INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME:	**PERSON SEX (PATIENT) (1-100)**		
	VALIDITY EDITS		
1-100-01V	MUST BE =	F	FEMALE **OR**
		M	MALE **OR**
		Z	NOT PROVIDED FROM DEERS
	RELATIONAL EDITS		
	NONE		

ELEMENT NAME:	**PATIENT ZIP CODE (1-105)**
	VALIDITY EDITS
1-105-01V	MUST BE 9 DIGITS **OR** 5 DIGITS WITH 4 BLANKS
	MUST BE A VALID ZIP CODE (BASED ON ADMISSION DATE) IN THE GOVERNMENT PROVIDED ELECTRONIC ZIP CODE FILE **OR**
	MUST BE A 3 CHARACTER FOREIGN COUNTRY CODE (BASED ON THE COUNTRY CODES TABLE[1]) FOLLOWED BY 6 BLANKS
	RELATIONAL EDITS
NO ERROR	IF ADMISSION DATE IS OLDER THAN 6 YEARS
	THEN DO NOT CHECK **IF** ZIP CODE IS IN CATCHMENT AREA[4]
1-105-01R	IF CA/NAS EXCEPTION REASON IS **CODED**
	THEN PATIENT ZIP CODE MUST BE **WITHIN** AN MTF[3] CATCHMENT AREA[4]

[1] WHEN FOREIGN COUNTRY CODES ARE SUBMITTED, THE FIRST 3 CHARACTERS WILL BE EDITED AGAINST CHAPTER 2, ADDENDUM A.
[2] STSF IS A REGIONAL 200 MILES, 48 CONTIGUOUS STATES, OR MULTI-REGIONAL CATCHMENT AREA, DEPENDING ON TYPE OF STSF BEING PROCESSED.
[3] MTF IS A 40 MILES CATCHMENT AREA.
[4] CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (1-110)			
VALIDITY EDITS			
1-110-01V	MUST BE A VALID ENROLLMENT/HEALTH PLAN CODE (REFER TO CHAPTER 2, SECTION 2.5)		
1-110-02V	IF ENROLLMENT/HEALTH PLAN CODE =	SO	SHCP - NON-TRICARE ELIGIBLE **OR**
		ST	SHCP - TRICARE ELIGIBLE
	THEN BEGIN DATE OF CARE MUST BE < 06/01/2004		
1-110-03V	IF ENROLLMENT/HEALTH PLAN CODE =	TS	TSS
	THEN BEGIN DATE OF CARE MUST BE < 12/31/2002		
1-110-04V	IF ENROLLMENT/HEALTH PLAN CODE =	BB	TSP
	THEN BEGIN DATE OF CARE MUST BE < 12/31/2001		
RELATIONAL EDITS			
1-110-02R	IF ENROLLMENT/HEALTH PLAN CODE =	Y	CHCBP - STANDARD **OR**
		AA	CHCBP - EXTRA
	THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE CAN =	CL	CLINICAL TRIALS **OR**
		PF	ECHO
1-110-03R	IF ENROLLMENT/HEALTH PLAN CODE =	W	TPR ADSM - USA
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	GU	ADSM ENROLLED IN TPR
1-110-05R	IF ENROLLMENT/HEALTH PLAN CODE =	BB	TSP
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	MN	TSP - NON-NETWORK **OR**
		MS	TSP - NETWORK
1-110-06R	IF ENROLLMENT/HEALTH PLAN CODE =	SN	SHCP - NON-MTF-REFERRED CARE **OR**
		SO	SHCP - NON-TRICARE ELIGIBLE **OR**
		SR	SHCP - REFERRED CARE **OR**
		ST	SHCP - TRICARE ELIGIBLE
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AN	SHCP - NON-MTF-REFERRED CARE **OR**
		AR	SHCP - REFERRED CARE **OR**
		CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM **OR**

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

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (1-110) (CONTINUED)			
		SC	SHCP - NON-TRICARE ELIGIBLE **OR**
		SE	SHCP - TRICARE ELIGIBLE **OR**
		SM	SHCP - EMERGENCY
1-110-07R	IF ENROLLMENT/HEALTH PLAN CODE =	Z	TRICARE PRIME, MTF/PCM
	THEN ADMISSION DATE MUST BE ≥ 10/01/1997		
1-110-08R	IF ENROLLMENT/HEALTH PLAN CODE =	TS	TSS
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	SN	TSS - NON-NETWORK **OR**
		SS	TSS - NETWORK
1-110-09R	• TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE Š 10/01/2001. WHEN BEGIN DATE OF CARE IS < 10/01/2001, THE LINE ITEMS MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.		
	IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD
	AND TYPE OF INSTITUTION ≠	10	GENERAL MEDICAL AND SURGICAL
	THEN BEGIN DATE OF CARE MUST BE ≥ 10/01/2001		
	AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	FF	TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) **OR**
		FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) **OR**
		FS	TFL (SECOND PAYOR)
	ELSE IF BEGIN DATE OF CARE IS < 10/01/2001		
	THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAILED LINE ITEM (EXCEPT FOR LINE CONTAINING REVENUE CODE 0001) MUST =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER **OR**
		26	EXPENSES INCURRED PRIOR TO COVERAGE **OR**
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED **OR**
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING OR RESIDENCY REQUIREMENTS **OR**

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

ELEMENT NAME:	ENROLLMENT/HEALTH PLAN CODE (1-110) (CONTINUED)		
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED **OR**
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED **OR**
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE **OR**
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORN **OR**
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION **OR**
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
1-110-10R	• TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001 **UNLESS** THE BENEFICIARY IS AN INPATIENT AND THE ADMISSION DATE WAS PRIOR TO 10/01/2001, TFL WILL PAY FOR THE ENTIRE HOSPITAL STAY.		
	IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD
	AND TYPE OF INSTITUTION =	10	GENERAL MEDICAL AND SURGICAL
	THEN END DATE OF CARE ≥ 10/01/2001		
	AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	FF	TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) **OR**
		FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) **OR**
		FS	TFL (SECOND PAYOR)
1-110-11R	• TFL CLAIMS: THE PATIENT MUST BE 64 YEARS AND 11 MONTHS OR GREATER. IF THE PATIENT IS LESS THAN THIS AGE THE LINE ITEMS MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.		
	IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD
	THEN PATIENT AGE[1] MUST BE ≥ 64 YEARS AND 11 MONTHS		
	ELSE IF PATIENT AGE[1] IS < 64 YEARS AND 11 MONTHS		

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

ELEMENT NAME:	ENROLLMENT/HEALTH PLAN CODE (1-110) (CONTINUED)		
	THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAILED LINE ITEM (EXCEPT LINE CONTAINING REVENUE CODE 0001) MUST =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER **OR**
		26	EXPENSES INCURRED PRIOR TO COVERAGE **OR**
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED **OR**
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS **OR**
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED **OR**
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED **OR**
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE **OR**
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS **OR**
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION **OR**
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
1-110-12R	IF ENROLLMENT/HEALTH PLAN CODE =	WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	THEN BEGIN DATE OF CARE IS ≥ 09/01/2002		

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

ELEMENT NAME:	HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111)		
	VALIDITY EDITS		
1-111-01V	MUST BE A VALID HCDP PLAN COVERAGE CODE LISTED IN CHAPTER 2, ADDENDUM M.		
	RELATIONAL EDITS		
1-111-01R	IF HCDP PLAN COVERAGE CODE =	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
		406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
		407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) **OR**
		408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) **OR**
		409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE **OR**
		410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE **OR**
		411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR**
		412	TRS SURVIVOR NEW FAMILY COVERAGE **OR**
		413	TRS MEMBER-ONLY COVERAGE **OR**
		414	TRS MEMBER AND FAMILY COVERAGE
	THEN ENROLLMENT/ HEALTH PLAN CODE MUST =	T	TRICARE STANDARD **OR**
		V	TRICARE EXTRA **OR**
		FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD **OR**
		PS	TSRx **OR**
		SR	SHCP-REFERRED CARE
1-111-02R	IF HCDP PLAN COVERAGE CODE =	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**

ELEMENT NAME:	HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111)		
		406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
		407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) **OR**
		408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) **OR**
		409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE **OR**
		410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE **OR**
		411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR**
		412	TRS SURVIVOR NEW FAMILY COVERAGE **OR**
		413	TRS MEMBER-ONLY COVERAGE **OR**
		414	TRS MEMBER AND FAMILY COVERAGE
	THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE CAN =	PF	ECHO
1-111-03R	IF HCDP PLAN COVERAGE CODE =	417	TRANSITIONAL CARE FOR SERVICE-RELATED CONDITIONS (TCSRC)
	THEN ENROLLMENT/ HEALTH PLAN CODE MUST =	X	FOREIGN ADSM **OR**
		SR	SHCP - REFERRED CARE

ELEMENT NAME:	REGION INDICATOR (1-112)		
	VALIDITY EDITS		
1-112-01V	MUST BE VALID REGION INDICATOR (REFER TO CHAPTER 2, SECTION 2.8)		
1-112-02V	IF TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	AND REGION INDICATOR =	NC	NORTH CONTRACT **OR**
		SC	SOUTH CONTRACT **OR**
		WC	WEST CONTRACT
	THEN ADJUSTMENT KEY MUST =	0	BATCH **OR**
		5	VOUCHER
	RELATIONAL EDITS		
	NONE		

ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (1-115)			
VALIDITY EDITS			
1-115-01V	MUST BE A VALID FOUR DIGIT PCM LOCATION DMIS-ID.		
1-115-02V	• REVISED FINANCING		
	IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE **OR**
		6	VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE
	AND ENROLLMENT/HEALTH PLAN CODE =	Z	TRICARE PRIME, MTF/CLINIC
	AND TYPE OF SUBMISSION ≠	B	ADJUTMENT NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN PCM LOCATION DMIS-ID MUST EQUAL A VALID MTF/CLINIC DMIS-ID[1]		
	AND CANNOT = 6501, 6901-6915, 6917-6919, 7901-7912, 7916[2]-7919, 8000-8099, **OR** BLANK		
RELATIONAL EDITS			
NO ERROR	IF ANY OCCURRENCE OF OVERRIDE CODE =	S	ZIP CODE OVERRIDE TO BE USED WHEN A BENEFICIARY HAS MOVED OUT OF A REGION AND THE CONTRACTOR IS STILL RESPONSIBLE FOR THE CARE CLAIMED; OR IF A BENEFICIARY RESIDES IN A REGION DIFFERENT FROM THE REGION THEY ARE ENROLLED IN--**WITHIN THE SAME CONTRACT JURISDICTION**
	THEN BYPASS ALL PCM LOCATION DMIS-ID RELATIONAL EDITING.		
1-115-01R	IF DATE OF ADMISSION ≥ 10/01/1997		
	AND ENROLLMENT/HEALTH PLAN CODE =	BB	TSP
	THEN PCM LOCATION DMIS-ID MUST BE A VALID MTF/CLINIC DMIS-ID[1]		
	AND CANNOT = 6501, 6901-6915, 6917-6919, 7901-7912, 7916[2]-7919, 8000-8099, **OR** BLANK.		
1-115-02R	IF DATE OF ADMISSION ≥ 10/01/1999		
	AND ENROLLMENT/HEALTH PLAN CODE =	SR	SHCP - REFERRED CARE
	THEN PCM LOCATION DMIS-ID MUST EQUAL A VALID MTF/CLINIC DMIS-ID[1]		
	AND CANNOT = 6501, 6901-6915, 6917-6919, 7901-7912, 7916[2]-7919, **OR** 8000-8099		
	UNLESS HCDP PLAN COVERAGE CODE =	417	TRANSITIONAL CARE FOR SERVICE-RELATED CONDITIONS (TCSRC)
	THEN BYPASS THIS EDIT.		
1-115-04R	IF DATE OF ADMISSION ≥ 10/01/1997 **AND** < 09/01/2002		

[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:	**PCM LOCATION DMIS-ID (ENROLLMENT) CODE (1-115) (CONTINUED)**		
	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		
	OR REGION INDICATOR =	~~b~~	BLANK **OR**
		SC	SOUTH CONTRACT
	THEN DMIS-ID MUST = 6903, 6904, 6906, 6913, 6914, **OR** 6915		
	OR REGION INDICATOR =	~~b~~	BLANK **OR**
		WC	WEST CONTRACT
	THEN DMIS-ID MUST = 6907, 6908, 6909, 6910, 6911, **OR** 6912		
1-115-05R	IF DATE OF ADMISSION ≥ 10/01/1997 **AND** < 10/01/1999		
	AND ENROLLMENT/HEALTH PLAN CODE =	W	TPR ADSM - USA
	AND REGION INDICATOR =	~~b~~	BLANK **OR**
		NC	NORTH CONTRACT
	THEN DMIS-ID MUST = 7901, 7902, 7905, 8000-8099, **OR** BLANK		
1-115-06R	IF DATE OF ADMISSION ≥ 10/01/1999 **AND** < 09/01/2002		
	AND ENROLLMENT/HEALTH PLAN CODE =	W	TPR ADSM - USA
	AND REGION INDICATOR =	~~b~~	BLANK **OR**
		NC	NORTH CONTRACT
	THEN DMIS-ID MUST = 7901, 7902, 7905, **OR** 8000-8099		
	OR REGION INDICATOR =	~~b~~	BLANK **OR**
		SC	SOUTH CONTRACT
	THEN DMIS-ID MUST = 7903, 7904, **OR** 7906		
	OR REGION INDICATOR =	~~b~~	BLANK **OR**
		WC	WEST CONTRACT
	THEN DMIS-ID MUST = 7907, 7908, 7909, 7910, 7911, 7912, **OR** 7916[2]		
1-115-07R	IF DATE OF ADMISSION ≥ 10/01/1997		
	AND ENROLLMENT/HEALTH PLAN CODE ≠	U	TRICARE PRIME, CIVILIAN PCM **OR**
		W	TPR 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**
		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.**

ELEMENT NAME:	**PCM LOCATION DMIS-ID (ENROLLMENT) CODE (1-115) (CONTINUED)**		
		WO	TPR FOREIGN ADFM **OR**
		XF	FOREIGN ADFM
	THEN PCM LOCATION DMIS-ID MUST =	~~b~~	BLANK
	UNLESS HCDP PLAN COVERAGE CODE =	140	TRICARE PLUS WITH CHC COVERAGE FOR ADFMs **OR**
		141	TRICARE PLUS COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		142	TRICARE PLUS WITH CHC COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		143	TRICARE PLUS COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		144	TRICARE PLUS WITH CHC COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		145	TRICARE PLUS COVERAGE FOR RETIRED SPONSORS, FAMILY MEMBERS AND MEDAL OF HONOR **OR**
		146	TRICARE PLUS WITH CHC COVERAGE FOR RETIRED SPONSORS, FAMILY MEMBERS AND MEDAL OF HONOR **OR**
		147	TRICARE PLUS WITH CHC COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/ RESERVE DECEASED SPONSORS **OR**
		148	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS **OR**
		149	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED **OR**
		150	TRICARE PLUS COVERAGE FOR ADFMs **OR**
		151	TRICARE PLUS COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/ RESERVE DECEASED SPONSORS
1-115-08R	IF DATE OF ADMISSION ≥ 09/01/2002		
	AND ENROLLMENT/HEALTH PLAN CODE =	U	TRICARE PRIME, CIVILIAN PCM
	AND REGION INDICATOR =	~~b~~	BLANK **OR**
		NC	NORTH CONTRACT
	THEN DMIS-ID MUST = 6901, 6902, 6905, 6917, 8007, **OR** 8009		
	OR REGION INDICATOR =	~~b~~	BLANK **OR**
		SC	SOUTH CONTRACT
	THEN DMIS-ID MUST = 6903, 6904, 6906, 6913, 6914, 6915, **OR** 6918		

[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:	PCM LOCATION DMIS-ID (ENROLLMENT) CODE (1-115) (CONTINUED)		
	OR REGION INDICATOR =	~~b~~	BLANK **OR**
		WC	WEST CONTRACT
	THEN DMIS-ID MUST = 6907, 6908, 6909, 6910, 6911, 6912, **OR** 6919		
1-115-09R	IF DATE OF ADMISSION ≥ 09/01/2002		
	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		

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

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

ELEMENT NAME:	AMOUNT PATIENT COST-SHARE (1-135)		
	VALIDITY EDITS		
1-135-01V	MUST BE NUMERIC.		
	RELATIONAL EDITS		
1-135-01R	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		
1-135-02R	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 (1-136)
	VALIDITY EDITS
1-136-01V	MUST BE A VALID HCC COPAYMENT FACTOR CODE LISTING IN CHAPTER 2, SECTION 2.5.
	RELATIONAL EDITS
	NONE

ELEMENT NAME:	AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) (1-140)		
	VALIDITY EDITS		
1-140-01V	MUST BE NUMERIC.		
	RELATIONAL EDITS		
1-140-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		I	INITIAL SUBMISSION **OR**
		R	RESUBMISSION
	THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST BE ≥ ZERO		
1-140-02R	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL
	THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST = ZERO		

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		

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 AGE[1] 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 AGE[1] 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 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
1-160-06R	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.**

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 AGE[1] 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.**

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.**

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**

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		

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		

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.

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

[1] **CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.**
[2] **MTF IS A 40 MILES CATCHMENT AREA.**

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

[1] **CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.**
[2] **MTF IS A 40 MILES CATCHMENT AREA.**

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

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.

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

[1] **CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.**
[2] **MTF IS A 40 MILES CATCHMENT AREA.**

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

[1] **CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.**
[2] **MTF IS A 40 MILES CATCHMENT AREA.**

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185)			
VALIDITY EDITS			
1-185-01V	OCCURRENCE NUMBER 1--MUST BE A VALID SPECIAL PROCESSING CODE[1]		
1-185-02V	OCCURRENCE NUMBER 2--MUST BE A VALID SPECIAL PROCESSING CODE[1]		
1-185-03V	OCCURRENCE NUMBER 3--MUST BE A VALID SPECIAL PROCESSING CODE[1]		
1-185-04V	OCCURRENCE NUMBER 4--MUST BE A VALID SPECIAL PROCESSING CODE[1]		
1-185-05V	A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).		
1-185-06V	SPECIAL PROCESSING CODE OCCURRENCES MUST BE LEFT JUSTIFIED.		
1-185-07V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AN	SHCP - NON-MTF-REFERRED CARE **OR**
		AR	SHCP - REFERRED CARE **OR**
	THEN BEGIN DATE OF CARE MUST BE < 06/01/2004		
1-185-08V	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		
1-185-10V	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		
1-185-11V	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		
1-185-13V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PD	PHARMACY REDESIGN PILOT PROGRAM
	THEN BEGIN DATE OF CARE MUST BE < 04/01/2001		
1-185-14V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	ST	SPECIALIZED TREATMENT
	THEN BEGIN DATE OF CARE MUST BE < 10/01/2004		
1-185-15V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	WR	MENTAL HEALTH WRAPAROUND DEMONSTRATION
	THEN BEGIN DATE OF CARE MUST BE < 06/30/2001		
RELATIONAL EDITS			
1-185-04R	IF PRINCIPAL/SECONDARY OP/NSP CODE IS 41.02 **OR** 41.03		
	THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST =	3	ALLOGENEIC BONE MARROW RECIPIENT-WILFORD HALL REFERRED ONLY
1-185-05R	IF BEGIN DATE OF CARE < 03/01/1997 **OR** (> 02/19/1998 **AND** < 09/01/1999)		
	AND PRINCIPAL/SECONDARY OP/NSP CODE IS 50.51 **OR** 50.59		

[1] **AS STATED IN SECTION 2.8 OR BLANK.**
[2] **PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.**

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

[1] **AS STATED IN SECTION 2.8 OR BLANK.**
[2] **PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.**

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

[1] **AS STATED IN SECTION 2.8 OR BLANK.**
[2] **PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.**

ELEMENT NAME:	SPECIAL PROCESSING CODE (1-185) (CONTINUED)		
	AND ENROLLMENT/ HEALTH PLAN CODE MUST =	FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD
	ELSE IF BEGIN DATE OF CARE IS < 10/01/2001		
	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	• TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 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)

[1] **AS STATED IN SECTION 2.8 OR BLANK.**
[2] **PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.**

ELEMENT NAME:	SPECIAL PROCESSING CODE (1-185) (CONTINUED)		
	AND TYPE OF INSTITUTION =	10	GENERAL MEDICAL AND SURGICAL
	THEN END DATE OF CARE MUST BE ≥ 10/01/2001		
	AND ENROLLMENT/ HEALTH PLAN CODE MUST =	FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD
1-185-38R	• SPECIAL PROCESSING CODE 'V' IS USED FOR CARE PROVIDED WITHIN NORMAL LIMITS - WHILE SPECIAL PROCESSING CODE "W" IS USED FOR CARE OVER AND ABOVE THOSE NORMAL LIMITS		
	IF BEGIN DATE OF CARE IS ≥ 12/28/2001		
	AND ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	CT	CCTP
	THEN AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	V	FINANCIALLY UNDERWRITTEN PAYMENT BY CLAIMS PROCESSOR **OR**
		W	NON-FINANCIALLY UNDERWRITTEN PAYMENT BY FINANCIALLY UNDERWRITTEN CLAIMS PROCESSOR
1-185-39R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF	ECHO
	THEN HCDP PLAN COVERAGE CODE MUST ≠	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
		406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
		407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) **OR**
		408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) **OR**
		409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE **OR**
		410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE **OR**

[1] **AS STATED IN SECTION 2.8 OR BLANK.**
[2] **PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.**

ELEMENT NAME:	SPECIAL PROCESSING CODE (1-185) (CONTINUED)		
		411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR**
		412	TRS SURVIVOR NEW FAMILY COVERAGE **OR**
		413	TRS MEMBER-ONLY COVERAGE **OR**
		414	TRS MEMBER AND FAMILY COVERAGE
1-185-49R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AU	AUTISM DEMONSTRATION
	THEN BEGIN DATE OF CARE MUST BE ≥ 03/15/2008		
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	PF	ECHO
	AND PATIENT AGE[2] MUST BE ≥ 18 MONTHS		
1-185-50R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	49	HOSPITAL REIMBURSEMENT REDUCED BY MANUFACTURER CREDIT/REPLACEMENT OF DEVICE DURING WARRANTY PERIOD **OR**
		50	HOSPITAL REIMBURSEMENT REDUCED BY MANUFACTURER CREDIT/RECALLED DEVICE
	THEN DRG NUMBER MUST EQUAL A DRG SUBJECT TO THE REPLACEMENT DEVICE POLICY POSTED ON TRICARE'S DRG WEB PAGE AT HTTP://WWW.TRICARE.MIL/DRGRATES/		
	AND DATE OF ADMISSION MUST BE ≥ THE DRG EFFECTIVE DATE AND ≤ THE DRG TERMINATION DATE AS PER THE REPLACEMENT DEVICE POLICY POSTED ON TRICARE'S DRG WEB PAGE AT HTTP://WWW.TRICARE.MIL/DRGRATES/		

[1] **AS STATED IN SECTION 2.8 OR BLANK.**
[2] **PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.**

ELEMENT NAME:	HEALTH CARE DELIVERY PROGRAM (HCDP) SPECIAL ENTITLEMENT CODE (1-186)
	VALIDITY EDITS
1-186-01V	MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE LISTING IN SECTION 2.5.
	RELATIONAL EDITS
	NONE

ELEMENT NAME: PRICING RATE CODE (1-190)			
VALIDITY EDITS			
1-190-01V	VALUE MUST BE A VALID INSTITUTIONAL PRICING RATE CODE.		
RELATIONAL EDITS			
1-190-01R	IF FILING STATE/COUNTRY CODE =	MD	MARYLAND
	THEN PRICING RATE CODE MUST ≠	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER **OR**
		I	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER **OR**
		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER
1-190-02R	IF DRG NUMBER IS CODED (OTHER THAN ZERO)		
	THEN PRICING RATE CODE MUST =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER **OR**
		I	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER **OR**
		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER **OR**
		U	SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS **OR**
		V	MEDICARE REIMBURSEMENT RATE
1-190-03R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	11	HOSPICE
	THEN PRICING RATE CODE MUST =	D	DISCOUNT RATE AGREEMENT **OR**
		P	PER DIEM RATE AGREEMENT **OR**
		U	SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS **OR**
		V	MEDICARE REIMBURSEMENT RATE
	UNLESS TYPE OF SUBMISSION =	D	COMPLETE DENIAL
1-190-04R	IF PRICING RATE CODE =	V	MEDICARE REIMBURSEMENT RATE
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) **AND** EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 **OR**
		FS	TFL (SECOND PAYOR) **OR**
		MN	TSP - NON-NETWORK **OR**
		MS	TSP - NETWORK
	OR TYPE OF INSTITUTION =	70	HOME HEALTH AGENCY **OR**
		76	SKILLED NURSING FACILITY

ELEMENT NAME:	PRICING RATE CODE (1-190) (CONTINUED)		
1-190-05R	IF PRICING RATE CODE =	U	SHCP CLAIM OR ACTIVE DUTY MEMBER TPR CLAIM PAID OUTSIDE NORMAL LIMITS
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AN	SHCP - NON-MTF-REFERRED CARE **OR**
		AR	SHCP - REFERRED CARE **OR**
		CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM **OR**
		GU	ADSM ENROLLED IN TPR **OR**
		SC	SHCP - NON-TRICARE ELIGIBLE **OR**
		SE	SHCP - TRICARE ELIGIBLE **OR**
		SM	SHCP - EMERGENCY
	OR ENROLLMENT/ HEALTH PLAN CODE MUST =	SN	SHCP - NON-MTF-REFERRED CARE **OR**
		SR	SHCP - REFERRED CARE
1-190-06R	IF ANY OCCURRENCE OF REVENUE CODE =	0022	SKILLED NURSING FACILITY CHARGE
	THEN PRICING RATE CODE MUST =	D	DISCOUNT RATE AGREEMENT **OR**
		V	MEDICARE REIMBURSEMENT RATE
1-190-07R	IF ANY OCCURRENCE OF REVENUE CODE =	0023	HOME HEALTH AGENCY (HHA-PPS)
	THEN PRICING RATE CODE MUST =	D	DISCOUNT RATE AGREEMENT **OR**
		V	MEDICARE REIMBURSEMENT RATE
1-190-08R	IF PRICING RATE CODE =	CA	CAH REIMBURSEMENT
	THEN ADMISSION DATE MUST BE ≥ 12/01/2009		
	UNLESS PROVIDER STATE OR COUNTRY CODE =	AK	ALASKA
	THEN ADMISSION DATE MUST BE ≥ 07/01/2007		

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 RECORD[1] 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).**