



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

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TRICARE
MANAGEMENT ACTIVITY

PCSIB

CHANGE 77
7950.1-M
SEPTEMBER 15, 2009

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE SYSTEMS MANUAL (TSM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to 7950.1-M, reissued August 2002.

CHANGE TITLE: NUMBER OF SERVICES BY PROCEDURE CODE

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change provides the capability to control the maximum number of services by procedure code by individual procedure code. This change complies with National Defense Authorization Act (NDAA) 2007, Section 731(d) regarding Standardization of Claims Processing under the TRICARE program and Medicare program.

EFFECTIVE AND IMPLEMENTATION DATE: February 1, 2010.


Jack Arendale
Chief, Purchased Care Systems
Integration Branch

ATTACHMENT(S): 12 PAGES
DISTRIBUTION: 7950.1-M

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

CHANGE 77
7950.1-M
SEPTEMBER 15, 2009

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 2

Section 2.6, pages 1, 2, 17, and 18

Section 6.2, pages 27 through 32

Section 2.6, pages 1, 2, 17, and 18

Section 6.2, pages 27 through 34

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

DATA ELEMENT DEFINITION

ELEMENT NAME: NATIONAL DRUG CODE			
RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-170	Up to 99	Yes ¹
PRIMARY PICTURE (FORMAT) Eleven (11) alphanumeric characters.			
DEFINITION Number assigned to pharmaceutical products by the Food and Drug Administration (FDA).			
CODE/VALUE SPECIFICATIONS Unique number assigned to include pharmaceutical by the FDA.			
ALGORITHM N/A			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		GROUP	
N/A		N/A	

NOTES AND SPECIAL INSTRUCTIONS:

¹ Only required for Outpatient Drug claim. For non-pharmacy claims blank fill.

This data element must be present for Mail Order Pharmacy **and Retail Pharmacy**.

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 2.6

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

DATA ELEMENT DEFINITION

ELEMENT NAME: NUMBER OF SERVICES			
RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-175	Up to 99	Yes
PRIMARY PICTURE (FORMAT) Three (3) signed numeric digits.			
DEFINITION Number of procedures performed/services or supplies rendered for medical, dental, and mental health care.			
CODE/VALUE SPECIFICATIONS N/A			
ALGORITHM Identical procedures must be combined when performed by the same provider, with the same charge for each, and within the same calendar month, provided the reason for allowance/denial is the same for each charge and combining procedures does not conflict with other TED record requirements (i.e., Number of Services field size). For ambulance services, allergy testing, DME rental, or POV mileage for the Extended Care Health Option (ECHO), enter 01 for each service regardless of number of units or mileage. When multiple units are used in a single episode of care, such as one box of twelve syringes, code only one (1) supply or service. Allowed prescription drugs must be combined separately from disallowed prescription drugs. For prescriptions report the number of prescriptions.			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		GROUP	
N/A		N/A	

NOTES AND SPECIAL INSTRUCTIONS:
 Number of Services should be reported as 999 for HCPCS J-codes when the actual quantity of the services on the claim form exceeds 999.
For a list of the maximum number of services allowed for a procedure code per day, refer to the Maximum Number of Services by Procedure Code list on TMA's web site at <http://www.tricare.mil/tma/Rates.aspx>. These values conform to CMS' Medically Unlikely Edits (MUE) program for CPT/HCPCS codes that have been assigned a limit by CMS. Any CPT/HCPCS code not assigned a limit by CMS have been assigned a limit deemed reasonable by TRICARE. The edits for the MUE program are published on the CMS web site at http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp.

DATA ELEMENT DEFINITION

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

NOTES AND SPECIAL INSTRUCTIONS:

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

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

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

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

Many of the Financial Edits in [Chapter 2, Section 8.1](#) try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any [Chapter 2, Section 8.1](#) edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

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

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CHAPTER 2, SECTION 2.6

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

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	H2 ²	Benefit payment made using incorrect BATCH/VOUCHER ASAP Number, Government caused error.
	NC	Non-Certified Providers (does not include sanctioned/suspended providers) (Effective 08/01/2003)
	NS	Contractor has determined that number of services is medically necessary.
ALGORITHM N/A		
SUBORDINATE AND/OR GROUP ELEMENTS		
SUBORDINATE	GROUP	
N/A	PROCESSING INFORMATION	

NOTES AND SPECIAL INSTRUCTIONS:

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Many of the Financial Edits in [Chapter 2, Section 8.1](#) try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any [Chapter 2, Section 8.1](#) edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

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

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: NUMBER OF SERVICES (2-175)

VALIDITY EDITS

2-175-01V MUST BE NUMERIC.

RELATIONAL EDITS

2-175-01R IF TYPE OF SUBMISSION =

A	ADJUSTMENT OR
C	COMPLETE CANCELLATION OR
D	COMPLETE DENIAL OR
I	INITIAL SUBMISSION OR
O	ZERO PAYMENT WITH 100% OHI/TPL OR
R	RESUBMISSION

THEN NUMBER OF SERVICES FOR EACH OCCURRENCE MUST BE > ZERO

UNLESS TYPE OF SERVICE (SECOND POSITION) =

M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS
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AND OCCURRENCE/LINE ITEM NUMBER = 002

THEN NUMBER OF SERVICES ON THIS LINE ITEM MUST = ZERO

2-175-02R² • SURGERY PROCEDURE CODES

IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO

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

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

UNLESS PROCEDURE CODE = 11201, 11721, 13102, 13122, 13133, 13153, 15001, 15003, 15101, 15201, 15221, 15241, 15261, 15301, 15321, 15331, 15341, 15343, 15361, 15366, 15401, 15421, 15431, 17003, 17004, 17110, 17111, OR 17310

OR ANY OCCURRENCE OF OVERRIDE CODE =

NS	CONTRACTOR HAS DETERMINED THAT NUMBER OF SERVICES IS MEDICALLY NECESSARY
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2-175-03R² • E/M PROCEDURE CODES

IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO

AND PROCEDURE CODE¹ =

99201-99205 (OFFICE VISITS - NEW PATIENTS)	OR
99211-99215 (OFFICE VISITS - ESTABLISHED PATIENTS)	OR
99217 (DISCHARGE SERVICES)	OR
99221-99233 (HOSPITAL CARE PER DAY)	OR

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² EDITS 2-175-02R, 2-175-03R, 2-175-04R, AND 2-175-06R ARE ONLY EXECUTED FOR FILING DATES < 02/01/2010.

³ EDIT 2-175-07R IS ONLY EXECUTED FOR FILING DATES ≥ 02/01/2010. PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-175-07R. BYPASS EDIT 2-175-07R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.

⁴ TO DETERMINE MAXIMUM NUMBER OF SERVICES REFER TO THE MAXIMUM NUMBER OF SERVICES CODE LIST AT [HTTP://WWW.TRICARE.MIL/TMA/RATES.ASPX](http://www.tricare.mil/tma/rates.aspx).

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME:	NUMBER OF SERVICES (2-175) (CONTINUED)
	99234-99236 (OBSERVATION OR IMPATIENT CARE SERVICES) OR
	99238-99239 (HOSPITAL DISCHARGE SERVICES) OR
	99241-99245 (OFFICE CONSULTATIONS) OR
	99251-99255 (INITIAL INPATIENT CONSULTATIONS) OR
	99261-99263 (FOLLOW-UP INPATIENT CONSULTATIONS) OR
	99271-99275 (CONFIRMATORY CONSULTATIONS) OR
	99281-99285 (EMERGENCY DEPARTMENT VISIT) OR
	99291 (CRITICAL CARE) (NOTE: CODE 99292 EXCLUDED BECAUSE UTILIZED TO REPORT FOR EACH ADDITIONAL 15 MINUTES OF CARE) OR
	99295-99298 (NEONATAL INTENSIVE CARE) OR
	99301-99315 (NURSING FACILITY CHARGES) OR
	99321-99333 (DOMICILIARY, REST HOME, OR CUSTODIAL CARE SERVICES) OR
	99341-99350 (HOME SERVICES) OR
	99354 (PROLONGED SERVICES) (NOTE: CODE 99355 EXCLUDED BECAUSE UTILIZED TO REPORT FOR EACH ADDITIONAL 30 MINUTES OF CARE) OR
	99356 (PROLONGED SERVICES) (NOTE: CODE 99357 EXCLUDED BECAUSE UTILIZED TO REPORT FOR EACH ADDITIONAL 30 MINUTES OF CARE) OR
	99361-99373 (CASE MANAGEMENT SERVICES) OR
	99374-99380 (CARE PLAN OVERSIGHT) OR
	99381-99429 (PREVENTIVE MEDICINE SERVICES) OR
	99431-99440 (NEWBORN CARE) OR
	99450-99456 (SPECIAL EVALUATION AND MANAGEMENT SERVICES)

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³ EDIT 2-175-07R IS ONLY EXECUTED FOR FILING DATES ≥ 02/01/2010. PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-175-07R. BYPASS EDIT 2-175-07R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.

⁴ TO DETERMINE MAXIMUM NUMBER OF SERVICES REFER TO THE MAXIMUM NUMBER OF SERVICES CODE LIST AT [HTTP://WWW.TRICARE.MIL/TMA/RATES.ASPX](http://www.tricare.mil/tma/rates.aspx).

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM CANNOT EXCEED 3 PER DAY

UNLESS ANY OCCURRENCE OF
OVERRIDE CODE = NS CONTRACTOR HAS DETERMINED THAT
NUMBER OF SERVICES IS MEDICALLY
NECESSARY

2-175-04R² • MEDICAL PROCEDURE CODES

IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO

AND PROCEDURE CODE¹ = 99500-99512 (HOME HEALTH VISIT) OR
99551-99568 (HOME INFUSION PER DIEM
CODES)

THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM CANNOT EXCEED 3 PER DAY

UNLESS ANY OCCURRENCE OF
OVERRIDE CODE = NS CONTRACTOR HAS DETERMINED THAT
NUMBER OF SERVICES IS MEDICALLY
NECESSARY

2-175-06R² • VACCINES (VACCINE PRODUCT ONLY) PROCEDURE CODES

IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO

AND PROCEDURE CODE¹ = 90476-90479 (VACCINES, TOXOIDS) OR

THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM CANNOT EXCEED 3 PER DAY

UNLESS ANY OCCURRENCE OF
OVERRIDE CODE = NS CONTRACTOR HAS DETERMINED THAT
NUMBER OF SERVICES IS MEDICALLY
NECESSARY

2-175-07R³ IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO

THEN NUMBER OF SERVICES CANNOT EXCEED THE MAXIMUM ALLOWED
NUMBER OF SERVICES PER DAY FOR THE PROCEDURE CODE ON THIS LINE ITEM⁴

UNLESS ANY OCCURRENCE OF
OVERRIDE CODE = NS CONTRACTOR HAS DETERMINED THAT
NUMBER OF SERVICES IS MEDICALLY
NECESSARY

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³ EDIT 2-175-07R IS ONLY EXECUTED FOR FILING DATES ≥ 02/01/2010. PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-175-07R. BYPASS EDIT 2-175-07R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.

⁴ TO DETERMINE MAXIMUM NUMBER OF SERVICES REFER TO THE MAXIMUM NUMBER OF SERVICES CODE LIST AT [HTTP://WWW.TRICARE.MIL/TMA/RATES.ASPX](http://www.tricare.mil/tma/rates.aspx).

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

VALIDITY EDITS

2-180-01V	MUST BE NUMERIC.
2-180-02V	<p>IF CONTRACT NUMBER = MDA90602C0013</p> <p>THEN IF PROCEDURE CODE = 000MN PRESCRIPTION MEDICAL NECESSITY REVIEWS OR</p> <p>000PA PRESCRIPTION PRIOR AUTHORIZATIONS</p> <p>THEN AMOUNT BILLED BY PROCEDURE CODE MUST > ZERO</p> <p>ELSE IF TYPE OF SUBMISSION = C COMPLETE CANCELLATION TO TED RECORD DATA</p> <p>OR ADJUSTMENT/DENIAL REASON CODE IS A DENIAL REASON CODE LISTED IN ADDENDUM H, FIGURE 2-H-1 FOR THAT OCCURRENCE/LINE ITEM</p> <p>THEN AMOUNT BILLED BY PROCEDURE CODE MUST = ZERO</p> <p>AND AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO</p> <p>AND AMOUNT PAID BY OHI MUST = ZERO</p> <p>AND AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO</p> <p>AND AMOUNT PATIENT COST SHARE MUST = ZERO</p> <p>ELSE IF OCCURRENCE/LINE ITEM NUMBER = 002</p> <p>THEN AMOUNT BILLED BY PROCEDURE CODE MUST = ZERO</p>
2-180-03V	<p>IF CONTRACT NUMBER = MDA90602C0013</p> <p>AND AMOUNT BILLED BY PROCEDURE CODE = ZERO</p> <p>THEN TYPE OF SUBMISSION MUST = C COMPLETE CANCELLATION TO TED RECORD DATA</p> <p>OR OCCURRENCE/LINE ITEM NUMBER MUST = 002</p> <p>OR ADJUSTMENT/DENIAL REASON CODE MUST BE A DENIAL REASON CODE LISTED IN ADDENDUM H, FIGURE 2-H-1 FOR THAT OCCURRENCE/LINE ITEM</p>

RELATIONAL EDITS

2-180-00R	<p>IF TYPE OF SUBMISSION ≠ D COMPLETE DENIAL</p> <p>THEN TOTAL OF ALL OCCURRENCES OF AMOUNT BILLED BY PROCEDURE CODE FOR THIS TED RECORD MUST NOT EXCEED TMA LIMIT OF \$1,000,000.00</p>
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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: AMOUNT ALLOWED BY PROCEDURE CODE (2-185)	
VALIDITY EDITS	
2-185-01V	MUST BE NUMERIC.
RELATIONAL EDITS	
2-185-00R	TOTAL OF ALL OCCURRENCES OF AMOUNT ALLOWED BY PROCEDURE CODE FOR THIS TED RECORD EXCEEDS TMA LIMIT OF \$1,000,000.00.
2-185-01R	IF TYPE OF SUBMISSION = C COMPLETE CANCELLATION OR D COMPLETE DENIAL
	THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO FOR ALL OCCURRENCE/LINE ITEM
2-185-02R	IF PRICING RATE CODE = b NO SPECIAL RATE OR D DISCOUNT RATE OR V MEDICARE REIMBURSEMENT RATE
	AND NO OCCURRENCE OF SPECIAL PROCESSING CODE = T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR FS TFL (SECOND PAYOR)
	AND TYPE OF SUBMISSION = A ADJUSTMENT OR I INITIAL SUBMISSION OR O ZERO PAYMENT WITH 100% OHI/TPL OR R RESUBMISSION
	THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE ≤ AMOUNT BILLED BY PROCEDURE CODE FOR EACH OCCURRENCE/LINE ITEM
2-185-03R	IF PRICING RATE CODE = 4 PAID AS BILLED OR I CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, PAID AS BILLED
	AND TYPE OF SUBMISSION = A ADJUSTMENT OR I INITIAL SUBMISSION OR O ZERO PAYMENT WITH 100% OHI/TPL OR R RESUBMISSION
	THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE = AMOUNT BILLED BY PROCEDURE CODE
2-185-04R	IF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM MUST BE A CODE LISTED IN ADDENDUM H, FIGURE 2-H-1 OR FIGURE 2-H-2
	UNLESS TYPE OF SUBMISSION = B ADJUSTMENT NON-TED DATA (HCSR) DATA OR E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
2-185-05R	IF TYPE OF SUBMISSION = E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO
2-185-06R	IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

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

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

VALIDITY EDITS

2-190-01V MUST BE NUMERIC.

RELATIONAL EDITS

2-190-00R	TOTAL OF ALL OCCURRENCES OF AMOUNT PAID BY OHI FOR THIS TED RECORD EXCEEDS TMA LIMIT OF \$1,000,000.00.		
2-190-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		C	COMPLETE CANCELLATION OR
		D	COMPLETE DENIAL OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION
	THEN AMOUNT PAID BY OHI MUST BE ≥ ZERO.		
2-190-02R	IF ANY OCCURRENCE OF OVERRIDE CODE =	U	BENEFICIARY INDEMNIFICATION PAYMENT
	THEN AMOUNT PAID BY OHI MUST EQUAL ZERO.		

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

VALIDITY EDITS

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

RELATIONAL EDITS

2-191-01R	IF OGP TYPE CODE =	V	CHAMPVA
	THEN TYPE OF SUBMISSION MUST =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		C	COMPLETE CANCELLATION OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

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

VALIDITY EDITS

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

RELATIONAL EDITS

NONE

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: AMOUNT APPLIED TOWARD DEDUCTIBLE (2-195)	
VALIDITY EDITS	
2-195-01V	MUST BE NUMERIC.
RELATIONAL EDITS	
2-195-00R	TOTAL OF ALL OCCURRENCES OF AMOUNT APPLIED TOWARD DEDUCTIBLE FOR THIS TED RECORD EXCEEDS TMA LIMIT OF \$1,000,000.00.
2-195-01R	IF TYPE OF SUBMISSION =
	A ADJUSTMENT OR
	I INITIAL SUBMISSION OR
	O ZERO PAYMENT WITH 100% OHI/TPL OR
	R RESUBMISSION
	THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST BE ≥ ZERO
2-195-02R	IF TYPE OF SUBMISSION =
	C COMPLETE CANCELLATION OR
	D COMPLETE DENIAL
	THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST BE = ZERO
2-195-03R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	NE OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM DEMONSTRATION
	AND BEGIN DATE OF CARE ≥ 09/14/2001 AND < 11/01/2009
	AND ENROLLMENT/HEALTH PLAN CODE =
	T TRICARE STANDARD PROGRAM OR
	V TRICARE EXTRA
	THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO
2-195-04R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	PF ECHO OR
	DE TDRL PHYSICAL EXAMS
	THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO