



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

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TRICARE  
MANAGEMENT ACTIVITY

PCSIB

CHANGE 82  
7950.1-M  
JULY 9, 2010

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE SYSTEMS MANUAL (TSM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

**CHANGE TITLE:** TRICARE ENCOUNTER DATA (TED) INTERIM HOSPITAL BILLING

**CONREQ:** 14999

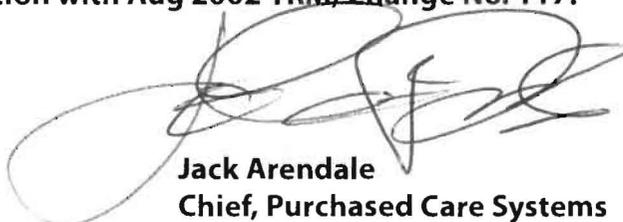
**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** This draft change will allow the processing of inpatient facility interim-interim and interim-final billings, with the exception of interim billings reimbursed under Diagnosis Related Group (DRG) or Home Health Agency (HHA) payment methodology, as unique TED records rather than as adjustments to the TED record for the initial billing.

**EFFECTIVE DATE:** November 1, 2010.

**IMPLEMENTATION DATE:** Upon direction of the Contracting Officer.

**This change is made in conjunction with Aug 2002 TRM, Change No. 117.**



**Jack Arendale  
Chief, Purchased Care Systems  
Integration Branch**

**ATTACHMENT(S):** 13 PAGES  
**DISTRIBUTION:** 7950.1-M

**CHANGE 82**  
**7950.1-M**  
**JULY 9, 2010**

**REMOVE PAGE(S)**

**CHAPTER 2**

Section 1.1, pages 9 through 13

Section 2.5, pages 7 and 8

Section 4.1, pages 1 through 4

Section 5.3, page 5 and 6

**INSERT PAGE(S)**

Section 1.1, pages 9 through 13

Section 2.5, pages 7 and 8

Section 4.1, pages 1 through 4

Section 5.3, page 5 and 6

## **6.0. BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER SELECTION CRITERIA FOR REGIONAL CONTRACTORS<sup>1</sup>**

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

### **6.1. Batches**

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

### **6.2. Vouchers**

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

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

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

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<sup>1</sup> These guidelines apply only to the benefit CLINS, they DO NOT apply to the Administrative CLINs.

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

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

**6.2.3. Criteria For Selecting Financially Underwritten CLINs (excludes claims that meet criteria specified under [paragraphs 6.2.1.](#) and [6.2.2.](#))**

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

**6.2.4. Criteria For Selecting BATCH/VOUCHER CLIN/ASAP Account Number Based On 'active' Dates (Fiscal Year and Option Period)**

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

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

**7.0. INTERIM INSTITUTIONAL PAYMENTS**

**7.1.** In certain cases, providers can submit interim bills for institutional claims as a method to facilitate cash flow. Interim-interim and interim-final TED records with filing dates before January 1, 2011 must be submitted as an adjustment using the same TED Record Indicator (TRI) as the initial submission.

**7.2.** Interim-interim and interim-final TED records (FREQUENCY CODES '3' and '4') with filing dates on or after January 1, 2011 with the exception of interim billings reimbursed under the Diagnosis Related Group (DRG) or Home Health Agency (HHA)

**payment methodology** must be submitted with a unique TRI and must be submitted on batch/vouchers with HEADER TYPE INDICATOR '0' or '5'. DRG and HHA interim-interim and interim-final TED records will continue to be submitted as an adjustment using the same TRI as the initial submission.

**7.3.** For claims that are reimbursed under the TRICARE DRG payment methodology please see the TRICARE Reimbursement Manual (TRM), Chapter 6, Section 3 for requirements on submitting DRG interim bills.

**7.4.** For claims that are reimbursed under the Home Health Agency Prospective Payment System (HHA PPS) methodology, please see the guidelines on submitting interim bills in the TRM, Chapter 12, Section 6.

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

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

### **8.1. Special Processing Code**

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

### **8.2. "Amount" Field Reporting**

The "amount" fields must contain the following:

#### **8.2.1. Amount Billed/Amount Billed By Procedure Code**

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

#### **8.2.2. Amount Allowed/Amount Allowed By Procedure Code**

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

#### **8.2.3. Amount Paid By Government Contractor**

The AMOUNT PAID BY GOVERNMENT CONTRACTOR field must equal the "lesser" of the amount allowed minus (PATIENT COST-SHARE plus AMOUNT APPLIED TOWARD DEDUCTIBLE) or AMOUNT ALLOWED minus amount of OHI. If the "Lesser"

computed amount is negative, AMOUNT PAID BY GOVERNMENT CONTRACTOR must = \$0.00.

## **9.0. PROCESS FOR REPORTING BLOOD CLOTTING FACTOR DATA TO TMA**

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

### **9.1. Blood Clotting Factor**

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

### **9.2. Calculation of Charge**

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

#### **9.2.1. First Step**

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

#### **9.2.2. Second Step**

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

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

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

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

#### **9.2.3. Data Reporting**

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

##### **9.2.3.1. Amount Billed**

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

**9.2.3.2. Amount Allowed**

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

**9.2.3.3. Amount of OHI**

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

**9.2.3.4. Patient Cost-Share**

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

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

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

**9.2.3.4.2. Patient Cost-Share (For ADFMs)**

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

**9.2.3.4.3. Amount Paid By Government Contractor**

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



TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 2.5

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (E - L)

DATA ELEMENT DEFINITION

ELEMENT NAME: FREQUENCY CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-250	1	Yes <sup>1</sup>

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

**DEFINITION** Code that describes the frequency of billing from the institution. For filing dates before January 1, 2011, all TED Records for interim-interim and interim-final institutional bills must be submitted as an adjustment using the same TRI as the initial submission. Effective with filing dates on or after January 1, 2011, all TED records for interim-interim and interim-final institutional bills with the exception of interim billings reimbursed under the DRG or HHA payment methodology must be submitted as a unique TRI. See Section 1.1, paragraph 7.0.

CODE/VALUE SPECIFICATIONS		
	0	Non-Payment/Zero Claim
	1	Admit thru Discharge TED Record
	2	Interim - Initial TED Record
	3	Interim - Interim TED Record
	4	Interim - Final TED Record
	7	Replacement of Prior Claim
	8	Void/Cancel of Prior Claim
	9	Final claim for Home Health Agency (HHA PPS) Episode

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	TYPE OF BILL

NOTES AND SPECIAL INSTRUCTIONS:

<sup>1</sup> The Initial, Interim, and Final TED Records, when used, must be submitted to TMA in correct sequence. If the patient is transferred and the care is processed under DRG rules, then Code '1' must be used; all other Transfers must use Code '1' or '4' as appropriate.

Effective with filing dates on or after January 1, 2011, interim-interim and interim-final TED records (FREQUENCY CODES '3' and '4') must be submitted on batch/vouchers with HEADER TYPE INDICATOR '0' or '5'. DRG and HHA interim billings are excluded from this requirement.

**TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002**

CHAPTER 2, SECTION 2.5

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (E - L)

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: HEALTH CARE COVERAGE (HCC) COPAYMENT FACTOR CODE**

**RECORDS/LOCATOR NUMBERS**

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-136	1	Yes
Non-Institutional	2-201	Up to 99	Yes

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

**DEFINITION** The code used to identify for each insured in managed care the category of copayment and deductible they must pay based on external forces for a particular health care coverage period. Actual rates depend on Health Care Delivery Program Plan Coverage Code. Download field from DEERS.

CODE/VALUE SPECIFICATIONS		
	A	Active duty E-4 and below rate
	B	Active duty E-5 and above rate
	C	Retiree rate
	W	Unknown copayment factor
	Z	Not applicable

**ALGORITHM** N/A

**SUBORDINATE AND/OR GROUP ELEMENTS**

SUBORDINATE	GROUP
N/A	N/A

**NOTES AND SPECIAL INSTRUCTIONS:**

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

## HEADER EDIT REQUIREMENTS (ELN 000 - 099)

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

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

**TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002**

CHAPTER 2, SECTION 4.1

HEADER EDIT REQUIREMENTS (ELN 000 - 099)

<b>ELEMENT NAME: HEADER TYPE INDICATOR (0-001) (CONTINUED)</b>		
<b>0-001-03R</b>	IF HEADER TYPE INDICATOR =	0 BATCH HEADER (USED ON ALL PROVIDER, PRICING BATCHES, AND FOR INSTITUTIONAL/NON-INSTITUTIONAL AT-RISK NON-ADMIN CLAIM RATE ELIGIBLE TED RECORDS) <b>OR</b>
		9 BATCH HEADER (INSTITUTIONAL/NON-INSTITUTIONAL AT-RISK ADMIN CLAIM RATE ELIGIBLE RED RECORDS)
	AND TYPE OF SUBMISSION ≠	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>
		E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	AND BATCH/VOUCHER IDENTIFIER =	5 INSTITUTIONAL/NON-INSTITUTIONAL
	THEN ADJUSTMENT KEY MUST =	0 BATCH
<b>0-001-04R</b>	IF HEADER TYPE INDICATOR =	5 VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE <b>OR</b>
		6 VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE
	AND TYPE OF SUBMISSION =	D COMPLETE DENIAL <b>OR</b>
		O ZERO PAYMENT TED RECORD DUE TO 100% OHI
	THEN AMOUNT INTEREST PAYMENT MUST =	ZERO
	AND FOR INSTITUTIONAL RECORDS AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST =	ZERO
	FOR NON-INSTITUTIONAL RECORDS THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST =	ZERO
<b>0-001-05R</b>	IF DRG NUMBER IS NOT BLANK <b>OR</b>	
	TYPE OF INSTITUTION =	70 HOME HEALTH AGENCY (HHA)
	THEN BYPASS THIS EDIT	
	ELSE IF FILING DATE IS ≥ 01/01/2011	
	AND FREQUENCY CODE ON ANY INSTITUTIONAL RECORD =	3 INTERIM - INTERIM <b>OR</b>
		4 INTERIM - FINAL
	THEN HEADER TYPE INDICATOR MUST =	0 BATCH HEADER (USED ON ALL PROVIDER BATCHES, AND FOR INSTITUTIONAL/NON-INSTITUTIONAL FINANCIALLY UNDERWRITTEN NON-ADMIN CLAIM RATE ELIGIBLE TED RECORDS) <b>OR</b>
		5 VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE

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

**TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002**

CHAPTER 2, SECTION 4.1

HEADER EDIT REQUIREMENTS (ELN 000 - 099)

**ELEMENT NAME: CONTRACT NUMBER (0-010)**

**VALIDITY EDITS**

**0-010-01V** MUST BE A VALID VALUE FOUND ON THE TMA DATABASE.

**RELATIONAL EDITST**

NONE

**ELEMENT NAME: BATCH/VOUCHER IDENTIFIER (0-015)**

**VALIDITY EDITS**

<b>0-015-01V</b>	MUST =	3	PROVIDER <b>OR</b>
		4	PRICING <b>OR</b>
		5	INSTITUTIONAL/NON-INSTITUTIONAL

**RELATIONAL EDITS**

<b>0-015-01R</b>	IF BATCH/VOUCHER IDENTIFIER =	5	INSTITUTIONAL/NON-INSTITUTIONAL
	<b>THEN RECORD TYPE (FOR EVERY TED RECORD IN THE BATCH/VOUCHER) MUST =</b>	1	INSTITUTIONAL <b>OR</b>
		2	NON-INSTITUTIONAL
<b>0-015-02R</b>	IF BATCH/VOUCHER IDENTIFIER =	3	PROVIDER
	<b>THEN RECORD TYPE (FOR EVERY TED RECORD IN THE BATCH/VOUCHER) MUST =</b>	3	PROVIDER
<b>0-015-03R</b>	IF BATCH/VOUCHER IDENTIFIER =	4	PRICING
	<b>THEN RECORD TYPE (FOR EVERY TED RECORD IN THE BATCH/VOUCHER) MUST =</b>	4	PRICING

**NOTE: IF THIS EDIT FAILS FOR ANY TED RECORD, THE ENTIRE BATCH/VOUCHER FAILS.**

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CHAPTER 2, SECTION 4.1

HEADER EDIT REQUIREMENTS (ELN 000 - 099)

**ELEMENT NAME: BATCH/VOUCHER NUMBER (0-020)**

**VALIDITY EDITS**

NONE

**RELATIONAL EDITS**

**0-020-01R** IF BATCH/VOUCHER IDENTIFIER = 5 INSTITUTIONAL/NON-INSTITUTIONAL  
**AND** BATCH/VOUCHER RESUBMISSION NUMBER > 0

**THEN** CONTRACT IDENTIFIER MUST BE A UNIQUE (KEY) COMBINATION OF CONTRACT NUMBER, BATCH/VOUCHER IDENTIFIER **AND** BATCH/VOUCHER NUMBER<sup>1</sup>.

**0-020-02R** IF BATCH/VOUCHER IDENTIFIER = 5 INSTITUTIONAL/NON-INSTITUTIONAL  
**AND** BATCH/VOUCHER RESUBMISSION NUMBER > 0

**THEN** BATCH/VOUCHER NUMBER **AND** HEADER TYPE INDICATOR MUST BE ON THE TMA DATABASE.

**0-020-03R** IF HEADER TYPE INDICATOR = 0 BATCH HEADER (USED ON ALL PROVIDER, PRICING BATCHES, AND FOR INSTITUTIONAL/NON-INSTITUTIONAL FINANCIALLY UNDERWRITTEN NON-ADMIN CLAIM RATE ELIGIBLE TED RECORDS) **OR**

5 VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE **OR**

6 VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE **OR**

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

**AND** BATCH/VOUCHER RESUBMISSION NUMBER = 0

**THEN** BATCH/VOUCHER NUMBER MUST **NOT** EXIST ON THE TMA DATABASE

**AND** CONTRACT IDENTIFIER MUST BE A UNIQUE (KEY) COMBINATION OF CONTRACT NUMBER, BATCH/VOUCHER IDENTIFIER **AND** BATCH/VOUCHER NUMBER WITHIN THIS TMA PROCESSING CYCLE.

**0-020-04R** IF HEADER TYPE INDICATOR = 0 BATCH HEADER (USED ON ALL PROVIDER, PRICING BATCHES, AND FOR INSTITUTIONAL/NON-INSTITUTIONAL FINANCIALLY UNDERWRITTEN NONADMIN CLAIM RATE ELIGIBLE TED RECORDS) **OR**

5 VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE **OR**

6 VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE **OR**

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

<sup>1</sup> TMA DATABASE.

**TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002**

CHAPTER 2, SECTION 5.3

INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

**ELEMENT NAME: FREQUENCY CODE (1-250)**

**VALIDITY EDITS**

**1-250-01V** MUST BE A VALID FREQUENCY CODE

**1-250-02V** IF DRG NUMBER IS NOT BLANK

AND TYPE OF SUBMISSION = A ADJUSTMENT TO TED RECORD DATA OR

C COMPLETE CANCELLATION TO TED RECORD DATA OR

I INITIAL TED RECORD SUBMISSION OR

O ZERO PAYMENT TED RECORD DUE TO 100% OHI OR

R RESUBMISSION OF AN INITIAL TED RECORD

AND FREQUENCY CODE = 2 INTERIM - INITIAL TED RECORD OR

3 INTERIM - INTERIM TED RECORD OR

4 INTERIM - FINAL TED RECORD

THEN THE FREQUENCY CODE SUBMISSION MUST FOLLOW THE DIRECTIONS IN THE TABLE BELOW

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

**RELATIONAL EDITS**

**1-250-01R** IF PATIENT STATUS = 30 STILL A PATIENT

AND AMOUNT ALLOWED (TOTAL) ≠ 0

OR NO OCCURRENCE OF SPECIAL PROCESSING CODE =

T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYER) OR

FS TFL (SECOND PAYER)

THEN FREQUENCY CODE MUST = 2 INTERIM-INITIAL OR

3 INTERIM-INTERIM

UNLESS TYPE OF INSTITUTION = 70 HOME HEALTH AGENCY

THEN FREQUENCY CODE MUST = 2 INTERIM-INITIAL OR

3 INTERIM-INTERIM OR

7 REPLACEMENT OF PRIOR CLAIM OR

8 VOID/CANCEL OF PRIOR CLAIM OR

9 FINAL CLAIM FOR HOME HEALTH AGENCY EPISODE

**1-250-02R** IF PATIENT STATUS = 01 DISCHARGED OR

02 TRANSFERRED OR

20 EXPIRED

**TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002**

CHAPTER 2, SECTION 5.3

INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

**ELEMENT NAME: FREQUENCY CODE (1-250) (CONTINUED)**

	<b>THEN FREQUENCY CODE MUST =</b>	0	NON-PAYMENT/ZERO CLAIM <b>OR</b>
		1	ADMIT THRU DISCHARGE <b>OR</b>
		4	INTERIM-FINAL <b>OR</b>
		7	REPLACEMENT OF PRIOR CLAIM <b>OR</b>
		8	VOID/CANCELLATION OF PRIOR CLAIM <b>OR</b>
		9	FINAL CLAIM FOR HOME HEALTH AGENCY (HHA-PPS) EPISODE
<b>1-250-03R</b>	<b>IF PRICING RATE CODE =</b>	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER
	<b>THEN FREQUENCY CODE MUST =</b>	1	ADMIT THRU DISCHARGE

**ELEMENT NAME: TYPE OF ADMISSION (1-255)**

**VALIDITY EDITS**

<b>1-255-01V</b>	VALUE MUST BE A VALID TYPE OF ADMISSIONS CODE.		
	<b>UNLESS REVENUE CODE ON ANY OF THE OCCURRENCES/LINE ITEMS =</b>	0023	HOME HEALTH AGENCY
	<b>OR TYPE OF INSTITUTION =</b>	70	HHA
	<b>OR AMOUNT ALLOWED (TOTAL) = ZERO</b>		
	<b>OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =</b>	11	HOSPICE
	<b>THEN VALUE MUST BE BLANK OR A VALID TYPE OF ADMISSIONS CODE</b>		

**RELATIONAL EDITS**

<b>1-255-02R</b>	<b>IF CA/NAS EXCEPTION REASON =</b>	2	EMERGENCY
	<b>THEN TYPE OF ADMISSION MUST =</b>	1	EMERGENCY <b>OR</b>
		4	NEWBORN
<b>1-255-03R</b>	<b>IF TYPE OF ADMISSION =</b>	4	NEWBORN
	<b>THEN PRINCIPAL DIAGNOSIS MUST BE A NEWBORN DIAGNOSIS (REFER TO ADDENDUM E, FIGURE 2-E-1).</b>		