS

2-105-02R IF CLAIM FORM TYPE/EMC INDICATOR =

J OTHER

AND TYPE OF SERVICE SECOND POSITION = B RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS **OR**

M MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS

THEN PROCEDURE CODE MUST =

000MN PRESCRIPTION MEDICAL NECESSITY REVIEWS **OR**

000PA PRESCRIPTION PRIOR AUTHORIZATIONS

ELEMENT NAME: ADMINISTRATIVE CLIN (2-108)

VALIDITY EDITS

2-108-01V MUST BE BLANKS **OR A VALID CLIN FOR THE CONTRACT NUMBER ON THE TMA DATABASE**

2-108-02V IF TYPE OF SUBMISSION = A ADJUSTMENT **OR**

B **HCSR ADJUSTMENT OR**

C COMPLETE CANCELLATION **OR**

E **HCSR CANCELLATION**

AND ADMINISTRATIVE CLAIM COUNT CODE (TMA DERIVED FIELD) ON TMA FILE =

1 CLAIM RATE HAS BEEN PAID

THEN ADMINISTRATIVE CLIN ON THE ADJUSTMENT MUST = ADMINISTRATIVE CLIN ON TMA DATABASE¹

RELATIONAL EDITS

REFER TO [CHAPTER 2, SECTION 8.1](#).

¹ THIS EDIT IS CHECKED DURING THE MATCH AND MARRY PROCESS.

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

VALIDITY EDITS

2-110-01V	MUST BE A VALID 4 DIGIT DMIS-ID CODE.
2-110-02V	<ul style="list-style-type: none"> 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 ADJUSTMENT 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-ID¹
	AND CANNOT = 6501, 6901-6915, 6917-6919, 7901-7912, 7916²-7919, 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.		
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-ID¹		
	AND CANNOT = 6501, 6901-6915, 6917-6919, 7901-7912, 7916²-7919, 8000-8099, OR BLANK		
2-110-02R	IF BEGIN DATE OF CARE ≥ 10/01/1999		
	AND ENROLLMENT/HEALTH PLAN CODE =	SR	SHCP - REFERRED CARE
	THEN PCM LOCATION DMIS-ID MUST BE A VALID MTF/CLINIC DMIS-ID¹		
	AND CANNOT = 6501, 6901-6915, 6917-6919, 7901-7912, 7916²-7919, 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 =	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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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (2-110) (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
2-110-05R	IF BEGIN DATE OF CARE ≥ 10/01/1997 AND < 10/01/1999
	AND ENROLLMENT/HEALTH PLAN CODE =
	W TPR ADSM - USA
	AND REGION INDICATOR = h BLANK OR
	NC NORTH CONTRACT
	THEN DMIS-ID MUST = 7901, 7902, 7905, OR 8000-8099 OR BLANK
	OR REGION INDICATOR = h BLANK OR
	WC WEST CONTRACT
	THEN DMIS-ID MUST = 6911 OR BLANK
2-110-06R	IF BEGIN DATE OF CARE ≥ 10/01/1999 AND < 09/01/2002
	AND ENROLLMENT/HEALTH PLAN CODE =
	W TPR ADSM - 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
2-110-07R	IF BEGIN DATE OF CARE ≥ 10/01/1997
	AND ENROLLMENT/HEALTH PLAN CODE ≠
	U TRICARE PRIME, CIVILIAN PCM OR
	W TPR ADSM - USA OR
	X FOREIGN ADSM OR
	Z TRICARE PRIME, MTF/CLINIC OR
	BB TSP OR
	SN SHCP - NON-MTF REFERRED CARE OR
	SR SHCP - REFERRED CARE OR
	SU SHCP - REFERRAL DESIGNATION UNKNOWN OR
	WA TPR FOREIGN ADSM OR
	WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM OR

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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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS (2-115)

VALIDITY EDITS

2-115-01V FOR FILING DATE PRIOR TO 10/01/2004 VALUE MUST BE A VALID DIAGNOSIS CODE, EXCLUDING E800.0-E999.1.

2-115-02V FOR FILING DATE ON OR AFTER 10/01/2004 VALUE MUST BE A VALID DIAGNOSIS CODE, EXCLUDING E800.0-E999.1

AND FOR AT LEAST ONE LINE ITEM

EITHER BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE

OR END DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE

RELATIONAL EDITS

2-115-01R 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

2-115-02R IF ANY PRINCIPAL TREATMENT DIAGNOSIS CODE IS FOR MALE

AND NOT FOR CIRCUMCISION (PROCEDURE CODE² 54150 OR 54160)

AND SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-3)

AND PERSON SEX (PATIENT) IS FEMALE

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

2-115-03R IF PRINCIPAL TREATMENT DIAGNOSIS CODE HAS AN AGE PARAMETER RESTRICTION

THEN PATIENT'S AGE MUST BE CONSISTENT WITH RESTRICTIONS (i.e., NEWBORN (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-1)

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

OR TYPE OF SERVICE
(SECOND POSITION) = B RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS **OR**

M MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS

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

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS (2-115) (CONTINUED)	
OR AT LEAST ONE OCCURRENCE OF PROCEDURE CODE =	A4281 TUBING FOR BREAST PUMP, REPLACEMENT OR
	A4282 ADAPTER FOR BREAST PUMP, REPLACEMENT OR
	A4283 CAP FOR BREAST PUMP, REPLACEMENT OR
	A4284 BREAST SHIELD AND SPLASH PROTECTOR FOR USE WITH BREAST PUMP, REPLACEMENT OR
	A4285 POLYCARBONATE BOTTLE FOR USE WITH BREAST PUMP, REPLACEMENT OR
	A4286 LOCKING RING FOR BREAST PUMP, REPLACEMENT OR
	E0604 BREAST PUMP, HEAVY DUTY, HOSPITAL GRADE, PISTON OPERATED, PULSATILE VACUUM SUCTION/RELEASE CYCLES, VACUUM REGULATOR, SUPPLIES, TRANSFORMER, ELECTRIC (AC AND/OR DC)
2-115-04R	IF SECONDARY TREATMENT DIAGNOSIS = MATERNITY (630-676 OR V22-V24 OR V270-V289)
	AND PATIENT AGE¹ < 12
	THEN ONE OCCURRENCE OF OVERRIDE CODE MUST =
	E DIAGNOSIS IS MATERNITY; PATIENT IS UNDER 12 YEARS OF AGE
2-115-05R	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 (ADFM _s ONLY) OR
	I INPATIENT OR
	N OUTPATIENT COST-SHARED AS INPATIENT OR
	O OUTPATIENT, EXCLUDING M, P, OR N
	AND TYPE OF SERVICE (SECOND POSITION) MUST =
	4 DIAGNOSTIC/THERAPEUTIC X-RAY OR
	5 DIAGNOSTIC LABORATORY OR
	7 ANESTHESIA
	UNLESS TYPE OF SUBMISSION = D COMPLETE DENIAL

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

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS (2-115) (CONTINUED)	
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE = 1 MEDICAID
2-115-06R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = PF ECHO
	THEN PRINCIPAL DIAGNOSIS CANNOT = 799.9
	UNLESS TYPE OF SUBMISSION = D COMPLETE DENIAL
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE = 1 MEDICAID
¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.	
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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS-1 - 7 (2-120 THROUGH 2-137)

VALIDITY EDITS

2-XXX-01V¹	FOR FILING DATES PRIOR TO 10/01/2004, VALUE IF PRESENT, MUST BE VALID DIAGNOSIS CODE OR BLANK-FILLED.
2-XXX-02V¹	FOR FILING DATE ON OR AFTER 10/01/2004 VALUE IF PRESENT MUST BE A VALID DIAGNOSIS CODE AND FOR AT LEAST ONE LINE ITEM EITHER BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE OR END DATE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE
2-XXX-03V¹	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-01R¹	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-02R¹	IF ANY SECONDARY TREATMENT DIAGNOSIS CODE IS FOR MALE AND NOT FOR CIRCUMCISION (PROCEDURE CODE ³ 54150 OR 54160) AND SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY (CHAPTER 2, ADDENDUM E, FIGURE 2-E-3) AND PERSON SEX (PATIENT) IS FEMALE THEN AT LEAST ONE OVERRIDE CODE MUST = H DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE
2-XXX-03R¹	IF SECONDARY TREATMENT DIAGNOSIS CODE HAS AN AGE PARAMETER RESTRICTION THEN PATIENT'S AGE MUST BE CONSISTENT WITH RESTRICTIONS (i.e., NEWBORN (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-1) 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

¹ XXX EQUALS ELN (120 THROUGH 137) FOR EACH OCCURRENCE OF SECONDARY TREATMENT DIAGNOSIS.

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

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS-1 - 7 (2-120 THROUGH 2-137)	
OR TYPE OF SERVICE (SECOND POSITION) =	B RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS OR
	M MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
OR AT LEAST ONE OCCURRENCE OF PROCEDURE CODE =	A4281 TUBING FOR BREAST PUMP, REPLACEMENT OR
	A4282 ADAPTER FOR BREAST PUMP, REPLACEMENT OR
	A4283 CAP FOR BREAST PUMP, REPLACEMENT OR
	A4284 BREAST SHIELD AND SPLASH PROTECTOR FOR USE WITH BREAST PUMP, REPLACEMENT OR
	A4285 POLYCARBONATE BOTTLE FOR USE WITH BREAST PUMP, REPLACEMENT OR
	A4286 LOCKING RING FOR BREAST PUMP, REPLACEMENT OR
	E0604 BREAST PUMP, HEAVY DUTY, HOSPITAL GRADE, PISTON OPERATED, PULSATILE VACUUM SUCTION/RELEASE CYCLES, VACUUM REGULATOR, SUPPLIES, TRANSFORMER, ELECTRIC (AC AND/OR DC)
2-XXX-04R¹	IF SECONDARY TREATMENT DIAGNOSIS = MATERNITY (630-676 OR V22-V24 OR V270-V289)
	AND PATIENT AGE² < 12
	THEN ONE OCCURRENCE OF OVERRIDE CODE MUST =
	E DIAGNOSIS IS MATERNITY; PATIENT IS UNDER 12 YEARS OF AGE

¹ XXX EQUALS ELN (120 THROUGH 137) FOR EACH OCCURRENCE OF SECONDARY TREATMENT DIAGNOSIS.

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

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: TED RECORD CORRECTION INDICATOR (2-139)

VALIDITY EDITS

2-139-01V	VALUE MUST BE A VALID TED RECORD CORRECTION INDICATOR		
2-139-02V	IF TED RECORD CORRECTION INDICATOR =	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. (NOT TO BE USED TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD) 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
	THEN TYPE OF SUBMISSION MUST =	A	ADJUSTMENT OR
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		C	COMPLETE CANCELLATION OF TED RECORD DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
2-139-03V	IF 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 CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD
	THEN A MATCH TO A PROVISIONALLY ACCEPTED TED RECORD MUST BE PRESENT ON THE TMA DATABASE.		
2-139-04V	IF TED RECORD CORRECTION INDICATOR =	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
	THEN A CORRESPONDING PROVISIONALLY ACCEPTED TED RECORD MUST NOT BE PRESENT ON THE TMA DATABASE.		

RELATIONAL EDITS

NONE

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

VALIDITY EDITS

2-150-01V MUST BE A VALID GREGORIAN DATE **AND CANNOT BE > TMA CURRENT SYSTEM DATE.**

2-150-02V **CANNOT BE MORE THAN 10 YEARS PRIOR TO TMA CURRENT SYSTEM DATE.**

2-150-03V **BEGIN DATE OF CARE MUST BE ≤ END DATE OF CARE.**

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 OR
B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
C	COMPLETE CANCELLATION OR
E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

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

UNLESS TED RECORD CORRECTION INDICATOR =

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

AND DATE ADJUSTMENT IDENTIFIED = ZEROES.

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

UNLESS AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO

OR ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM =

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 PROVIDER SPECIALTY = 172A00000X (OTHER SERVICE PROVIDER/DRIVERS) **OR** 344600000X (TRANSPORTATION SERVICES/TAXI)

¹ "AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON **NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER MAJOR SPECIALTY, PROVIDER ZIP CODE, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (2-240-04R).**

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: BEGIN DATE OF CARE (2-150) (CONTINUED)	
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
	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 PROVIDER FILE

¹ "AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON **NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER MAJOR SPECIALTY, PROVIDER ZIP CODE, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (2-240-04R).**

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

VALIDITY EDITS

2-155-01V MUST BE A VALID GREGORIAN DATE **AND CANNOT BE > TMA CURRENT SYSTEM DATE.**

2-155-02V **CANNOT BE MORE THAN 10 YEARS PRIOR TO TMA CURRENT SYSTEM DATE.**

2-155-03V **END DATE OF CARE MUST BE > OR EQUAL TO BEGIN DATE OF CARE.**

RELATIONAL EDITS

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 OR
B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
C	COMPLETE CANCELLATION OR
E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

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

UNLESS TED RECORD CORRECTION INDICATOR =

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

AND DATE ADJUSTMENT IDENTIFIED = ZEROES.

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

UNLESS AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO

OR ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM =

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 PROVIDER SPECIALTY = 172A00000X (OTHER SERVICE PROVIDER/DRIVERS) **OR** 344600000X (TRANSPORTATION SERVICES/TAXI)

¹ "AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON **NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER MAJOR SPECIALTY, PROVIDER ZIP CODE, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (2-240-04R).**

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE = T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 **OR**

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 PROVIDER FILE

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

¹ **"AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER MAJOR SPECIALTY, PROVIDER ZIP CODE, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (2-240-04R).**

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PROCEDURE CODE (2-160)

VALIDITY EDITS

2-160-01V² FOR FILING DATE PRIOR TO 01/01/2005, VALUE MUST BE A VALID PROCEDURE CODE

AND PROCEDURE CODE MUST MATCH ONE OF THE RECORDS IN THE PROCEDURE CODE DATABASE USING THE FOLLOWING DATE LOGIC:

FOR TYPE OF SUBMISSION =	D	COMPLETE DENIAL OR
	I	INITIAL TED RECORD SUBMISSION OR
	O	ZERO PAYMENT WITH 100% OHI/TPL OR
	R	RESUBMISSION OF AN INITIAL TED RECORD (TYPE OF SUBMISSION WAS 'T') THAT WAS REJECTED DUE TO ERRORS

THE DATE TED RECORD PROCESSED TO COMPLETION MUST BE ON OR AFTER THE PROCESSING EFFECTIVE DATE **AND** BEFORE THE PROCESSING TERMINATION DATE

AND THE BEGIN DATE OF CARE MUST BE ON **OR** AFTER THE CARE EFFECTIVE DATE **AND** BEFORE THE CARE TERMINATION DATE

FOR TYPE OF SUBMISSION =	A	ADJUSTMENT TO TED RECORD DATA OR
	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	C	COMPLETE CANCELLATION OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

THE DATE TED RECORD PROCESSED TO COMPLETION MUST BE ON **OR** AFTER THE PROCESSING EFFECTIVE DATE

AND THE BEGIN DATE OF CARE MUST BE ON **OR** AFTER THE CARE EFFECTIVE DATE **AND** BEFORE THE CARE TERMINATION DATE

2-160-02V² FOR FILING DATE ON OR AFTER 01/01/2005 VALUE MUST BE A VALID PROCEDURE CODE

AND PROCEDURE CODE MUST MATCH ONE OF THE RECORDS IN THE PROCEDURE CODE REFERENCE TABLE USING THE FOLLOWING DATE LOGIC:

BEGIN DATE OF CARE MUST BE ON **OR** AFTER THE PROCEDURE CODE EFFECTIVE DATE **AND** NOT LATER THAN THE PROCEDURE CODE TERMINATION DATE.

RELATIONAL EDITS

2-160-01R³ IF **ON THE MATCHING RECORD THE** PROCEDURE CODE DATABASE GOVERNMENT PAY CODE = 'N'

THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE ≤ ZERO

UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE = T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 **OR**

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² PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDITS 2-160-01R, 2-160-02R, 2-160-03R, AND 2-160-04R.

³ BYPASS EDITS 2-160-01R, 2-160-02R, 2-160-03R, AND 2-160-04R IF RECORD FAILS EDIT 2-160-01V OR 2-160-01-2V.

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PROCEDURE CODE (2-160) (CONTINUED)	
	AN SHCP - NON-MTF-REFERRED CARE OR
	AR SHCP - REFERRED CARE OR
	CE SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
	CL CLINICAL TRIALS OR
	FG TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) OR
	FS TFL (SECOND PAYOR) 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
	OR FILING STATE AND COUNTRY CODE MUST = A FOREIGN COUNTRY CODE (REFER TO CHAPTER 2, ADDENDUM A)
2-160-02R³	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
2-160-03R³	IF ANY PROCEDURE CODE IS FOR MALE AND NOT FOR CIRCUMCISION (PROCEDURE CODE ¹ 54150 OR 54160) AND SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY (CHAPTER 2, ADDENDUM E, FIGURE 2-E-3) AND PERSON SEX (PATIENT) IS FEMALE THEN AT LEAST ONE OVERRIDE CODE MUST = H DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE
2-160-04R³	IF PROCEDURE CODE HAS AN AGE PARAMETER RESTRICTION THEN PATIENT'S AGE MUST BE CONSISTENT WITH RESTRICTIONS
¹ CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2005 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS APPLY TO GOVERNMENT USE.	
² PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDITS 2-160-01R, 2-160-02R, 2-160-03R, AND 2-160-04R.	
³ BYPASS EDITS 2-160-01R, 2-160-02R, 2-160-03R, AND 2-160-04R IF RECORD FAILS EDIT 2-160-01V OR 2-160-01-2V.	

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

	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
2-160-05R	IF PROCEDURE CODE ¹ = A0100, A0110, A0120, A0130, A0140, A0170, L3000 - L3649, 99082		
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	PF	ECHO
	UNLESS ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM IS A CODE LISTED IN CHAPTER 2, ADDENDUM H, 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 OR
		SN	SHCP - NON-MTF-REFERRED CARE OR
		SR	SHCP - REFERRED CARE OR
		WA	TPR - FOREIGN ADSM
2-160-06R	IF TYPE OF SERVICE (FIRST POSITION) =	I	INPATIENT
	THEN PROCEDURE CODE MUST NOT BE FOR OUTPATIENT ONLY CARE (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-2).		
2-160-07R	IF PROCEDURE CODE ¹ = 90892-90898		
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	WR	MENTAL HEALTH WRAPAROUND DEMONSTRATION
2-160-08R	IF PROCEDURE CODE ¹ =	98800	FOR DRUGS OR
		000MN	PRESCRIPTION MEDICAL NECESSITY REVIEWS OR

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² PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDITS 2-160-01R, 2-160-02R, 2-160-03R, AND 2-160-04R.

³ BYPASS EDITS 2-160-01R, 2-160-02R, 2-160-03R, AND 2-160-04R IF RECORD FAILS EDIT 2-160-01V OR 2-160-01-2V.

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

000PA PRESCRIPTION PRIOR AUTHORIZATIONS

THEN TYPE OF SERVICE
(SECOND POSITION) MUST =

B RETAIL DRUGS, SUPPLIES, PRESCRIPTION,
AUTHORIZATIONS, AND REVIEWS **OR**

M MAIL ORDER PHARMACY DRUGS,
SUPPLIES, PRESCRIPTION,
AUTHORIZATIONS, AND REVIEWS

AND NATIONAL DRUG CODE MUST ≠ BLANK

UNLESS PROVIDER STATE OR COUNTRY CODE IS A FOREIGN COUNTRY CODE
(CHAPTER 2, ADDENDUM A)

2-160-10R IF PROCEDURE CODE = A4281 - A4286 **OR** E0604

AND AMOUNT ALLOWED BY PROCEDURE CODE > ZERO.

THEN EITHER PRIMARY OR ANY OCCURRENCE OF SECONDARY DIAGNOSIS
CODE MUST = 765.00 - 765.09, 765.10 - 765.19, **OR** 765.21 - 765.28.

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APPLY TO GOVERNMENT USE.

² PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDITS
2-160-01R, 2-160-02R, 2-160-03R, AND 2-160-04R.

³ BYPASS EDITS 2-160-01R, 2-160-02R, 2-160-03R, AND 2-160-04R IF RECORD FAILS EDIT 2-160-01V OR
2-160-01-2V.

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PROCEDURE CODE MODIFIER (2-165)

VALIDITY EDITS

2-165-01V MUST BE A VALID PROCEDURE CODE MODIFIER AS DEFINED IN [CHAPTER 2, SECTION 2.7](#)

RELATIONAL EDITS

NONE

ELEMENT NAME: NATIONAL DRUG CODE (2-170)

VALIDITY EDITS

2-170-01V MUST BE A VALID NATIONAL DRUG CODE OR BLANK

RELATIONAL EDITS

2-170-01R IF NATIONAL DRUG CODE = BLANK

THEN TYPE OF SERVICE
(SECOND POSITION) MUST ≠

B

RETAIL DRUGS, SUPPLIES, PRESCRIPTION,
AUTHORIZATIONS, AND REVIEWS OR

M

MAIL ORDER PHARMACY DRUGS,
SUPPLIES, PRESCRIPTION,
AUTHORIZATIONS, AND REVIEWS

AND PROCEDURE CODE¹
MUST ≠

98800 FOR DRUGS

UNLESS PROVIDER STATE OR COUNTRY CODE IS A FOREIGN COUNTRY CODE
([CHAPTER 2, ADDENDUM A](#))

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

THEN TYPE OF SERVICE
(SECOND POSITION) MUST =

B

RETAIL DRUGS, SUPPLIES, PRESCRIPTION,
AUTHORIZATIONS, AND REVIEWS OR

M

MAIL ORDER PHARMACY DRUGS,
SUPPLIES, PRESCRIPTION,
AUTHORIZATIONS, AND REVIEWS

AND PROCEDURE CODE¹
MUST =

98800 FOR DRUGS OR

99070 FOR SUPPLIES OR

000MN PRESCRIPTION MEDICAL NECESSITY
REVIEWS OR

000PA PRESCRIPTION PRIOR AUTHORIZATIONS

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

**UNLESS TYPE OF SERVICE
(SECOND POSITION) =**

M MAIL ORDER PHARMACY DRUGS,
SUPPLIES, PRESCRIPTION,
AUTHORIZATIONS, AND REVIEWS

AND OCCURRENCE/LINE ITEM NUMBER = 002

THEN NUMBER OF SERVICES ON THIS LINE ITEM MUST = ZERO

2-175-02R • SURGERY PROCEDURE CODES

IF PROCEDURE CODE¹ = 10000-36399 **OR** 36800-69999 (SURGERY)

THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM CANNOT EXCEED 10

2-175-03R • E/M PROCEDURE CODES

IF PROCEDURE CODE¹ =

99201-99205 (OFFICE VISITS - NEW PATIENTS)	OR
99211-99215 (OFFICE VISITS - ESTABLISHED PATIENTS)	OR
99217 (DISCHARGE SERVICES)	OR
99221-99233 (HOSPITAL CARE PER DAY)	OR
99234-99236 (OBSERVATION OR IMPATIENT CARE SERVICES)	OR
99238-99239 (HOSPITAL DISCHARGE SERVICES)	OR
99241-99245 (OFFICE CONSULTATIONS)	OR
99251-99255 (INITIAL INPATIENT CONSULTATIONS)	OR
99261-99263 (FOLLOW-UP INPATIENT CONSULTATIONS)	OR
99271-99275 (CONFIRMATORY CONSULTATIONS)	OR
99281-99285 (EMERGENCY DEPARTMENT VISIT)	OR

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: NUMBER OF SERVICES (2-175) (CONTINUED)	
	99291 (CRITICAL CARE) (NOTE: CODE 99292 EXCLUDED BECAUSE UTILIZED TO REPORT FOR EACH ADDITIONAL 15 MINUTES OF CARE) OR
	99295-99298 (NEONATAL INTENSIVE CARE) OR
	99301-99315 (NURSING FACILITY CHARGES) OR
	99321-99333 (DOMICILIARY, REST HOME, OR CUSTODIAL CARE SERVICES) OR
	99341-99350 (HOME SERVICES) OR
	99354 (PROLONGED SERVICES) (NOTE: CODE 99355 EXCLUDED BECAUSE UTILIZED TO REPORT FOR EACH ADDITIONAL 30 MINUTES OF CARE) OR
	99356 (PROLONGED SERVICES) (NOTE: CODE 99357 EXCLUDED BECAUSE UTILIZED TO REPORT FOR EACH ADDITIONAL 30 MINUTES OF CARE) OR
	99361-99373 (CASE MANAGEMENT SERVICES) OR
	99374-99380 (CARE PLAN OVERSIGHT) OR
	99381-99429 (PREVENTIVE MEDICINE SERVICES) OR
	99431-99440 (NEWBORN CARE) OR
	99450-99456 (SPECIAL EVALUATION AND MANAGEMENT SERVICES)
	THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM CANNOT EXCEED 3 PER DAY
2-175-04R	• MEDICAL PROCEDURE CODES
	IF PROCEDURE CODE ¹ = 99500-99512 (HOME HEALTH VISIT) OR
	99551-99568 (HOME INFUSION PER DIEM CODES)
	THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM CANNOT EXCEED 3 PER DAY
2-175-05R	• ANESTHESIOLOGY PROCEDURE CODES
	IF PROCEDURE CODE ¹ = 00100-01999 (ANESTHESIA)
	THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM CANNOT EXCEED 10
2-175-06R	• VACCINES (VACCINE PRODUCT ONLY) PROCEDURE CODES
	IF PROCEDURE CODE ¹ = 90476-90479 (VACCINES, TOXOIDS) OR
	THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM CANNOT EXCEED 3 PER DAY

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

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

VALIDITY EDITS

2-185-01V MUST BE NUMERIC.

RELATIONAL EDITS

2-185-00R TOTAL OF ALL OCCURRENCES OF AMOUNT ALLOWED BY PROCEDURE CODE FOR THIS TED RECORD EXCEEDS TMA LIMIT OF \$1,000,000.00.

2-185-01R IF TYPE OF SUBMISSION = C COMPLETE CANCELLATION OR

D COMPLETE DENIAL

THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO FOR ALL OCCURRENCE/LINE ITEM

2-185-02R IF PRICING RATE CODE = ~~b~~ NO SPECIAL RATE OR

D DISCOUNT RATE OR

V MEDICARE REIMBURSEMENT RATE

AND NO OCCURRENCE OF SPECIAL PROCESSING CODE = T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR

FS TFL (SECOND PAYOR)

AND TYPE OF SUBMISSION = A ADJUSTMENT OR

I INITIAL SUBMISSION OR

O ZERO PAYMENT WITH 100% OHI/TPL OR

R RESUBMISSION

THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE ≤ AMOUNT BILLED BY PROCEDURE CODE FOR EACH OCCURRENCE/LINE ITEM

2-185-03R IF PRICING RATE CODE = 4 PAID AS BILLED OR

I CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, PAID AS BILLED

AND TYPE OF SUBMISSION = A ADJUSTMENT OR

I INITIAL SUBMISSION OR

O ZERO PAYMENT WITH 100% OHI/TPL OR

R RESUBMISSION

THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE = AMOUNT BILLED BY PROCEDURE CODE

2-185-04R IF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: AMOUNT ALLOWED BY PROCEDURE CODE (2-185) (CONTINUED)		
<p>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</p>		
	UNLESS TYPE OF SUBMISSION =	B ADJUSTMENT NON-TED DATA (HCSR) DATA OR
		E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
2-185-05R	IF TYPE OF SUBMISSION =	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
<p>THEN AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO</p>		
2-185-06R	IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO	
	THEN TYPE OF SUBMISSION MUST =	A ADJUSTMENT OR
		B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		I INITIAL SUBMISSION OR
		O ZERO PAYMENT WITH 100% OHI/TPL OR
		R RESUBMISSION
2-185-07R	IF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO	
<p>THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO</p>		
	UNLESS TYPE OF SUBMISSION =	B ADJUSTMENT NON-TED DATA (HCSR) DATA OR
		E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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.
2-190-01R	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 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.

ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) TYPE CODE (2-191)	
VALIDITY EDITS	
2-191-01V	MUST BE A VALID OGP TYPE CODE LISTING IN CHAPTER 2, SECTION 2.6 .
RELATIONAL EDITS	
2-191-01R	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 (2-192)	
VALIDITY EDITS	
2-192-01V	MUST BE A VALID OGP BEGIN REASON CODE LISTING IN CHAPTER 2, SECTION 2.6 .
RELATIONAL EDITS	
	NONE

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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
2-195-03R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	NE OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM
	AND BEGIN DATE OF CARE ≥ 09/14/2001 AND < 11/01/2007
	AND ENROLLMENT/HEALTH PLAN CODE =
	T TRICARE STANDARD PROGRAM OR
	V TRICARE EXTRA
	THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO
2-195-04R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	PF ECHO
	THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: AMOUNT PATIENT COST-SHARE (2-200)	
VALIDITY EDITS	
2-200-01V	MUST BE NUMERIC.
RELATIONAL EDITS	
2-200-00R	TOTAL OF ALL OCCURRENCES OF AMOUNT PATIENT COST-SHARE FOR THIS TED RECORD EXCEEDS TMA LIMIT OF \$1,000,000.00.
2-200-01R	IF TYPE OF SUBMISSION =
	A ADJUSTMENT OR
	I INITIAL SUBMISSION OR
	O ZERO PAYMENT WITH 100% OHI/TPL OR
	R RESUBMISSION
	THEN AMOUNT PATIENT COST-SHARE MUST BE ≥ ZERO
2-200-02R	IF TYPE OF SUBMISSION =
	C COMPLETE CANCELLATION OR
	D COMPLETE DENIAL
	THEN AMOUNT PATIENT COST-SHARE MUST BE = ZERO
ELEMENT NAME: HEALTH CARE COVERAGE (HCC) COPAYMENT FACTOR CODE (2-201)	
VALIDITY EDITS	
2-201-01V	MUST BE A VALID HCC COPAYMENT FACTOR CODE LISTED IN CHAPTER 2, SECTION 2.5 .
RELATIONAL EDITS	
	NONE

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CHAPTER 2, SECTION 6.3

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE (2-205)

VALIDITY EDITS

2-205-01V MUST BE NUMERIC.

RELATIONAL EDITS

2-205-00R TOTAL OF ALL OCCURRENCES OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE FOR THIS TED RECORD EXCEEDS TMA LIMIT OF \$1,000,000.00.

2-205-01R IF TYPE OF SUBMISSION =

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

THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST BE ≥ ZERO

2-205-02R IF TYPE OF SUBMISSION =

C	COMPLETE CANCELLATION OR
D	COMPLETE DENIAL

THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST BE = ZERO

ELEMENT NAME: ADJUSTMENT/DENIAL REASON CODE (2-220)

VALIDITY EDITS

2-220-01V VALUE MUST BE A VALID ADJUSTMENT/DENIAL REASON CODE (REFER TO [CHAPTER 2, ADDENDUM H](#)).

RELATIONAL EDITS

2-220-01R IF TYPE OF SUBMISSION =

C	COMPLETE CANCELLATION OR
D	COMPLETE DENIAL

THEN ALL OCCURRENCE/LINE ITEMS MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN [FIGURE 2-H-1](#) OR [FIGURE 2-H-2](#)

2-220-02R IF ADJUSTMENT/DENIAL REASON CODE IS A DENIAL REASON CODE LISTED IN [FIGURE 2-H-1](#), FOR THAT OCCURRENCE/LINE ITEM

AND 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 ALLOWED BY PROCEDURE CODE MUST = ZERO

2-220-03R IF TYPE OF SUBMISSION =

B	ADJUSTMENT TO NON-TED (HCSR) DATA OR
E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

AND ADJUSTMENT/DENIAL REASON CODE IS A DENIAL REASON CODE LISTED IN [FIGURE 2-H-1](#), FOR THAT OCCURRENCE/LINE ITEM

THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE ≤ZERO

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: PROVIDER INDIVIDUAL NPI NUMBER (RESERVED) (2-225)

VALIDITY EDITS

2-225-01V MUST BE BLANK FILLED.

RELATIONAL EDITS

NONE

ELEMENT NAME: PROVIDER GROUP NPI NUMBER (RESERVED) (2-230)

VALIDITY EDITS

2-230-01V MUST BE BLANK FILLED.

RELATIONAL EDITS

NONE

ELEMENT NAME: PROVIDER STATE OR COUNTRY CODE (2-235)

VALIDITY EDITS

2-235-01V VALUE MUST BE A VALID STATE (REFER TO [CHAPTER 2, ADDENDUM B](#))
OR COUNTRY CODE (REFER TO [CHAPTER 2, ADDENDUM A](#)).

2-235-02V ALL OCCURRENCES OF PROVIDER STATE OR COUNTRY CODE FOR THIS RECORD MUST BE ALL CONUS OR ALL OCONUS.

RELATIONAL EDITS

2-235-01R PROVIDER STATE/COUNTRY CODE MUST MATCH THE CORRESPONDING RECORD¹ IN THE PROVIDER FILE.

UNLESS AMOUNT ALLOWED BY PROCEDURE CODE IS ≤ ZERO

**OR ADJUSTMENT/DENIAL
REASON CODE FOR THAT
OCCURRENCE/LINE ITEM =**

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 PROVIDER SPECIALTY = 172A00000X (OTHER SERVICE PROVIDER/DRIVERS)
OR

344600000X (TRANSPORTATION SERVICES/TAXI)

**OR ANY OCCURRENCE OF
SPECIAL PROCESSING CODE =** T MEDICARE/TRICARE DUAL ENTITLEMENT
(SECOND PAYOR) **AND** BEGIN DATE OF
CARE ≥ 10/01/2001 **OR**

¹ "CORRESPONDING RECORD" ON PROVIDER FILE IS BASED ON NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER MAJOR SPECIALTY, PROVIDER SUB-IDENTIFIER, PROVIDER ZIP CODE, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (2-240-04R).

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CHAPTER 2, SECTION 6.3

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: PROVIDER STATE OR COUNTRY CODE (2-235) (CONTINUED)

FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE 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 PROVIDER FILE

¹ **“CORRESPONDING RECORD” ON PROVIDER FILE IS BASED ON NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER MAJOR SPECIALTY, PROVIDER SUB-IDENTIFIER, PROVIDER ZIP CODE, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (2-240-04R).**

ELEMENT NAME: PROVIDER TAXPAYER NUMBER (2-240)

VALIDITY EDITS

2-240-01V	MUST BE NUMERIC
	OR (FIRST 3 POSITIONS MUST BE A VALID STATE/COUNTRY CODE
	AND LAST 6 POSITIONS MUST BE NUMERIC)
	OR (FIRST 3 POSITIONS MUST BE A VALID STATE/COUNTRY CODE
	AND FOURTH POSITION MUST BE = ‘A’
	AND LAST 5 POSITIONS MUST BE NUMERIC)

RELATIONAL EDITS

NO ERROR	IF ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM =	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

THEN DO NOT CHECK FOR MATCH ON PROVIDER FILE FOR THAT PROVIDER

NO ERROR	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE FOR THAT OCCURRENCE =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
		FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) OR

¹ **ONLY THE FIRST 5 DIGITS OF THE PROVIDER ZIP CODE IS USED IN THE MATCH.**

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: PROVIDER TAXPAYER NUMBER (2-240) (CONTINUED)	
	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 FOR THAT PROVIDER
NO ERROR	IF AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO
	THEN DO NOT CHECK PROVIDER FILE FOR THAT PROVIDER
NO ERROR	IF PROVIDER SPECIALTY = 172A00000X (OTHER SERVICE PROVIDERS/DRIVER) OR 344600000X (TRANSPORTATION SERVICES/TAXI)
	THEN DO NOT CHECK PROVIDER FILE FOR THAT PROVIDER
2-240-02R	IF PROVIDER TAXPAYER NUMBER IS ALL NINES
	THEN PROVIDER SPECIALTY MUST = 172A00000X (OTHER SERVICE PROVIDERS/DRIVER) OR 344600000X (TRANSPORTATION SERVICES/TAXI)
	AND PROVIDER PARTICIPATION INDICATOR MUST = N NO
2-240-03R	PROVIDER TAXPAYER NUMBER CANNOT BE ALL NINES.
	UNLESS PROVIDER SPECIALTY = 172A00000X (OTHER SERVICE PROVIDERS/DRIVER) OR 344600000X (TRANSPORTATION SERVICES/TAXI)
	AND PROVIDER PARTICIPATION INDICATOR = N NO
2-240-04R	IF ANY OCCURRENCE OF OVERRIDE CODE = NC NON-CERTIFIED PROVIDER
	THEN THE NON-CERTIFIED PROVIDER MUST MATCH THE PROVIDER ON THE PROVIDER FILE USING THE FOLLOWING: NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER AND PROVIDER MAJOR SPECIALTY AND PROVIDER ZIP CODE¹ AND PROVIDER SUB-IDENTIFIER AND ACCEPTANCE AND TERMINATION DATES MUST = ZEROES AND PROVIDER CONTRACT AFFILIATION CODE MUST = '5' (NON-CERTIFIED PROVIDER)
	IF NO OCCURRENCE OF OVERRIDE CODE = NC NON-CERTIFIED PROVIDER
	THEN THE CERTIFIED PROVIDER MUST MATCH THE PROVIDER ON THE PROVIDER FILE USING THE FOLLOWING: NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER AND PROVIDER MAJOR SPECIALTY AND PROVIDER ZIP CODE¹ AND PROVIDER SUB-IDENTIFIER

¹ ONLY THE FIRST 5 DIGITS OF THE PROVIDER ZIP CODE IS USED IN THE MATCH.

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: PROVIDER SUB-IDENTIFIER (2-245)

VALIDITY EDITS

2-245-01V MUST BE 4 CHARACTERS
FIRST CHARACTER ALPHANUMERIC, LAST 3 CHARACTERS NUMERIC
OR FIRST 2 CHARACTERS ALPHANUMERIC, LAST 2 CHARACTERS NUMERIC
OR ALL 4 NUMERIC

RELATIONAL EDITS

NONE

ELEMENT NAME: PROVIDER ZIP CODE (2-250)

VALIDITY EDITS

2-250-01V MUST BE 9 DIGITS OR 5 DIGITS WITH 4 BLANKS
MUST BE A VALID ZIP CODE (BASED ON BEGIN DATE OF CARE) IN THE
GOVERNMENT PROVIDED ELECTRONIC ZIP CODE FILE OR
MUST BE A 3 CHARACTER FOREIGN COUNTRY CODE (BASED ON THE COUNTRY
CODES TABLE¹) FOLLOWED BY 6 BLANKS

RELATIONAL EDITS

NONE

¹ WHEN FOREIGN COUNTRY CODES ARE SUBMITTED, THE FIRST 3 CHARACTERS WILL BE EDITED AGAINST CHAPTER 2, ADDENDUM A.

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: TYPE OF SERVICE (2-280)

VALIDITY EDITS

2-280-01V	FIRST POSITION MUST BE = 'A', 'C', 'I', 'K', 'M', 'N', 'O', OR 'P'.
	SECOND POSITION MUST BE = 1-9; A-M.
	IF FIRST POSITION = 'A'; SECOND POSITION MUST ≠ 'C'.
	IF FIRST POSITION = 'P'; SECOND POSITION MUST = 'H'.
	IF FIRST POSITION = 'N'; SECOND POSITION MUST = 'I'.

RELATIONAL EDITS

2-280-01R	IF AMOUNT ALLOWED BY PROCEDURE CODE > 0. THEN TYPE OF SERVICE (SECOND POSITION) MUST BE CONSISTENT WITH PROCEDURE CODE (REFER TO CHAPTER 2, ADDENDUM F).
2-280-02R	IF PROCEDURE CODE ¹ = 92891, 92892, 92893, 92895, 92898, 92899, H0035, OR H0037. AND ADJUSTMENT/ DENIAL REASON CODE CANNOT EQUAL ANY CODE LISTED IN CHAPTER 2, ADDENDUM H, FIGURE 2-H-1 OR FIGURE 2-H-2 THEN TYPE OF SERVICE (FIRST POSITION) MUST =
	P PARTIAL PSYCHIATRIC OUTPATIENT
2-280-04R	IF PROVIDER SPECIALTY = 261QB0400X (AMBULATORY HEALTH CARE FACILITIES/CLINIC/CENTER BIRTHING) THEN TYPE OF SERVICE (FIRST POSITION) MUST =
	M MATERNITY OR
	O OUTPATIENT
2-280-05R	IF TYPE OF SERVICE (FIRST POSITION) =
	M OUTPATIENT MATERNITY CARE COST-SHARED AS INPATIENT THEN PRINCIPAL OR SECONDARY TREATMENT DIAGNOSIS MUST BE MATERNITY (630-676 OR V22-V24 OR V270-289)
2-280-06R	IF TYPE OF SERVICE (SECOND POSITION) =
	C AMBULATORY SURGERY THEN HCC MEMBER CATEGORY CODE MUST ≠
	A ACTIVE DUTY OR
	G NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J ACADEMY STUDENT OR
	P TAMP MEMBER OR
	S RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	T FOREIGN MILITARY MEMBER
2-280-07R	IF TYPE OF SERVICE (FIRST POSITION) =
	A AMBULATORY SURGERY COST SHARED AS INPATIENT (ACTIVE DUTY DEPENDENTS ONLY) OR
	M OUTPATIENT MATERNITY COST SHARED AS INPATIENT OR

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME:	TYPE OF SERVICE (2-280) (CONTINUED)
	N OUTPATIENT COST SHARED AS INPATIENT OR
	O OUTPATIENT, EXCLUDING M, P, OR N OR
	P OUTPATIENT PARTIAL PSYCHIATRIC HOSPITALIZATION COST SHARED AS INPATIENT
	THEN PLACE OF SERVICE CANNOT = 21 INPATIENT HOSPITAL
2-280-08R	IF TYPE OF SERVICE (SECOND POSITION) = B RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	THEN NATIONAL DRUG CODE MUST ≠ BLANK
	UNLESS PROVIDER STATE OR COUNTRY CODE IS A FOREIGN COUNTRY CODE (CHAPTER 2, ADDENDUM A)
2-280-09R	IF TYPE OF SERVICE (SECOND POSITION) = M MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	THEN TYPE OF SUBMISSION MUST ≠ B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	AND AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO
	AND CA/NAS EXCEPTION REASON MUST = BLANK
	AND CA/NAS NUMBER MUST = BLANK
	AND CA/NAS REASON FOR ISSUANCE MUST = BLANK
	AND CONTRACT NUMBER MUST = MDA90602C0013
	AND NATIONAL DRUG CODE MUST ≠ BLANK
	AND PLACE OF SERVICE MUST = 19 PHARMACY
	AND PRICING RATE CODE MUST = 0
	AND PROVIDER NETWORK STATUS INDICATOR MUST = 1 NETWORK PROVIDER
	AND PROVIDER PARTICIPATING INDICATOR MUST = Y YES
	AND PROVIDER SPECIALTY MUST = 183500000X (PHARMACY SERVICE PROVIDERS/PHARMACIST)
	AND IF PROCEDURE CODE = 000MN PRESCRIPTION MEDICAL NECESSITY REVIEWS OR
	000PA PRESCRIPTION PRIOR AUTHORIZATIONS

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: TYPE OF SERVICE (2-280) (CONTINUED)	
THEN AMOUNT BILLED BY PROCEDURE CODE MUST BE > ZERO	
AND AMOUNT PATIENT COST-SHARE MUST = ZERO	
AND CLAIM FORM TYPE/EMC INDICATOR MUST = J OTHER	
ELSE IF OCCURRENCE/LINE ITEM NUMBER = 002	
THEN AMOUNT BILLED BY PROCEDURE CODE ON THIS LINE ITEM MUST = ZERO	
AND AMOUNT PATIENT COST-SHARE ON THIS LINE ITEM MUST = ZERO	
AND NUMBER OF SERVICES ON THIS LINE ITEM MUST = ZERO	
ELSE AMOUNT BILLED BY PROCEDURE CODE MUST BE ≥ \$10.20 AND ≤ \$11.48	
AND CLAIM FORM TYPE/EMC INDICATOR MUST = I ELECTRONIC DRUG CLAIM SUBMISSION	
AND NUMBER OF SERVICES = 1	
2-280-10R	IF TYPE OF SERVICE (SECOND POSITION) = B RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS OR M MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
THEN REGION INDICATOR MUST = BLANK	
UNLESS PROVIDER STATE OR COUNTRY CODE IS A FOREIGN COUNTRY CODE (CHAPTER 2, ADDENDUM A)	
2-280-11R	IF TYPE OF SERVICE (SECOND POSITION) = M MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
AND OCCURRENCE/LINE ITEM COUNT = 002	
THEN PROCEDURE CODE¹ MUST = 99070 SUPPLIES	
2-280-12R	IF TYPE OF SERVICE (SECOND POSITION) = G DENTAL
THEN PROCEDURE CODE¹ ≠ 00100 - 09999	
2-280-13R	IF TYPE OF SERVICE (SECOND POSITION) = B RETAIL PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS OR M MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
AND CLAIM FORM TYPE/EMC INDICATOR = J OTHER	
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CHAPTER 2, SECTION 6.3

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: TYPE OF SERVICE (2-280) (CONTINUED)

THEN PROCEDURE CODE
MUST =

000MN PRESCRIPTION MEDICAL NECESSITY
REVIEWS **OR**

000PA PRESCRIPTION PRIOR AUTHORIZATIONS

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APPLY TO GOVERNMENT USE.

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER CATEGORY CODE (2-285)	
VALIDITY EDITS	
2-285-01V	MUST BE A VALID HCC MEMBER CATEGORY CODE (REFER TO CHAPTER 2, SECTION 2.5)
RELATIONAL EDITS	
2-285-01R	IF HCC MEMBER RELATIONSHIP CODE =
	A SELF
	THEN HCC MEMBER CATEGORY MUST ≠
	A ACTIVE DUTY OR
	G NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J ACADEMY STUDENT OR
	N NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR
	S RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	T FOREIGN MILITARY MEMBER OR
	V RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS)
	UNLESS ENROLLMENT/HEALTH PLAN CODE =
	W TPR AD SM - USA OR
	X FOREIGN AD SM OR
	Y CHCBP - STANDARD OR
	AA CHCBP - EXTRA OR
	SN SHCP - NON-MTF-REFERRED CARE OR
	SO SHCP - NON-TRICARE ELIGIBLE OR
	SR SHCP - REFERRED CARE OR
	ST SHCP - TRICARE ELIGIBLE OR
	SU SHCP - REFERRAL DESIGNATION UNKNOWN OR
	WA TPR FOREIGN AD SM
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	SC SHCP - NON-TRICARE ELIGIBLE OR
	SE SHCP - TRICARE ELIGIBLE OR
	SM SHCP - EMERGENCY
	OR HCDP PLAN COVERAGE CODE =
	401 TRICARE RESERVE SELECT TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR
	402 TRICARE RESERVE SELECT TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405 TRICARE RESERVE SELECT TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER CATEGORY CODE (2-285) (CONTINUED)	
406	TRICARE RESERVE SELECT TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
407	TRICARE RESERVE SELECT TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
408	TRICARE RESERVE SELECT TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
409	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
410	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
411	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW INDIVIDUAL COVERAGE OR
412	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW FAMILY COVERAGE
2-285-02R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = PF ECHO
	THEN HHC MEMBER CATEGORY CODE MUST =
	A ACTIVE DUTY OR
	G NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J ACADEMY STUDENT OR
	P TAMP MEMBER OR
	S RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE)
2-285-03R	IF TYPE OF SERVICE (FIRST POSITION) =
	THEN HCC MEMBER CATEGORY CODE MUST =
	A AMBULATORY SURGERY COST-SHARED AS INPATIENT
	A ACTIVE DUTY OR
	G NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J ACADEMY STUDENT OR
	P TRANSITIONAL ASSISTANCE MANAGEMENT PROGRAM (TAMP) MEMBER OR
	S RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	T FOREIGN MILITARY MEMBER OR
	Z UNKNOWN

UNLESS AMOUNT ALLOWED BY PROCEDURE CODE = 0

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER CATEGORY CODE (2-285) (CONTINUED)

2-285-04R	IF TYPE OF SERVICE (SECOND POSITION) =	C	AMBULATORY SURGERY
	THEN HCC MEMBER CATEGORY CODE MUST =	D	DISABLED AMERICAN VETERAN OR
		F	FORMER MEMBER OR
		H	MEDAL OF HONOR RECIPIENT OR
		R	RETIRED OR
		W	FORMER SPOUSE OR
		Z	UNKNOWN
	UNLESS AMOUNT ALLOWED BY PROCEDURE CODE = 0		

2-285-05R	IF HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER
	THEN ONE OCCURRENCE OF OVERRIDE CODE =	M	NATO

ELEMENT NAME: PAY GRADE CODE (SPONSOR) (2-291)

VALIDITY EDITS

2-291-01V	MUST BE A VALID PAY GRADE CODE (SPONSOR) (REFER TO CHAPTER 2, SECTION 2.7)
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RELATIONAL EDITS

NONE

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: PAY PLAN CODE (SPONSOR) (2-292)

VALIDITY EDITS

2-292-01V MUST BE A VALID PAY PLAN CODE (SPONSOR) (REFER TO [CHAPTER 2, SECTION 2.7](#))

RELATIONAL EDITS

2-292-01R	IF HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER
	THEN PAY PLAN CODE (SPONSOR) MUST =	FA	FOREIGN SERVICE CHIEFS OF MISSION OR
		FC	FOREIGN COMPENSATION AGENCY FOR INTERNATIONAL DEVELOPMENT OR
		FD	FOREIGN DEFENSE OR
		FE	SENIOR FOREIGN SERVICE OR
		FO	FOREIGN SERVICE OFFICERS OR
		FP	FOREIGN SERVICE PERSONNEL OR
		FZ	CONSULAR AGENT DEPARTMENT OF STATE OR
		MC	CADET OR
		ME	ENLISTED OR
		MO	OFFICER OR
		MW	WARRANT OFFICER OR
		ZZ	NOT APPLICABLE
2-292-02R	IF SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) =	H	PHS OR
		O	NOAA
	THEN PAY PLAN CODE (SPONSOR) MUST ≠	ME	ENLISTED
2-292-03R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF	ECHO
	THEN PAY PLAN CODE (SPONSOR) MUST =	ME	ENLISTED OR
		MO	OFFICER OR
		MW	WARRANT OFFICER OR
		ZZ	NOT APPLICABLE

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER RELATIONSHIP CODE (2-295)

VALIDITY EDITS

2-295-01V MUST BE A VALID HCC MEMBER RELATIONSHIP CODE (REFER TO [CHAPTER 2, SECTION 2.5](#))

RELATIONAL EDITS

2-295-01R	IF PATIENT AGE ¹ < 17. THEN HCC MEMBER RELATIONSHIP CODE MUST ≠	A	SELF
2-295-02R	IF PATIENT AGE ¹ < 12 THEN HCC MEMBER RELATIONSHIP CODE MUST ≠	B	SPOUSE OR
		G	SURVIVING SPOUSE
	UNLESS ONE OCCURRENCE OF OVERRIDE CODE =	B	PATIENT IS A SPOUSE UNDER 12 YEARS OF AGE
2-295-03R	IF PATIENT AGE ¹ ≥ 21 AND PERSON BIRTH CALENDAR DATE (PATIENT) ≠ 19111111 THEN HCC MEMBER RELATIONSHIP CODE MUST ≠	C	CHILD OR STEPCHILD OR
		D	PRE-ADOPTIVE CHILD OR
		E	WARD (COURT ORDERED)
	UNLESS ONE OCCURRENCE OF OVERRIDE CODE MUST =	D	PATIENT IS DEPENDENT 21 YEARS OF AGE
2-295-04R	IF PERSON BIRTH CALENDAR DATE (PATIENT) INDICATES AGE ¹ < 34 THEN 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))
	AND HCC MEMBER CATEGORY CODE ≠	W	FORMER SPOUSE
	UNLESS ONE OCCURRENCE OF OVERRIDE CODE =	I	PATIENT IS A FORMER SPOUSE UNDER 34 YEARS OF AGE
2-295-05R	IF HCC MEMBER CATEGORY CODE = AND HCC MEMBER RELATIONSHIP CODE ≠	T	FOREIGN MILITARY MEMBER
		A	SELF
	THEN HCC MEMBER RELATIONSHIP CODE MUST CODE MUST =	B	SPOUSE OR
		C	CHILD OR STEPCHILD OR

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

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER RELATIONSHIP CODE (2-295) (CONTINUED)	
	D PRE-ADOPTIVE CHILD OR
	E WARD (COURT ORDERED)
2-295-06R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = PF ECHO
	THEN HCC MEMBER RELATIONSHIP CODE MUST =
	B SPOUSE OR
	C CHILD OR STEPCHILD OR
	D PRE-ADOPTIVE CHILD OR
	E WARD (COURT ORDERED) OR
	G SURVIVING SPOUSE
2-295-07R	IF TYPE OF SERVICE (FIRST POSITION) = A AMBULATORY SURGERY COST-SHARED AS INPATIENT
	THEN HCC MEMBER RELATIONSHIP CODE MUST =
	A SELF OR
	B SPOUSE OR
	C CHILD OR STEPCHILD OR
	D PRE-ADOPTIVE CHILD OR
	E WARD (COURT ORDERED) OR
	G SURVIVING SPOUSE OR
	Z UNKNOWN
	AND HCC MEMBER CATEGORY CODE ≠
	W FORMER SPOUSE
	UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	SC SHCP - NON-TRICARE ELIGIBLE
2-295-08R	IF HCC MEMBER CATEGORY CODE = H MEDAL OF HONOR RECIPIENT
	THEN HCC MEMBER RELATIONSHIP CODE MUST =
	A SELF OR
	B SPOUSE OR
	C CHILD OR STEPCHILD OR
	G SURVIVING SPOUSE
2-295-10R	IF HCC MEMBER CATEGORY CODE = T FOREIGN MILITARY MEMBER
	AND HCC MEMBER RELATIONSHIP CODE =
	A SELF
	THEN ANY OCCURRENCE OF SPECIAL PROCESSING CODE MUST =
	AN SHCP - NON-REFERRED CARE OR
	AR SHCP - REFERRED CARE OR
	SC SHCP - NON-TRICARE ELIGIBLE OR
	SM SHCP - EMERGENCY

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

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

**ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER RELATIONSHIP CODE
(2-295) (CONTINUED)**

OR ENROLLMENT/
HEALTH PLAN CODE
CODE MUST =

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

SO SHCP - NON-TRICARE ELIGIBLE **OR**

SR SHCP - REFERRED **OR**

SU SHCP - REFERRAL DESIGNATION
UNKNOWN

UNLESS AMOUNT ALLOWED BY PROCEDURE CODE = ZERO

THEN BYPASS THIS EDIT

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

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300)	
VALIDITY EDITS	
2-300-01V	MUST BE A VALID ENROLLMENT/HEALTH PLAN CODE (REFER TO CHAPTER 2, SECTION 2.5)
2-300-02V	IF ENROLLMENT/HEALTH PLAN CODE =
	SO SHCP - NON-TRICARE ELIGIBLE OR
	ST SHCP - TRICARE ELIGIBLE
	THEN BEGIN DATE OF CARE MUST < 06/01/2004
2-300-03V	IF ENROLLMENT/HEALTH PLAN CODE =
	TS TSS
	THEN BEGIN DATE OF CARE MUST < 12/31/2002
2-300-04V	IF ENROLLMENT/HEALTH PLAN CODE =
	BB TSP
	THEN BEGIN DATE OF CARE MUST < 12/31/2001
RELATIONAL EDITS	
2-300-02R	IF ENROLLMENT/HEALTH PLAN CODE =
	Y CHCBP - STANDARD OR
	AA CHCBP - EXTRA
	THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE MAY =
	CL CLINICAL TRIALS OR
	PF ECHO
2-300-03R	IF ENROLLMENT/HEALTH PLAN CODE =
	W TPR ADSM - USA
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =
	GU ADSM ENROLLED IN TPR
2-300-05R	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
2-300-06R	IF ENROLLMENT/HEALTH PLAN CODE =
	Z TRICARE PRIME, MTF/PCM
	THEN BEGIN DATE OF CARE MUST BE ≥ 10/01/1997

¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (CONTINUED)			
2-300-07R	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	
	SC	SHCP - NON-TRICARE ELIGIBLE OR	
	SE	SHCP - TRICARE ELIGIBLE OR	
SM	SHCP - EMERGENCY		
2-300-09R	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	
2-300-10R	IF ENROLLMENT/HEALTH PLAN CODE =	PS	TSRx
		THEN TYPE OF SERVICE (SECOND POSITION) MUST =	
	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS OR	
	M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS	
2-300-11R	IF ENROLLMENT/HEALTH PLAN CODE =	PS	TSRx
		THEN BEGIN DATE OF CARE MUST BE ≥ 04/01/2001	
	AND NATIONAL DRUG CODE CANNOT BE BLANK.		
	UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	1	MEDICAID
2-300-12R	<ul style="list-style-type: none"> TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001. FOR EACH LINE ITEM WHERE BEGIN DATE OF CARE IS < 10/01/2001, THE LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT. 		
	IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL - EXTRA OR
		FS	TFL - STANDARD
	THEN BEGIN DATE OF CARE MUST BE ≥ 10/01/2001		
¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES			

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME:		ENROLLMENT/HEALTH PLAN CODE (2-300) (CONTINUED)	
	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., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) OR
		FS	TFL (SECOND PAYOR)
ELSE IF BEGIN DATE OF CARE IS < 10/01/2001 (FOR THAT DETAILED LINE ITEM)			
	THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE 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
2-300-13R	<ul style="list-style-type: none"> TFL CLAIMS: THE PATIENT MUST BE 64 YEARS AND 11 MONTHS OR GREATER. IF THE PATIENT IS LESS THAN THIS AGE, THE LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT. 		
	IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL - EXTRA OR
		FS	TFL - STANDARD OR
		PS	TSRx

¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (CONTINUED)			
	AND TYPE OF SERVICE (SECOND POSITION) ≠	M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
THEN PATIENT AGE ¹ MUST BE ≥ 64 YEARS AND 11 MONTHS			
ELSE IF PATIENT AGE ¹ IS < 64 YEARS AND 11 MONTHS			
	THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE 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
2-300-14R	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			
2-300-15R	IF ENROLLMENT/HEALTH PLAN CODE =	SU	SCHP - REFERRAL DESIGNATION UNKNOWN
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS OR
¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES			

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (CONTINUED)	
	M MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
2-300-16R	IF ENROLLMENT/HEALTH PLAN CODE = SU SCHP - REFERRAL DESIGNATION UNKNOWN
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =
	SC SHCP - NON-TRICARE ELIGIBLE OR
	SE SHCP - TRICARE ELIGIBLE
2-300-17R	<ul style="list-style-type: none"> FOR TMOP ONLY: FOR TSRx, THE PATIENT MUST BE 64 YEARS AND 8 MONTHS OR GREATER. IF THE PATIENT IS LESS THAN THIS AGE, THE LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.
	IF ENROLLMENT/HEALTH PLAN CODE = PS TSRx
	AND TYPE OF SERVICE (SECOND POSITION) = M MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	THEN PATIENT AGE¹ MUST BE ≥ 64 YEARS AND 8 MONTHS
	ELSE IF PATIENT AGE¹ < 64 YEARS AND 8 MONTHS
	THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE 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

¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (CONTINUED)	
	141 CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
2-300-18R	IF ENROLLMENT/HEALTH PLAN CODE =
	X FOREIGN ADMS
	THEN HCC MEMBER
	RELATIONSHIP CODE MUST =
	A SELF OR
	T FOREIGN MILITARY MEMBER
	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
	J ACADEMY STUDENT OR
	N NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR
	S RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	V RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS)

¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: SPECIAL PROCESSING CODE (2-305)

VALIDITY EDITS

2-305-01V	OCCURRENCE NUMBER 1--MUST BE A VALID SPECIAL PROCESSING CODE ¹
2-305-02V	OCCURRENCE NUMBER 2--MUST BE A VALID SPECIAL PROCESSING CODE ¹
2-305-03V	OCCURRENCE NUMBER 3--MUST BE A VALID SPECIAL PROCESSING CODE ¹
2-305-04V	OCCURRENCE NUMBER 4--MUST BE A VALID SPECIAL PROCESSING CODE ¹
2-305-05V	A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).
2-305-06V	SPECIAL PROCESSING CODE OCCURRENCES MUST BE LEFT JUSTIFIED.
2-305-07V	<ul style="list-style-type: none"> • SHCP REFERRED/NON-REFERRED
	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	AN SHCP - NON-MTF-REFERRED CARE OR
	AR SHCP - REFERRED CARE
	THEN BEGIN DATE OF CARE MUST BE < 06/01/2004
2-305-08V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	GF TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADMS
	THEN BEGIN DATE OF CARE MUST BE < 09/01/2002
2-305-09V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	U BRAC PHARMACY
	THEN BEGIN DATE OF CARE MUST BE < 04/01/2001
2-305-10V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	MN TSP - NON-NETWORK OR
	MS TSP - NETWORK
	THEN BEGIN DATE OF CARE MUST BE < 12/31/2001
2-305-11V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	SN TSS - NON-NETWORK OR
	SS TSS - NETWORK
	THEN BEGIN DATE OF CARE MUST BE < 12/31/2002
2-305-13V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	PD PHARMACY REDESIGN PILOT PROGRAM
	THEN BEGIN DATE OF CARE MUST BE < 04/01/2001
2-305-14V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	ST SPECIALIZED TREATMENT
	THEN BEGIN DATE OF CARE MUST BE < 10/01/2004
2-305-15V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	WR MENTAL HEALTH WRAPAROUND DEMONSTRATION
	THEN BEGIN DATE OF CARE MUST BE < 06/30/2001

RELATIONAL EDITS

2-305-02R	IF CA/NAS EXCEPTION REASON =	6	RESOURCE SHARING
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¹ AS STATED IN CHAPTER 2, SECTION 2.8 OR BLANK

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (CONTINUED)	
	THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST = S RESOURCE SHARING - EXTERNAL
2-305-05R	(LIVER TRANSPLANT) IF ANY OCCURRENCE/LINE ITEM = PROCEDURE CODES ² 47133, 47135, OR 47136 AND BEGIN DATE OF CARE < 03/01/1997 OR (> 02/19/1998 AND < 09/01/1999) THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST = 5 LIVER TRANSPLANT ELSE IF BEGIN DATE OF CARE (≥ 03/01/1997 AND ≤ 02/19/1998) OR (≥ 09/01/1999 AND ≤ 05/31/2003) THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST = ST SPECIALIZED TREATMENT
2-305-06R	IF ANY OCCURRENCE/LINE ITEM = PROCEDURE CODE ² 33945 THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST = 7 HEART TRANSPLANT
2-305-07R	IF ANY OCCURRENCE/LINE ITEM = PROCEDURE CODE ² 90199 THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST = 6 HHC
2-305-08R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = PF ECHO THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE MAY = 6 HHC OR A PARTNERSHIP PROGRAM OR E HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP) OR S RESOURCE SHARING - EXTERNAL OR CM ICMP OR CT CCTP OR RI RESOURCE SHARING - INTERNAL
2-305-09R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = X PARTIAL HOSPITALIZATION-PROVIDERS NOT CONTRACTED WITH OR EMPLOYED BY THE PARTIAL HOSPITALIZATION PROGRAM WHO BILL FOR PSYCHOTHERAPY SERVICES IN A PARTIAL HOSPITALIZATION PROGRAM THEN AT LEAST ONE PROCEDURE CODE ² MUST = 90812, 90813, 90814, 90815, 90816, 90817, 90843, 90844, 90846, 90847, 90849, OR 90855
2-305-12R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = U BRAC MEDICARE PHARMACY

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (CONTINUED)			
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
AND BEGIN DATE OF CARE MUST BE < 04/01/2001			
2-305-13R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	16	AMBULATORY SURGERY FACILITY CHARGE
	THEN PRICING RATE CODE MUST =	0	PRICING NOT APPLICABLE (DENIED SERVICE/SUPPLIES AND ALLOWED DRUGS) OR
		1	PRICED MANUALLY OR
		C	AMBULATORY SURGERY FACILITY PAYMENT RATE OR
		D	DISCOUNTED AMBULATORY SURGERY - FACILITY PAYMENT RATE OR
		E	AMBULATORY SURGERY-PAID AS BILLED OR
		P	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY- FACILITY PAYMENT RATE OR
		Q	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, DISCOUNTED AMBULATORY SURGERY-FACILITY PAYMENT RATE OR
		R	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY- PAID AS BILLED OR
		V	MEDICARE REIMBURSEMENT RATE
2-305-14R	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
2-305-15R	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 OR
		X	FOREIGN ADSM OR
		WA	TPR FOREIGN ADSM

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (CONTINUED)			
2-305-21R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	MN	TSP - NON-NETWORK OR
		MS	TSP - NETWORK
	THEN ENROLLMENT/ HEALTH PLAN CODE MUST =	BB	TSP
2-305-22R	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 =	SN	SHCP - NON-MTF-REFERRED CARE OR
		SO	SHCP - NON-TRICARE ELIGIBLE OR
		SR	SHCP - REFERRED CARE OR
		ST	SHCP - TRICARE ELIGIBLE OR
	SU	SHCP - REFERRAL DESIGNATION UNKNOWN	
2-305-23R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	SN	TSS - NON-NETWORK OR
		SS	TSS - NETWORK
	THEN ENROLLMENT/ HEALTH PLAN CODE MUST =	TS	TSS
2-305-24R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	E	HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP)
			THEN BEGIN DATE OF CARE MUST BE ≥ 03/15/1999
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	CM	ICMP
2-305-25R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	GF	TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADSM
			THEN BEGIN DATE OF CARE IS ≥ 10/30/2000 AND < 09/01/2002
	AND HHC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR	

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (CONTINUED)	
	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 PRE-ADOPTIVE CHILD OR
	E WARD (COURT ORDERED)
2-305-26R	<ul style="list-style-type: none"> TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001. FOR EACH LINE ITEM WHERE DATE OF CARE IS < 10/01/2001, THE LINE ITEM 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., MEDICAL 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 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

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (CONTINUED)	
	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
2-305-29R	<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
	<p>AND ANY OCCURRENCE OF SPECIAL PROCESSING CODE =</p> <p align="center">CT CCTP</p>
	<p>THEN AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =</p> <p align="center">V FINANCIALLY UNDERWRITTEN PAYMENT BY CLAIMS PROCESSOR OR</p> <p align="center">W NON-FINANCIALLY UNDERWRITTEN PAYMENT BY FINANCIALLY UNDERWRITTEN CLAIMS PROCESSOR</p>
2-305-30R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	PF ECHO
	<p>THEN HCDP PLAN COVERAGE CODE MUST ≠</p> <p align="center">401 TRICARE RESERVE SELECT TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR</p> <p align="center">402 TRICARE RESERVE SELECT TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR</p> <p align="center">405 TRICARE RESERVE SELECT TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR</p> <p align="center">406 TRICARE RESERVE SELECT TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR</p> <p align="center">407 TRICARE RESERVE SELECT TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR</p> <p align="center">408 TRICARE RESERVE SELECT TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR</p> <p align="center">409 TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR</p>

¹ AS STATED IN [CHAPTER 2, SECTION 2.8](#) OR BLANK

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (CONTINUED)

410 TRICARE RESERVE SELECT TIER 1 SURVIVOR
CONTINUING WITH FAMILY COVERAGE
OR

411 TRICARE RESERVE SELECT TIER 1 SURVIVOR
NEW INDIVIDUAL COVERAGE **OR**

412 TRICARE RESERVE SELECT TIER 1 SURVIVOR
NEW FAMILY COVERAGE

¹ AS STATED IN [CHAPTER 2, SECTION 2.8](#) OR BLANK

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ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) SPECIAL ENTITLEMENT CODE (2-306)

VALIDITY EDITS

2-306-01V MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE LISTING IN [CHAPTER 2,](#)
[SECTION 2.5](#)

RELATIONAL EDITS

NONE

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: CA/NAS NUMBER (2-310)

VALIDITY EDITS

2-310-01V 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 BEGIN DATE OF CARE 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

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 BEGIN DATE OF CARE.

² MTF IS A 40 MILES CATCHMENT AREA.

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: CA/NAS NUMBER (2-310) (CONTINUED)	
	PS TSRx OR
	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 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 FOR THAT DETAIL OCCURRENCE =
	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 TRICARE RESERVE SELECT TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR

¹ CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.
² MTF IS A 40 MILES CATCHMENT AREA.

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: CA/NAS NUMBER (2-310) (CONTINUED)

	402	TRICARE RESERVE SELECT TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405	TRICARE RESERVE SELECT TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406	TRICARE RESERVE SELECT TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407	TRICARE RESERVE SELECT TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408	TRICARE RESERVE SELECT TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW FAMILY COVERAGE
2-310-02R	IF CA/NAS EXCEPTION REASON ≠ BLANK THEN CA/NAS NUMBER MUST = BLANK	
2-310-03R	• MENTAL HEALTH CHECK IF CA/NAS EXCEPTION REASON = BLANK AND TYPE OF SERVICE (FIRST POSITION) = I INPATIENT AND PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316 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 THEN CA/NAS NUMBER MUST = BLANK	
2-310-04R	IF CA/NAS NUMBER IS CODED THEN CA/NAS EXCEPTION REASON MUST = BLANK	

¹ CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.

² MTF IS A 40 MILES CATCHMENT AREA.

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: CA/NAS REASON FOR ISSUANCE (2-315)	
VALIDITY EDITS	
2-315-01V	VALUE MUST A VALID CA/NAS REASON FOR ISSUANCE.
RELATIONAL EDITS	
2-315-02R	IF CA/NAS NUMBER = BLANK THEN CA/NAS REASON FOR ISSUANCE MUST = BLANK.
2-315-03R	IF CA/NAS REASON FOR ISSUANCE =
	7 ENROLLEE NETWORK CARE AUTHORIZATION/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 PROGRAM OR
	U TRICARE PRIME, CIVILIAN PCM OR
	V TRICARE EXTRA OR
	Z TRICARE PRIME, MTF/PCM OR
	XF FOREIGN ADFM

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320)

VALIDITY EDITS

2-320-01V VALUE MUST BE A VALID CA/NAS EXCEPTION REASON.

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 BEGIN DATE OF CARE 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-NOT A MEDICARE BENEFIT) **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

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 BEGIN DATE OF CARE.

² MTF IS A 40 MILES CATCHMENT AREA.

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320) (CONTINUED)

	PS	TSRx	OR
	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
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THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING.

NO ERROR	IF ANY OCCURRENCE OF ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE =	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		

¹ CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.

² MTF IS A 40 MILES CATCHMENT AREA.

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320) (CONTINUED)

NO ERROR	IF HCDP PLAN COVERAGE CODE =	401	TRICARE RESERVE SELECT TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR
		402	TRICARE RESERVE SELECT TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
		405	TRICARE RESERVE SELECT TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
		406	TRICARE RESERVE SELECT TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
		407	TRICARE RESERVE SELECT TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
		408	TRICARE RESERVE SELECT TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
		409	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
		410	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
		411	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW INDIVIDUAL COVERAGE OR
		412	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW FAMILY COVERAGE

2-320-01R IF PATIENT ZIP CODE IS **NOT** IN AN MTF² CATCHMENT AREA¹
THEN CA/NAS EXCEPTION REASON MUST = BLANK

2-320-02R IF CA/NAS NUMBER IS CODED
THEN CA/NAS EXCEPTION REASON MUST = BLANK

2-320-04R IF PATIENT ZIP CODE IS IN AN MTF CATCHMENT AREA
AND TYPE OF SERVICE (FIRST POSITION) = I INPATIENT
AND PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316
AND CA/NAS NUMBER NOT CODED
THEN CA/NAS EXCEPTION REASON MUST BE CODED

¹ CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.
² MTF IS A 40 MILES CATCHMENT AREA.

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: PRICING RATE CODE (2-325)			
VALIDITY EDITS			
2-325-01V	VALUE MUST A VALID NON-INSTITUTIONAL PRICING RATE CODE.		
RELATIONAL EDITS			
2-325-01R	IF PRICING RATE CODE =	C	AMBULATORY SURGERY FACILITY PAYMENT RATE OR
		D	DISCOUNTED AMBULATORY SURGERY FACILITY PAYMENT RATE OR
		E	AMBULATORY SURGERY-PAID AS BILLED OR
		P	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-FACILITY PAYMENT RATE OR
		Q	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, DISCOUNTED AMBULATORY SURGERY-FACILITY PAYMENT RATE OR
		R	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-PAID AS BILLED
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	16	AMBULATORY SURGERY FACILITY CHARGE
2-325-02R	IF ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM IS A CODE LISTED IN CHAPTER 2, ADDENDUM H, FIGURE 2-H-1 .		
	THEN PRICING RATE CODE MUST = ZERO	0	PRICING NOT APPLICABLE (DENIED SERVICE/SUPPLIES AND ALLOWED DRUGS)
2-325-03R	IF PRICING RATE CODE FOR THAT OCCURRENCE/LINE ITEM =	0	PRICING NOT APPLICABLE (DENIED SERVICE/SUPPLIES AND ALLOWED DRUGS)
	THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO		
	UNLESS TYPE OF SERVICE (SECOND POSITION) =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS OR
		M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR)
2-325-04R	IF PRICING RATE CODE =	V	MEDICARE REIMBURSEMENT RATE
¹ CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2005 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS APPLY TO GOVERNMENT USE.			

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: PRICING RATE CODE (2-325) (CONTINUED)		
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	16 AMBULATORY SURGERY FACILITY CHARGE OR
		T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
		FS TFL (SECOND PAYOR) OR
		MN TSP - NON-NETWORK OR
		MS TSP - NETWORK
2-325-05R	IF PRICING RATE CODE =	U SHCP CLAIM OR ACTIVE DUTY MEMBER TPR PAID OUTSIDE NORMAL LIMITS
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AR SHCP - REFERRED CARE OR
		AN SHCP - NON-MTF-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
2-325-06R	IF PRICING CODE =	W PRICED OVER CMAC
	AND ENROLLMENT/HEALTH PLAN CODE =	T TRICARE STANDARD PROGRAM
	AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	NE OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM
	AND BEGIN DATE OF CARE ≥ 09/14/2001 AND < 11/01/2007	
	THEN PROVIDER PARTICIPATING INDICATOR MUST =	N NO
2-325-07R	IF PRICING RATE CODE =	GG GLOBAL RATE AGREEMENT (USED WITH CORPORATE SERVICE PROVIDERS ONLY) OR
		GP PER DIEM RATE AGREEMENT (USED WITH CORPORATE SERVICE PROVIDERS ONLY)

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: PRICING RATE CODE (2-325) (CONTINUED)

THEN PROVIDER SPECIALITY MUST =		261QS1200X (CLINIC/CENTER - SLEEP DISORDER DIAGNOSTIC) OR
		293D00000X (PHYSIOLOGICAL LAB) OR
		261QE0700X (CLINIC/CENTER END STAGE RENAL DISEASE TREATMENT) OR
		261QM1200X (CLINIC/CENTER MAGNETIC RESONANCE IMAGING) OR
		261QR0401X (CLINIC/CENTER REHABILITATION, COMPREHENSIVE OUTPATIENT REHAB FACILITY (CORF)) OR
		2514H0200X (HOME HEALTH AGENCY) OR
		261QR0404X (CLINIC/CENTER REHAB CARDIAC FACILITIES) OR
		261QX0203X (CLINIC/CENTER ONCOLOGY, RADIATION) OR
		261QR0200X (CLINIC/CENTER RADIOLOGY)
2-325-08R	IF PRICING RATE CODE =	P1 OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) OR
		P2 OUTPATIENT PROSPECTIVE PAYMENT SYSTEM WITH COST OUTLIER OR
		P3 OUTPATIENT PROSPECTIVE PAYMENT SYSTEM WITH DISCOUNT OR
		P5 PARTIAL HOSPITALIZATION - PAID AS OPPS
THEN AMBULATORY PAYMENT CLASSIFICATION CODE MUST ≠ BLANK OR ZEROES.		

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ELEMENT NAME: AMBULATORY PAYMENT CLASSIFICATION CODE (APC) (2-330)

VALIDITY EDITS

2-330-01V	MUST BE A VALID APC CODE AS LISTED ON TMA'S OPPS WEB SITE AT HTTP://WWW.TRICARE.MIL/OPPS , BLANK, OR ALL ZEROES
	UNLESS AMOUNT ALLOWED BY PROCEDURE CODE = ZERO

RELATIONAL EDITS

2-330-01R	IF AMBULATORY PAYMENT CLASSIFICATION CODE = BLANK OR ZEROES.
THEN PRICING RATE CODE ≠	P1 OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) OR
	P2 OUTPATIENT PROSPECTIVE PAYMENT SYSTEM WITH COST OUTLIER OR
	P3 OUTPATIENT PROSPECTIVE PAYMENT SYSTEM WITH DISCOUNT OR
	P5 PARTIAL HOSPITALIZATION - PAID AS OPPS

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: OPPTS PAYMENT STATUS INDICATOR CODE (2-331)

VALIDITY EDITS

2-331-01V MUST BE A VALID OPPTS PAYMENT STATUS INDICATOR CODE (REFER TO [CHAPTER 2, SECTION 2.6](#)) OR BLANK.

RELATIONAL EDITS

2-331-01R IF OPPTS PAYMENT STATUS INDICATOR CODE = BLANK
THEN AMBULATORY PAYMENT CLASSIFICATION CODE MUST = ALL ZEROES OR BLANK.

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CHAPTER 2, SECTION 7.1

PROVIDER EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: PROVIDER NAME (3-035)

VALIDITY EDITS

3-035-01V MUST BE LEFT JUSTIFIED AND BLANK FILLED.
MUST NOT BE ALL SPACES.
NO BLANKS IN A ROW ALLOWED UNTIL BLANK FILLING.

RELATIONAL EDITS

NONE

¹ AN APOSTROPHE IS A LEGAL CHARACTER IN PROVIDER'S NAME.

ELEMENT NAME: PROVIDER STREET ADDRESS (3-045)

VALIDITY EDITS

3-045-01V IF **THIRD POSITION OF** PROVIDER STATE/COUNTRY CODE = BLANK (NOT A FOREIGN COUNTRY)

THEN PROVIDER STREET ADDRESS MUST BE LEFT JUSTIFIED AND BLANK FILLED.

NO BLANKS IN A ROW ALLOWED UNTIL THE BLANK FILLING AREA.
MUST NOT BE ALL BLANKS.

RELATIONAL EDITS

NONE

ELEMENT NAME: PROVIDER CITY (3-050)

VALIDITY EDITS

3-050-01V MUST BE LEFT JUSTIFIED AND BLANK FILLED.
TWO BLANKS IN A ROW **NOT** ALLOWED UNTIL THE BLANK FILLING AREA.
MUST NOT BE ALL BLANKS.

RELATIONAL EDITS

NONE

ELEMENT NAME: PROVIDER STATE OR COUNTRY CODE (3-055)

VALIDITY EDITS

3-055-01V **MUST BE A VALID PROVIDER STATE OR COUNTRY CODE** IN **CHAPTER 2, ADDENDUM A OR ADDENDUM B.**

RELATIONAL EDITS

NONE

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CHAPTER 2, SECTION 7.1

PROVIDER EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: PROVIDER ZIP CODE (3-060)

VALIDITY EDITS

3-060-01V MUST BE 9 DIGITS OR 5 DIGITS WITH 4 BLANKS

MUST BE A VALID ZIP CODE (BASED ON CURRENT SYSTEM DATE) IN THE GOVERNMENT PROVIDED ELECTRONIC ZIP CODE FILE

UNLESS TRANSACTION CODE =

I INACTIVATE A RECORD OR

M MODIFY A RECORD

OR MUST BE A 3 CHARACTER FOREIGN COUNTRY CODE (BASED ON THE COUNTRY CODES TABLE¹) FOLLOWED BY 6 BLANKS

RELATIONAL EDITS

3-060-01R PROVIDER ZIP CODE MUST BE WITHIN THE CONTRACTOR NUMBER AREA OF RESPONSIBILITY (REFER TO [CHAPTER 2, ADDENDUM J](#) FOR A LISTING OF VALID STATES FOR EACH CONTRACTOR NUMBER)².

¹ WHEN FOREIGN COUNTRY CODES ARE SUBMITTED, THE FIRST 3 CHARACTERS WILL BE EDITED AGAINST [CHAPTER 2, ADDENDUM A](#).

² **DO NOT PERFORM THIS EDIT IF PROVIDER ZIP CODE IS A 3 CHARACTER COUNTRY CODE (BASED ON THE COUNTRY CODES TABLE).**

ELEMENT NAME: PROVIDER BILLING STREET ADDRESS (3-070)

VALIDITY EDITS

3-070-01V MUST BE LEFT JUSTIFIED AND BLANK FILLED.
TWO BLANKS IN A ROW NOT ALLOWED UNTIL THE BLANK FILLING AREA.

RELATIONAL EDITS

NONE

ELEMENT NAME: PROVIDER BILLING CITY (3-075)

VALIDITY EDITS

3-075-01V MUST BE LEFT JUSTIFIED AND BLANK FILLED.
TWO BLANKS IN A ROW NOT ALLOWED UNTIL THE BLANK FILLING AREA.

RELATIONAL EDITS

NONE

ELEMENT NAME: PROVIDER BILLING STATE COUNTRY CODE (3-080)

VALIDITY EDITS

3-080-01V MUST BE ALL BLANKS OR APPEAR IN [CHAPTER 2, ADDENDUM A](#) AND [ADDENDUM B](#) LISTING VALID STATE OR COUNTRY CODE FIGURES.

RELATIONAL EDITS

NONE

PROVIDER EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: AMERICAN HOSPITAL ASSOCIATION ID NUMBER (3-100)	
VALIDITY EDITS	
3-100-01V	MUST BE LEFT JUSTIFIED AND BLANK FILLED OR BLANK.
RELATIONAL EDITS	
3-100-01R	IF INSTITUTIONAL/NON- INSTITUTIONAL INDICATOR = N NON-INSTITUTIONAL THEN AMERICAN HOSPITAL ASSOCIATION (AHA) ID NUMBER MUST= BLANK.
ELEMENT NAME: AHA MULTI-HOSPITAL SYSTEM CODE (3-105)	
VALIDITY EDITS	
3-105-01V	MUST BE NUMERIC OR BLANK.
RELATIONAL EDITS	
3-105-01R	IF INSTITUTIONAL/NON- INSTITUTIONAL INDICATOR = N NON-INSTITUTIONAL THEN AHA MULTI-SYSTEM CODE MUST = BLANK.
ELEMENT NAME: MEDICARE NUMBER (3-110)	
VALIDITY EDITS	
3-110-01V	FIRST TWO DIGITS MUST BE VALID MEDICARE STATE CODE, IF PRESENT (REFER TO CHAPTER 2, ADDENDUM B, FIGURE 2-B-2) THIRD DIGIT MUST BE ONE OF THE FOLLOWING MEDICARE TYPE OF INSTITUTION CODES - 'S', 'T', 'U', 'W', 'Y', 'Z', '0', '1', '2', '3', '4', '5', '6', '7', '8', '9' DIGITS 4-6 MUST BE NUMERIC
RELATIONAL EDITS	
3-110-01R	IF PROVIDER STATE/COUNTRY CODE (THIRD POSITION) IS NOT BLANK AND PROVIDER STATE/ COUNTRY CODE ≠ PRI PUERTO RICO THEN MEDICARE NUMBER MUST = BLANK.
3-110-02R	IF INSTITUTIONAL/NON- INSTITUTIONAL INDICATOR = N NON-INSTITUTIONAL THEN MEDICARE NUMBER MUST = BLANK.
3-110-03R	IF DRG EXEMPT/NON-EXEMPT INDICATOR = N DRG NON-EXEMPT THEN MEDICARE NUMBER CANNOT = BLANK.

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PROVIDER EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PROVIDER ACCEPTANCE DATE (3-115)

VALIDITY EDITS

3-115-01V MUST BE A VALID GREGORIAN DATE OR ALL ZEROES AND CANNOT BE > TMA CURRENT SYSTEM DATE.

RELATIONAL EDITS

3-115-01R PROVIDER TERMINATION DATE ≥ PROVIDER ACCEPTANCE DATE
OR PROVIDER TERMINATION DATE = ZEROES

3-115-02R IF PROVIDER ACCEPTANCE DATE = ZEROES
THEN PROVIDER TERMINATION DATE MUST = ZEROES

ELEMENT NAME: PROVIDER TERMINATION DATE (3-120)

VALIDITY EDITS

3-120-01V MUST BE A VALID GREGORIAN DATE OR ALL ZEROES.

RELATIONAL EDITS

3-120-01R PROVIDER ACCEPTANCE DATE ≤ PROVIDER TERMINATION DATE

ELEMENT NAME: RURAL/URBAN INDICATOR (3-125)

VALIDITY EDITS

3-125-01V MUST BE A VALID RURAL/URBAN INDICATOR.

RELATIONAL EDITS

3-125-01R IF THIRD POSITION OF PROVIDER STATE/COUNTRY CODE IS NOT BLANK
AND PROVIDER STATE/
COUNTRY CODE ≠ PRI PUERTO RICO
THEN RURAL/URBAN INDICATOR MUST = BLANK.

3-125-02R IF DRG EXEMPT/NON-EXEMPT
INDICATOR = C DRG NON-EXEMPT/CONTRACTOR
REIMBURSEMENT ARRANGEMENT OR
N DRG NON-EXEMPT
AND INSTITUTIONAL/NON-
INSTITUTIONAL INDICATOR = I INSTITUTIONAL
THEN RURAL/URBAN
INDICATOR MUST = L LARGE URBAN OR
R RURAL OR
U URBAN
ELSE RURAL/URBAN INDICATOR MUST = BLANK

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CHAPTER 2, SECTION 7.2

PROVIDER EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: IDME RATIO (3-130)

VALIDITY EDITS

3-130-01V MUST BE NUMERIC.

RELATIONAL EDITS

3-130-01R IF INSTITUTIONAL/NON-
INSTITUTIONAL INDICATOR = N NON-INSTITUTIONAL
THEN IDME RATIO MUST = ZEROES.

ELEMENT NAME: IDME RATIO EFFECTIVE DATE (3-135)

VALIDITY EDITS

3-135-01V MUST BE A VALID GREGORIAN DATE OR ALL ZEROES.

RELATIONAL EDITS

3-135-01R IF IDME RATIO = ZEROES
THEN IDME RATIO EFFECTIVE DATE MUST = ZEROES

ELEMENT NAME: AREA WAGE INDEX (3-140)

VALIDITY EDITS

3-140-01V MUST BE NUMERIC.

RELATIONAL EDITS

3-140-01R IF INSTITUTIONAL/NON-
INSTITUTIONAL INDICATOR = N NON-INSTITUTIONAL
THEN AREA WAGE INDEX MUST = ZEROES.

3-140-02R IF DRG EXEMPT/NON-EXEMPT
INDICATOR = N DRG NON-EXEMPT
THEN AREA WAGE INDEX MUST ≠ ZEROES.

ELEMENT NAME: AREA WAGE INDEX EFFECTIVE DATE (3-145)

VALIDITY EDITS

3-145-01V MUST BE A VALID GREGORIAN DATE OR ALL ZEROES AND CANNOT BE > TMA
CURRENT SYSTEM DATE.

RELATIONAL EDITS

3-145-01R IF AREA WAGE INDEX = ZEROES
THEN EFFECTIVE DATE MUST = ZEROES

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CHAPTER 2, SECTION 7.2

PROVIDER EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: DRG EXEMPT/NON-EXEMPT INDICATOR (3-150)	
VALIDITY EDITS	
3-150-01V	MUST BE A VALID DRG EXEMPT/NON-EXEMPT INDICATOR
RELATIONAL EDITS	
3-150-01R	IF INSTITUTIONAL/NON- INSTITUTIONAL INDICATOR = N NON-INSTITUTIONAL THEN DRG EXEMPT/NON-EXEMPT INDICATOR MUST BE BLANK.
3-150-02R	IF INSTITUTIONAL/NON- INSTITUTIONAL INDICATOR = I INSTITUTIONAL THEN DRG EXEMPT/NON-EXEMPT INDICATOR MUST NOT = BLANK.
3-150-03R	IF THIRD POSITION OF PROVIDER STATE/COUNTRY CODE IS NOT BLANK AND PROVIDER STATE/ COUNTRY CODE ≠ PRI PUERTO RICO AND INSTITUTIONAL/NON- INSTITUTIONAL INDICATOR = I INSTITUTIONAL THEN DRG INDICATOR MUST = E DRG EXEMPT
3-150-04R	IF INSTITUTIONAL/NON- INSTITUTIONAL INDICATOR = I INSTITUTIONAL AND PROVIDER STATE/ COUNTRY CODE = MD MARYLAND THEN DRG EXEMPT/NON- EXEMPT INDICATOR MUST = E DRG EXEMPT
3-150-05R	IF DRG EXEMPT/NON-EXEMPT INDICATOR = C DRG NON-EXEMPT/CONTRACTED REIMBURSEMENT ARRANGEMENT OR N DRG NON-EXEMPT AND INSTITUTIONAL/NON- INSTITUTIONAL INDICATOR = I INSTITUTIONAL THEN PROVIDER MAJOR SPECIALTY/TYPE OF INSTITUTION MUST = DRG NON- EXEMPT TYPE OF INSTITUTION (REFER TO CHAPTER 2, ADDENDUM D).

ELEMENT NAME: DRG EXEMPT/NON-EXEMPT EFFECTIVE DATE (3-155)	
VALIDITY EDITS	
3-155-01V	MUST BE A VALID GREGORIAN DATE OR ALL ZEROES AND CANNOT BE > TMA CURRENT SYSTEM DATE.
RELATIONAL EDITS	
3-155-01R	IF DRG EXEMPT/NON-EXEMPT INDICATOR = BLANK THEN DRG EXEMPT/NON-EXEMPT EFFECTIVE DATE MUST = ZEROES

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PROVIDER EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: TRANSACTION CODE (3-160) (CONTINUED)

AND PROVIDER MAJOR SPECIALTY/TYPE OF INSTITUTION = FACILITY CHARGES = 251G00000X, 273R00000X, 273Y00000X, 276400000X, 281P00000X, 281PC2000X, 282N00000X, 282NC2000X, 282NW0100X, 283Q00000X, 283X00000X, 284300000X, 287300000X, 313M00000X, 314000000X, 315D00000X, 315P00000X, 320600000X, 322D00000X

ALREADY EXISTS ON THE PROVIDER FILE.

3-160-06R IF TRANSACTION CODE = I INACTIVATE A RECORD OR
M MODIFY A RECORD

AND INSTITUTIONAL/NON-INSTITUTIONAL INDICATOR = I INSTITUTIONAL

THEN AN ACTIVE PROVIDER RECORD MUST EXIST ON THE PROVIDER FILE FOR THE SAME PROVIDER TAXPAYER NUMBER, PROVIDER ZIP CODE, AND PROVIDER MAJOR SPECIALTY/TYPE OF INSTITUTION. (IN THE CASE OF FOREIGN COUNTRY, ZIP WILL BE BLANK; ANY DUPLICATES ADDED WILL HAVE TO BE ASSIGNED ANOTHER PROVIDER TAXPAYER NUMBER.)

3-160-07R IF TRANSACTION CODE = I INACTIVATE A RECORD OR
M MODIFY A RECORD

AND INSTITUTIONAL/NON-INSTITUTIONAL INDICATOR = N NON-INSTITUTIONAL

THEN AN ACTIVE PROVIDER RECORD MUST EXIST ON THE PROVIDER FILE FOR THE SAME PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, AND PROVIDER ZIP CODE.

3-160-08R IF TRANSACTION CODE = I INACTIVATE A RECORD

AND INSTITUTIONAL/NON-INSTITUTIONAL INDICATOR = N NON-INSTITUTIONAL

AND PROVIDER MAJOR SPECIALTY/TYPE OF INSTITUTION = MULTI-SPECIALTY GROUP = 193200000X
SINGLE-SPECIALTY GROUP = 193400000X

THEN ALL ASSOCIATED RECORDS USING THE SAME PROVIDER TAXPAYER NUMBER AND PROVIDER ZIP CODE AND THE SAME ALPHA PREFIX OF THE SUB-IDENTIFIER MUST ALSO BE INACTIVATED.

ELEMENT NAME: RECORD EFFECTIVE DATE (3-165)

VALIDITY EDITS

3-165-01V MUST BE A VALID GREGORIAN DATE AND CANNOT BE > TMA CURRENT SYSTEM DATE.

RELATIONAL EDITS

NONE

FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL (1-000)	
VALIDITY EDITS	
NONE	
RELATIONAL EDITS	
1-000-01F	• BATCH/VOUCHER ASAP ACCOUNT NUMBER VALIDATION - ACCRUAL FUND CHECK
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2 BENEFIT PAYMENT USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER GOVERNMENT CAUSED ERROR
OR CONTRACT NUMBER =	MDA906-03-C-0015 (TDEFIC)
OR TYPE OF SUBMISSION =	D COMPLETE DENIAL OR
	O ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN BYPASS THIS EDIT	
ELSE IF OTHER GOVERNMENT PROGRAM TYPE CODE =	A MEDICARE PART A OR
	C MEDICARE PART A & B OR
	H MEDICARE HMO
AND HEALTH CARE DELIVERY PROGRAM PLAN COVERAGE CODE =	005 TRICARE STANDARD FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	010 TRICARE STANDARD FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSOR OR
	015 TRICARE STANDARD FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	017 TRICARE STANDARD FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	020 TFL FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	021 TFL FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR

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FINANCIAL EDIT REQUIREMENTS

**ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL
(1-000) (CONTINUED)**

022	TFL FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
023	TFL FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
110	TRICARE PRIME FOR INDIVIDUAL COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
111	TRICARE PRIME FAMILY COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
131	TRICARE PRIME INDIVIDUAL COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
132	TRICARE PRIME FAMILY COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
134	TRICARE PRIME INDIVIDUAL COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
135	TRICARE PRIME FAMILY COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
136	TRICARE PRIME INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
137	TRICARE PRIME FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS 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
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

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FINANCIAL EDIT REQUIREMENTS

**ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL
(1-000) (CONTINUED)**

	149	TRICARE PLUS COVERAGE WITH CHC FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	151	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS
OR HCC MEMBER CATEGORY CODE =	F	FORMER MEMBER OR
	H	MEDAL OF HONOR RECIPIENT OR
	R	RETIRED OR
	W	DoD BENEFICIARY
THEN BATCH/VOUCHER ASAP ACCOUNT NUMBER APPROPRIATION TYPE FOUND IN CORAMS MUST =	TF	TRUST/ACCRUAL FUND
ELSE BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER APPROPRIATION TYPE FOUND IN CORAMS MUST ≠	TF	TRUST/ACCRUAL FUND
1-000-02F		• NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - NORTH CONTRACT
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR AMOUNT PAID BY GOVT CONTRACTOR (TOTAL) = ZERO		
THEN BYPASS THIS EDIT		
ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD	TRICARE DOMESTIC
AND CONTRACT NUMBER =		MDA906-03-C-0011 (NORTH)
AND BEGIN DATE OF CARE ≥ 09/01/2004		
THEN SPECIAL PROCESSING CODE MUST =	AR	SHCP - REFERRED CARE OR
	CL	CLINICAL TRIALS OR
	CM	INDIVIDUAL CASE MANAGEMENT OR
	CT	CUSTODIAL CARE

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FINANCIAL EDIT REQUIREMENTS

**ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL
(1-000) (CONTINUED)**

OR ENROLLMENT/ HEALTH PLAN CODE =	SR	SHCP - REFERRED CARE
OR HCDP PLAN COVERAGE CODE MUST =	401	TRICARE RESERVE SELECT TIER 1 MEMBER- ONLY COVERAGE (CONTINGENCY OPERATIONS) OR
	402	TRICARE RESERVE SELECT TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405	TRICARE RESERVE SELECT TIER 2 MEMBER- ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406	TRICARE RESERVE SELECT TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407	TRICARE RESERVE SELECT TIER 3 MEMBER- ONLY COVERAGE (SERVICE AGREEMENT) OR
	408	TRICARE RESERVE SELECT TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW FAMILY COVERAGE
OR HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD > 30 DAYS OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD < 30 DAYS OR
	S	RESERVE > 30 DAYS OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE < 30 DAYS OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL (1-000) (CONTINUED)

1-000-03F	• NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - SOUTH CONTRACT
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR TYPE OF SUBMISSION =	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR AMOUNT PAID BY GOVT CONTRACTOR (TOTAL) = ZERO	
THEN BYPASS THIS EDIT	
ELSE IF BATCH/VOUCHER CLIN/ ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD TRICARE DOMESTIC
AND CONTRACT NUMBER =	MDA906-03-C-0010 (SOUTH)
AND BEGIN DATE OF CARE ≥ 11/01/2004	
THEN ENROLLMENT CODE/HEALTH PLAN CODE MUST =	Y CHCBP OR
	AA CHCBP - EXTRA OR
	SR SHCP - REFERRED CARE
OR HCDP PLAN COVERAGE CODE MUST =	401 TRICARE RESERVE SELECT TIER 1 MEMBER- ONLY COVERAGE OR
	402 TRICARE RESERVE SELECT TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405 TRICARE RESERVE SELECT TIER 2 MEMBER- ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406 TRICARE RESERVE SELECT TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407 TRICARE RESERVE SELECT TIER 3 MEMBER- ONLY COVERAGE (SERVICE AGREEMENT) OR
	408 TRICARE RESERVE SELECT TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409 TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR

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FINANCIAL EDIT REQUIREMENTS

**ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL
(1-000) (CONTINUED)**

	410	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW FAMILY COVERAGE
OR SPECIAL PROCESSING CODE MUST =	AR	SHCP - REFERRED CARE OR
	CL	CLINICAL TRIALS OR
	CM	INDIVIDUAL CASE MANAGEMENT OR
	CT	CUSTODIAL CARE
OR HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD > 30 DAYS OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD < 30 DAYS OR
	S	RESERVE > 30 DAYS OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE < 30 DAYS OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN
1-000-04F		• NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - WEST CONTRACT
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR AMOUNT PAID BY GOVT CONTRACTOR (TOTAL) = ZERO		
THEN BYPASS THIS EDIT		
ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD	TRICARE DOMESTIC

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL (1-000) (CONTINUED)

AND CONTRACT NUMBER = MDA906-03-C-0009 (WEST)

AND BEGIN DATE OF CARE ≥ 10/01/2004

THEN SPECIAL

PROCESSING CODE MUST = AR SHCP - REFERRED CARE **OR**

CL CLINICAL TRIALS **OR**

CM INDIVIDUAL CASE MANAGEMENT **OR**

CT CUSTODIAL CARE

OR ENROLLMENT/
HEALTH PLAN CODE =

SR SHCP - REFERRED CARE

OR HCDP PLAN
COVERAGE CODE
MUST =

401 TRICARE RESERVE SELECT TIER 1 MEMBER-
ONLY COVERAGE **OR**

402 TRICARE RESERVE SELECT TIER 1 MEMBER
AND FAMILY COVERAGE (CONTINGENCY
OPERATIONS) **OR**

405 TRICARE RESERVE SELECT TIER 2 MEMBER-
ONLY COVERAGE (CERTIFIED
QUALIFICATIONS) **OR**

406 TRICARE RESERVE SELECT TIER 2 MEMBER
AND FAMILY COVERAGE (CERTIFIED
QUALIFICATIONS) **OR**

407 TRICARE RESERVE SELECT TIER 3 MEMBER-
ONLY COVERAGE (SERVICE AGREEMENT)
OR

408 TRICARE RESERVE SELECT TIER 3 MEMBER
AND FAMILY COVERAGE (SERVICE
AGREEMENT) **OR**

409 TRICARE RESERVE SELECT TIER 1 SURVIVOR
CONTINUING WITH INDIVIDUAL
COVERAGE **OR**

410 TRICARE RESERVE SELECT TIER 1 SURVIVOR
CONTINUING WITH FAMILY COVERAGE
OR

411 TRICARE RESERVE SELECT TIER 1 SURVIVOR
NEW INDIVIDUAL COVERAGE **OR**

412 TRICARE RESERVE SELECT TIER 1 SURVIVOR
NEW FAMILY COVERAGE

OR PATIENT ZIP CODE IS IN ALASKA

OR PCM DMIS ID STATE = ALASKA

OR HCC MEMBER
CATEGORY CODE
MUST =

A ACTIVE DUTY **OR**

G NATIONAL GUARD > 30 DAYS **OR**

J ACADEMY STUDENT **OR**

N NATIONAL GUARD < 30 DAYS **OR**

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FINANCIAL EDIT REQUIREMENTS

**ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL
(1-000) (CONTINUED)**

	S	RESERVE > 30 DAYS OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE < 30 DAYS OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (1-060)

VALIDITY EDITS

REFER TO [CHAPTER 2, SECTION 5.1](#)

RELATIONAL EDITS

1-060-01F	• FOREIGN EDITS [ACTIVE DUTY SERVICE MEMBER]		
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN /ASAP NUMBER, CONTRACTOR ERROR OR	
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN /ASAP NUMBER, GOVERNMENT CAUSED ERROR	
THEN BYPASS THIS EDIT			
ELSE 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 =	X	FOREIGN ADSM	
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR	
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR	
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR	
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI	
THEN BATCH/VOUCHER CLIN /ASAP ACCOUNT NUMBER ASAP DESCRIPTION IN THE TMA DATABASE MUST =	TF	TRICARE FOREIGN	
AND SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A	ARMY OR	
	C	COAST GUARD OR	
	F	AIR FORCE OR	
	H	PUBLIC HEALTH SERVICE OR	
	M	MARINES OR	
	N	NAVY OR	
	O	NOAA OR	
	Z	NOT PROVIDED FROM DEERS	
AND HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR	

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (1-060) (CONTINUED)	
	G NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J ACADEMY STUDENT OR
	N NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR
	S RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	T FOREIGN MILITARY MEMBER OR
	V RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS)
	AND HCC MEMBER RELATIONSHIP CODE MUST = A SELF
1-060-02F	• TPR FOREIGN EDITS [ACTIVE DUTY SERVICE MEMBER]
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN /ASAP NUMBER, CONTRACTOR ERROR OR
	H2 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN /ASAP NUMBER, GOVERNMENT CAUSED ERROR
	THEN BYPASS THIS EDIT
ELSE 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 =	WA TPR FOREIGN ADSM
AND TYPE OF SUBMISSION ≠	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	D COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
	O ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN BATCH/VOUCHER CLIN /ASAP ACCOUNT NUMBER ASAP DESCRIPTION IN THE TMA DATABASE MUST =	TF TRICARE FOREIGN
AND SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A ARMY OR
	C COAST GUARD OR

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (1-060) (CONTINUED)		
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
	O	NOAA OR
	Z	NOT PROVIDED FROM DEERS
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
	J	ACADEMY STUDENT OR
	S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE)
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF
1-060-11F	²	TRICARE PRIME REMOTE (TPR) [ACTIVE DUTY SERVICE MEMBER]
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 =	W	TPR ADSM - USA
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	GU	ADSM ENROLLED IN TPR
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
	O	NOAA OR
	Z	NOT PROVIDED FROM DEERS

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (1-060) (CONTINUED)		
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
	J	ACADEMY STUDENT OR
	S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE)
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF
1-060-16F	• TFL [RETIREE AND FAMILY MEMBER]	
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 =	FE	TFL - EXTRA OR
	FS	TFL - STANDARD
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	R	MEDICARE/TRICARE DUAL ENTITLEMENT - FIRST PAYOR OR
	T	MEDICARE/TRICARE DUAL ENTITLEMENT - SECOND PAYOR OR
	RS	MEDICARE/TRICARE DUAL ENTITLEMENT - FIRST PAYOR NO TRICARE PROVIDER CERTIFICATION
AND HCC MEMBER CATEGORY CODE ≠	A	ACTIVE DUTY OR
	G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR
	S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 30 DAYS OR MORE) OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS)
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (1-060) (CONTINUED)		
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
	O	NOAA OR
	Z	NOT PROVIDED FROM DEERS
AND HCC MEMBER CATEGORY CODE MUST =	F	FORMER MEMBER (RESERVE SERVICE) OR
	H	MEDAL OF HONOR RECIPIENT OR
	R	RETIRED MILITARY MEMBER ELIGIBLE FOR RETIRED PAY OR
	W	FORMER SPOUSE
AND OTHER GOVERNMENT PROGRAM TYPE CODE MUST =	C	MEDICARE PART A & B OR
	H	MEDICARE HMO
1-060-18F	• SHCP VOUCHER (ADSM CLAIMS ONLY)	
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 =	SN	SHCP - NON-MTF REFERRED OR
	SO	SHCP - NON-TRICARE ELIGIBLE OR
	ST	SHCP - TRICARE ELIGIBLE
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AN	SHCP - NON-REFERRED CARE OR
	CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
	SC	SHCP - NON-TRICARE ELIGIBLE OR
	SE	SHCP - TRICARE ELIGIBLE OR
	SM	SHCP - EMERGENCY
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR

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CHAPTER 2, SECTION 8.1

FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (1-060) (CONTINUED)		
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
	O	NOAA OR
	Z	NOT PROVIDED FROM DEERS
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
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR
	S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS)
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF
1-060-19F	• TPR ADFM INTERIM	
IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE OR
	6	VOUCHER HEADER ADMIN CLAIM RATE-ELIGIBLE
AND ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	GF	TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADSM
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR

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CHAPTER 2, SECTION 8.1

FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (1-060) (CONTINUED)		
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN SERVICE BRANCH CLASSIFICATION CODE MUST =	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
	O	NOAA OR
	Z	NOT PROVIDED FROM DEERS
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
	J	ACADEMY STUDENT 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)
1-060-20F	• TFL [ACTIVE DUTY FAMILY MEMBER]	
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 =	FE	TFL - EXTRA OR
	FS	TFL - STANDARD
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	R	MEDICARE/TRICARE DUAL ENTITLEMENT - FIRST PAYOR OR
	T	MEDICARE/TRICARE DUAL ENTITLEMENT - SECOND PAYOR OR
	RS	MEDICARE/TRICARE DUAL ENTITLEMENT - FIRST PAYOR NO TRICARE PROVIDER CERTIFICATION

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CHAPTER 2, SECTION 8.1

FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (1-060) (CONTINUED)

AND HCC MEMBER CATEGORY CODE =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR
	S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS)
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
	O	NOAA OR
	Z	NOT PROVIDED FROM DEERS
AND HCC MEMBER RELATIONSHIP CODE MUST ≠	A	SELF
AND OTHER GOVERNMENT PROGRAM TYPE CODE MUST =	A	MEDICARE PART A OR
	C	MEDICARE PART A & B OR
	H	MEDICARE HMO
1-060-23F	• CONUS NON-FINANCIALLY UNDERWRITTEN BANK ACCOUNT VALIDATION	
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN /ASAP NUMBER, CONTRACTOR ERROR OR

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (1-060) (CONTINUED)		
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN /ASAP NUMBER, GOVERNMENT CAUSED ERROR
THEN BYPASS THIS EDIT		
ELSE IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE OR
	6	VOUCHER HEADER ADMIN CLAIM RATE-ELIGIBLE
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
AND ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	V	FINANCIALLY UNDERWRITTEN PAYMENT BY CLAIMS PROCESSOR
THEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN THE TMA DATABASE MUST ≠	AS	ARMY SHCP CLIN OR
	FS	AIR FORCE SHCP CLIN OR
	NS	NAVY SHCP CLIN OR
	TD	TRICARE DOMESTIC ASAP OR
	TF	TRICARE FOREIGN ASAP
1-060-26F	• FOREIGN ADFM	
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN /ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN /ASAP NUMBER, GOVERNMENT CAUSED ERROR
THEN BYPASS THIS EDIT		
ELSE IF HEADER TYPE INDICATOR =	5	NON-CLAIM RATE VOUCHER OR
	6	CLAIM RATE VOUCHER
AND ENROLLMENT CODE/ HEALTH PLAN CODE =	XF	FOREIGN ADFM
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD OR
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (1-060) (CONTINUED)	
	E COMPLETE CANCELLATION NON-TED RECORD OR
	O ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN THE TMA DATABASE MUST =	TF TRICARE FOREIGN
AND SERVICE BRANCH CLASSIFICATION CODE MUST =	A ARMY OR
	C COAST GUARD OR
	F AIR FORCE OR
	H PUBLIC HEALTH SERVICE OR
	M MARINES OR
	N NAVY OR
	O NOAA OR
	Z UNKNOWN
AND HCC MEMBER CATEGORY CODE MUST =	A ACTIVE DUTY OR
	G NATIONAL GUARD > 30 DAYS OR
	J ACADEMY STUDENT OR
	N NATIONAL GUARD > 30 DAYS OR
	S RESERVE > 30 DAYS OR
	T FOREIGN MILITARY MEMBER OR
	V RESERVE < 30 DAYS
AND HCC MEMBER RELATIONSHIP CODE MUST ≠	A SELF
1-060-27F	• TPR FOREIGN EDITS (ADFM)
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
THEN BYPASS THIS EDIT	
ELSE IF HEADER TYPE INDICATOR =	5 NON-CLAIM RATE VOUCHER OR
	6 CLAIM RATE VOUCHER
AND ENROLLMENT CODE/ HEALTH PLAN CODE =	WO TPR FOREIGN ADFM

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (1-060) (CONTINUED)		
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD OR
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
	E	COMPLETE CANCELLATION NON-TED RECORD OR
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN THE TMA DATABASE MUST =	TF	TRICARE FOREIGN
AND SERVICE BRANCH CLASSIFICATION CODE MUST =	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
	O	NOAA OR
	Z	UNKNOWN
AND HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD > 30 DAYS OR
	J	ACADEMY STUDENT OR
	S	RESERVE > 30 DAYS
AND HCC MEMBER RELATIONSHIP CODE MUST =	B	SPOUSE OR
	C	CHILD OR
	D	PRE-ADOPTIVE CHILD OR
	E	WARD
1-060-28F	• NAVY LINE OF DUTY CLAIMS	
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
THEN BYPASS THIS EDIT		
ELSE IF HEADER TYPE INDICATOR =	5	NON-CLAIM RATE VOUCHER OR

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (1-060) (CONTINUED)

		6	CLAIM RATE VOUCHER
AND CONTRACTOR NUMBER =			MDA906-03-C-0010 (SOUTH)
AND BATCH/VOUCHER ASAP ACCOUNT NUMBER POSITION 8 = 5			
THEN BRANCH CLASSIFICATION CODE MUST =		N	NAVY OR
		Z	UNKNOWN
1-060-29F	• MARINE LINE OF DUTY CLAIMS		
IF ANY OCCURRENCE OF OVERRIDE CODE =		H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN /ASAP NUMBER, CONTRACTOR ERROR OR
		H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN /ASAP NUMBER, GOVERNMENT CAUSED ERROR
THEN BYPASS THIS EDIT			
ELSE IF HEADER TYPE INDICATOR =		5	NON-CLAIM RATE VOUCHER OR
		6	CLAIM RATE VOUCHER
AND CONTRACTOR NUMBER =			MDA906-03-C-0010 (SOUTH)
AND BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER POSITION 8 = 6			
THEN BRANCH CLASSIFICATION CODE MUST =		M	MARINE OR
		Z	UNKNOWN

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CHAPTER 2, SECTION 8.1

FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: AGR SERVICE LEGAL AUTHORITY CODE (1-065)

VALIDITY EDITS

REFER TO [CHAPTER 2, SECTION 5.3](#).

RELATIONAL EDITS

1-065-01F	IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE OR
		6	VOUCHER HEADER ADMIN CLAIM RATE-ELIGIBLE
	AND HCC MEMBER CATEGORY CODE =	G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE)
	AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT NON-TED RECORD (HCSR) DATA OR
		D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
		O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
	THEN AGR SERVICE LEGAL AUTHORITY CODE MUST =	A	AGR UNDER 10 U.S.C. 10301 (REFERENCE (B)) OR
		B	AGR UNDER 10 U.S.C. 10211 (REFERENCE (B)) OR
		C	AGR UNDER 10 U.S.C. 12301(D) (REFERENCE (B)) OR
		D	AGR UNDER 10 U.S.C. 12310 (REFERENCE (B)) OR
		E	AGR UNDER 10 U.S.C. 12501 (REFERENCE (B)) OR
		F	AGR UNDER 10 U.S.C. 3015/301938019 (REFERENCE (B)) OR
		G	AGR UNDER 10 U.S.C. 3033/8033 (REFERENCE (B)) OR
		H	AGR UNDER 10 U.S.C. 3496/8496 (REFERENCE (B)) OR
		I	AGR: 14 U.S.C. 276 OR
		J	AGR UNDER 32 U.S.C. 502(F) (REFERENCE (M)) OR
		K	AGR UNDER 32 U.S.C. 503 (REFERENCE (M)) OR
		L	AGR UNDER 32 U.S.C. 708 (REFERENCE (M)) OR
		X	AGR: OTHER OR
		Z	UNKNOWN/NOT APPLICABLE

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CHAPTER 2, SECTION 8.1

FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: ADMINISTRATIVE CLIN (1-283)

VALIDITY EDITS

REFER TO [CHAPTER 2, SECTION 5.3](#).

RELATIONAL EDITS

1-283-02F • NO DUPLICATE CLINS ON TED RECORD

IF HEADER TYPE INDICATOR = 6 VOUCHER HEADER (USED ONLY FOR INSTITUTIONAL/NON-INSTITUTIONAL NON-FINANCIALLY UNDERWRITTEN ADMIN CLAIM RATE ELIGIBLE TED RECORDS) **OR**

9 BATCH HEADER (INSTITUTIONAL/NON-INSTITUTIONAL FINANCIALLY UNDERWRITTEN ADMIN CLAIM RATE ELIGIBLE TED RECORDS)

THEN ANY OCCURRENCE OF ADMINISTRATIVE CLIN (POSITIONS 3-6) MUST HAVE NO DUPLICATE IN ANY OCCURRENCES (DUPLICATE BLANK ADMINISTRATIVE CLIN OCCURRENCES ARE ALLOWED)

1-283-08F¹ • OPTION PERIOD

IF HEADER TYPE INDICATOR = 6 CLAIM RATE VOUCHER **OR**

9 CLAIM RATE BATCH

AND CLIN FIELD ON TED RECORD NOT = BLANK

AND NET MASTER VALUE OF DERIVED ADMIN CLAIM COUNT FIELD = 0

AND TYPE OF SUBMISSION = A ADJUSTMENT **OR**

B ADJUSTMENT TO NON-TED RECORD **OR**

E COMPLETE CANCELLATION NON-TED RECORD

THEN THE CLIN MUST BE VALID IN THE CURRENT OR PRIOR OPTION PERIOD FOR THAT CONTRACT ON THE TMA DATABASE BASED ON THE DATE TED RECORD PROCESSED TO COMPLETION

ELSE THE CLIN MUST BE VALID IN THE CURRENT OPTION PERIOD FOR THAT CONTRACT ON THE TMA DATABASE BASED ON THE DATE TED RECORD PROCESSED TO COMPLETION

1-283-09F¹ • CLIN MATCHES APPROPRIATION TYPE

IF HEADER TYPE INDICATOR = 6 CLAIM RATE VOUCHER **OR**

9 CLAIM RATE BATCH

AND CLIN FIELD ON TED RECORD NOT = BLANK

AND NET MASTER VALUE OF DERIVED ADMIN CLAIM COUNT FIELD = 0

ADMINISTRATIVE CLIN EDIT ERRORS ARE NOT COUNTED AGAINST THE CONTRACTORS PERFORMANCE STANDARDS. THE EDITS ARE DESIGNED TO INFORM THE CONTRACTOR WHEN REQUEST FOR ADMINISTRATIVE PAYMENT HAS BEEN DENIED BY TMA, CRM AND HOW TO CORRECT THE ERROR.

¹ **BYPASS EDIT 1-283-08F IF RECORD FAILS 1-283-02F.**

BYPASS EDIT 1-283-09F IF RECORD FAILS 1-283-02F OR 1-283-08F OR 1-283-10F.

BYPASS EDIT 1-283-10F IF RECORD FAILS 1-283-02F OR 1-283-08F.

ALL 1-283-XXF EDITS ARE BYPASSED FOR TYPE OF SUBMISSION 'C - COMPLETE CANCELLATION OF A TED RECORD'

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: ADMINISTRATIVE CLIN (1-283) (CONTINUED)

THEN THE APPROPRIATION ASSOCIATED WITH THE ADMINISTRATIVE CLIN CLAIMED ON THE TED RECORD MUST MATCH THE APPROPRIATION ASSOCIATED WITH THE BATCH/VOUCHER ASAP NUMBER ASSIGNED BY TMA/CRM AND USED IN THE VOUCHER HEADER (**CLIN CAN BE FOUND IN CURRENT OR ANY PRIOR OPTION PERIOD**).

1-283-10F¹

• **CLIN MATCHES APPROPRIATION TYPE**

IF HEADER TYPE INDICATOR = 6 CLAIM RATE VOUCHER **OR**

9 CLAIM RATE BATCH

AND CLIN FIELD ON TED RECORD **NOT** = BLANK

AND NET MASTER VALUE OF DERIVED ADMIN CLAIM COUNT FIELD = 0

THEN THE RATE TYPE FOR THAT CLIN IN THE TMA DATABASE MUST =

D SINGLE **OR**

S DISPENSING FEE

OR IF THE RATE TYPE FOR THAT CLIN IN THE TMA DATABASE =

E ELECTRONIC

THEN THE CLAIM FORM TYPE/EMC INDICATOR ON THE TED RECORD MUST =

G ELECTRONIC INSTITUTIONAL CLAIM SUBMISSION **OR**

H ELECTRONIC NON-INSTITUTIONAL CLAIM SUBMISSION **OR**

I ELECTRONIC DRUG CLAIM SUBMISSION

OR IF RATE TYPE FOR THAT CLIN IN THE TMA DATABASE =

P PAPER

THEN THE CLAIM FORM TYPE/EMC INDICATOR ON THE TED RECORD MUST =

B DD FORM 2642 **OR**

C HCFA FORM 1500 **OR**

F UB 92 **OR**

J OTHER

OR IF RATE TYPE FOR THAT CLIN IN THE TMA DATABASE =

F FOREIGN

ADMINISTRATIVE CLIN EDIT ERRORS ARE NOT COUNTED AGAINST THE CONTRACTORS PERFORMANCE STANDARDS. THE EDITS ARE DESIGNED TO INFORM THE CONTRACTOR WHEN REQUEST FOR ADMINISTRATIVE PAYMENT HAS BEEN DENIED BY TMA, CRM AND HOW TO CORRECT THE ERROR.

¹ BYPASS EDIT 1-283-08F IF RECORD FAILS 1-283-02F.

BYPASS EDIT 1-283-09F IF RECORD FAILS 1-283-02F OR 1-283-08F OR 1-283-10F.

BYPASS EDIT 1-283-10F IF RECORD FAILS 1-283-02F OR 1-283-08F.

ALL 1-283-XXF EDITS ARE BYPASSED FOR TYPE OF SUBMISSION 'C - COMPLETE CANCELLATION OF A TED RECORD'

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: ADMINISTRATIVE CLIN (1-283) (CONTINUED)

THEN THE THIRD CHARACTER OF THE FILING STATE/COUNTRY CODE ON THE
TED ≠ A SPACE

1-283-11F • CLAIM SUBMITTED UNDER WRONG HEADER TYPE INDICATOR

IF HEADER TYPE INDICATOR = 6 CLAIM RATE VOUCHER OR

9 CLAIM RATE BATCH

THEN AT LEAST ONE OCCURRENCE OF ADMINISTRATIVE CLIN ≠ BLANK

ADMINISTRATIVE CLIN EDIT ERRORS ARE NOT COUNTED AGAINST THE CONTRACTORS
PERFORMANCE STANDARDS. THE EDITS ARE DESIGNED TO INFORM THE CONTRACTOR WHEN
REQUEST FOR ADMINISTRATIVE PAYMENT HAS BEEN DENIED BY TMA, CRM AND HOW TO
CORRECT THE ERROR.

¹ **BYPASS EDIT 1-283-08F IF RECORD FAILS 1-283-02F.**

BYPASS EDIT 1-283-09F IF RECORD FAILS 1-283-02F OR 1-283-08F OR 1-283-10F.

BYPASS EDIT 1-283-10F IF RECORD FAILS 1-283-02F OR 1-283-08F.

**ALL 1-283-XXF EDITS ARE BYPASSED FOR TYPE OF SUBMISSION 'C - COMPLETE CANCELLATION
OF A TED RECORD'**

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - NON-INSTITUTIONAL (2-000)

VALIDITY EDITS

NONE

RELATIONAL EDITS

2-000-01F	• BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - ACCRUAL FUND CHECK
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR CONTRACT NUMBER =	MDA906-03-C-0015 (TDEFIC)
OR TYPE OF SUBMISSION =	D COMPLETE DENIAL OR
	O ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN BYPASS THIS EDIT	
ELSE IF OTHER GOVERNMENT PROGRAM TYPE CODE =	A MEDICARE PART A OR
	C MEDICARE PART A & B OR
	H MEDICARE HMO
AND HEALTH CARE PROGRAM PLAN COVERAGE CODE =	005 TRICARE STANDARD FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	010 TRICARE STANDARD FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSOR OR
	015 TRICARE STANDARD FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	017 TRICARE STANDARD FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS
	020 TFL FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	021 TFL FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	022 TFL FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	023 TFL FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	110 TRICARE PRIME FOR INDIVIDUAL COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR

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FINANCIAL EDIT REQUIREMENTS

**ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - NON-INSTITUTIONAL
(2-000) (CONTINUED)**

111	TRICARE PRIME FAMILY COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
131	TRICARE PRIME INDIVIDUAL COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
132	TRICARE PRIME FAMILY COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
134	TRICARE PRIME INDIVIDUAL COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
135	TRICARE PRIME FAMILY COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
136	TRICARE PRIME INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
137	TRICARE PRIME FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
141	TRICARE PLUS COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
142	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
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 WITH CHC COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
151	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS
	OR HCC MEMBER CATEGORY CODE =
F	FORMER MEMBER OR
H	MEDAL OF HONOR RECIPIENT OR
R	RETIRED OR
W	DoD BENEFICIARY

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - NON-INSTITUTIONAL (2-000) (CONTINUED)

	THEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER APPROPRIATION TYPE FOUND IN CORAMS MUST =	TF	TRUST/ACCRUAL FUND
	ELSE BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER APPROPRIATION TYPE FOUND IN CORAMS MUST ≠	TF	TRUST/ACCRUAL FUND
2-000-02F	• NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - NORTH CONTRACT		
	IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
		H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
	OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	OR THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT PAID BY GOVT CONTRACTOR BY PROCEDURE CODE = ZERO		
	THEN BYPASS THIS EDIT		
	ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD	TRICARE DOMESTIC)
	AND CONTRACT NUMBER =		MDA906-03-C-0011 (NORTH)
	AND BEGIN DATE OF CARE ≥ 09/01/2004		
	THEN SPECIAL PROCESSING CODE MUST =	AR	SHCP - REFERRED CARE OR
		CL	CLINICAL TRIALS OR
		CM	INDIVIDUAL CASE MANAGEMENT OR
		CT	CUSTODIAL CARE
	OR ENROLLMENT/HEALTH PLAN CODE =	SR	SHCP - REFERRED CARE
	OR HCDP PLAN COVERAGE CODE MUST =	401	TRICARE RESERVE SELECT TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR
		402	TRICARE RESERVE SELECT TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - NON-INSTITUTIONAL (2-000) (CONTINUED)

	405	TRICARE RESERVE SELECT TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406	TRICARE RESERVE SELECT TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407	TRICARE RESERVE SELECT TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408	TRICARE RESERVE SELECT TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW FAMILY COVERAGE
		OR HCC MEMBER CATEGORY CODE MUST =
	A	ACTIVE DUTY OR
	G	NATIONAL GUARD > 30 DAYS OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD < 30 DAYS OR
	S	RESERVE > 30 DAYS OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE < 30 DAYS OR
	Z	UNKNOWN
		AND HCC MEMBER RELATIONSHIP CODE MUST =
	A	SELF OR
	Z	UNKNOWN
2-000-03F		• NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - SOUTH CONTRACT
		IF ANY OCCURRENCE OF OVERRIDE CODE =
	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
		OR TYPE OF SUBMISSION =
	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - NON-INSTITUTIONAL (2-000) (CONTINUED)

	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT PAID BY GOVT CONTRACTOR BY PROCEDURE CODE = ZERO		
THEN BYPASS THIS EDIT		
ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD	TRICARE DOMESTIC)
AND CONTRACT NUMBER =	MDA906-03-C-0010 (SOUTH)	
AND BEGIN DATE OF CARE ≥ 11/01/2004		
THEN ENROLLMENT CODE/HEALTH PLAN CODE MUST =	Y	CHCBP OR
	AA	CHCBP - EXTRA OR
	SR	SHCP - REFERRED CARE
OR HCDP PLAN COVERAGE CODE MUST =	401	TRICARE RESERVE SELECT TIER 1 MEMBER-ONLY COVERAGE OR
	402	TRICARE RESERVE SELECT TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405	TRICARE RESERVE SELECT TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406	TRICARE RESERVE SELECT TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407	TRICARE RESERVE SELECT TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408	TRICARE RESERVE SELECT TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW FAMILY COVERAGE
OR SPECIAL PROCESSING CODE MUST =	AR	SHCP - REFERRED CARE OR

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - NON-INSTITUTIONAL (2-000) (CONTINUED)

	CL	CLINICAL TRIALS OR
	CM	INDIVIDUAL CASE MANAGEMENT OR
	CT	CUSTODIAL CARE
OR HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD > 30 DAYS OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD < 30 DAYS OR
	S	RESERVE > 30 DAYS OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE < 30 DAYS OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN
2-000-04F		• NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - WEST CONTRACT
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT PAID BY GOVT CONTRACTOR BY PROCEDURE CODE = ZERO		
THEN BYPASS THIS EDIT		
ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD	TRICARE DOMESTIC)
AND CONTRACT NUMBER =		MDA906-03-C-0009 (WEST)
AND BEGIN DATE OF CARE ≥ 10/01/2004		
THEN SPECIAL PROCESSING CODE MUST =	AR	SHCP - REFERRED CARE OR
	CL	CLINICAL TRIALS OR
	CM	INDIVIDUAL CASE MANAGEMENT OR
	CT	CUSTODIAL CARE

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - NON-INSTITUTIONAL (2-000) (CONTINUED)

OR ENROLLMENT/ HEALTH PLAN CODE =	SR	SHCP - REFERRED CARE
OR HCDP PLAN COVERAGE CODE MUST =	401	TRICARE RESERVE SELECT TIER 1 MEMBER- ONLY COVERAGE OR
	402	TRICARE RESERVE SELECT TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405	TRICARE RESERVE SELECT TIER 2 MEMBER- ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406	TRICARE RESERVE SELECT TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407	TRICARE RESERVE SELECT TIER 3 MEMBER- ONLY COVERAGE (SERVICE AGREEMENT) OR
	408	TRICARE RESERVE SELECT TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410	TRICARE RESERVE SELECT TIER 1 SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRICARE RESERVE SELECT TIER 1 SURVIVOR NEW FAMILY COVERAGE
OR PATIENT ZIP CODE IS IN ALASKA		
OR PCM DMIS ID STATE = ALASKA		
OR HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD > 30 DAYS OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD < 30 DAYS OR
	S	RESERVE > 30 DAYS OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE < 30 DAYS OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055)

VALIDITY EDITS

REFER TO [CHAPTER 2, SECTION 6.1](#).

RELATIONAL EDITS

2-055-01F • FOREIGN EDITS [ACTIVE DUTY MEMBER]

IF CONTRACT NUMBER = MDA 906-02-C-0013 (TMOP) **OR**
MDA 906-03-C-0019 (TRRx)

**OR IF ANY OCCURRENCE OF
OVERRIDE CODE =**

H1 BENEFIT PAYMENT MADE USING
INCORRECT BATCH/VOUCHER **CLIN**/ASAP
NUMBER, CONTRACTOR ERROR **OR**

H2 BENEFIT PAYMENT MADE USING
INCORRECT BATCH/VOUCHER **CLIN**/ASAP
NUMBER, GOVERNMENT CAUSED ERROR

THEN BYPASS THIS EDIT

**ELSE 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 =**

X FOREIGN ADSM

AND TYPE OF SUBMISSION ≠

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

**D COMPLETE DENIAL INITIAL TED RECORD
SUBMISSION OR**

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

**O ZERO PAYMENT TED RECORD DUE TO 100%
OHI**

**THEN BATCH/VOUCHER
CLIN/ASAP ACCOUNT
NUMBER ASAP
DESCRIPTION FOUND IN
THE TMA DATABASE
MUST =**

TF TRICARE FOREIGN

**OR CONTRACT
NUMBER =**

MDA906-02-C-0013 (TMOP) OR

MDA906-03-C-0019

**AND SERVICE BRANCH
CLASSIFICATION CODE
(SPONSOR) MUST =**

A ARMY **OR**

C COAST GUARD **OR**

F AIR FORCE **OR**

H PUBLIC HEALTH SERVICE **OR**

M MARINES **OR**

N NAVY **OR**

O NOAA **OR**

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (CONTINUED)	
	Z NOT PROVIDED FROM DEERS
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
	J ACADEMY STUDENT OR
	N NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR
	S RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	T FOREIGN MILITARY MEMBER OR
	V RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS)
AND HCC MEMBER RELATIONSHIP CODE MUST =	A SELF
2-055-02F	• TPR FOREIGN EDITS [ACTIVE DUTY SERVICE MEMBER]
IF CONTRACT NUMBER =	MDA 906-02-C-0013 (TMOP) OR MDA 906-03-C-0019 (TRRx)
OR IF ANY OCCURRENCE OF OVERRIDE CODE =	H1 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN /ASAP NUMBER, CONTRACTOR ERROR OR
	H2 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN /ASAP NUMBER, GOVERNMENT CAUSED ERROR
THEN BYPASS THIS EDIT	
ELSE 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 =	WA TPR FOREIGN ADSM
AND TYPE OF SUBMISSION ≠	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	D COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
	O ZERO PAYMENT TED RECORD DUE TO 100% OHI

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (CONTINUED)		
THEN BATCH/VOUCHER ASAP ACCOUNT NUMBER CLIN/ASAP DESCRIPTION FOUND IN THE TMA DATABASE MUST =	TF	TRICARE FOREIGN
OR CONTRACT NUMBER =	MDA906-02-C-0013 (TMOP) OR MDA906-03-C-0019 (TRRx)	
AND SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
	O	NOAA OR
	Z	NOT PROVIDED FROM DEERS
AND HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	J	ACADEMY STUDENT 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 =	A	SELF
2-055-11F	• TPR [ACTIVE DUTY SERVICE MEMBER]	
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 =	W	TPR ADSM - USA
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	GU	ADSM ENROLLED IN TPR
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (CONTINUED)		
THEN SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
	O	NOAA OR
	Z	NOT PROVIDED FROM DEERS
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
	J	ACADEMY STUDENT OR
	S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE)
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF
2-055-16F	• TRICARE SENIOR PHARMACY (TSRx) [ACTIVE DUTY FAMILY MEMBER]	
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 =	PS	TSRx
AND HCC MEMBER CATEGORY CODE =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR
	S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE)
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (CONTINUED)		
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
	O	NOAA OR
	Z	NOT PROVIDED FROM DEERS
AND TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS OR
	M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
AND HCC MEMBER RELATIONSHIP CODE MUST ≠	A	SELF
AND OTHER GOVERNMENT PROGRAM TYPE CODE MUST =	A	MEDICARE PART A OR
	C	MEDICARE PART A & B OR
	H	MEDICARE HMO
2-055-17F • TRICARE SENIOR PHARMACY (TSRx) [RETIREE AND FAMILY MEMBER]		
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 =	PS	TSRx
AND HCC MEMBER CATEGORY CODE ≠	A	ACTIVE DUTY OR
	G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR
	S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (CONTINUED)		
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS)
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
	O	NOAA OR
	Z	NOT PROVIDED FROM DEERS
AND TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS OR
	M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
AND HCC MEMBER CATEGORY CODE MUST =	F	FORMER MEMBER OR
	H	MEDAL OF HONOR RECIPIENT OR
	R	RETIRED MILITARY MEMBER ELIGIBLE FOR RETIRED PAY OR
	W	FORMER SPOUSE
AND OTHER GOVERNMENT PROGRAM TYPE CODE MUST =	A	MEDICARE A OR
	C	MEDICARE A & B OR
	H	MEDICARE HMO
2-055-18F • TFL [RETIREE AND FAMILY MEMBER]		
IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE OR
	6	VOUCHER HEADER ADMIN CLAIM RATE-ELIGIBLE

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (CONTINUED)		
AND ENROLLMENT/HEALTH PLAN CODE =	FE	TFL - EXTRA OR
	FS	TFL - STANDARD
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	R	MEDICARE/TRICARE DUAL ENTITLEMENT - FIRST PAYOR OR
	T	MEDICARE/TRICARE DUAL ENTITLEMENT - SECOND PAYOR OR
	RS	MEDICARE/TRICARE DUAL ENTITLEMENT - FIRST PAYOR NO TRICARE PROVIDER CERTIFICATION
AND HCC MEMBER CATEGORY CODE ≠	A	ACTIVE DUTY OR
	G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR
	S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS)
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
THEN SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
O	NOAA OR	
AND HHC MEMBER CATEGORY CODE MUST =	Z	NOT PROVIDED FROM DEERS
	F	FORMER MEMBER OR
	H	MEDAL OF HONOR RECIPIENT OR

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (CONTINUED)		
	R	RETIRED MILITARY MEMBER ELIGIBLE FOR RETIRED PAY OR
	W	FORMER SPOUSE
AND OTHER GOVERNMENT PROGRAM TYPE CODE MUST =	C	MEDICARE PART A & B OR
	H	MEDICARE HMO
2-055-20F • SHCP VOUCHERS (ADSM CLAIMS ONLY)		
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 =	SN	SHCP - NON-MTF REFERRED OR
	SO	SHCP - NON-TRICARE ELIGIBLE OR
	ST	SHCP - TRICARE ELIGIBLE OR
	SU	SHCP - REFERRAL DESIGNATION UNKNOWN
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AN	SHCP - NON-REFERRED CARE OR
	CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
	SC	SHCP - NON-TRICARE ELIGIBLE OR
	SE	SHCP - TRICARE ELIGIBLE OR
	SM	SHCP - EMERGENCY
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
	O	NOAA OR
	Z	NOT PROVIDED FROM DEERS

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (CONTINUED)		
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
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR
	S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS)
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF
2-055-21F	• TPR ADFM INTERIM	
IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE OR
	6	VOUCHER HEADER ADMIN CLAIM RATE- ELIGIBLE
AND ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	GF	TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADSM
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
	O	NOAA OR
	Z	NOT PROVIDED FROM DEERS
AND HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (CONTINUED)		
	G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J	ACADEMY STUDENT 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	PRE-ADOPTIVE CHILD OR
	E	WARD (COURT ORDERED)
2-055-22F	• TFL [ACTIVE DUTY FAMILY MEMBER]	
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 =	FE	TFL - EXTRA OR
	FS	TFL - STANDARD
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	R	MEDICARE/TRICARE DUAL ENTITLEMENT - FIRST PAYOR OR
	T	MEDICARE/TRICARE DUAL ENTITLEMENT - SECOND PAYOR OR
	RS	MEDICARE/TRICARE DUAL ENTITLEMENT - FIRST PAYOR NO TRICARE PROVIDER CERTIFICATION
AND HCC MEMBER CATEGORY CODE =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR
	S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS)
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (CONTINUED)

		O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A	ARMY OR	
	C	COAST GUARD OR	
	F	AIR FORCE OR	
	H	PUBLIC HEALTH SERVICE OR	
	M	MARINES OR	
	N	NAVY OR	
	O	NOAA OR	
	Z	NOT PROVIDED FROM DEERS	
AND HCC MEMBER RELATIONSHIP CODE MUST ¼	A	SELF	
AND OTHER GOVERNMENT PROGRAM TYPE CODE MUST =	A	MEDICARE PART A OR	
	C	MEDICARE PART A & B OR	
	H	MEDICARE HMO	
2-055-25F			• NON-FINANCIALLY UNDERWRITTEN BANK ACCOUNT VALIDATION
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR	
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR	
THEN BYPASS THIS EDIT			
ELSE IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE OR	
	6	VOUCHER HEADER ADMIN CLAIM RATE-ELIGIBLE	
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR	
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR	
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR	
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI	
AND ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	V	FINANCIALLY UNDERWRITTEN PAYMENT BY CLAIMS PROCESSOR	

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (CONTINUED)

THEN BATCH/VOUCHER ASAP ACCOUNT NUMBER HEADER TYPE FOUND IN THE TMA DATABASE MUST ≠	AS	ARMY SHCP CLIN OR
	FS	AIR FORCE SHCP CLIN OR
	NS	NAVY SHCP CLIN OR
	TD	TRICARE DOMESTIC ASAP OR
	TF	TRICARE FOREIGN ASAP
2-055-28F	•	FOREIGN ADFM
OR IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
THEN BYPASS THIS EDIT		
ELSE IF HEADER TYPE INDICATOR =	5	NON-CLAIM RATE VOUCHER OR
	6	CLAIM RATE VOUCHER
AND ENROLLMENT CODE/ HEALTH PLAN CODE =	XF	FOREIGN ADFM
AND TYPE OF SUBMISSION NOT =	B	ADJUSTMENT TO NON-TED RECORD OR
	D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
	E	COMPLETE CANCELLATION NON-TED RECORD OR
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN THE TMA DATABASE MUST =	TF	TRICARE FOREIGN
OR CONTRACT NUMBER =		MDA906-02-C-0013 (TMOP) OR MDA906-03-C-0019 (TRRx)
AND SERVICE BRANCH CLASSIFICATION CODE MUST =	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (CONTINUED)	
	N NAVY OR
	O NOAA OR
	Z UNKNOWN
AND HCC MEMBER CATEGORY CODE MUST =	A ACTIVE DUTY OR
	G NATIONAL GUARD > 30 DAYS OR
	J ACADEMY STUDENT OR
	N NATIONAL GUARD < 30 DAYS OR
	S RESERVE > 30 DAYS OR
	T FOREIGN MILITARY MEMBER OR
	V RESERVE < 30 DAYS
AND HCC MEMBER RELATIONSHIP CODE MUST ≠	A SELF
2-055-29F • TPR FOREIGN EDITS (ADFM)	
OR IF ANY OCCURRENCE OF OVERRIDE CODE =	H1 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
THEN BYPASS THIS EDIT	
ELSE IF HEADER TYPE INDICATOR =	5 NON-CLAIM RATE VOUCHER OR
	6 CLAIM RATE VOUCHER
AND ENROLLMENT CODE/ HEALTH PLAN CODE =	WO TPR FOREIGN ADFM
AND TYPE OF SUBMISSION NOT =	B ADJUSTMENT TO NON-TED RECORD OR
	D COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
	E COMPLETE CANCELLATION NON-TED RECORD OR
	O ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN THE TMA DATABASE MUST =	TF TRICARE FOREIGN
OR CONTRACT NUMBER =	MDA906-02-C-0013 (TMOP) OR
	MDA906-03-C-0019 (TRRx)

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (CONTINUED)

AND SERVICE BRANCH CLASSIFICATION CODE MUST =		A	ARMY OR
		C	COAST GUARD OR
		F	AIR FORCE OR
		H	PUBLIC HEALTH SERVICE OR
		M	MARINES OR
		N	NAVY OR
		O	NOAA OR
		Z	UNKNOWN
AND HCC MEMBER CATEGORY CODE MUST =		A	ACTIVE DUTY OR
		G	NATIONAL GUARD > 30 DAYS OR
		J	ACADEMY STUDENT OR
		S	RESERVE > 30 DAYS
AND HCC MEMBER RELATIONSHIP CODE MUST =		B	SPOUSE OR
		C	CHILD OR
		D	PRE-ADOPTIVE CHILD OR
		E	WARD
2-055-30F	• NAVY LINE OF DUTY CLAIMS		
IF ANY OCCURRENCE OF OVERRIDE CODE =		H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN /ASAP NUMBER, CONTRACTOR ERROR OR
		H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN /ASAP NUMBER, GOVERNMENT CAUSED ERROR
THEN BYPASS THIS EDIT			
ELSE IF HEADER TYPE INDICATOR =		5	NON-CLAIM RATE VOUCHER OR
		6	CLAIM RATE VOUCHER
AND CONTRACT NUMBER =		MDA906-03-0010 (SOUTH)	
AND BATCH/VOUCHER ASAP ACCOUNT NUMBER POSITION 8 =		5	
THEN SERVICE BRANCH CLASSIFICATION CODE MUST =		N	NAVY OR
		Z	UNKNOWN
2-055-31F	• MARINE LINE OF DUTY CLAIMS		
IF ANY OCCURRENCE OF OVERRIDE CODE =		H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN /ASAP NUMBER, CONTRACTOR ERROR OR

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (CONTINUED)

H2 BENEFIT PAYMENT MADE USING
INCORRECT BATCH/VOUCHER **CLIN**/ASAP
NUMBER, GOVERNMENT CAUSED ERROR

THEN BYPASS THIS EDIT

ELSE IF HEADER TYPE
INDICATOR =

5 NON-CLAIM RATE VOUCHER **OR**
6 CLAIM RATE VOUCHER

AND CONTRACT NUMBER = MDA906-03-0010 (SOUTH)

AND BATCH/VOUCHER ASAP ACCOUNT NUMBER POSITION 8 = 6

THEN SERVICE BRANCH
CLASSIFICATION CODE
MUST =

M MARINE **OR**
Z UNKNOWN

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CHAPTER 2, SECTION 8.1

FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: AGR SERVICE LEGAL AUTHORITY CODE (2-056)

VALIDITY EDITS

REFER TO [CHAPTER 2, SECTION 6.1](#)

RELATIONAL EDITS

2-056-01F	IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE OR
		6	VOUCHER HEADER ADMIN CLAIM RATE-ELIGIBLE
	AND HCC MEMBER CATEGORY CODE =	G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE)
	AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT NON-TED RECORD (HCSR) DATA OR
		D	COMPLETE DENIAL INITIAL TED RECORD SUBMISSION OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
		O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
	THEN AGR SERVICE LEGAL AUTHORITY CODE MUST =	A	AGR UNDER 10 U.S.C. 10301 (REFERENCE (B)) OR
		B	AGR UNDER 10 U.S.C. 10211 (REFERENCE (B)) OR
		C	AGR UNDER 10 U.S.C. 12301(D) (REFERENCE (B)) OR
		D	AGR UNDER 10 U.S.C. 12310 (REFERENCE (B)) OR
		E	AGR UNDER 10 U.S.C. 12501 (REFERENCE (B)) OR
		F	AGR UNDER 10 U.S.C. 3015/301938019 (REFERENCE (B)) OR
		G	AGR UNDER 10 U.S.C. 3033/8033 (REFERENCE (B)) OR
		H	AGR UNDER 10 U.S.C. 3496/8496 (REFERENCE (B)) OR
		I	AGR: 14 U.S.C. 276 OR
		J	AGR UNDER 32 U.S.C. 502(F) (REFERENCE (M)) OR
		K	AGR UNDER 32 U.S.C. 503 (REFERENCE (M)) OR
		L	AGR UNDER 32 U.S.C. 708 (REFERENCE (M)) OR
		X	AGR: OTHER OR
		Z	UNKNOWN/NOT APPLICABLE

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CHAPTER 2, SECTION 8.1

FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: ADMINISTRATIVE CLIN (2-108)

VALIDITY EDITS

REFER TO [CHAPTER 2, SECTION 5.2](#)

RELATIONAL EDITS

2-108-02F	• NO DUPLICATE CLINS ON TED RECORD
IF HEADER TYPE INDICATOR =	6 VOUCHER HEADER (USED ONLY FOR INSTITUTIONAL/NON-INSTITUTIONAL NON-FINANCIALLY UNDERWRITTEN ADMIN CLAIM RATE ELIGIBLE TED RECORDS) OR
	9 BATCH HEADER (INSTITUTIONAL/NON-INSTITUTIONAL FINANCIALLY UNDERWRITTEN ADMIN CLAIM RATE ELIGIBLE TED RECORDS)
THEN ANY OCCURRENCE OF ADMINISTRATIVE CLIN (POSITIONS 3-6) MUST HAVE NO DUPLICATE IN ANY OCCURRENCES (DUPLICATE BLANK ADMINISTRATIVE CLIN OCCURRENCES ARE ALLOWED)	
2-108-11F	• NO BASE ADMINISTRATIVE PAYMENT FOR DENIAL OF SERVICES
IF HEADER TYPE INDICATOR =	6 VOUCHER HEADER (USED ONLY FOR INSTITUTIONAL/NON-INSTITUTIONAL NON-FINANCIALLY UNDERWRITTEN ADMIN CLAIM RATE ELIGIBLE TED RECORDS) OR
	9 BATCH HEADER (INSTITUTIONAL/NON-INSTITUTIONAL FINANCIALLY UNDERWRITTEN ADMIN CLAIM RATE ELIGIBLE TED RECORDS)
AND CONTRACT NUMBER = MDA906-02-C-0002 (TMOP)	
AND TYPE OF SUBMISSION =	D COMPLETE DENIAL
THEN RATE TYPE FOR CLIN IN THE TMA DATABASE MUST ≠	D DISPENSING FEE
2-108-16F¹	• OPTION PERIOD
IF HEADER TYPE INDICATOR =	6 CLAIM RATE VOUCHER OR
	9 CLAIM RATE BATCH
AND CLIN FIELD ON TED RECORD NOT = BLANK	
AND NET MASTER VALUE OF DERIVED ADMIN CLAIM COUNT FIELD = 0	
THEN IF TYPE OF SUBMISSION =	A ADJUSTMENT OR

ADMINISTRATIVE CLIN EDIT FAILURES ARE NOT COUNTED AGAINST THE CONTRACTORS PERFORMANCE STANDARDS. THE EDITS ARE DESIGNED TO INFORM THE CONTRACTORS WHEN REQUEST FOR AN ADMINISTRATIVE PAYMENT HAS BEEN DENIED BY TMA, CRM AND HOW TO CORRECT THE ERROR.

**¹ BYPASS EDIT 2-108-16F IF RECORD FAILS 2-108-02F.
 BYPASS EDIT 2-108-17F IF RECORD FAILS 2-108-02F OR 2-108-16F OR 2-108-18F.
 BYPASS EDIT 2-108-18F IF RECORD FAILS 2-108-02F OR 2-108-16F.
 ALL 2-108-XXF EDITS ARE BYPASSED FOR TYPE OF SUBMISSION 'C - COMPLETE CANCELLATION OF A TED RECORD'**

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CHAPTER 2, SECTION 8.1

FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: ADMINISTRATIVE CLIN (2-108) (CONTINUED)

B ADJUSTMENT NON-TED RECORD (HCSR) DATA OR

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

THEN THE CLIN MUST BE VALID IN THE CURRENT OR PRIOR OPTION PERIOD FOR THAT **CONTRACT** ON THE TMA DATABASE

ELSE THE CLIN MUST BE VALID IN THE CURRENT OPTION PERIOD FOR THAT **CONTRACT** ON THE TMA DATABASE.

2-108-17F¹ • CLIN MATCHES APPROPRIATION TYPE

IF HEADER TYPE INDICATOR = **6 CLAIM RATE VOUCHER OR**

9 CLAIM RATE BATCH

AND CLIN FIELD ON TED RECORD **NOT** = BLANK

AND NET MASTER VALUE OF DERIVED ADMIN CLAIM COUNT FIELD = 0

THEN THE APPROPRIATION ASSOCIATED WITH THE ADMINISTRATIVE CLIN CLAIMED ON THE TED RECORD MUST MATCH THE APPROPRIATION ASSOCIATED WITH THE BATCH/VOUCHER ASAP NUMBER ASSIGNED BY TMA/CRM AND USED IN THE VOUCHER HEADER.

THE APPROPRIATION ASSOCIATED WITH THE ADMINISTRATIVE CLIN CLAIMED ON THE TED RECORD MUST MATCH THE APPROPRIATION ASSOCIATED WITH THE BATCH/VOUCHER ASAP NUMBER ASSIGNED BY TMA/CRM AND USED IN THE VOUCHER HEADER.

2-108-18F¹ • CLIN vs. CLAIM FORM TYPE

IF HEADER TYPE INDICATOR = **6 CLAIM RATE VOUCHER OR**

9 CLAIM RATE BATCH

AND CLIN FIELD ON TED RECORD **NOT** = BLANK

AND NET MASTER VALUE OF DERIVED ADMIN CLAIM COUNT FIELD = 0

THEN THE RATE TYPE FOR THAT CLIN IN THE TMA DATABASE MUST = **D DISPENSING FEE OR**

S SINGLE

OR IF THE RATE TYPE FOR THAT CLIN IN THE TMA DATABASE = **E ELECTRONIC**

ADMINISTRATIVE CLIN EDIT FAILURES ARE NOT COUNTED AGAINST THE CONTRACTORS PERFORMANCE STANDARDS. THE EDITS ARE DESIGNED TO INFORM THE CONTRACTORS WHEN REQUEST FOR AN ADMINISTRATIVE PAYMENT HAS BEEN DENIED BY TMA, CRM AND HOW TO CORRECT THE ERROR.

¹ **BYPASS EDIT 2-108-16F IF RECORD FAILS 2-108-02F.**

BYPASS EDIT 2-108-17F IF RECORD FAILS 2-108-02F OR 2-108-16F OR 2-108-18F.

BYPASS EDIT 2-108-18F IF RECORD FAILS 2-108-02F OR 2-108-16F.

ALL 2-108-XXF EDITS ARE BYPASSED FOR TYPE OF SUBMISSION 'C - COMPLETE CANCELLATION OF A TED RECORD'

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CHAPTER 2, SECTION 8.1
FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: ADMINISTRATIVE CLIN (2-108) (CONTINUED)

	THEN THE CLAIM FORM TYPE/EMC INDICATOR ON THE TED RECORD MUST =	G	ELECTRONIC INSTITUTIONAL CLAIM SUBMISSION OR
		H	ELECTRONIC NON-INSTITUTIONAL CLAIM SUBMISSION OR
		I	ELECTRONIC DRUG CLAIM SUBMISSION
	OR IF RATE TYPE FOR THAT CLIN IN THE TMA DATABASE =	P	PAPER
	THEN THE CLAIM FORM TYPE/EMC INDICATOR ON THE TED RECORD MUST =	B	DD FORM 2642 OR
		C	HCFA FORM 1500 OR
		F	UB 92 OR
		J	OTHER
	OR IF RATE TYPE FOR THAT CLIN IN THE TMA DATABASE =	F	FOREIGN
	THEN THE THIRD CHARACTER OF THE FILING STATE/COUNTRY CODE ON THE TED MUST ≠ A SPACE.		
2-108-19F	• ONLY ONE BASE ADMINISTRATIVE PAYMENT PER EPISODE OF CARE		
	IF CONTRACT NUMBER =	MDA906-02-C-0002 (TMOP) OR MDA906-03-C-0019 (TRRx)	
	AND HEADER TYPE INDICATOR =	9	CLAIM RATE ELIGIBLE BATCH
	AND CLIN NOT = BLANK		
	THEN RATE TYPE FOR THAT CLIN IN THE TMA DATABASE MUST ≠	D	DISPENSING FEE OR
		E	ELECTRONIC OR
		P	PAPER

2-108-20F	• ONLY ONE BASE ADMINISTRATIVE PAYMENT PER EPISODE OF CARE		
	IF CONTRACT NUMBER =	MDA906-02-C-0002 (TMOP) OR	

ADMINISTRATIVE CLIN EDIT FAILURES ARE NOT COUNTED AGAINST THE CONTRACTORS PERFORMANCE STANDARDS. THE EDITS ARE DESIGNED TO INFORM THE CONTRACTORS WHEN REQUEST FOR AN ADMINISTRATIVE PAYMENT HAS BEEN DENIED BY TMA, CRM AND HOW TO CORRECT THE ERROR.

¹ **BYPASS EDIT 2-108-16F IF RECORD FAILS 2-108-02F.
BYPASS EDIT 2-108-17F IF RECORD FAILS 2-108-02F OR 2-108-16F OR 2-108-18F.
BYPASS EDIT 2-108-18F IF RECORD FAILS 2-108-02F OR 2-108-16F.
ALL 2-108-XXF EDITS ARE BYPASSED FOR TYPE OF SUBMISSION 'C - COMPLETE CANCELLATION OF A TED RECORD'**

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CHAPTER 2, SECTION 8.1

FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: ADMINISTRATIVE CLIN (2-108) (CONTINUED)

MDA906-03-C-0019 (TRRx)

AND HEADER TYPE
INDICATOR =

6

CLAIM RATE ELIGIBLE VOUCHER

THEN RATE TYPE FOR
THAT CLIN IN THE TMA
DATABASE ≠

S

SINGLE RATE

ADMINISTRATIVE CLIN EDIT FAILURES ARE NOT COUNTED AGAINST THE CONTRACTORS PERFORMANCE STANDARDS. THE EDITS ARE DESIGNED TO INFORM THE CONTRACTORS WHEN REQUEST FOR AN ADMINISTRATIVE PAYMENT HAS BEEN DENIED BY TMA, CRM AND HOW TO CORRECT THE ERROR.

¹ **BYPASS EDIT 2-108-16F IF RECORD FAILS 2-108-02F.**

BYPASS EDIT 2-108-17F IF RECORD FAILS 2-108-02F OR 2-108-16F OR 2-108-18F.

BYPASS EDIT 2-108-18F IF RECORD FAILS 2-108-02F OR 2-108-16F.

ALL 2-108-XXF EDITS ARE BYPASSED FOR TYPE OF SUBMISSION 'C - COMPLETE CANCELLATION OF A TED RECORD'

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CHAPTER 2, SECTION 8.1

FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: AMOUNT INTEREST PAYMENT (2-112)

VALIDITY EDITS

REFER TO [CHAPTER 2, SECTION 2.4](#).

RELATIONAL EDITS

2-112-01F • INTEREST VALIDATION ON PHARMACY BATCHES

IF CONTRACT NUMBER = MDA906-02-C-0002 (TMOP) **OR**
MDA906-03-C-0019 (TRRx)

AND HEADER TYPE
INDICATOR = 0 NON-CLAIM RATE BATCH **OR**
9 CLAIM RATE BATCH

THEN AMOUNT INTEREST PAYMENT MUST = ZERO

ELEMENT NAME: AMOUNT PATIENT COST-SHARE (2-200)

VALIDITY EDITS

REFER TO [CHAPTER 2, SECTION 2.4](#).

RELATIONAL EDITS

2-200-01F • COST-SHARE VALIDATION ON PHARMACY BATCHES

IF CONTRACT NUMBER = MDA906-02-C-0002 (TMOP) **OR**
MDA906-03-C-0019 (TRRx)

AND HEADER TYPE
INDICATOR = 0 NON-CLAIM RATE BATCH **OR**
9 CLAIM RATE BATCH

THEN AMOUNT PATIENT COST-SHARE MUST = ZERO

DATA REQUIREMENTS - COUNTRY AND/OR ISLANDS CODES

REGION ¹	TRICARE RESERVE SELECT REGION ⁴	TRICARE COUNTRY AND/OR ISLAND	CODE
13	20	Afghanistan	AFG
13	20	Aland Islands	ALA
13	20	Albania	ALB
13	20	Algeria	DZA
14	21	American Samoa	ASM
13	20	Andorra	AND
13	20	Angola	AGO
15	22	Anguilla	AIA
14	21	Antartica	ATA
15	22	Antigua and Barbuda	ATG
15	22	Argentina	ARG
13	20	Armenia	ARM
15	22	Aruba	ABW
14	21	Australia	AUS
13	20	Austria	AUT
13	20	Azerbaijan	AZE
15	22	Bahamas	BHS

In accordance with HIPAA requirements, TRICARE utilizes the International Organization for Standardization (ISO) 3166 for country and island code determination. The ISO 3166 can also be used if more detailed information is required to assign territories and islands into these countries.

¹ OCONUS Region: Region 13 = Europe, Region 14 = Pacific, and Region 15 = Latin America.

² The TRICARE Southeast (Region 3)/Latin America & Canada (Region 15 and Region 22) Regional Director is responsible for health care support for beneficiaries residing in Canada (CA), as well as for beneficiaries residing in Puerto Rico and the Virgin Islands.

³ Edits 1-020-01 and 2-020-01 use this table to check validity.

⁴ OCONUS TRICARE Reserve Select Region: Region 20 = Europe, Region 21 = Pacific, and Region 22 = Latin America.

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CHAPTER 2, ADDENDUM A

DATA REQUIREMENTS - COUNTRY AND/OR ISLANDS CODES

REGION ¹	TRICARE RESERVE SELECT REGION ⁴	TRICARE COUNTRY AND/OR ISLAND (CONTINUED)	CODE
13	20	Bahrain	BHR
14	21	Bangladesh	BGD
15	22	Barbados	BRB
13	20	Belarus	BLR
13	20	Belgium	BEL
15	22	Belize	BLZ
13	20	Benin	BEN
15	22	Bermuda	BMU
14	21	Bhutan	BTN
15	22	Bolivia	BOL
13	20	Bosnia and Herzegovina	BIH
13	20	Botswana	BWA
13	20	Bouvet Island	BVT
15	22	Brazil	BRA
14	21	British Indian Ocean Territory	IOT
15	22	British Virgin Islands	VGB
15	22	Brunei Darussalam	BRN
13	20	Bulgaria	BGR
13	20	Burkina Faso (formerly Upper Volta)	BFA
13	20	Burundi	BDI
14	21	Cambodia (formerly Khmer Republic/Kampuchea, Democratic)	KHM
13	20	Cameroon	CMR
15	22	Canada ²	CAN

In accordance with HIPAA requirements, TRICARE utilizes the International Organization for Standardization (ISO) 3166 for country and island code determination. The ISO 3166 can also be used if more detailed information is required to assign territories and islands into these countries.

¹ OCONUS Region: Region 13 = Europe, Region 14 = Pacific, and Region 15 = Latin America.

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⁴ OCONUS TRICARE Reserve Select Region: Region 20 = Europe, Region 21 = Pacific, and Region 22 = Latin America.

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DATA REQUIREMENTS - COUNTRY AND/OR ISLANDS CODES

REGION ¹	TRICARE RESERVE SELECT REGION ⁴	TRICARE COUNTRY AND/OR ISLAND (CONTINUED)	CODE
13	20	Cape Verde	CPV
15	22	Cayman Islands	CYM
13	20	Central African Republic	CAF
13	20	Chad	TCD
15	22	Chile	CHL
14	21	China	CHN
14	21	Christmas Island	CXR
14	21	Cocos (Keeling) Islands	CCK
15	22	Columbia	COL
13	20	Comoros	COM
13	20	Congo (formerly Zaire)	COG
13	20	Congo, the Democratic Republic of the	COD
14	21	Cook Islands	COK
15	22	Costa Rica	CRI
13	20	Cote D'Ivoire	CIV
15	22	Cuba	CUB
13	20	Croatia	HRV
13	20	Cyprus	CYP
13	20	Czech Republic	CZE
13	20	Denmark	DNK
13	20	Djibouti (formerly French Afars and Issass)	DJI
15	22	Dominica	DMA
15	22	Dominican Republic	DOM
15	22	Ecuador	ECU

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DATA REQUIREMENTS - COUNTRY AND/OR ISLANDS CODES

REGION¹	TRICARE RESERVE SELECT REGION⁴	TRICARE COUNTRY AND/OR ISLAND (CONTINUED)	CODE
13	20	Egypt	EGY
15	22	El Salvador	SLV
13	20	Equatorial Guinea	GNQ
13	20	Eritrea	ERI
13	20	Estonia	EST
13	20	Ethiopia	ETH
15	22	Falkland Islands (Malvinas)	FLK
13	20	Faroe Island	FRO
14	21	Fiji	FJI
13	20	Finland	FIN
13	20	France	FRA
15	22	French Guiana	GUF
14	21	French Polynesia	PYF
14	21	French Southern Territories	ATF
13	20	Gabon	GAB
13	20	Gambia	GMB
13	20	Georgia	GEO
13	20	Germany	DEU
13	20	Ghana	GHA
13	20	Gibraltar	GIB
13	20	Greece	GRC
13	20	Greenland	GRL
15	22	Grenada	GRD
15	22	Guadeloupe	GLP

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DATA REQUIREMENTS - COUNTRY AND/OR ISLANDS CODES

REGION ¹	TRICARE RESERVE SELECT REGION ⁴	TRICARE COUNTRY AND/OR ISLAND (CONTINUED)	CODE
14	21	Guam	GUM
15	22	Guatemala	GTM
13	20	Guinea	GIN
13	20	Guinea-Bissau (formerly Portuguese Guinea)	GNB
15	22	Guyana	GUY
15	22	Haiti	HTI
14	21	Heard Island and McDonald Islands	HMD
13	20	Holy See (formerly Vatican City State)	VAT
15	22	Honduras	HND
14	21	Hong Kong	HKG
13	20	Hungary	HUN
13	20	Iceland	ISL
14	21	India	IND
14	21	Indonesia	IDN
13	20	Iran, Islamic Republic of	IRN
13	20	Iraq	IRQ
13	20	Ireland	IRL
13	20	Israel	ISR
13	20	Italy	ITA
15	22	Jamaica	JAM
14	21	Japan	JPN
13	20	Jordan	JOR
13	20	Kazakhstan	KAZ
13	20	Kenya	KEN

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DATA REQUIREMENTS - COUNTRY AND/OR ISLANDS CODES

REGION ¹	TRICARE RESERVE SELECT REGION ⁴	TRICARE COUNTRY AND/OR ISLAND (CONTINUED)	CODE
14	21	Kiribati (formerly Gilbert Islands)	KIR
14	21	Korea, Democratic People's Republic of	PRK
14	21	Korea, Republic of	KOR
13	20	Kuwait	KWT
13	20	Kyrgyzstan	KGZ
14	21	Lao People's Democratic Republic	LAO
13	20	Latvia	LVA
13	20	Lebanon	LBN
13	20	Lesotho	LSO
13	20	Liberia	LBR
13	20	Libyan Arab Jamahiriya	LBY
13	20	Liechtenstein	LIE
13	20	Lithuania	LTU
13	20	Luxembourg	LUX
14	21	Macao	MAC
13	20	Macedonia, the Former Yugoslav Republic of	MKD
14	21	Madagascar	MDG
13	20	Malawi	MWI
14	21	Malaysia	MYS
14	21	Maldives	MDV
13	22	Mali	MLI
13	20	Malta	MLT
14	21	Marshall Islands	MHL
15	22	Martinique	MTQ

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DATA REQUIREMENTS - COUNTRY AND/OR ISLANDS CODES

REGION ¹	TRICARE RESERVE SELECT REGION ⁴	TRICARE COUNTRY AND/OR ISLAND (CONTINUED)	CODE
13	20	Mauritania	MRT
14	21	Mauritius	MUS
14	21	Mayotte	MYT
15	22	Mexico	MEX
14	21	Micronesia, Federated States of	FSM
13	20	Moldova, Republic of	MDA
13	20	Monaco	MCO
14	21	Mongolia	MNG
15	22	Montserrat	MSR
13	20	Morocco	MAR
13	20	Mozambique	MOZ
14	21	Myanmar (formerly Burma)	MMR
13	20	Namibia	NAM
14	21	Nauru	NRU
14	21	Nepal	NPL
13	20	Netherlands	NLD
15	22	Netherlands Antilles	ANT
14	21	New Caledonia	NCL
14	21	New Zealand	NZL
15	22	Nicaragua	NIC
13	20	Niger	NER
13	20	Nigeria	NGA
14	21	Niue	NIU
14	21	Norfolk Island	NFK

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DATA REQUIREMENTS - COUNTRY AND/OR ISLANDS CODES

REGION ¹	TRICARE RESERVE SELECT REGION ⁴	TRICARE COUNTRY AND/OR ISLAND (CONTINUED)	CODE
14	21	Northern Mariana Islands	MNP
13	20	Norway	NOR
13	20	Oman (formerly Muscat and Oman)	OMN
13	20	Pakistan	PAK
14	21	Palau	PLW
13	20	Palestinian Territory, Occupied	PSE
15	22	Panama	PAN
14	21	Papua New Guinea	PNG
15	22	Paraguay	PRY
15	22	Peru	PER
14	21	Philippines	PHL
14	21	Pitcairn	PCN
13	20	Poland	POL
13	20	Portugal	PRT
15	22	Puerto Rico ²	PRI
13	20	Qatar	QAT
14	21	Reunion	REU
13	20	Romania	ROU
13	20	Russian Federation	RUS
13	20	Rwanda	RWA
13	20	Saint Helena	SHN
14	21	Saint Kitts and Nevis	KNA
15	22	Saint Lucia	LCA
13	20	Saint Pierre and Miquelon	SPM

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DATA REQUIREMENTS - COUNTRY AND/OR ISLANDS CODES

REGION ¹	TRICARE RESERVE SELECT REGION ⁴	TRICARE COUNTRY AND/OR ISLAND (CONTINUED)	CODE
15	22	Saint Vincent and the Grenadines	VCT
15	22	Samoa	WSM
13	20	San Marino	SMR
13	20	Sao Tome and Principe	STP
13	20	Saudi Arabia	SAU
13	20	Senegal	SEN
13	20	Serbia and Montenegro (formerly Yugoslavia)	SCG
13	20	Seychelles	SYC
13	20	Sierra Leone	SLE
14	21	Singapore	SGP
13	20	Slovakia	SVK
13	20	Slovenia	SVN
14	21	Solomon Islands (formerly British Solomon Islands)	SLB
13	20	Somalia	SOM
13	20	South Africa	ZAF
15	22	South Georgia and the South Sandwich Islands	SGS
13	20	Spain	ESP
14	21	Sri Lanka (formerly Ceylon)	LKA
13	20	Sudan	SDN
15	22	Suriname	SUR
13	20	Svalbard and Jan Mayen	SJM
13	20	Swaziland	SWZ
13	20	Sweden	SWE
13	20	Switzerland	CHE

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DATA REQUIREMENTS - COUNTRY AND/OR ISLANDS CODES

REGION¹	TRICARE RESERVE SELECT REGION⁴	TRICARE COUNTRY AND/OR ISLAND (CONTINUED)	CODE
13	20	Syrian Arab Republic	SYR
14	21	Taiwan, Province of China	TWN
13	20	Tajikistan	TJK
13	20	Tanzania, United Republic of	TZA
14	21	Thailand	THA
14	21	Timor-Leste, Democratic Republic of	TLS
13	20	Togo	TGO
14	21	Tokelau	TKL
14	21	Tonga	TON
15	22	Trinidad and Tobago	TTO
13	20	Tunisia	TUN
13	20	Turkey	TUR
13	20	Turkmenistan	TKM
15	22	Turks and Caicos Islands	TCA
14	21	Tuvalu	TUV
13	20	Uganda	UGA
13	20	Ukraine	UKR
13	20	United Arab Emirates (formerly Trucial States)	ARE
13	20	United Kingdom	GBR
15	22	Uruguay	URY
13	20	Uzbekistan	UZB
14	21	Vanuatu (formerly New Hebrides)	VUT
15	22	Venezuela	VEN
14	21	Viet Nam	VNM

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DATA REQUIREMENTS - COUNTRY AND/OR ISLANDS CODES

REGION ¹	TRICARE RESERVE SELECT REGION ⁴	TRICARE COUNTRY AND/OR ISLAND (CONTINUED)	CODE
15	22	Virgin Islands, British	VGB
15	22	Virgin Islands, U.S. ²	VIR
14	21	Wallis and Futuna	WLF
13	20	Western Sahara (formerly Spanish Sahara)	ESH
13	20	Yemen	YEM
13	20	Zambia	ZMB
13	20	Zimbabwe (formerly Southern Rhodesia)	ZWE

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DATA REQUIREMENTS - PROVIDER'S MAJOR SPECIALTY CODES

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES

TED CODE	SPECIALITY DESCRIPTION
AGENCIES	
251B00000X	Case Management
251C00000X	Day Training, Developmentally Disabled Services
251E00000X	Home Health
251F00000X	Home Infusion
251G00000X	Hospice Care, Community Based
251300000X	Local Education Agency (LEA)
251J00000X	Nursing Care
251K00000X	Public Health or Welfare
251V00000X	Voluntary or Charitable
NOTES AND SPECIAL INSTRUCTIONS:	
The provider taxonomy codes (currently Version 6.0) are maintained by the National Uniform Claim Committee (NUCC). The list is scheduled to be updated twice a year (April & October).	

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 DATA REQUIREMENTS - PROVIDER'S MAJOR SPECIALTY CODES

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
ALLOPATHIC AND OSTEOPATHIC PHYSICIANS	
207K00000X	Allergy & Immunology
207KA0200X	Allergy
207K10005X	Clinical & Laboratory Immunology
207L00000X	Anesthesiology
207LA0401X	Addiction Medicine
207LC0200X	Critical Care Medicine
207LP2900X	Pain Medicine
208U00000X	Clinical Pharmacology
208C00000X	Colon & Rectal Surgery
207N00000X	Dermatology
207NI0002X	Clinical Laboratory Dermatological Immunology
207NS0135X	Dermatological Surgery
207ND0900X	Dermatopathology
207ND0101X	MOHS-Micrographic Surgery
207NP0225X	Pediatric Dermatology
207P00000X	Emergency Medicine
207PE0004X	Emergency Medical Services
207PT0002X	Medical Toxicology
207PP0204X	Pediatric Emergency Medicine
207PS0010X	Sports Medicine
207PE0005X	Undersea & Hyperbaric Medicine
207Q00000X	Family Practice
207QA0401X	Addiction Medicine
207QA0000X	Adolescent Medicine
207QA0505X	Adult Medicine
207QG0300X	Geriatric Medicine
207QS0010X	Sports Medicine
208D00000X	General Practice
208M00000X	Hospitalist
207R00000X	Internal Medicine
207RA0401X	Addiction Medicine

NOTES AND SPECIAL INSTRUCTIONS:

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 DATA REQUIREMENTS - PROVIDER'S MAJOR SPECIALTY CODES

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALTY DESCRIPTION (CONTINUED)
ALLOPATHIC AND OSTEOPATHIC PHYSICIANS (CONTINUED)	
207RA0000X	Adolescent Medicine
207RA0201X	Allergy & Immunology
207RC0000X	Cardiovascular Disease
207RI0001X	Clinical & Laboratory Immunology
207RC0001X	Clinical Cardiac Electrophysiology
207RC0200X	Critical Care Medicine
207RE0101X	Endocrinology, Diabetes & Metabolism
207RG0100X	Gastroenterology
207RG0300X	Geriatric Medicine
207RH0000X	Hematology
207RH0003X	Hematology & Oncology
207RI0008X	Hepatology
207RI0200X	Infectious Disease
207RI0011X	Interventional Cardiology
207RM1200X	Magnetic Resonance Imaging (MRI)
207RX0202X	Medical Oncology
207RN0300X	Nephrology
207RP1001X	Pulmonary Disease
207RR0500X	Rheumatology
207RS0010X	Sports Medicine
209800000X	Legal Medicine
	Medical Genetics
207SG0202X	Clinical Biochemical Genetics
207SC0300X	Clinical Cytogenetics
207SG0201X	Clinical Genetics (M.D.)
207SG0203X	Clinical Molecular Genetics
207SM0001X	Molecular Genetic Pathology
207SG0205X	Ph.D. Medical Genetics
207T00000X	Neurological Surgery
204D00000X	Neuromusculoskeletal Medicine & OMM
204C00000X	Neuromusculoskeletal Medicine, Sports Medicine

NOTES AND SPECIAL INSTRUCTIONS:

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 DATA REQUIREMENTS - PROVIDER'S MAJOR SPECIALTY CODES

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION (CONTINUED)
ALLOPATHIC AND OSTEOPATHIC PHYSICIANS (CONTINUED)	
207U00000X	Nuclear Medicine
207UN0903X	In Vivo & In Vitro Nuclear Medicine
207UN0901X	Nuclear Cardiology
207UN0902X	Nuclear Imaging & Therapy
207V00000X	Obstetrics & Gynecology
207VC0200X	Critical Care Medicine
207VX0201X	Gynecologic Oncology
207VG0400X	Gynecology
207VM0101X	Maternal & Fetal Medicine
207VX0000X	Obstetrics
207VE0102X	Reproductive Endocrinology
207W00000X	Ophthalmology
204E00000X	Oral & Maxillofacial Surgery
207X00000X	Orthopedic Surgery
207XS0114X	Adult Reconstructive Orthopedic Surgery
207XX0004X	Foot and Ankle Orthopedics
207XS0106X	Hand Surgery
207XS0117X	Orthopedic Surgery of the Spine
207XX0801X	Orthopedic Trauma
207XX0005X	Sports Medicine
207Y00000X	Otolaryngology
207YS0123X	Facial Plastic Surgery
207YX0602X	Otolaryngic Allergy
207YX0905X	Otolaryngology/Facial Plastic Surgery
207YX0901X	Otology & Neurotology
207YP0228X	Pediatric Otolaryngology
207YX0007X	Plastic Surgery Within the Head and Neck
	Pain Medicine
208VP0014X	Interventional Pain Management
208VP0000X	Pain Medicine

NOTES AND SPECIAL INSTRUCTIONS:

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 DATA REQUIREMENTS - PROVIDER'S MAJOR SPECIALTY CODES

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALTY DESCRIPTION (CONTINUED)
ALLOPATHIC AND OSTEOPATHIC PHYSICIANS (CONTINUED)	
Pathology	
207ZP0101X	Anatomic Pathology
207ZP0102X	Anatomic Pathology & Clinical Pathology
207ZB0001X	Blood Banking & Transfusion Medicine
207ZP0104X	Chemical Pathology
207ZP0105X	Clinical Pathology/Laboratory Medicine
207ZC0500X	Cytopathology
207ZD0900X	Dermatopathology
207ZF0201X	Forensic Pathology
207ZH0000X	Hematology
207ZI0100X	Immunopathology
207ZM0300X	Medical Microbiology
207ZP0007X	Molecular Genetic Pathology
207ZN0500X	Neuropathology
207ZP0213X	Pediatric Pathology
Pediatrics	
2080A0000X	Adolescent Medicine
2080I0007X	Clinical & Laboratory Immunology
2080P0006X	Developmental - Behavioral Pediatrics
2080T0002X	Medical Toxicology
2080N0001X	Neonatal-Perinatal Medicine
2080P0008X	Neurodevelopmental Disabilities
2080P0201X	Pediatric Allergy & Immunology
2080P0202X	Pediatric Cardiology
2080P0203X	Pediatric Critical Care Medicine
2080P0204X	Pediatric Emergency Medicine
2080P0205X	Pediatric Endocrinology
2080P0206X	Pediatric Gastroenterology
2080P0207X	Pediatric - Hematology Oncology
2080P0208X	Pediatric Infectious Diseases
2080P0210X	Pediatric Nephrology

NOTES AND SPECIAL INSTRUCTIONS:

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TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002
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 DATA REQUIREMENTS - PROVIDER'S MAJOR SPECIALTY CODES

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION (CONTINUED)
ALLOPATHIC AND OSTEOPATHIC PHYSICIANS (CONTINUED)	
2080P0214X	Pediatric Pulmonology
2080P0216X	Pediatric Rheumatology
2080S0010X	Sports Medicine
208100000X	Physical Medicine & Rehabilitation
2081P2900X	Pain Medicine
2081P0010X	Pediatric Rehabilitation Medicine
2081P0004X	Spinal Cord Injury Medicine
2081S0010X	Sports Medicine
208200000X	Plastic Surgery
2082S0099X	Plastic Surgery Within the Head and Neck
2082S0105X	Surgery of the Hand
	Preventive Medicine
2083A0100X	Aerospace Medicine
2083T0002X	Medical Toxicology
2083X0100X	Occupational Medicine
2083P0500X	Preventive Medicine/Occupational Environmental Medicine
2083P0901X	Public Health & General Preventive Medicine
2083S0010X	Sports Medicine
2083P0011X	Underseas & Hyperbaric Medicine
	Psychiatry & Neurology
2084A0401X	Addiction Medicine
2084P0802X	Addiction Psychiatry
2084P0804X	Child & Adolescent Psychiatry
2084N0600X	Clinical Neurophysiology
2084F0202X	Forensic Psychiatry
2084P0805X	Geriatric Psychiatry
2084P0005X	Neurodevelopmental Disabilities
2084N0400X	Neurology
2084N0402X	Neurology with Special Qualifications in Child Neurology
2084P2900X	Pain Medicine
2084P0800X	Psychiatry

NOTES AND SPECIAL INSTRUCTIONS:

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 DATA REQUIREMENTS - PROVIDER'S MAJOR SPECIALTY CODES

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALTY DESCRIPTION (CONTINUED)
ALLOPATHIC AND OSTEOPATHIC PHYSICIANS (CONTINUED)	
2084S0010X	Sports Medicine
2084V0102X	Vascular Neurology
	Radiology
2085B0100X	Body Imaging
2085R0202X	Diagnostic Radiology
2085U0001X	Diagnostic Ultrasound
2085N0700X	Neuroradiology
2085N0904X	Nuclear Radiology
2085P0229X	Pediatric Radiology
2085R0001X	Radiation Oncology
2085R0205X	Radiological Physics
2085R0203X	Therapeutic Radiology
2085R0204X	Vascular & Interventional Radiology
208600000X	Surgery
2086S0120X	Pediatric Surgery
2086S0122X	Plastic & Reconstructive Surgery
2086S0105X	Surgery of the Hand
2086S0102X	Surgical Critical Care
2086X0206X	Surgical Oncology
2086S0127X	Trauma Surgery
2086S0129X	Vascular Surgery
208G00000X	Thoracic Surgery
204F00000X	Transplant Surgery
208800000X	Urology

NOTES AND SPECIAL INSTRUCTIONS:

The provider taxonomy codes (currently Version 6.0) are maintained by the National Uniform Claim Committee (NUCC). The list is scheduled to be updated twice a year (April & October).

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
AMBULATORY HEALTH CARE FACILITIES	
261Q00000X	Clinic/Center
261QM0855X	Adolescent and Children Mental Health
261QA0600X	Adult Day Care
261QM0850X	Adult Mental Health
261QA0005X	Ambulatory Family Planning Facility
261QA0006X	Ambulatory Fertility Facility
261QA1903X	Ambulatory Surgical
261QA0900X	Amputee
261QA3000X	Augmentative Communication
261QB0400X	Birthing
261QC1500X	Community Health
261QC1800X	Corporate Health
261QC0050X	Critical Access Hospital
261QD0000X	Dental
261QD1600X	Developmental Disabilities
261QE0002X	Emergency Care
261QE0800X	Endoscopy
261QE0700X	End-Stage Renal Disease (ESRD) Treatment
261QF0050X	Family Planning, Non-Surgical
261QF0400X	Federally Qualified Health Center (FQHC)
261QG0250X	Genetics
261QH0100X	Health
261QH0700X	Hearing and Speech
261QI0500X	Infusion Therapy
261QL0400X	Lithotripsy
261QM1200X	Magnetic Resonance Imaging (MRI)
261QM2500X	Medical Specialty
261QM3000X	Medically Fragile Infants and Children Day Care
261QM0801X	Mental Health (Including Community Mental Health Center)
261QM2800X	Methadone
261QM1000X	Migrant Health

NOTES AND SPECIAL INSTRUCTIONS:

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALTY DESCRIPTION (CONTINUED)
AMBULATORY HEALTH CARE FACILITIES (CONTINUED)	
261QM1100X	Military
261QM1103X	Military Ambulatory Procedure Visits Operational (Transportable)
261QM1102X	Military Operational (Transportable) Component
261QM1101X	Military Outpatient Ambulatory Procedure
261QM1300X	Multi-Specialty
261QX0100X	Occupational Medicine
261QX0200	Oncology
261QX0203X	Oncology, Radiation
261QS0132X	Ophthalmologic Surgery
261QS0112X	Oral & Maxillofacial Surgery
261QP3300X	Pain
261QP2000X	Physical Therapy
261QP1100X	Podiatric
261QP2300X	Primary Care
261QP2400X	Prison Health
261QP0904X	Public Health, Federal
261QP0905X	Public Health, State or Local
261QR0200X	Radiology
261QR0206X	Mammography
261QR0208X	Mobile
261QR0207X	Mobile Mammography
261QR0800X	Recovery Care
261QR0400X	Rehabilitation
261QR0404X	Rehabilitation: Cardiac Facilities
261QR0401X	Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)
261QR0405X	Rehabilitation, Substance Use Disorder
261QR1100X	Research
261QR1300X	Rural Health
261QS1200X	Sleep Disorder Diagnostic
261QS1000X	Student Health
261QU0200X	Urgent Care
NOTES AND SPECIAL INSTRUCTIONS:	
The provider taxonomy codes (currently Version 6.0) are maintained by the National Uniform Claim Committee (NUCC). The list is scheduled to be updated twice a year (April & October).	

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION (CONTINUED)
AMBULATORY HEALTH CARE FACILITIES (CONTINUED)	
261QV0200X	VA

NOTES AND SPECIAL INSTRUCTIONS:

The provider taxonomy codes (currently Version 6.0) are maintained by the National Uniform Claim Committee (NUCC). The list is scheduled to be updated twice a year (April & October).

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
BEHAVIORAL HEALTH AND SOCIAL SERVICE PROVIDERS	
101Y00000X	Counselor
101YA0400X	Addiction (Substance Use Disorder)
101YM0800X	Mental Health
101YP1600X	Pastoral
101YP2500X	Professional
101YS0200X	School
106H00000X	Marriage & Family Therapist
103G00000X	Neuropsychologist
103GC0700X	Clinical
103T00000X	Psychologist
103TA0400X	Addiction (Substance Use Disorder)
103TA0700X	Adult Development & Aging
103TB0200X	Behavioral
103TC2200X	Child, Youth & Family
103TC0700X	Clinical
103TC1900X	Counseling
103TE1000X	Educational
103TE1100X	Exercise & Sports
103TF0000X	Family
103TF0200X	Forensic
103TH0100X	Health
103TM1700X	Men & Masculinity
103TM1800X	Mental Retardation & Developmental Disabilities

NOTES AND SPECIAL INSTRUCTIONS:

The provider taxonomy codes (currently Version 6.0) are maintained by the National Uniform Claim Committee (NUCC). The list is scheduled to be updated twice a year (April & October).

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALTY DESCRIPTION (CONTINUED)
BEHAVIORAL HEALTH AND SOCIAL SERVICE PROVIDERS (CONTINUED)	
103TP0814X	Psychoanalysis
103TP2700X	Psychotherapy
103TP2701X	Psychotherapy, Group
103TR0400X	Rehabilitation
103TS0200X	School
103TW0100X	Women
104100000X	Social Worker
1041C0700X	Clinical
1041S0200X	School
NOTES AND SPECIAL INSTRUCTIONS:	
The provider taxonomy codes (currently Version 6.0) are maintained by the National Uniform Claim Committee (NUCC). The list is scheduled to be updated twice a year (April & October).	

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALTY DESCRIPTION
CHIROPRACTIC PROVIDERS	
111N00000X	Chiropractor
111NI0900X	Internist
111NN0400X	Neurology
111NN1001X	Nutrition
111NX0100X	Occupational Medicine
111NX0800X	Orthopedic
111NR0200X	Radiology
111NS0005X	Sports Physician
111NT0100X	Thermography
NOTES AND SPECIAL INSTRUCTIONS:	
The provider taxonomy codes (currently Version 6.0) are maintained by the National Uniform Claim Committee (NUCC). The list is scheduled to be updated twice a year (April & October).	

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
DENTAL PROVIDERS	
126800000X	Dental Assistant
124Q00000X	Dental Hygienist
126900000X	Dental Laboratory Technician
122300000X	Dentist
1223D0001X	Dental Public Health
1223E0200X	Endodontics
1223G0001X	General Practice
1223P0106X	Oral and Maxillofacial Pathology
1223X0008X	Oral and Maxillofacial Radiology
1223S0112X	Oral and Maxillofacial Surgery
1223X0400X	Orthodontics and Dentofacial Orthopedics
1223P0221X	Pediatric Dentistry
1223P0300X	Periodontics
1223P0700X	Prosthodontics
122400000X	Denturist

NOTES AND SPECIAL INSTRUCTIONS:

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
DIETARY AND NUTRITIONAL SERVICE PROVIDERS	
132700000X	Dietary Manager
136A00000X	Dietetic Technician, Registered
133V00000X	Dietician, Registered
133VN1006X	Nutrition, Metabolic
133VN1004X	Nutrition, Pediatric
133VN1005X	Nutrition, Renal
133N00000X	Nutritionist
133NN1002X	Nutrition, Education

NOTES AND SPECIAL INSTRUCTIONS:

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
EMERGENCY MEDICAL SERVICE PROVIDERS	
146N00000X	Emergency Medical Technician, Basic
146M00000X	Emergency Medical Technician, Intermediate
146L00000X	Emergency Medical Technician, Paramedic
146D00000X	Personal Emergency Response Attendant
NOTES AND SPECIAL INSTRUCTIONS:	
The provider taxonomy codes (currently Version 6.0) are maintained by the National Uniform Claim Committee (NUCC). The list is scheduled to be updated twice a year (April & October).	

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
EYE AND VISION SERVICE PROVIDERS	
152W00000X	Optometrist
152WC0802X	Corneal & Contact Management
152WL0500X	Low Vision Rehabilitation
152WX0102X	Occupational Vision
152WP0200X	Pediatrics
152WS0006X	Sports Vision
152WV0400X	Vision Therapy
156F00000X	Technician/Technologist
156FC0800X	Contact Lens
156FC0801X	Contact Lens Fitter
156FX1700X	Ocularist
156FX1100X	Ophthalmic
156FX1101X	Ophthalmic Assistant
156FX1800X	Optician
156FX1201X	Optometric Assistant
156FX1202X	Optometric Technician
156FX1900X	Orthoptist
NOTES AND SPECIAL INSTRUCTIONS:	
The provider taxonomy codes (currently Version 6.0) are maintained by the National Uniform Claim Committee (NUCC). The list is scheduled to be updated twice a year (April & October).	

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
GROUP	
193200000X	Multi-Specialty Group
193400000X	Single Specialty Group

NOTES AND SPECIAL INSTRUCTIONS:

The provider taxonomy codes (currently Version 6.0) are maintained by the National Uniform Claim Committee (NUCC). The list is scheduled to be updated twice a year (April & October).

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
HOSPITALS	
287300000X	Christian Science Sanitarium (Hospital Services)
281P00000X	Chronic Disease Hospital
281PC2000X	Children
282N00000X	General Acute Care Hospital
282NC2000X	Children
282NC00600X	Critical Access
282NR1301X	Rural
282NW0100X	Women
286500000X	Military Hospital
2865C1500X	Community Health (inactive as of 4/1/2005)
2865M2000X	General Acute Care
2865X1600X	General Acute Care, Operational (Transportable)
283Q00000X	Psychiatric Hospital
283X00000X	Rehabilitation Hospital
283XC2000X	Children
284300000X	Special Hospital

NOTES AND SPECIAL INSTRUCTIONS:

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
HOSPITAL UNITS	
275N00000X	Medicare Defined Swing Bed Unit
273R00000X	Psychiatric Unit
273Y00000X	Rehabilitation Unit
276400000X	Rehabilitation, Substance Use Disorder Unit
NOTES AND SPECIAL INSTRUCTIONS:	
The provider taxonomy codes (currently Version 6.0) are maintained by the National Uniform Claim Committee (NUCC). The list is scheduled to be updated twice a year (April & October).	

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
LABORATORIES	
291U00000X	Clinical Medical Laboratory
292200000X	Dental Laboratory
291900000X	Military Clinical Medical Laboratory
293D00000X	Physiological Laboratory (Independent Physiological Lab)
NOTES AND SPECIAL INSTRUCTIONS:	
The provider taxonomy codes (currently Version 6.0) are maintained by the National Uniform Claim Committee (NUCC). The list is scheduled to be updated twice a year (April & October).	

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
MANAGED CARE ORGANIZATIONS	
302F00000X	Exclusive Provider Organization
302R00000X	Health Maintenance Organization
305S00000X	Point of Service
305R00000X	Preferred Provider Organization
NOTES AND SPECIAL INSTRUCTIONS:	
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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
NURSING AND CUSTODIAL CARE FACILITIES	
311500000X	Alzheimer Center/Dementia Center/Dementia Special Care Unit
310400000X	Assisted Living Facility
3104A0630X	Behavioral Disturbances
3104A0625	Mental Illness
317400000X	Christian Science Facility (Skilled Nursing Services)
311Z00000X	Custodial Care Facility
311ZA0620X	Adult Care Home
315D00000X	Hospice, Inpatient
310500000X	Intermediate Care, Mental Illness
315P00000X	Intermediate Care Facility, Mentally Retarded
313M00000X	Nursing Facility/Intermediate Care Facility
314000000X	Skilled Nursing Facility
3140N1450X	Nursing Care, Pediatric

NOTES AND SPECIAL INSTRUCTIONS:

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
NURSING SERVICE PROVIDERS	
164W00000X	Licensed Practical Nurse
167G00000X	Licensed Psychiatric Technician
164X00000X	Licensed Vocational Nurse
163W00000X	Registered Nurse
163WA0400X	Addiction (Substance Use Disorder)
163WA2000X	Administrator
163WP2201X	Ambulatory Care
163WC3500X	Cardiac Rehabilitation
163WC0400X	Case Management
163WC1400X	College Health
163WC1500X	Community Health
163WC2100X	Continence Care
163WC1600X	Continuing Education/Staff Development
163WC0200X	Critical Care Medicine
163WD0400X	Diabetes Educator
163WD1100X	Dialysis, Peritoneal
163WE0003X	Emergency
163WE0900X	Enterostomal Therapy
163WF0300X	Flight
163WG0100X	Gastroenterology
163WG0000X	General Practice
163WG0600X	Gerontology
163WH0500X	Hemodialysis
163WH0200X	Home Health
163WH1000X	Hospice
163WI0600X	Infection Control
163WI0500X	Infusion Therapy
163WL0100X	Lactation Consultant
163WM0102X	Maternal Newborn
163WM0705X	Medical-Surgical
163WN0002X	Neonatal Intensive Care

NOTES AND SPECIAL INSTRUCTIONS:

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION (CONTINUED)
NURSING SERVICE PROVIDERS (CONTINUED)	
163WN0003X	Neonatal, Low-Risk
163WN0300X	Nephrology
163WN0800X	Neuroscience
163WM1400X	Nurse Massage Therapist (NMT)
163WN1003X	Nutrition Support
163WX0002X	Obstetric, High-Risk
163WX0003X	Obstetric, Inpatient
163WX0106X	Occupational Health
163WX0200X	Oncology
163WX1100X	Ophthalmic
163WX0800X	Orthopedic
163WX1500X	Ostomy Care
163WX0601X	Otorhinolaryngology & Head-Neck
163WP0000X	Pain Management
163WP0218X	Pediatric Oncology
163WP0200X	Pediatrics
163WP1700X	Perinatal
163WS0121X	Plastic Surgery
163WP0808X	Psychiatric/Mental Health
163WP0809X	Psychiatric/Mental Health, Adult
163WP0807X	Psychiatric/Mental Health, Child & Adolescent
163WR0400X	Rehabilitation
163WR1000X	Reproductive Endocrinology/Infertility
163WS0200X	School
163WU0100X	Urology
163WW0101X	Women's Health Care, Ambulatory
163WW0000X	Wound Care

NOTES AND SPECIAL INSTRUCTIONS:

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
NURSING SERVICE RELATED PROVIDERS	
372600000X	Adult Companion
3747A0650X	Attendant Care Provider
372500000x	Chore Provider
374T00000X	Christian Science Practitioner/Nurse
373H00000X	Day Training/Habilitation Specialist
374U00000X	Home Health Aide
376J00000X	Homemaker
376K00000X	Nurse's Aide
376G00000X	Nursing Home Administrator
374700000X	Technician
3747P1801X	Personal Care Attendant

NOTES AND SPECIAL INSTRUCTIONS:

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
OTHER SERVICE PROVIDERS	
171100000X	Acupuncturist
171W00000X	Contractor
171WH0202X	Home Modifications
171WV0202X	Vehicle Modifications
172A00000X	Driver
176P00000X	Funeral Director
170300000X	Genetic Counselor, MS
175L00000X	Homeopath
173000000X	Legal Medicine
177F00000X	Lodging
176B00000X	Midwife, Certified
175M00000X	Midwife, Lay
1710I1002X	Military Health Care Provider - Independent Duty Corpsman
1710I1003X	Military Health Care Provider - Independent Duty Medical Technicians
175F00000X	Naturopath
170100000X	Ph.D. Medical Genetics
174400000X	Specialist
1744G0900X	Graphics Designer
1744P3200X	Prosthetics Case Management
1744R1103X	Research Data Abstracter/Coder
1744R1102X	Research Study
174M00000X	Veterinarian
174MM1900X	Medical Research
390200000X	Student, Health Care - Student in an Organized Health Care Education/Training Program

NOTES AND SPECIAL INSTRUCTIONS:

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
PHARMACY SERVICE PROVIDERS	
183500000X	Pharmacist
1835G0000X	General Practice
1835N0905X	Nuclear Pharmacy
1835N1003X	Nutrition Support
1835P1200X	Pharmacotherapy
1835P1300X	Psychopharmacy
183700000X	Pharmacy Technician

NOTES AND SPECIAL INSTRUCTIONS:

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSING PROVIDERS	
367H00000X	Anesthesiologist Assistant
364S00000X	Clinical Nurse Specialist
364SA2100X	Acute Care
364SA2200X	Adult Health
364SC2300X	Chronic Care
364SC1501X	Community Health/Public Health
364SC0200X	Critical Care Medicine
364SE0003X	Emergency
364SE1400X	Ethics
364SF0001X	Family Health
364SG0600X	Gerontology
364SH1100X	Holistic
364SH0200X	Home Health
364SI0800X	Informatics
364SL0600X	Long-Term Care
364SM0705X	Medical-Surgical
364SN0000X	Neonatal
364SN0800X	Neuroscience
364SX0106X	Occupational Health
364SX0200X	Oncology
364SX0204X	Oncology, Pediatrics
364SP0200X	Pediatrics
364SP1700X	Perinatal
364SP2800X	Perioperative
364SP0808X	Mental Health
364SP0809X	Psychiatric/Mental Health, Adult
364SP0807X	Psychiatric/Mental Health, Child & Adolescent
364SP0810X	Psychiatric/Mental Health, Child & Family
364SP0811X	Psychiatric/Mental Health, Chronically Ill
364SP0812X	Psychiatric/Mental Health, Community
364SR0400X	Rehabilitation

NOTES AND SPECIAL INSTRUCTIONS:

The provider taxonomy codes (currently Version 6.0) are maintained by the National Uniform Claim Committee (NUCC). The list is scheduled to be updated twice a year (April & October).

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALTY DESCRIPTION (CONTINUED)
PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSING PROVIDERS (CONTINUED)	
364SS0200X	School
364ST0500X	Transplantation
364SW0102X	Women's Health
367A00000X	Midwife, Certified Nurse
367500000X	Nurse Anesthetist, Certified Registered
363L00000X	Nurse Practitioner
363LA2100X	Acute Care
363LA2200X	Adult Health
363LC1500X	Community Health
363LC0200X	Critical Care Medicine
363LF0000X	Family
363LG0600X	Gerontology
363LN0000X	Neonatal
363LN0005X	Neonatal, Critical Care
363LX0001X	Obstetrics & Gynecology
363LX0106X	Occupational Health
363LP0200X	Pediatrics
363LP0222X	Pediatrics, Critical Care
363LP1700X	Perinatal
363LP2300X	Primary Care
363LP0808X	Psychiatric/Mental Health
363LS0200X	School
363LW0102X	Women's Health
363A00000X	Physician Assistant
363AM0700X	Medical
363AS0400X	Surgical

NOTES AND SPECIAL INSTRUCTIONS:

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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
PODIATRIC MEDICINE AND SURGERY PROVIDERS	
211D00000X	Assistant, Podiatric
213E00000X	Podiatrist
213ES0103X	Surgery, Foot & Ankle
213ES0131X	Surgery, Foot
213EG0000X	General Practice
213EP1101X	Primary Podiatric Medicine
213EP0504X	Public Health
213ER0200X	Radiology
213ES0000X	Sports Medicine

NOTES AND SPECIAL INSTRUCTIONS:

The provider taxonomy codes (currently Version 6.0) are maintained by the National Uniform Claim Committee (NUCC). The list is scheduled to be updated twice a year (April & October).

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
RESIDENTIAL TREATMENT FACILITIES	
320800000X	Community Based Residential Treatment Facility, Mental Illness
320900000X	Community Based Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities
320600000X	Mental Retardation and/or Developmental Disabilities
320700000X	Physical Disabilities
323P00000X	Psychiatric Residential Treatment Center
322D00000X	Residential Treatment Center for Emotionally Disturbed Children
3245S0500X	Substance Abuse Treatment, Children
324500000X	Substance Use Disorder Rehabilitation Facility

NOTES AND SPECIAL INSTRUCTIONS:

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TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002
CHAPTER 2, ADDENDUM C
DATA REQUIREMENTS - PROVIDER'S MAJOR SPECIALTY CODES

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
RESPITE CARE FACILITY	
385H00000X	Respite Care
385HR2050X	Camp
385HR2055X	Mental Illness, Child
385HR2060X	Mental Retardation and/or Developmental Disabilities, Child
385HR2065X	Physical Disabilities, Child

NOTES AND SPECIAL INSTRUCTIONS:

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TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002
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 DATA REQUIREMENTS - PROVIDER'S MAJOR SPECIALTY CODES

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
RESPIRATORY, REHABILITATIVE AND RESTORATIVE SERVICES PROVIDERS	
221700000X	Art Therapist
225600000X	Dance Therapist
226300000X	Kinesiotherapist
225700000X	Massage Therapist
225X00000X	Occupational Therapist
225XE1200X	Ergonomics
225XH1200X	Hand
225XH1300X	Human Factors
225XN1300X	Neurorehabilitation
225XP0200X	Pediatrics
225XR0403X	Rehabilitation, Driver
224Z00000X	Occupational Therapy Assistant
225000000X	Orthotics/Prosthetics Fitter
222Z00000X	Orthotist
225100000X	Physical Therapist
2251C2600X	Cardiopulmonary
2251E1300X	Electrophysiology, Clinical
2251E1200X	Ergonomics
2251G0304X	Geriatrics
2251H1200X	Hand
2251H1300X	Human Factors
2251N0400X	Neurology
2251X0800X	Orthopedic
2251P0200X	Pediatrics
2251S0007X	Sports
225200000X	Physical Therapy Assistant
224P00000X	Prosthetist
225B00000X	Pulmonary Function Technologist
225800000X	Recreation Therapist
225C00000X	Rehabilitation Counselor
225CA2400X	Assistive Technology Practitioner

NOTES AND SPECIAL INSTRUCTIONS:

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TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002
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 DATA REQUIREMENTS - PROVIDER'S MAJOR SPECIALTY CODES

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALTY DESCRIPTION (CONTINUED)
RESPIRATORY, REHABILITATIVE AND RESTORATIVE SERVICES PROVIDERS (CONTINUED)	
225CA2500X	Assistive Technology Supplier
225400000X	Rehabilitation Practitioner
227800000X	Respiratory Therapist, Certified
2278C0205X	Critical Care
2278E1000X	Patient Educational
2278E0002X	Emergency Care
2278G1100X	General Care
2278G0305X	Geriatric Care
2278H0200X	Home Care
2278P3900X	Neonatal/Pediatrics
2278P3800X	Palliative/Hospice
2279P4000X	Patient Transport
2278P1004X	Pulmonary Diagnostics
2278P1006X	Pulmonary Function Technologist
2278P1005X	Pulmonary Rehabilitation
2278S1500X	SNF/Subacute Care
227900000X	Respiratory Therapist, Registered
2279C0205X	Critical Care
2279E1000X	Patient Education
2279E0002X	Emergency Care
2279G1100X	General Care
2279G0305X	Geriatric Care
2279H0200X	Home Care
2279P3900X	Neonatal/Pediatric
2279P3800X	Palliative/Hospice
2278P4000X	Patient Transport
2279P1004X	Pulmonary Diagnostics
2279P1006X	Pulmonary Function Technologist
2279P1005X	Pulmonary Rehabilitation
2279S1500X	SNF/Subacute Care

NOTES AND SPECIAL INSTRUCTIONS:

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TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002
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FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION (CONTINUED)
RESPIRATORY, REHABILITATIVE AND RESTORATIVE SERVICES PROVIDERS (CONTINUED)	
225500000X	Specialist/Technologist
2255A2300X	Athletic Trainer
2255R0406X	Rehabilitation, Blind

NOTES AND SPECIAL INSTRUCTIONS:

The provider taxonomy codes (currently Version 6.0) are maintained by the National Uniform Claim Committee (NUCC). The list is scheduled to be updated twice a year (April & October).

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
SPEECH, LANGUAGE AND HEARING PROVIDERS	
231H00000X	Audiologist
231HA2400X	Assistive Technology Practitioner
231HA2500X	Assistive Technology Supplier
237600000X	Audiologist-Hearing Aid Fitter
237700000X	Hearing Instrument Specialist
235500000X	Specialist/Technologist
2355A2700X	Audiology Assistant
2355S0801X	Speech-Language Assistant
235Z00000X	Speech-Language Pathologist

NOTES AND SPECIAL INSTRUCTIONS:

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TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002
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 DATA REQUIREMENTS - PROVIDER'S MAJOR SPECIALTY CODES

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
SUPPLIERS	
331L00000X	Blood Bank
3336C0002X	Clinic Pharmacy Specialization
3336C0003X	Community/Retail Pharmacy Specialization
332100000X	Department of Veterans Affairs (VA) Pharmacy
332B00000X	Durable Medical Equipment & Medical Supplies
332BC3200X	Customized Equipment
332BD1200X	Dialysis Equipment & Supplies
332BN1400X	Nursing Facility Supplies
332BX2000X	Oxygen Equipment & Supplies
332BP3500X	Parenteral & Enteral Nutrition
332G00000X	Eye Bank
332H00000X	Eyewear Supplier
332S00000X	Hearing Aid Equipment
332U00000X	Home Delivered Meals
3336H0001X	Home Infusion Therapy Pharmacy Specialization
332800000X	Indian Health Service/Tribal/Urban Indian Health (I/T/U) Pharmacy
3336I0012X	Institutional Pharmacy Specialization
3336L0003X	Long Term Care Pharmacy Specialization
3336M0002X	Mail Order Pharmacy Specialization
3336M0003X	Managed Care Organization Pharmacy Specialization
332000000X	Military Pharmacy
332900000X	Non-Pharmacy Dispensing Site
3336N0007X	Nuclear Pharmacy Specialization
335U00000X	Organ Procurement Organization
333600000X	Pharmacy
335V00000X	Portable X-Ray Supplier
335E00000X	Prosthetic/Orthotic Supplier
3336S0011X	Specialty Pharmacy Specialization

NOTES AND SPECIAL INSTRUCTIONS:

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 CHAPTER 2, ADDENDUM C
 DATA REQUIREMENTS - PROVIDER'S MAJOR SPECIALTY CODES

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
TECHNOLOGIST, TECHNICIAN, AND OTHER TECHNICAL SERVICE PROVIDERS	
247100000X	Radiologic Technologist
2471B0102X	Bone Densitometry
2471C1106X	Cardiac-Interventional Technology
2471C1101X	Cardiovascular-Interventional Technology
2471C3401X	Computed Tomography
2471M1202X	Magnetic Resonance Imaging
2471M2300X	Mammography
2471N0900X	Nuclear Medicine Technology
2471Q0001X	Quality Management
2471R0002X	Radiation Therapy
2471C3402X	Radiography
2471S1302X	Radiologic Technologist, Sonography
2471V0105X	Vascular Sonography
2471V0106X	Vascular-Interventional Technology
246X00000X	Specialist/Technologist, Cardiovascular
246XC2901X	Cardiovascular Invasive Specialist
246XS1301X	Specialist/Technologist Cardiovascular, Sonography
246XC2903X	Vascular Specialist
246Y00000X	Specialist/Technologist, Health Information
246YC3301X	Coding Specialist, Hospital Based
246YC3302X	Coding Specialist, Physician Office Based
246YR1600X	Registered Record Administrator
246Z00000X	Specialist/Technologist, Other
246ZA2600X	Art, Medical
246ZB0500X	Biochemist
246ZB0301X	Biomedical Engineering
246ZB0302X	Biomedical Photographer
246ZB0600X	Biostatistician
246ZE0500X	EEG
246ZE0600X	Electroneurodiagnostic
246ZG1000X	Geneticist, Medical (PhD)

NOTES AND SPECIAL INSTRUCTIONS:

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TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002
 CHAPTER 2, ADDENDUM C
 DATA REQUIREMENTS - PROVIDER'S MAJOR SPECIALTY CODES

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALTY DESCRIPTION (CONTINUED)
TECHNOLOGIST, TECHNICIAN, AND OTHER TECHNICAL SERVICE PROVIDERS (CONTINUED)	
246ZG0701X	Graphics Methods
246ZI1000X	Illustration, Medical
246ZN0300X	Nephrology
246ZS0400X	Surgical
246Q00000X	Specialist/Technologist, Pathology
246QB0000X	Blood Banking
246QC1000X	Chemistry
246QC2700X	Cytotechnology
246QH0401X	Hemapheresis Practitioner
246QH0000X	Hematology
246QH0600X	Histology
246QI0000X	Immunology
246QL0900X	Laboratory Management
246QL0901X	Laboratory Management, Diplomate
246QM0706X	Medical Technologist
246QM0900X	Microbiology
246W00000X	Technician, Cardiology
247000000X	Technician, Health Information
247200000X	Technician, Other
2472B0301X	Biomedical Engineering
2472D0500X	Darkroom
2472E0500X	EEG
2472R0900X	Renal Dialysis
2472V0600X	Veterinary
246R00000X	Technician, Pathology
246RH0600X	Histology
246RM2200X	Medical Laboratory
246RP1900X	Phlebotomy

NOTES AND SPECIAL INSTRUCTIONS:

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TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002
 CHAPTER 2, ADDENDUM C
 DATA REQUIREMENTS - PROVIDER'S MAJOR SPECIALTY CODES

FIGURE 2-C-1 PROVIDER MAJOR SPECIALTY CODES (CONTINUED)

TED CODE	SPECIALITY DESCRIPTION
TRANSPORTATION SERVICES	
341600000X	Ambulance
3416A0800X	Air Transport
3416L0300X	Land Transport
3416S0300X	Water Transport
347B00000X	Bus
343900000X	Non-emergency Medical Transport (Van)
347C00000X	Private Vehicle
343800000X	Secured Medical Transport (Van)
344600000X	Taxi
347D00000X	Train
347E00000X	Transportation Broker

NOTES AND SPECIAL INSTRUCTIONS:

The provider taxonomy codes (currently Version **6.0**) are maintained by the National Uniform Claim Committee (NUCC). The list is scheduled to be updated twice a year (April & October).

CHAPTER 2
 ADDENDUM F

DATA REQUIREMENTS - PROCEDURE CODE FOR TYPE OF SERVICE

PROCEDURE CODE FOR TYPE OF SERVICE ¹				
TYPE OF SERVICE DESP.	CODE	PROCEDURE CODE		
		CPT-4 ³	HCPCS	CHAMPUS ASSIGNED
AMBULANCE	I	93005-93041	A0021-A0999 C1744, C9000-C9010, C9105 J0120-J8999 Q3014, Q3017, Q3019, Q3020	98305-98318, 98330-98338
AMBULATORY SURGERY	C	0001T, 0002T, 0005T-0009T, 0014T-0017T, 0019T-0021T, 0027T, 0031T-0039T, 0048T-0057T, 0090T-0100T, 0120T-0124T, 0133T-0143T, 0153T 10000-69999, 92950-92998, 93015-93025, 93580, 93581, 96920-96922	C1305, C1762, C1763, C1774, C9000-C9010, C9105, C9123, C9704, C9713, C9716, C9724, C9725 G0001, G0002, G0104-G0106, G0120-G0122, G0127, G0159, G0160, G0168, G0173, G0183-G0187, G0251, G0259, G0260, G0267-G0269, G0272, G0279, G0280, G0289-G0291, G0293, G0294, G0297-G0300, G0302-G0305, G0343-G0365 J0120-J9999 Q0068, Q0136, Q1001-Q1005, Q9920-Q9940	36526, 38298, 47150 W0002-W0019

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TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002
 CHAPTER 2, ADDENDUM F
 DATA REQUIREMENTS - PROCEDURE CODE FOR TYPE OF SERVICE

PROCEDURE CODE FOR TYPE OF SERVICE ¹ (CONTINUED)				
TYPE OF SERVICE DESP.	CODE	PROCEDURE CODE		
		CPT-4 ³	HCPCS	CHAMPUS ASSIGNED
AMBULATORY SURGERY (Continued)			S0079-S0189, S0206, S0630, S0800-S2351, S2360-S2363, S2400-S2405, S2409, S2411, S2900, S8030	
ANESTHESIA	7	00100-01999, 99100, 99116, 99135, 99140-99150	C9000-C9010, C9105	
ASSIST AT SURGERY	8	0001T, 0002T, 0005T-0009T, 0014T-0017T, 0019T-0021T, 0027T, 0031T-0039T, 0048T-0057T, 0090T-0100T, 0120T-0124T, 0133T-0143T, 0153T 10000-69999, 92950-92998, 93015-93025, 93580, 93581, 96920-96922	C1305, C1762, C1763, C1774, C9000-C9010, C9105, C9123, C9704, C9713, C9716, C9724, C9725 G0001, G0002, G0104-G0106, G0120-G0122, G0127, G0159, G0160, G0168, G0173, G0183-G0187, G0251, G0259, G0260, G0267-G0269, G0272, G0279, G0280, G0289-G0291, G0293, G0294, G0297-G0300, G0302-G0305, G0343-G0365 J0120-J9999 Q0068, Q0136, Q1001-Q1005, Q9920-Q9940 S0079-S0189, S0206, S0630, S0800-S2351, S2360-S2363, S2400-S2405, S2409, S2411, S2900, S8030	36526, 38298, 47150 W0002-W0019
CONSULTATION	3	76140, 77336-77370, 80500-80502, 88321-88332, 99241-99275	Q3014	
DENTAL ²	G		D0120-D9999 ²	

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TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002
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 DATA REQUIREMENTS - PROCEDURE CODE FOR TYPE OF SERVICE

PROCEDURE CODE FOR TYPE OF SERVICE ¹ (CONTINUED)				
TYPE OF SERVICE DESP.	CODE	PROCEDURE CODE		
		CPT-4 ³	HCPCS	CHAMPUS ASSIGNED
DIAGNOSTIC LAB	5	0004T, 0010T, 0022T, 0023T, 0026T, 0030T, 0041T, 0043T, 0046T, 0058T, 0059T 80048-89399	C1010-C1018, C9503, C9723 G0001, G0026, G0027, G0101, G0103, G0107, G0123, G0124, G0141-G0148, G0265, G0266, G0306, G0307 P2028-P9615 Q0091, Q0111-Q0115 S3600, S3601, S3620, S3625, S3626 , S3630, S3645-S3652, S3701, S3708, S3818-S3820, S3822, S3823, S3828-S3831, S3833-S3835, S3837, S3840-S3853, S3890, S3900, S4011, S4015, S4016, S4018, S4020-S4022, S4025-S4031	84999, 90593 W0002-W0019
DIAGNOSTIC X-RAY	4	0003T, 0008T, 0012T, 0013T, 0025T, 0028T, 0040T, 0042T, 0144T-0152T, 0154T 31632, 31633 70010-76999 78000-79999 91110	A9500- A9700 C1064-C1066, C1079, C1080, C1082, C1088, C1122, C1188-C1202, C1348, C1770, C1775 , C8900-C8914, C8918-C8920, C9013, C9100-C9103, C9400-C9405 E2000, E2100, E2101 G0030-G0050, G0117, G0118, G0125, G0130-G0132, G0193-G0196, G0202-G0236, G0242, G0243, G0252-G0254, G0259, G0260, G0262, G0275-G0278, G0288, G0296, G0347, G0348 Q0092, Q3000, Q3002-Q3012, Q9945-Q9964	76499

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 DATA REQUIREMENTS - PROCEDURE CODE FOR TYPE OF SERVICE

PROCEDURE CODE FOR TYPE OF SERVICE ¹ (CONTINUED)				
TYPE OF SERVICE DESP.	CODE	PROCEDURE CODE		
		CPT-4 ³	HCPCS	CHAMPUS ASSIGNED
DIAGNOSTIC X-RAY (Continued)			R0070-R0076 S0820, S8035-S8092, S9022-S9024	
DME RENTAL/ PURCHASE	A	95991	A6530-A6549, A9282, A9300, A9901, A9999 B9000-B9006 C1170, C1175-C1177, C1179, C1300, C1321- C1324, C1329, C1368, C1713, C1721, C1722, C1760, C1764, C1767, C1768, C1771-C1773, C1776, C1780-C1782, C1784-C1789, C1813- C1819, C1874-C1884, C1891, C1895-C1899, C2617-C2622, C2625, C2626, C2631, C8514, C8515, C8517, C9708, C9711 E0100-E2621, E8000- E8002 G0329 K0001-K0547, K0549- K0559, K0600-K0609, K0618-K0620, K0627- K0669 L0100-L9900 Q0101-Q0105, Q0132, Q0480-Q0512, Q1001- Q1005 S1030, S1031, S5036, S5497, S5498, S5501, S5502, S5517, S5518, S5520-S5523, S8095- S8300 T5001 V2020-V2799, V5030- V5299, V5336	

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TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002
 CHAPTER 2, ADDENDUM F
 DATA REQUIREMENTS - PROCEDURE CODE FOR TYPE OF SERVICE

PROCEDURE CODE FOR TYPE OF SERVICE ¹ (CONTINUED)				
TYPE OF SERVICE DESP.	CODE	PROCEDURE CODE		
		CPT-4 ³	HCPCS	CHAMPUS ASSIGNED
HOSPICE	D	All payable codes to be accepted.		
MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS	M	99070		98800 000MN, 000PA
MATERNITY CARE	F	0500F-0502F 59000-59899, 99201-99215	G9011, G9012 H1000-H1005 Q3014 S3625, S9208, S9209, S9211-S9214, S9216-S9218, S3625, S3626	99590, 99591, 99592
MEDICAL CARE (EXCLUSIVE OF CONSULTATIONS, SECOND OPINION, MENTAL HEALTH, AMBULANCE, ECHO)	1	0001F-0011F 0018T, 0024T, 0029T, 0044T-0047T, 0101T-0117T, 0124T, 0126T, 0130T, 0140T-0143T, 0149T 90201-90799, 90901-92700, 92950-99602	A9150 C1178, C1300, C8899-C9010, C9105, C9109, C1166, C1167, C1207, C1762, C1763, C1768, C1771, C1773, C1774, C1776, C1781, C1782, C1784, C1787, C1788, C1819, C8950-C8957, C9113, C9202-C9218, C9223-C9225, C9399, C9410-C9439, C9704 G0004-G0025, G0101, G0102, G0108-G0118, G0122, G0128, G0151-G0156, G0166, G0167, G0175-G0182, G0192, G0197-G0201, G0237-G0241, G0244-G0250, G0255, G0257, G0258, G0263, G0264, G0270, G0271, G0281-G0283, G0292, G0295-G9020, G9050-G9130 J0120-J9999 L0100-L9900	90199, 90599, 92190, 94799, 98691, 99070, 99088

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TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002
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 DATA REQUIREMENTS - PROCEDURE CODE FOR TYPE OF SERVICE

PROCEDURE CODE FOR TYPE OF SERVICE ¹ (CONTINUED)				
TYPE OF SERVICE DESP.	CODE	PROCEDURE CODE		
		CPT-4 ³	HCPCS	CHAMPUS ASSIGNED
MEDICAL CARE (EXCLUSIVE OF CONSULTATIONS, SECOND OPINION, MENTAL HEALTH, AMBULANCE, ECHO) (Continued)			M0064-M0302 P9612 Q0034, Q0035, Q0081, Q0083-Q0085, Q0092, Q0136, Q0137, Q0144, Q0163-Q0184, Q0187, Q0510-Q0512, Q0515, Q1001-Q1005, Q2002- Q2022, Q3014, Q3021- Q3026, Q4052-Q4055, Q4075-Q4077, Q4079, Q4080, Q9920-Q9944 S0009-S0630, S1025, S1030, S1031, S2083, S2120, S2152, S2370, S2371, S3000, S3620- S5001, S5010-S5014, S5035, S5036, S5100- S5199, S5497, S5498, S5501, S5502, S5517, S5518, S5520-S5523, S8301, S8940, S8950- S9001, S9015, S9025, S9034, S9055-S9075, S9083, S9088, S9090- S9127, S9140-S9543, S9558-S9562, S9590, S9800, S9810, S9981 T1000-T1005, T1013- T2007, T2010-T2046, T2101 V2790, V5008-V5020, V5095, V5298	
MENTAL HEALTH CARE	H	90801-90899, 96100- 96155	G0175-G0177 H0001-H2037 Q0082 S3005, S9475-S9495 T1006-T1012, T2048	90834, 90892- 90896, 92845- 92899

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 DATA REQUIREMENTS - PROCEDURE CODE FOR TYPE OF SERVICE

PROCEDURE CODE FOR TYPE OF SERVICE ¹ (CONTINUED)				
TYPE OF SERVICE DESP.	CODE	PROCEDURE CODE		
		CPT-4 ³	HCPCS	CHAMPUS ASSIGNED
OTHER MEDICAL SERVICE & SUPPLIES	9	Any code that is considered a medical supply or which has not been assigned a type of service classification.		
ECHO CARE	J	All payable codes to be accepted.		
PHYSICAL/ OCCUPATIONAL THERAPY	K	4018F 97001-97799	G0129, G0151, G0152, G9041-G9044 Q0086, Q0103, Q0104, Q0109, Q0110 S8948, S8990, S9129, S9033, S9131	92845
RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS	B	99070	A9150 J8499, J8999 Q0513, Q0514	98800 000MN, 000PA
SECOND OPINION- ELECTIVE SURGERY	E	99271-99275		
SPEECH THERAPY	L	92506-92508	G0153 S9128 V5336, V5362-V5364	
SURGERY	2	0001T, 0002T, 0005T- 0009T, 0014T-0017T, 0019T-0021T, 0027T, 0031T-0039T, 0048T- 0057T, 0090T-0100T, 0120T-0124T, 0133T- 0143T, 0153T 10000-69999, 92950- 92998, 93015-93025, 93580, 93581, 96920- 96922	C1305, C1762, C1763, C1774, C9000-C9010, C9105, C9123, C9704, C9713, C9716, C9724, C9725 G0001, G0002, G0104- G0106, G0120-G0122, G0127, G0159, G0160, G0168, G0173, G0183- G0187, G0251, G0259, G0260, G0267-G0269, G0272, G0279, G0280, G0289-G0291, G0293, G0294, G0297-G0300, G0302-G0305, G0343- G0365 J0120-J9999 Q0068, Q0136, Q1001- Q1005, Q9920-Q9940	36526, 38298, 47150 W0002-W0019

¹ This table is used in type of service edits 2-280-01R and does not determine government pay status.

² Only Dental HCPCS codes are used.

³ CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

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 CHAPTER 2, ADDENDUM F
 DATA REQUIREMENTS - PROCEDURE CODE FOR TYPE OF SERVICE

PROCEDURE CODE FOR TYPE OF SERVICE ¹ (CONTINUED)				
TYPE OF SERVICE DESP.	CODE	PROCEDURE CODE		
		CPT-4 ³	HCPCS	CHAMPUS ASSIGNED
SURGERY (Continued)			S0079-S0189, S0206, S0630, S0800-S2351, S2360-S2363, S2400-S2405, S2409, S2411, S2900 , S8030	
THERAPEUTIC RADIOLOGY	6	0054T-0057T, 0060T, 0061T 77261-77799	C1081, C1083, C1715-C1720, C2616, C2632-C2637 G0173, G0179, G0251, G0256, G0261, G0273, G0274 J9000-J9999 Q3001 S8004-S8030, S8049	

¹ This table is used in type of service edits 2-280-01R and does not determine government pay status.
² Only Dental HCPCS codes are used.
³ CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

DATA REQUIREMENTS - ADJUSTMENT/DENIAL REASON CODES

FIGURE 2-H-1 DENIAL CODES

ADJUST/DENIAL REASON CODE	DESCRIPTION
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using remittance advice remarks codes whenever appropriate.
18	Duplicate claim/service.
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	Claim denied because this injury/illness is covered by the liability carrier.
21	Claim denied because this injury/illness is the liability of the no-fault carrier.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.

HIPAA Adjustment Reason Codes Release 09/01/2003.

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002
 CHAPTER 2, ADDENDUM H
 DATA REQUIREMENTS - ADJUSTMENT/DENIAL REASON CODES

FIGURE 2-H-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
25	Payment denied. Your Stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
28	Coverage not in effect at the time the service was provided.
29	The time limit for filing has expired.
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
31	Claim denied as patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Claim denied. Insured has no dependent coverage.
34	Claim denied. Insured has no coverage for newborns.
35	Lifetime benefit maximum has been reached.
38	Services not provided or authorized by designated (network) providers.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care.
46	This (these) service(s) is (are) not covered.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
48	This (these) procedure(s) is (are) not covered.
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50	These are non-covered services because this is not deemed a "medical necessity" by the payer.
51	These are non-covered services because this is a pre-existing condition
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case.
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56	Claim/service denied because procedure/treatment has not been deemed proven to be effective by the payer.

HIPAA Adjustment Reason Codes Release 09/01/2003.

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002
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 DATA REQUIREMENTS - ADJUSTMENT/DENIAL REASON CODES

FIGURE 2-H-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
60	Charges for outpatient services with this proximity to inpatient services are not covered.
89	Professional fees removed from charges.
96	Non-covered charge(s).
97	Payment is included in the allowance for another service/procedure.
98	The hospital must file the Medicare claim for this inpatient non-physician service.
106	Patient payment option/election not in effect.
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Payment adjusted as not furnished directly to the patient and/or not documented.
113	Payment denied because service/procedure was provided outside the United States or as a result of war.
114	Procedure/product not approved by the Food and Drug Administration.
115	Payment adjusted as procedure postponed or canceled.
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.
119	Benefit maximum for this time period has been reached.
128	Newborn's services are covered in the mother's Allowance.
129	Payment denied - Prior processing information appears incorrect.
134	Technical fees removed from charges.
135	Claim denied. Interim bills cannot be processed.
136	Claim Adjusted. Plan procedures of a prior payer were not followed.
138	Claim/service denied. Appeal procedures not followed or time limits not met.
140	Patient/Insured health identification number and name do not match.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.
147	Provider contracted/negotiated rate expired or not on file.

HIPAA Adjustment Reason Codes Release 09/01/2003.

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002
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 DATA REQUIREMENTS - ADJUSTMENT/DENIAL REASON CODES

FIGURE 2-H-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.
149	Benefit maximum for this time period or occurrence has been reached.
155	This claim is denied because the patient refused the service/procedure.
166	These services were submitted after this payers responsibility for processing claims under this plan ended.
167	This (these) diagnosis(es) is (are) not covered.
168	Payment denied as Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.
170	Payment is denied when performed/billed by this type of provider.
171	Payment is denied when performed/billed by this type of provider in this type of facility.
174	Payment denied because this service was not prescribed prior to delivery.
175	Payment denied because the prescription is incomplete.
176	Payment denied because the prescription is not current.
177	Payment denied because the patient has not met the required eligibility requirements.
181	Payment adjusted because this procedure code was invalid on the date of service.
182	Payment adjusted because the procedure modifier was invalid on the date of service.
183	The referring provider is not eligible to refer the service billed.
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.
185	The rendering provider is not eligible to perform the service billed.
188	This product/procedure is only covered when used according to FDA recommendations.
191	Claim denied because this is not a work related injury/illness and thus not the liability of the workers' compensation carrier.
A1	Claim denied charges.
A6	Prior hospitalization or 30 day transfer requirement not met.
A8	Claim denied; ungroupable DRG
B1	Non-covered visits.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.

HIPAA Adjustment Reason Codes Release 09/01/2003.

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

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DATA REQUIREMENTS - ADJUSTMENT/DENIAL REASON CODES

FIGURE 2-H-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B9	Services not covered because the patient is enrolled in a Hospice.
B12	Services not documented in patients' medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Payment denied because only one visit or consultation per physician per day is covered.
B15	Payment adjusted because this procedure/service is not paid separately.
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.
B23	Payment denied because this provider has failed an aspect of a proficiency testing program.
D1	Claim/service denied. Level of subluxation is missing or inadequate.
D2	Claim lacks the name, strength, or dosage of the drug furnished.
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.
D4	Claim/service does not indicate the period of time for which this will be needed.
D5	Claim/service denied. Claim lacks individual lab codes included in the test.
D6	Claim/service denied. Claim did not include patient's medical record for the service.
D7	Claim.service denied. Claim lacks date of patient's most recent physician visit.
D8	Claim/service denied. Claim lacks indicator that 'x-ray is available for review.'
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.
D10	Claim/service denied. Completed physician financial relationship form not on file.
D11	Claim lacks completed pacemaker registration form.
HIPAA Adjustment Reason Codes Release 09/01/2003.	

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 DATA REQUIREMENTS - ADJUSTMENT/DENIAL REASON CODES

FIGURE 2-H-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test of the amount you were charged for the test.
D13	Claim/service denied. Performed by the facility/supplier in which the ordering/referring physician has a financial interest.
D14	Claim lacks indication that plan of treatment is on file.
D15	Claim lacks indication that service was supervised or evaluated by a physician.
D16	Claim lacks prior payer payment information.
D17	Claim/Service has invalid non-covered days.
D18	Claim/Service has missing diagnosis information.
D19	Claim/Service lacks Physician/Operative or other supporting documentation.
D20	Claim/Service missing service/product information.
D21	This (these) diagnosis(es) is (are) missing or are invalid.
HIPAA Adjustment Reason Codes Release 09/01/2003.	

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 DATA REQUIREMENTS - ADJUSTMENT/DENIAL REASON CODES

FIGURE 2-H-2 DENIAL/ADJUSTMENT CODES

ADJUST/DENIAL REASON CODE	DESCRIPTION
23	Payment adjusted because charges have been paid by another payer.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
63	Correction to a prior claim.
65	Procedure code was incorrect. This payment reflects the correct code.
78	Non-Covered days/Room charge adjustment.
93	No Claim Level Adjustments.
95	Benefits adjusted. Plan procedures not followed.
108	Payment reduced because rent/purchase guidelines were not met.
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.
120	Patient is covered by a managed care plan.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using remittance advice remarks codes whenever appropriate.
137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
150	Payment adjusted because the payer deems the information submitted does not support this level of service.
151	Payment adjusted because the payer deems the information submitted does not support this many services.
152	Payment adjusted because the payer deems the information submitted does not support his length of service.
153	Payment adjusted because the payer deems the information submitted does not support this dosage.
154	Payment adjusted because the payer deems the information submitted does not support this day's supply.
157	Payment denied/reduced because the service/procedure was provided as a result of war.
158	Payment denied/reduced because the service was provided outside of the United States.

HIPAA Adjustment Reason Codes Release 09/01/2003.

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 DATA REQUIREMENTS - ADJUSTMENT/DENIAL REASON CODES

FIGURE 2-H-2 DENIAL/ADJUSTMENT CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
159	Payment denied/reduced because the service/procedure was provided as a result of terrorism.
160	Payment denied/reduced because injury/illness was a result of an activity that is a benefit exclusion.
163	Claim/Service adjusted because the attachment referenced on the claim was not received.
164	Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion.
165	Payment denied/reduced for absence of, or exceeded referral.
169	Payment adjusted because an alternate benefit has been provided.
172	Payment is adjusted when performed/billed by a provider of this specialty.
173	Payment adjusted because this service was not prescribed by a physician.
178	Payment adjusted because the patient has not met the required spend down requirements.
179	Payment adjusted because the patient has not met the required waiting requirements.
180	Payment adjusted because the patient has not met the required residency requirements.
186	Payment adjusted since the level of care changed.
189	Not otherwise classified or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.
A3	Medicare Secondary Payer liability met.
B4	Late filing penalty.
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.
B16	Payment adjusted because "New Patient" qualifications were not met.
B19	Claim/Service adjusted because of the finding of a Review Organization.
B21	The charges were reduced because the service/care was partially furnished by another physician.
B22	This payment is adjusted based on the diagnosis.

HIPAA Adjustment Reason Codes Release 09/01/2003.

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 DATA REQUIREMENTS - ADJUSTMENT/DENIAL REASON CODES

FIGURE 2-H-3 ADJUSTMENT/REMARK CODES

ADJUST/DENIAL REASON CODE	DESCRIPTION
1	Deductible amount
2	Coinsurance amount
3	Co-payment amount
36	Balance does not exceed co-payment amount.
37	Balance does not exceed deductible.
41	Discount agreed to in Preferred Provider contract.
42	Charges exceed our fee schedule or maximum allowable amount.
43	Gramm-Rudman reduction.
44	Prompt-pay discount.
45	Charges exceed your contracted/ legislated fee arrangement.
61	Charges adjusted as penalty for failure to obtain second surgical opinion.
64	Denial reversed per Medical Review.
66	Blood Deductible.
67	Lifetime reserve days. (Handled in QTY, QTY01=LA)
68	DRG weight. (Handled in CLP12)
69	Day outlier amount.
70	Cost outlier amount - Adjustment to compensate for additional costs.
71	Primary Payer amount.
72	Coinsurance day. (Handled in QTY, QTY01=CD)
73	Administrative days.
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
77	Covered days. (Handled in QTY, QTY01=CA)
79	Cost Report days. (Handled in MIA15)
80	Outlier days. (Handled in QTY, QTY01=OU)
81	Discharges.
82	PIP days.
83	Total Visits.
84	Capital Adjustment. (Handled in MIA)
85	Interest amount.
86	Statutory Adjustment.
87	Transfer amount.

HIPAA Adjustment Reason Codes Release 09/01/2003.

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 CHAPTER 2, ADDENDUM H
 DATA REQUIREMENTS - ADJUSTMENT/DENIAL REASON CODES

FIGURE 2-H-3 ADJUSTMENT/REMARK CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
88	Adjustment amount represents collection against receivable created in prior overpayment.
90	Ingredient cost adjustment.
91	Dispensing fee adjustment.
92	Claim Paid in full.
94	Processed in Excess of charges.
99	Medicare Secondary Payer Adjustment Amount.
100	Payment made to patient/insured/responsible party.
101	Predetermination: anticipated payment upon completion of services or claim adjudication.
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount).
104	Managed care withholding.
105	Tax withholding.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
118	Charges reduced for ESRD network support.
121	Indemnification adjustment.
122	Psychiatric reduction.
123	Payer refund due to overpayment.
124	Payer refund amount - not our patient.
126	Deductible -- Major Medical
127	Coinsurance -- Major Medical
130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
133	The disposition of this claim/service is pending further review.
139	Contracted funding agreement - Subscriber is employed by the provider of services.
142	Claim adjusted by the monthly Medicaid patient liability amount.
143	Portion of payment deferred.
144	Incentive adjustment, e.g., preferred product/service.
145	Premium payment withholding.
156	Flexible spending account payment.

HIPAA Adjustment Reason Codes Release 09/01/2003.

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CHAPTER 2, ADDENDUM H

DATA REQUIREMENTS - ADJUSTMENT/DENIAL REASON CODES

FIGURE 2-H-3 ADJUSTMENT/REMARK CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
161	Provider performance bonus.
162	State-mandated requirement for property and casualty.
187	Health Savings account payments.
192	Non-standard adjustment code from paper remittance advice.
A0	Patient refund amount.
A2	Contractual adjustment.
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A7	Presumptive Payment Adjustment
B2	Covered visits.
B3	Covered charges.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
W1	Workers Compensation State Fee Schedule Adjustment
HIPAA Adjustment Reason Codes Release 09/01/2003.	

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CHAPTER 2, ADDENDUM I

DATA REQUIREMENTS - REVENUE CODES

CODES	MAJOR/SUB-CATEGORY (CONTINUED)
083X	Peritoneal Dialysis - Outpatient or Home (to be submitted on Non-Institutional TED)
	A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.
	Subcategory
	0 General Classification
	1 Peritoneal/Composite or Other Rate
	2 Home Supplies
	3 Home Equipment
	4 Maintenance/100%
	5 Support Services
	9 Other Outpatient Peritoneal Dialysis
084X	Cont. Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home (To be submitted on Non-Institutional TED)
	A continuous dialysis process performed in an outpatient or home setting which uses the patient peritoneal membrane as a dialyzer.
	Subcategory
	0 General Classification
	1 CAPD/Composite or Other Rate
	2 Home Supplies
	3 Home Equipment
	4 Maintenance/100%
	5 Support Services
	9 Other Outpatient CAPD
085X	Cont. Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home (to be submitted on Non-Institutional TED)
	A continuous dialysis process performed in an outpatient or home setting which uses a machine to make automatic exchanges at night.
	Subcategory
	0 General Classification
	1 CCPD/Composite or Other Rate
	2 Home Supplies
	3 Home Equipment
	4 Maintenance/100%
	5 Support Services
	9 Other Outpatient CCPD

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CHAPTER 2, ADDENDUM I

DATA REQUIREMENTS - REVENUE CODES

CODES	MAJOR/SUB-CATEGORY (CONTINUED)
086X	RESERVED for Dialysis (National Assignment)
087X	RESERVED for Dialysis (National Assignment)
088X	Miscellaneous Dialysis
	Charges for dialysis services not identified elsewhere.
	Subcategory
0	General Classification
1	Ultrafiltration
2	Home Dialysis Aid Visit
9	Other Miscellaneous Dialysis
089X	RESERVED (Other Donor Bank was terminated 04/01/1994)
090X	Behavioral Health Treatments/Services
	Subcategory
0	General Classification
1	Electroshock Treatment
2	Milieu Therapy
3	Play Therapy
4	Activity Therapy
5	Intensive Outpatient Services - Psychiatric (Effective 10/16/2003)
6	Intensive Outpatient Services - Chemical Dependency (Effective 10/16/2003)
7	Community Behavioral Health Program (Day Treatment) (Effective 10/16/2003)
8	RESERVED for National Use (Effective 10/16/2003)
9	RESERVED for National Use

DATA REQUIREMENTS - CONTRACT AREA OF RESPONSIBILITY

FIGURE 2-J-1 CONTRACT AREAS OF RESPONSIBILITY¹

STATE/CONTRACT	PROVIDER STATE OR COUNTRY CODE	REGION	CONTRACTOR NUMBER
Alabama	AL	South	63
Alaska	AK	West	62
Arizona	AZ	West	62
Arkansas	AR	South	63
California	CA	West	62
Colorado	CO	West	62
Connecticut	CT	North	64
Delaware	DE	North	64
District Of Columbia	DC	North	64
Florida	FL	South	63
Georgia	GA	South	63
Hawaii	HI	West	62
Idaho	ID	West	62
Illinois	IL	North	64
Indiana	IN	North	64
Iowa ²	IA	West/North	62/64
Kansas	KS	West	62
Kentucky	KY	North	64
Louisiana	LA	South	63
Maine	ME	North	64
Maryland	MD	North	64
Massachusetts	MA	North	64
Michigan	MI	North	64
Minnesota	MN	West	62
Mississippi	MS	South	63
Missouri ²	MO	West/North	62/64

¹ Beneficiaries residing in these geographic areas.

² States that are shared with more than one contract.

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CHAPTER 2, ADDENDUM J

DATA REQUIREMENTS - CONTRACT AREA OF RESPONSIBILITY

FIGURE 2-J-1 CONTRACT AREAS OF RESPONSIBILITY¹ (CONTINUED)

STATE/CONTRACT	PROVIDER STATE OR COUNTRY CODE	REGION	CONTRACTOR NUMBER
Montana	MT	West	62
Nebraska	NE	West	62
Nevada	NV	West	62
New Hampshire	NH	North	64
New Jersey	NJ	North	64
New Mexico	NM	West	62
New York	NY	North	64
North Carolina	NC	North	64
North Dakota	ND	West	62
Ohio	OH	North	64
Oklahoma	OK	South	63
Oregon	OR	West	62
Pennsylvania	PA	North	64
Retail Pharmacy	National	National	61
Rhode Island	RI	North	64
South Carolina	SC	South	63
South Dakota	SD	West	62
Tennessee ²	TN	South/North	63/64
Texas ²	TX	West/South	62/63
TRICARE Mail Order Pharmacy	National	National	02
TRICARE Dual Eligible Fiscal Intermediary	National	National	65
Utah	UT	West	62
Vermont	VT	North	64
Virginia	VA	North	64
Washington	WA	West	62
West Virginia	WV	North	64
Wisconsin	WI	North	64
Wyoming	WY	West	62

¹ Beneficiaries residing in these geographic areas.

² States that are shared with more than one contract.

CHAPTER 2
ADDENDUM K

DATA REQUIREMENTS - PAY PLAN CODE VALID VALUES

VALID VALUES	DESCRIPTIONS
999	Other Civilian Pay Plan
AD	Administratively determined not elsewhere specified.
AF	American Family Members
AJ	Administrative judges, Nuclear Regulatory Commission
AL	Administrative Law judges
BB	Non supervisory negotiated pay employees
BL	Leader negotiated pay employees
BP	Printing and Lithographic negotiated pay employees
BS	Supervisory negotiated pay employees
CA	Board of contract appeals
CC	Commissioned Corps of Public Health Service
CE	Contract education
CG	Corporate graded Federal Deposit Insurance Corp.
CH	Non-appropriated funds, Childcare
CP	Compensation program Office of the Comptroller of the currency
CS	Skill Based Pay demonstration employees, DLA
CU	Credit Union employees
CY	Contract education Bureau of Indian Affairs
CZ	Canal Area General Schedule type positions

VALID VALUES	DESCRIPTIONS
DA	Demonstration administrative Director of Laboratory Programs (Navy)
DB	Demonstration Engineers and Scientists (entire DoD)
DC	Navy Test Program - Clerical
DE	Demonstration Engineers and Scientists Technicians (entire DoD)
DG	Demonstration general Director of Laboratory Programs (Navy)
DH	Demonstration hourly Air Force logistics command
DJ	Demonstration Administrative (entire DoD)
DK	Demonstration General Support (entire DoD)
DN	Defense Nuclear facilities safety board
DP	Demonstration professional Director of Laboratory Programs (Navy)
DR	Demonstration Air Force Scientist and Engineer
DS	Demonstration specialist Director of Laboratory Programs (Navy)
DT	Demonstration technician Director of Laboratory Programs (Navy)
DW	Demonstration salaried Air Force and DLA
DX	Demonstration Supervisory Air Force and DLA

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DATA REQUIREMENTS - PAY PLAN CODE VALID VALUES

VALID VALUES	DESCRIPTIONS	VALID VALUES	DESCRIPTIONS
EA	Administrative schedule (excluded) Tennessee Valley Authority	GH	GG employees converted to performance and management recognition system
EB	Clerical schedule (excluded) Tennessee Valley Authority	GM	Performance Management and Recognition system
EC	Engineering and Computing schedule (excluded) Tennessee Valley Authority	GN	Nurse at Warren G. Magnuson Clinical Center
ED	Expert	GS	General Schedule
EE	Expert (other)	GW	Employment under schedule A paid at GS rate Stay-In-School program
EF	Consultant	IE	Senior Intelligence Executive Service (SIES) Program
EG	Consultant (other)	IP	Senior Intelligence Professional Program
EH	Advisory committee member	JG	Graded tradesmen and craftsmen United States Courts
EI	Advisory committee member (other)	JL	Leaders of tradesmen and craftsmen United States Courts
EM	Executive schedule Office of the Comptroller of the currency	JP	Non supervisory lithographers and printers United States Courts
EO	FDIC executive pay	JQ	Lead lithographers and printers United States Courts
EP	Defense Intelligence Senior Executive Service	JR	Supervisory lithographers and printers United States Courts
ES	Senior Executive Service (SES)	JT	Supervisors for tradesmen and craftsmen United States Courts
ET	General Accounting Office Senior Executive Service	KA	Kleas Act Government Printing Office
EX	Executive pay	KG	Non-Craft non supervisory Bureau of Engraving and Printing
FA	Foreign Service Chiefs of mission	KL	Non-Craft leader Bureau of Engraving and Printing
FC	Foreign compensation Agency for International Development	KS	Non-Craft supervisory Bureau of Engraving and Printing
FD	Foreign defense	LE	United States Secret Service uniformed division Treasury
FE	Senior Foreign Service	LG	Liquidation graded FDIC
FO	Foreign Service Officers	MA	Milk Marketing Department of Agriculture
FP	Foreign Service personnel		
FZ	Consular Agent Department of State		
GD	Skill based pay demonstration project managers (DLA)		
GG	Grades similar to General Schedule		

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DATA REQUIREMENTS - PAY PLAN CODE VALID VALUES

VALID VALUES	DESCRIPTIONS	VALID VALUES	DESCRIPTIONS
MC	Cadet	PA	Attorneys and law clerks General Accounting Office
ME	Enlisted	PE	Evaluator and evaluator related General Accounting Office
MO	Officer	PG	Printing Office grades
MW	Warrant officer	PS	Non-appropriated funds, Patron service (to be replaced by NF)
NA	Non appropriated funds, non supervisory, non leader Federal Wage System	RS	Senior Biomedical Service
NC	Naval Research Lab Administrative Support	SA	Administrative schedule Tennessee Valley Authority
ND	Demonstration Scientific and Engineering (Navy Only)	SB	Clerical schedule (excluded) Tennessee Valley Authority
NF	Non-Appropriated Fund, Pay Band	SC	Engineering and Computing schedule Tennessee Valley Authority
NG	Demonstration General Support (Navy Only)	SD	Scientific and Programming schedule Tennessee Valley Authority
NH	Business Management and Technical Management Professional, DoD Acquisition Workforce Demonstration Project (entire DoD)	SE	Aide and Technician schedule Tennessee Valley Authority
NJ	Technical Management Support, DoD Acquisition Workforce	SF	Custodial schedule Tennessee Valley Authority
NK	Administration Support, DoD Acquisition Workforce Demonstration Project (entire DoD)	SG	Public Safety schedule Tennessee Valley Authority
NL	Non-appropriated funds, Crafts and trades worker	SH	Physicians schedule Tennessee Valley Authority
NO	Naval Research Lab Administrative Specialist/ Professional	SJ	Scientific and Programming schedule (excluded) Tennessee Valley Authority
NP	Naval Research Lab Science and Engineering Professional	SL	Senior Level Positions
NR	Naval Research Lab Science and Engineering Technical	SM	Management Schedule Tennessee Valley Authority
NS	Non appropriated funds, supervisory, Federal Wage System	SN	Senior Level System Nuclear Regulatory Commission
NT	Demonstration Administrative and Technical (Navy Only)	SP	Park Police Department of the Interior
OC	Office of the Comptroller of the Currency	SR	Statutory rates not elsewhere specified
		SS	Senior Staff positions
		ST	Scientific and professional

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DATA REQUIREMENTS - PAY PLAN CODE VALID VALUES

VALID VALUES	DESCRIPTIONS	VALID VALUES	DESCRIPTIONS
SZ	Canal Area Special category type positions	WD	Production facilitating non supervisory Federal Wage System
TA	Construction schedule	WE	Currency manufacturing Department of the Treasury
TB	Operating and Maintenance (power facilities) Tennessee Valley Authority	WF	Motion Picture Production
TC	Chemical Operators Tennessee Valley Authority	WG	Non supervisory pay schedule Federal Wage System
TD	Plant Operators schedule Tennessee Valley Authority	WI	Printing and Lithographic (D.C.)
TE	Operating and Maintenance (nonpower facilities) Tennessee Valley Authority	WJ	Hopper Dredge Schedule Supervisory Federal Wage System Dept of Army
TM	Federal Housing Finance board Executive level	WK	Hopper Dredge Schedule non supervisory Federal Wage System Dept of Army
TP	Teaching positions DoD schools only	WL	Leader pay schedules Federal Wage System
TR	Police Forces US Mint and Bureau of Engraving and Printing	WM	Maritime pay schedules
TS	Step System Federal Housing Finance board	WN	Production facilitating supervisory Federal Wage System
VC	Canteen Service Department of Veterans Affairs	WO	Navigation Lock and Dam Operation and maintenance leader USACE
VG	Clerical and Administrative support Farm Credit	WP	Printing and Lithographic (other than D.C.)
VH	Professional, Administrative, and Managerial Farm Credit	WQ	Aircraft Electronic Equipment and Optical Inst. repair supervisory
VM	Medical and Dental Department of Veterans Affairs	WR	Aircraft Electronic Equipment and Optical Inst. repair leader
VN	Nurses Department of Veterans Affairs	WS	Supervisor Federal Wage System
VP	Clinical Podiatrists and Optometrists Department of Veterans Affairs	WT	Apprentices and Shop trainees Federal Wage System
WA	Navigation Lock and Dam Operation and maintenance supervisory USACE	WU	Aircraft Electronic Equipment and Optical Inst. repair non supervisory
WB	Wage positions under Federal Wage System otherwise not designated	WW	Wage type excepted Stay-In-School Federal Wage System
		WY	Navigation Lock and Dam Operation and maintenance non supervisory USACE

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DATA REQUIREMENTS - PAY PLAN CODE VALID VALUES

VALID VALUES	DESCRIPTIONS	VALID VALUES	DESCRIPTIONS
WZ	Canal Area Wage System type positions	ZT	Scientific and Engineering Technician National Institute of Standards and Technology
XA	Special Overlap Area Rate Schedule non supervisory Dept of the Interior	ZZ	Not applicable (use only with pay basis without compensation when others N/A)
XB	Special Overlap Area Rate Schedule leader Dept of the Interior		
XC	Special Overlap Area Rate Schedule supervisory Dept of the Interior		
XD	Non supervisory production facilitating special schedule printing employees		
XF	Floating Plant Schedule non supervisory Dept of Army		
XG	Floating Plant Schedule leader Dept of Army		
XH	Floating Plant Schedule supervisory Dept of Army		
XL	Leader special schedule printing employees		
XN	Supervisory production facilitating special schedule printing employees		
XP	Non supervisory special schedule printing employees		
XS	Supervisory special schedule printing employees		
YV	Temporary summer aid employment		
YW	Student aid employment Stay-In-School		
ZA	Administrative National Institute of Standards and Technology		
ZP	Scientific and Engineering Professional National Institute of Standards and Technology		
ZS	Administrative Support National Institute of Standards and Technology		

