# 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** | | | |

| 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** | • 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**

| **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** | • 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**

| 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**

| 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** | • 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 AGE[1] MUST BE ≥ 64 YEARS AND 8 MONTHS | | |
| | **ELSE** IF PATIENT AGE[1] < 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**

| **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 ADSM |
| | **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** | | | |

| ELEMENT NAME: | HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (2-301) | | |
|---|---|---|---|
| | **VALIDITY EDITS** | | |
| **2-301-01V** | MUST BE A VALID HCDP PLAN COVERAGE CODE LISTED IN CHAPTER 2, ADDENDUM M. | | |
| | **RELATIONAL EDITS** | | |
| **2-301-01R** | IF HCDP PLAN COVERAGE CODE = | 401 | TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) **OR** |
| | | 402 | TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR** |
| | | 405 | TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) **OR** |
| | | 406 | TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) **OR** |
| | | 407 | TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) **OR** |
| | | 408 | TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) **OR** |
| | | 409 | TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE **OR** |
| | | 410 | TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE **OR** |
| | | 411 | TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR** |
| | | 412 | TRS SURVIVOR NEW FAMILY COVERAGE **OR** |
| | | 413 | TRS MEMBER-ONLY COVERAGE **OR** |
| | | 414 | TRS MEMBER AND FAMILY COVERAGE |
| | **THEN** ENROLLMENT/ HEALTH PLAN CODE MUST = | T | TRICARE STANDARD **OR** |
| | | V | TRICARE EXTRA **OR** |
| | | FE | TFL - EXTRA **OR** |
| | | FS | TFL - STANDARD **OR** |
| | | PS | TSRx **OR** |
| | | SR | SHCP-REFERRED CARE |
| **2-301-02R** | IF HCDP PLAN COVERAGE CODE = | 401 | TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) **OR** |
| | | 402 | TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR** |
| | | 405 | TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) **OR** |

| ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (2-301) | | | |
|---|---|---|---|
| | | 406 | TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) **OR** |
| | | 407 | TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) **OR** |
| | | 408 | TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) **OR** |
| | | 409 | TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE **OR** |
| | | 410 | TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE **OR** |
| | | 411 | TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR** |
| | | 412 | TRS SURVIVOR NEW FAMILY COVERAGE **OR** |
| | | 413 | TRS MEMBER-ONLY COVERAGE **OR** |
| | | 414 | TRS MEMBER AND FAMILY COVERAGE |
| | **THEN NO** OCCURRENCE OF SPECIAL PROCESSING CODE CAN = | PF | ECHO |

| ELEMENT NAME: REGION INDICATOR (2-303) | | | |
|---|---|---|---|
| **VALIDITY EDITS** | | | |
| **2-303-01V** | MUST BE A VALID REGION INDICATOR (REFER TO CHAPTER 2, SECTION 2.8) | | |
| **2-303-02V** | IF TYPE OF SUBMISSION ≠ | B | ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR** |
| | | E | COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA |
| | **AND** REGION INDICATOR = | NC | NORTH CONTRACT **OR** |
| | | SC | SOUTH CONTRACT **OR** |
| | | WC | WEST CONTRACT |
| | **THEN** ADJUSTMENT KEY MUST = | 0 | BATCH **OR** |
| | | 5 | VOUCHER |
| **RELATIONAL EDITS** | | | |
| | NONE | | |

| 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** | • 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 ADSM |
| | **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 |
| | **THEN** AT LEAST ONE SPECIAL PROCESSING CODE MUST = | S | RESOURCE SHARING - EXTERNAL |

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| **ELEMENT NAME:** | **SPECIAL PROCESSING CODE (2-305) (CONTINUED)** | | |
|---|---|---|---|
| **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 |
| | **THEN** TYPE OF SERVICE (SECOND POSITION) MUST = | B | RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS |

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| ELEMENT NAME: | SPECIAL PROCESSING CODE (2-305) (CONTINUED) | | |
|---|---|---|---|
| | **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 **OR** |
| | | P1 | OPPS **OR** |
| | | P2 | OPPS WITH COST OUTLIER **OR** |
| | | P3 | OPPS WITH DISCOUNT |
| **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 |
| **2-305-21R** | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | MN | TSP - NON-NETWORK **OR** |

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| ELEMENT NAME: | SPECIAL PROCESSING CODE (2-305) (CONTINUED) | | |
|---|---|---|---|
| | | 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** |
| | | S | RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) |

[1] **AS STATED IN CHAPTER 2, SECTION 2.8 OR BLANK**

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| ELEMENT NAME: | SPECIAL PROCESSING CODE (2-305) (CONTINUED) | | |
|---|---|---|---|
| | **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** | • 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** |
| | | 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] **AS STATED IN CHAPTER 2, SECTION 2.8 OR BLANK**

[2] **CPT ONLY © 2006 AMERICAN MEDICAL ASSOCIATION (OR SUCH OTHER DATE OF PUBLICATION OF CPT). ALL RIGHTS RESERVED.**

| ELEMENT NAME: | SPECIAL PROCESSING CODE (2-305) (CONTINUED) | | |
|---|---|---|---|
| **2-305-29R** | • SPECIAL PROCESSING CODE "V" IS USED FOR CARE PROVIDED WITHIN NORMAL LIMITS - WHILE SPECIAL PROCESSING CODE "W" IS USED FOR CARE OVER AND ABOVE THOSE NORMAL LIMITS | | |
| | IF BEGIN DATE OF CARE IS ≥ 12/28/2001 | | |
| | **AND** ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | CT | CCTP |
| | **THEN** AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | V | FINANCIALLY UNDERWRITTEN PAYMENT BY CLAIMS PROCESSOR **OR** |
| | | W | NON-FINANCIALLY UNDERWRITTEN PAYMENT BY FINANCIALLY UNDERWRITTEN CLAIMS PROCESSOR |
| **2-305-30R** | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | PF | ECHO |
| | **THEN** HCDP PLAN COVERAGE CODE MUST ≠ | 401 | TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) **OR** |
| | | 402 | TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR** |
| | | 405 | TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) **OR** |
| | | 406 | TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) **OR** |
| | | 407 | TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) **OR** |
| | | 408 | TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) **OR** |
| | | 409 | TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE **OR** |
| | | 410 | TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE **OR** |
| | | 411 | TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR** |
| | | 412 | TRS SURVIVOR NEW FAMILY COVERAGE **OR** |
| | | 413 | TRS MEMBER-ONLY COVERAGE **OR** |
| | | 414 | TRS MEMBER AND FAMILY COVERAGE |

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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 |

| 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.**

| 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 | TRS 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.**

| ELEMENT NAME: CA/NAS NUMBER (2-310) (CONTINUED) | | | |
|---|---|---|---|
| | | 402 | TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR** |
| | | 405 | TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) **OR** |
| | | 406 | TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) **OR** |
| | | 407 | TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) **OR** |
| | | 408 | TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) **OR** |
| | | 409 | TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE **OR** |
| | | 410 | TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE **OR** |
| | | 411 | TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR** |
| | | 412 | TRS SURVIVOR NEW FAMILY COVERAGE **OR** |
| | | 413 | TRS MEMBER-ONLY COVERAGE **OR** |
| | | 414 | TRS MEMBER AND FAMILY COVERAGE |
| **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.**

| **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 |

| 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.**

| 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 |
| | **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 | | |
| **NO ERROR** | IF HCDP PLAN COVERAGE CODE = | 401 | TRS 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.**

| ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320) (CONTINUED) | | |
|---|---|---|
| | 402 | TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR** |
| | 405 | TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) **OR** |
| | 406 | TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) **OR** |
| | 407 | TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) **OR** |
| | 408 | TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) **OR** |
| | 409 | TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE **OR** |
| | 410 | TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE **OR** |
| | 411 | TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR** |
| | 412 | TRS SURVIVOR NEW FAMILY COVERAGE **OR** |
| | 413 | TRS MEMBER-ONLY COVERAGE **OR** |
| | 414 | TRS MEMBER AND FAMILY COVERAGE |
| **2-320-01R** | IF PATIENT ZIP CODE IS **NOT** IN AN MTF[2] CATCHMENT AREA[1] | |
| | **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.**

| 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 |
| | **THEN** ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | 16 | AMBULATORY SURGERY FACILITY CHARGE **OR** |

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| ELEMENT NAME: | PRICING RATE CODE (2-325) (CONTINUED) | | |
|---|---|---|---|
| | | 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 = | NE | OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM |
| | **AND** BEGIN DATE OF CARE ≥ 09/14/2001 **AND** < 11/01/2008 | | |
| | **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) |
| | **THEN** PROVIDER SPECIALITY MUST = | | 261QS1200X (CLINIC/CENTER - SLEEP DISORDER DIAGNOSTIC) **OR** |
| | | | 293D00000X (PHYSIOLOGICAL LAB) **OR** |
| | | | 261QE0700X (CLINIC/CENTER END STAGE RENAL DISEASE TREATMENT) **OR** |

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| ELEMENT NAME: | PRICING RATE CODE (2-325) (CONTINUED) | | |
|---|---|---|---|
| | | | 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. | | |
| **2-325-09R** | IF PRICING RATE CODE = | CA | CAH REIMBURSEMENT |
| | **THEN** PROVIDER STATE OR COUNTRY CODE MUST = | AK | ALASKA |
| | **AND** BEGIN DATE OF CARE MUST BE ≥ 07/01/2007 | | |

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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 |

| ELEMENT NAME: | OPPS PAYMENT STATUS INDICATOR CODE (2-331) |
|---|---|
| | **VALIDITY EDITS** |
| **2-331-01V** | MUST BE A VALID OPPS PAYMENT STATUS INDICATOR CODE (REFER TO CHAPTER 2, SECTION 2.6) **OR** BLANK. |
| | **RELATIONAL EDITS** |
| **2-331-01R** | IF OPPS PAYMENT STATUS INDICATOR CODE = BLANK |
| | **THEN** AMBULATORY PAYMENT CLASSIFICATION CODE MUST = ALL ZEROES **OR** BLANK. |