

Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: TYPE OF SUBMISSION (2-100)	
VALIDITY EDITS	
2-100-01V	VALUE MUST BE A VALID TYPE OF SUBMISSION.
2-100-02V	IF TYPE OF SUBMISSION =
	B ADJUSTMENT OF NON-TED RECORD (HCSR) DATA OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN ADJUSTMENT KEY CANNOT =
	0 BATCH OR
	5 VOUCHER
	AND REGION INDICATOR MUST = BLANK
2-100-03V	IF TYPE OF SUBMISSION =
	A ADJUSTMENT OR
	B ADJUSTMENT OF NON-TED RECORD (HCSR) DATA OR
	C COMPLETE CANCELLATION OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN MATCH MUST BE FOUND ON THE TMA DATABASE
	AND TYPE OF SUBMISSION ON THE EXISTING TMA DATABASE RECORD \neq
	C COMPLETE CANCELLATION OR
	D COMPLETE DENIAL OR
	E COMPLETE CANCELLATION NON-TED RECORD (HCSR) DATA
	UNLESS THE RECORD HAS PROVISIONAL ERRORS
2-100-04V	IF TYPE OF SUBMISSION =
	D COMPLETE DENIAL OR
	I INITIAL SUBMISSION OR
	O ZERO PAYMENT WITH 100% OHI/TPL OR
	R RESUBMISSION
	THEN A TED RECORD MUST NOT BE PRESENT ON THE DATABASE WITH THE SAME TRI
2-100-06V	IF TYPE OF SUBMISSION =
	A ADJUSTMENT OR
	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	C COMPLETE CANCELLATION TO TED RECORD DATA OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	AND CONTRACT NUMBER =
	MDA906-02-C-0013 OR
	MDA906-03-C-0009 OR
	MDA906-03-C-0010 OR
	MDA906-03-C-0011 OR
	MDA906-03-C-0015 OR

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

MDA906-03-C-0019

THEN TED RECORD CORRECTION INDICATOR MUST =

- 1 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) **SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR**
- 2 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT CLAIM PROCESSING ERRORS OR TO UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION **OR**
- 3 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT **BOTH** CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD

RELATIONAL EDITS

2-100-01R IF TYPE OF SUBMISSION =

O ZERO PAYMENT WITH 100% OHI/TPL

THEN THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT OF OHI MUST BE > ZERO

AND THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE MUST > ZERO

AND THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO

2-100-02R IF ALL OCCURRENCES/LINE ITEMS ARE DENIED (REFER TO [ADDENDUM G, FIGURE 2.G-1](#))

THEN TYPE OF SUBMISSION MUST =

- C COMPLETE CANCELLATION **OR**
- D COMPLETE DENIAL **OR**
- E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

UNLESS THE TED RECORD CORRECTION 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

2-100-04R IF RESUBMISSION NUMBER = ZERO FOR THIS BATCH OR VOUCHER

THEN TYPE OF SUBMISSION MUST ≠ R RESUBMISSION

2-100-05R IF RESUBMISSION NUMBER > ZERO FOR THIS BATCH **OR** VOUCHER

THEN TYPE OF SUBMISSION MUST ≠ I INITIAL TED RECORD SUBMISSION

2-100-06R IF TYPE OF SUBMISSION =

- I INITIAL SUBMISSION **OR**
- R RESUBMISSION

THEN THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT BILLED BY PROCEDURE CODE, **AND** THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE MUST BE > 0.

2-100-07R IF TYPE OF SUBMISSION =

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

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

THEN BEGIN DATE OF CARE MUST BE < 10/01/2010

2-100-09R IF TYPE OF SUBMISSION = B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**

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

THEN TYPE OF SERVICE (SECOND POSITION) MUST ≠

M MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS

2-100-10R IF THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY OTHER HEALTH INSURANCE > 0

AND THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED (TOTAL) BY PROCEDURE CODE > 0

AND THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE = 0

AND DATE ADJUSTMENT IDENTIFIED = ZEROES

THEN TYPE OF SUBMISSION MUST = O ZERO PAYMENT TED RECORD DUE TO 100% OHI

UNLESS THE SUM OF THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PATIENT COST-SHARE **AND** THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT APPLIED TOWARD DEDUCTIBLE ≥ THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE

OR THE TED RECORD CORRECTION INDICATOR ≠ BLANK

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

VALIDITY EDITS

2-105-01V MUST BE A VALID CLAIM FORM TYPE/EMC INDICATOR.

RELATIONAL EDITS

2-105-01R IF CLAIM FORM TYPE/EMC INDICATOR = I ELECTRONIC DRUG CLAIM SUBMISSION

THEN TYPE OF SERVICE (SECOND POSITION) MUST =

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

M MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS

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

AND TYPE OF SERVICE SECOND POSITION =

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

M MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS

THEN PROCEDURE CODE MUST = 000MN PRESCRIPTION MEDICAL NECESSITY REVIEWS **OR**

000PA PRESCRIPTION PRIOR AUTHORIZATIONS

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Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: ADMINISTRATIVE CLIN (2-108)

VALIDITY EDITS

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

2-108-02V IF TYPE OF SUBMISSION =

A ADJUSTMENT **OR**

B HCSR ADJUSTMENT **OR**

C COMPLETE CANCELLATION **OR**

E HCSR CANCELLATION

AND CONTRACT NUMBER =

MDA906-02-C-0013 (TMOP) **OR**

MDA906-03-C-0009 (WEST) **OR**

MDA906-03-C-0010 (SOUTH) **OR**

MDA906-03-C-0011 (NORTH) **OR**

MDA906-03-C-0015 (TDEFIC) **OR**

MDA906-03-C-0019 (TRRx)

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

1 CLAIM RATE HAS BEEN PAID

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

2-108-03V IF CONTRACT NUMBER ≠

MDA906-02-C-0013 (TMOP) **OR**

MDA906-03-C-0009 (WEST) **OR**

MDA906-03-C-0010 (SOUTH) **OR**

MDA906-03-C-0011 (NORTH) **OR**

MDA906-03-C-0015 (TDEFIC) **OR**

MDA906-03-C-0019 (TRRx)

THEN ADMINISTRATIVE CLIN MUST BE BLANK

RELATIONAL EDITS

REFER TO [SECTION 8.1](#).

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

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Non-Institutional Edit Requirements (ELN 100 - 199)

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

VALIDITY EDITS

2-110-01V MUST BE A VALID FOUR DIGIT DMIS-ID CODE.

2-110-03V IF FILING DATE ≥ 09/01/2007

AND PCM LOCATION DMIS-ID =	0190	JOHNS HOPKINS MEDICAL SERVICES CORPORATION OR
	0191	BRIGHTON MARINE OR
	0192	CHRISTUS HEALTH/ST JOHN'S OR
	0193	ST VINCENTS CATHOLIC MEDICAL CENTERS OF NY OR
	0194	PACIFIC MEDICAL CLINICS OR
	0196	CHRISTUS HEALTH/ST JOSEPH'S OR
	0194	CHRISTUS HEALTH/ST MARY'S OR
	0198	MARTIN'S POINT HEALTH CARE OR
	0199	FAIRVIEW HEALTH SYSTEM

THEN THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO

RELATIONAL EDITS

NONE

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Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: AMOUNT INTEREST PAYMENT (2-112)	
VALIDITY EDITS	
2-112-01V	MUST BE NUMERIC
RELATIONAL EDITS	
2-112-01R	IF TYPE OF SUBMISSION =
	A ADJUSTMENT OR
	I INITIAL SUBMISSION OR
	O ZERO PAYMENT WITH 100% OHI/TPL OR
	R RESUBMISSION
	THEN AMOUNT INTEREST PAYMENT MUST BE ≥ ZERO
2-112-02R	IF TYPE OF SUBMISSION =
	C COMPLETE CANCELLATION OR
	D COMPLETE DENIAL
	THEN AMOUNT INTEREST PAYMENT MUST = ZERO
2-112-03R	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
2-112-04R	IF FILING STATE/COUNTRY CODE = FOREIGN COUNTRY INCLUDING PUERTO RICO (PRI)
	THEN AMOUNT INTEREST PAYMENT MUST BE = ZERO

ELEMENT NAME: REASON FOR INTEREST PAYMENT (2-113)	
VALIDITY EDITS	
2-113-01V	MUST BE A VALID REASON FOR INTEREST PAYMENT CODE (REFER TO SECTION 2.8).
RELATIONAL EDITS	
2-113-01R	IF REASON FOR INTEREST PAYMENT =
	A CLAIMS PENDED AT GOVERNMENT DIRECTION OR
	B CLAIMS REQUIRING GOVERNMENT INTERVENTION OR
	C CLAIMS REQUIRING DEVELOPMENT FOR POTENTIAL TPL OR
	D CLAIMS REQUIRING AN ACTION/INTERFACE WITH ANOTHER PRIME CONTRACTOR OR
	E CLAIMS RETAINED BY THE CONTRACTOR THAT DO NOT FALL INTO ONE OF THE ABOVE CATEGORIES
	THEN AMOUNT INTEREST PAYMENT MUST ≠ ZERO

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Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS (2-115)

VALIDITY EDITS

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

AND FOR AT LEAST ONE LINE ITEM

EITHER BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD-9-CM DIAGNOSIS REFERENCE TABLE

OR END DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD-9-CM DIAGNOSIS REFERENCE TABLE

RELATIONAL EDITS

- 2-115-01R** IF ANY PRINCIPAL TREATMENT DIAGNOSIS CODE IS FOR FEMALE

AND PERSON SEX (PATIENT) IS MALE

THEN AT LEAST ONE OVERRIDE CODE
MUST =

G DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE

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

AND NOT FOR CIRCUMCISION (PROCEDURE CODE¹ 54150 **OR** 54160)

AND SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY (REFER TO [ADDENDUM E, FIGURE 2.E-3](#))

AND PERSON SEX (PATIENT) IS FEMALE

THEN AT LEAST ONE OVERRIDE CODE
MUST =

H DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE

- 2-115-05R** IF PRINCIPAL TREATMENT DIAGNOSIS = 799.9

THEN CALCULATED AMOUNT BILLED (TOTAL) MUST > ZERO AND ≤ \$200.00

AND TYPE OF SERVICE (FIRST
POSITION) MUST =

A AMBULATORY SURGERY COST-SHARED AS INPATIENT (ADFMS ONLY) **OR**

I INPATIENT **OR**

N OUTPATIENT COST-SHARED AS INPATIENT **OR**

O OUTPATIENT, EXCLUDING M, P, **OR** N

AND TYPE OF SERVICE (SECOND
POSITION) MUST =

4 DIAGNOSTIC/THERAPEUTIC X-RAY **OR**

5 DIAGNOSTIC LABORATORY **OR**

7 ANESTHESIA

UNLESS TYPE OF SUBMISSION =

D COMPLETE DENIAL

OR ANY OCCURRENCE OF SPECIAL
PROCESSING CODE =

1 MEDICAID

- 2-115-06R** IF ANY OCCURRENCE OF SPECIAL
PROCESSING CODE =

PF ECHO

THEN PRINCIPAL DIAGNOSIS **CANNOT** = 799.9

UNLESS TYPE OF SUBMISSION =

D COMPLETE DENIAL

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ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS (2-115) (Continued)

OR ANY OCCURRENCE OF SPECIAL
PROCESSING CODE = 1 MEDICAID

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

VALIDITY EDITS

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

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

AND FOR AT LEAST ONE LINE ITEM

EITHER BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD-9-CM DIAGNOSIS REFERENCE TABLE

OR END DATE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD-9-CM DIAGNOSIS REFERENCE TABLE

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

RELATIONAL EDITS

2-XXX-01R¹ IF ANY SECONDARY TREATMENT DIAGNOSIS CODE IS FOR FEMALE

AND PERSON SEX (PATIENT) IS MALE

THEN AT LEAST ONE OVERRIDE CODE

MUST = G DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE

2-XXX-02R¹ IF ANY SECONDARY TREATMENT DIAGNOSIS CODE IS FOR MALE

AND NOT FOR CIRCUMCISION (PROCEDURE CODE² 54150 **OR** 54160)

AND SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY ([ADDENDUM E, FIGURE 2.E-3](#))

AND PERSON SEX (PATIENT) IS FEMALE

THEN AT LEAST ONE OVERRIDE CODE

MUST = H DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE

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

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

VALIDITY EDITS

2-139-01V VALUE MUST BE A VALID TED RECORD CORRECTION INDICATOR

2-139-02V IF TED RECORD CORRECTION INDICATOR = 1 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) **SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR**

2 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT CLAIM PROCESSING ERRORS OR TO UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION. **(NOT TO BE USED TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD) OR**

3 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT **BOTH** CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD

THEN TYPE OF SUBMISSION MUST = A ADJUSTMENT **OR**

B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**

C COMPLETE CANCELLATION OF TED RECORD DATA **OR**

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

AND CONTRACT NUMBER MUST = MDA906-02-C-0013 **OR**

MDA906-03-C-0009 **OR**

MDA906-03-C-0010 **OR**

MDA906-03-C-0011 **OR**

MDA906-03-C-0015 **OR**

MDA906-03-C-0019

2-139-03V IF TED RECORD CORRECTION INDICATOR = 1 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) **SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR**

3 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT **BOTH** CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD

THEN A MATCH TO A PROVISIONALLY ACCEPTED TED RECORD **MUST** BE PRESENT ON THE TMA DATABASE.

2-139-04V IF TED RECORD CORRECTION INDICATOR = 2 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT CLAIM PROCESSING ERRORS OR TO UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION

THEN A CORRESPONDING PROVISIONALLY ACCEPTED TED RECORD **MUST NOT** BE PRESENT ON THE TMA DATABASE.

RELATIONAL EDITS

NONE

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ELEMENT NAME: TOTAL OCCURRENCE/LINE ITEM COUNT (2-140)

VALIDITY EDITS

2-140-01V VALUE MUST BE IN RANGE: 001-099

AND MUST EQUAL THE PHYSICAL COUNT OF THE DETAIL OCCURRENCE/LINE ITEM ON THE TED RECORD.

2-140-02V IF TYPE OF SUBMISSION =

A ADJUSTMENT **OR**

B ADJUSTMENT OF NON-TED RECORD (HCSR) DATA **OR**

C COMPLETE CANCELLATION **OR**

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

THEN TOTAL OCCURRENCE/LINE ITEM COUNT MUST BE \geq TOTAL OCCURRENCE/LINE ITEM COUNT FROM TMA DATABASE

RELATIONAL EDITS

NONE

ELEMENT NAME: ADJUSTMENT SEQUENCE NUMBER (2-141)¹

VALIDITY EDITS

2-141-01V MUST BE NUMERIC.

RELATIONAL EDITS

2-141-01R IF TYPE OF SUBMISSION =

D COMPLETE DENIAL **OR**

I INITIAL SUBMISSION **OR**

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

R RESUBMISSION

THEN ADJUSTMENT SEQUENCE NUMBER MUST = 000 (ZEROES)

2-141-02R IF TYPE OF SUBMISSION =

A ADJUSTMENT **OR**

C COMPLETE CANCELLATION

THEN ADJUSTMENT SEQUENCE NUMBER MUST BE ONE GREATER THAN THE CURRENT VALUE IN THE TED DATABASE

2-141-03R IF TYPE OF SUBMISSION =

B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**

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

THEN ADJUSTMENT SEQUENCE NUMBER MUST = 000 (ZEROES)

¹ BYPASS ALL 2-141 EDITS FOR CONTRACT NUMBERS MDA90602C0013, MDA90603C0019, MDA90603C0009, MDA90603C0010, MDA90603C0011, AND MDA90603C0015.

ELEMENT NAME: OCCURRENCE/LINE ITEM NUMBER (2-145)

VALIDITY EDITS

2-145-01V EACH VALUE MUST BE NUMERIC AND NOT EQUAL TO ZERO.

2-145-02V OCCURRENCE/LINE ITEM NUMBER MUST BE CODED FOR EACH NUMBER OF OCCURRENCES SPECIFIED BY THE TOTAL OCCURRENCE/LINE ITEM COUNT.

2-145-03V OCCURRENCE/LINE ITEM NUMBER MUST BE REPORTED IN ASCENDING CONSECUTIVE ORDER.

RELATIONAL EDITS

NONE

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

VALIDITY EDITS

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

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

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

RELATIONAL EDITS

2-150-01R BEGIN DATE OF CARE MUST BE ≤ END DATE OF CARE.

2-150-02R BEGIN DATE OF CARE MUST BE ≤ FILING DATE.

2-150-03R BEGIN DATE OF CARE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION.

2-150-04R BEGIN DATE OF CARE MUST BE ≥ PERSON BIRTH CALENDAR DATE (PATIENT).

2-150-05R IF TYPE OF SUBMISSION =

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

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

UNLESS TED RECORD CORRECTION INDICATOR =

1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD
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AND DATE ADJUSTMENT IDENTIFIED = ZEROES.

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

UNLESS AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO

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

38	SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS OR
52	THE REFERRING/PRESCRIBING/RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE BILLED OR
B7	THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE

OR PROVIDER SPECIALTY =

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

OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) OR
FS	TFL (SECOND PAYOR) OR

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

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

RS MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) **AND** BEGIN DATE OF CARE ≥ 10/01/2001

THEN DO NOT CHECK PROVIDER FILE

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

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

VALIDITY EDITS

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

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

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

RELATIONAL EDITS

2-155-02R END DATE OF CARE MUST BE ≤ FILING DATE.

2-155-03R END DATE OF CARE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION.

2-155-04R IF TYPE OF SUBMISSION =

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

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

UNLESS TED RECORD CORRECTION INDICATOR =

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

AND DATE ADJUSTMENT IDENTIFIED = ZEROES.

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

UNLESS AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO

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

38	SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS OR
52	THE REFERRING/PRESCRIBING/RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE BILLED OR
B7	THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE

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

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

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Non-Institutional Edit Requirements (ELN 100 - 199)

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

OR ANY OCCURRENCE OF SPECIAL
PROCESSING CODE =

T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND
PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 **OR**

FG TFL (FIRST PAYOR-NO TRICARE PROVIDER
CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN
EXHAUSTED) **OR**

FS TFL (SECOND PAYOR) **OR**

RS MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST
PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e.,
MEDICARE BENEFITS HAVE BEEN EXHAUSTED) AND
BEGIN DATE OF CARE ≥ 10/01/2001

THEN DO NOT CHECK PROVIDER FILE

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

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

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Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: PROCEDURE CODE (2-160)

VALIDITY EDITS

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

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

FOR TYPE OF SUBMISSION =	D	COMPLETE DENIAL OR
	I	INITIAL TED RECORD SUBMISSION OR
	O	ZERO PAYMENT WITH 100% OHI/TPL OR
	R	RESUBMISSION OF AN INITIAL TED RECORD (TYPE OF SUBMISSION WAS 'I') THAT WAS REJECTED DUE TO ERRORS

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

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

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

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

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

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

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

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

RELATIONAL EDITS

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

THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE ≤ ZERO

UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
AN	SHCP - NON-MTF-REFERRED CARE OR
AR	SHCP - REFERRED CARE OR
CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
CL	CLINICAL TRIALS OR
FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) OR

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² PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-160-01R.

³ BYPASS EDIT 2-160-01R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.

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Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: PROCEDURE CODE (2-160) (Continued)	
	FS TFL (SECOND PAYOR) OR
	GU ADSM ENROLLED IN TPR OR
	MN TSP - NETWORK OR
	MS TSP - NON-NETWORK OR
	SC SHCP - NON-TRICARE ELIGIBLE OR
	SE SHCP - TRICARE ELIGIBLE OR
	SM SHCP - EMERGENCY
OR ENROLLMENT/HEALTH PLAN CODE MUST =	SN SHCP - NON-MTF-REFERRED CARE OR
	SR SHCP - REFERRED CARE
OR FILING STATE AND COUNTRY CODE MUST = A FOREIGN COUNTRY CODE (REFER TO ADDENDUM A)	
2-160-05R	IF PROCEDURE CODE ¹ = A0100, A0110, A0120, A0130, A0140, A0170, E0170 - E0172, E0241- E0245, E0270, E0273, E0625, E0701, E0911, E0912, L3000 - L3003, L3010, L3020, L3030, L3031, L3040, L3050, L3060, L3070, L3080, L3090, L3100, L3160, L3201 - L3207, L3212 - L3219, L3221 - L3223, L3230, L3250 -L3255, L3257, L3265, L3300, L3310, L3320, L3330, L3332, L3334, L3340, L3350, L3360, L3370, L3380, L3390, L3400, L3410, L3420, L3430, L3440, L3450, L3455, L3460, L3465, L3470, L3480, L3485, L3500, L3510, L3520, L3530, L3540, L3550, L3560, L3570, L3580, L3590, L3595, L3630, S1040, S9122 - S9124, OR 99082
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = PF ECHO
	UNLESS ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM IS A CODE LISTED IN ADDENDUM G, FIGURE 2.G-1 OR FIGURE 2.G-2
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AN SHCP - NON-MTF-REFERRED CARE OR
	AR SHCP - REFERRED CARE OR
	CE SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
	GU ADSM ENROLLED IN TPR OR
	MN TSP - NETWORK OR
	MS TSP - NON-NETWORK OR
	SC SHCP - NON-TRICARE ELIGIBLE OR
	SE SHCP - TRICARE ELIGIBLE OR
	SM SHCP - EMERGENCY
OR ENROLLMENT/HEALTH PLAN CODE =	X FOREIGN ADSM OR
	SN SHCP - NON-MTF-REFERRED CARE OR
	SR SHCP - REFERRED CARE OR
	WA TPR - FOREIGN ADSM
2-160-06R	IF TYPE OF SERVICE (FIRST POSITION) = I INPATIENT
	THEN PROCEDURE CODE MUST NOT BE FOR OUTPATIENT ONLY CARE (REFER TO ADDENDUM E, FIGURE 2.E-2).
2-160-08R	IF PROCEDURE CODE ¹ = 98800 FOR DRUGS OR
	00MN PRESCRIPTION MEDICAL NECESSITY REVIEWS OR

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² PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-160-01R.
³ BYPASS EDIT 2-160-01R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.

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Non-Institutional Edit Requirements (ELN 100 - 199)

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

	00PA	PRESCRIPTION PRIOR AUTHORIZATIONS
THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS OR
	M	MOP DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS
AND NATIONAL DRUG CODE MUST ≠ BLANK		
UNLESS PROVIDER STATE OR COUNTRY CODE IS A FOREIGN COUNTRY CODE (ADDENDUM A)		

2-160-11R IF PROCEDURE CODE¹ = S5108 **OR** 99080

THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = AU AUTISM DEMONSTRATION

UNLESS ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM IS A CODE LISTED IN [ADDENDUM G](#), [FIGURE 2.G-1](#) OR [FIGURE 2.G-2](#).

OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE = AN SHCP - NON-MTF-REFERRED CARE **OR**

AR SHCP - REFERRED CARE **OR**

CE SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM **OR**

GU ADSM ENROLLED IN TPR **OR**

MN TSP - NETWORK **OR**

MS TSP - NON-NETWORK **OR**

SC SHCP - NON-TRICARE ELIGIBLE **OR**

SE SHCP - TRICARE ELIGIBLE **OR**

SM SHCP - EMERGENCY

OR ENROLLMENT/HEALTH PLAN CODE = X FOREIGN ADSM **OR**

SN SHCP - NON-MTF-REFERRED CARE **OR**

SR SHCP - REFERRED CARE **OR**

WA TPR - FOREIGN ADSM

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² PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-160-01R.

³ BYPASS EDIT 2-160-01R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.

ELEMENT NAME: PROCEDURE CODE MODIFIER (2-165)

VALIDITY EDITS

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

RELATIONAL EDITS

NONE

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Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: NATIONAL DRUG CODE (2-170)	
VALIDITY EDITS	
2-170-01V	MUST BE A VALID NATIONAL DRUG CODE OR BLANK
RELATIONAL EDITS	
2-170-01R	IF NATIONAL DRUG CODE = BLANK
THEN TYPE OF SERVICE (SECOND POSITION) MUST ≠	B RETAIL DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS OR
	M MOP DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS
AND PROCEDURE CODE ¹ MUST ≠	98800 FOR DRUGS
UNLESS PROVIDER STATE OR COUNTRY CODE IS A FOREIGN COUNTRY CODE (ADDENDUM A)	
2-170-02R	IF NATIONAL DRUG CODE ≠ BLANK
THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B RETAIL DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS OR
	M MOP DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS
AND PROCEDURE CODE ¹ MUST =	98800 FOR DRUGS OR
	99070 FOR SUPPLIES OR
	000MN PRESCRIPTION MEDICAL NECESSITY REVIEWS OR
	000PA PRESCRIPTION PRIOR AUTHORIZATIONS
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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 MOP DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS

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 THA NUMBER OF SERVICES IS MEDICALLY NECESSARY

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**

99234-99236 (OBSERVATION OR IMPATIENT CARE SERVICES) **OR**

99238-99239 (HOSPITAL DISCHARGE SERVICES) **OR**

99241-99245 (OFFICE CONSULTATIONS) **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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Non-Institutional Edit Requirements (ELN 100 - 199)

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

	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)

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

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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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Non-Institutional Edit Requirements (ELN 100 - 199)

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

IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO

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

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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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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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 IF CONTRACT NUMBER = MDA906-02-C-0013
THEN IF PROCEDURE CODE = 000MN PRESCRIPTION MEDICAL NECESSITY REVIEWS **OR**
 000PA PRESCRIPTION PRIOR AUTHORIZATIONS

THEN AMOUNT BILLED BY PROCEDURE CODE MUST > ZERO

ELSE IF TYPE OF SUBMISSION = C COMPLETE CANCELLATION TO TED RECORD DATA
OR ADJUSTMENT/DENIAL REASON CODE IS A DENIAL REASON CODE LISTED IN [FIGURE 2.G-1](#) FOR THAT OCCURRENCE/LINE ITEM

THEN AMOUNT BILLED BY PROCEDURE CODE MUST = ZERO

AND AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO

AND AMOUNT PAID BY OHI MUST = ZERO

AND AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO

AND AMOUNT PAITENT COST SHARE MUST = ZERO

ELSE IF OCCURRENCE/LINE ITEM NUMBER = 002

THEN AMOUNT BILLED BY PROCEDURE CODE MUST = ZERO

ELSE AMOUNT BILLED BY PROCEDURE CODE MUST BE ≥ \$10.20 AND ≤ \$11.48

2-180-03V IF CONTRACT NUMBER = MDA906-02-C-0013

AND AMOUNT BILLED BY PROCEDURE CODE = ZERO

THEN TYPE OF SUBMISSION MUST = C COMPLETE CANCELLATION TO TED RECORD DATA

OR OCCURRENCE/LINE ITEM NUMBER MUST = 002

OR ADJUSTMENT/DENIAL REASON CODE MUST BE A DENIAL REASON CODE LISTED IN [FIGURE 2.G-1](#) FOR THAT OCCURRENCE/LINE ITEM

RELATIONAL EDITS

2-180-00R IF TYPE OF SUBMISSION ≠ D COMPLETE DENIAL

THEN TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT BILLED BY PROCEDURE CODE FOR THIS TED RECORD MUST NOT EXCEED TMA LIMIT OF \$1,000,000.00

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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/LINE ITEMS 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 OCCURRENCES/LINE ITEMS	
2-185-02R	IF PRICING RATE CODE =	h 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) OR 16 AMBULATORY SURGERY FACILITY CHARGE
	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 G, FIGURE 2.G-1 OR FIGURE 2.G-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	
	THEN TYPE OF SUBMISSION MUST =	A ADJUSTMENT OR B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR I INITIAL SUBMISSION OR

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Non-Institutional Edit Requirements (ELN 100 - 199)

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

	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 (2-190)

VALIDITY EDITS

2-190-01V MUST BE NUMERIC.

RELATIONAL EDITS

2-190-00R TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY OTHER HEALTH INSURANCE FOR THIS TED RECORD EXCEEDS TMA LIMIT OF \$1,000,000.00.

2-190-01R	IF TYPE OF SUBMISSION =	
	A	ADJUSTMENT OR
	C	COMPLETE CANCELLATION OR
	D	COMPLETE DENIAL OR
	I	INITIAL SUBMISSION OR
	O	ZERO PAYMENT WITH 100% OHI/TPL OR
	R	RESUBMISSION

THEN AMOUNT PAID BY OTHER HEALTH INSURANCE MUST BE ≥ ZERO.

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

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Non-Institutional Edit Requirements (ELN 100 - 199)

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

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/LINE ITEMS 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
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AND BEGIN DATE OF CARE ≥ 09/14/2001 **AND** < 11/01/2008

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 =

DE	TDRL PHYSICAL EXAMS	OR
PF	ECHO	

THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO

- END -