

Non-Institutional Edit Requirements (ELN 300 - 399)

<b>ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300)</b>			
<b>VALIDITY EDITS</b>			
<b>2-300-01V</b>	MUST BE A VALID ENROLLMENT/HEALTH PLAN CODE (REFER TO <a href="#">SECTION 2.5</a> )		
<b>RELATIONAL EDITS</b>			
<b>2-300-02R</b>	IF ENROLLMENT/HEALTH PLAN CODE =	Y	CHCBP - STANDARD <b>OR</b>
		AA	CHCBP - EXTRA
	<b>THEN NO</b> OCCURRENCE OF SPECIAL PROCESSING CODE =	CL	CLINICAL TRIALS <b>OR</b>
		PF	ECHO
<b>2-300-07R</b>	IF ENROLLMENT/HEALTH PLAN CODE =	SN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
		SO	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
		SR	SHCP - REFERRED CARE <b>OR</b>
		ST	SHCP - TRICARE ELIGIBLE
	<b>THEN</b> AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AN	SHCP -NON-MTF-REFERRED CARE <b>OR</b>
		AR	SHCP - REFERRED CARE <b>OR</b>
		CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM <b>OR</b>
		SC	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
		SE	SHCP - TRICARE ELIGIBLE <b>OR</b>
		SM	SHCP - EMERGENCY
<b>2-300-10R</b>	IF ENROLLMENT/HEALTH PLAN CODE =	PS	TSRx
	<b>THEN</b> TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS <b>OR</b>
		M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
<b>2-300-11R</b>	IF ENROLLMENT/HEALTH PLAN CODE =	PS	TSRx
	<b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 04/01/2001		
	<b>AND</b> NATIONAL DRUG CODE <b>CANNOT</b> BE BLANK.		
	UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	1	MEDICAID
<b>2-300-12R</b>	<ul style="list-style-type: none"> <li>TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001. FOR EACH LINE ITEM WHERE BEGIN DATE OF CARE IS &lt; 10/01/2001, THE LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.</li> </ul>		
	IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL - EXTRA <b>OR</b>
<sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.			

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<b>ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (Continued)</b>		
	FS	TFL - STANDARD
<b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 10/01/2001		
<b>AND</b> AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	FF	TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) <b>OR</b>
	FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b>
	FS	TFL (SECOND PAYOR)
ELSE IF BEGIN DATE OF CARE IS < 10/01/2001 (FOR THAT DETAILED LINE ITEM)		
<b>THEN</b> ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE MUST =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER <b>OR</b>
	26	EXPENSES INCURRED PRIOR TO COVERAGE <b>OR</b>
	27	EXPENSES INCURRED AFTER COVERAGE TERMINATED <b>OR</b>
	30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS <b>OR</b>
	31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED <b>OR</b>
	32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED <b>OR</b>
	33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE <b>OR</b>
	34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS <b>OR</b>
	62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION <b>OR</b>
	141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
<b>2-300-13R</b>	<ul style="list-style-type: none"> <li>TFL CLAIMS: THE PATIENT MUST BE 64 YEARS AND 11 MONTHS OR GREATER. IF THE PATIENT IS LESS THAN THIS AGE, THE LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.</li> </ul>	
IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL - EXTRA <b>OR</b>
	FS	TFL - STANDARD <b>OR</b>
	PS	TSRx
<b>AND</b> TYPE OF SERVICE (SECOND POSITION) ≠	M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
<b>THEN</b> PATIENT AGE <sup>1</sup> MUST BE ≥ 64 YEARS AND 11 MONTHS		
<b>ELSE</b> IF PATIENT AGE <sup>1</sup> IS < 64 YEARS AND 11 MONTHS		
<sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.		

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**ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (Continued)**

<b>THEN</b> ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE MUST =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER <b>OR</b>
	26	EXPENSES INCURRED PRIOR TO COVERAGE <b>OR</b>
	27	EXPENSES INCURRED AFTER COVERAGE TERMINATED <b>OR</b>
	30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS <b>OR</b>
	31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED <b>OR</b>
	32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED <b>OR</b>
	33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE <b>OR</b>
	34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS <b>OR</b>
	62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION <b>OR</b>
	141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
<b>2-300-15R</b> IF ENROLLMENT/HEALTH PLAN CODE =	SU	SCHP - REFERRAL DESIGNATION UNKNOWN
<b>THEN</b> TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS <b>OR</b>
	M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
<b>2-300-16R</b> IF ENROLLMENT/HEALTH PLAN CODE =	SU	SCHP - REFERRAL DESIGNATION UNKNOWN
<b>THEN</b> AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	SC	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
	SE	SHCP - TRICARE ELIGIBLE
<b>2-300-17R</b>		<ul style="list-style-type: none"> <li>FOR TMOP ONLY: FOR TSRx, THE PATIENT MUST BE 64 YEARS AND 8 MONTHS OR GREATER. IF THE PATIENT IS LESS THAN THIS AGE, THE LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.</li> </ul>
IF ENROLLMENT/HEALTH PLAN CODE =	PS	TSRx
<b>AND</b> TYPE OF SERVICE (SECOND POSITION) =	M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
<b>THEN</b> PATIENT AGE <sup>1</sup> MUST BE ≥ 64 YEARS AND 8 MONTHS		
ELSE IF PATIENT AGE <sup>1</sup> < 64 YEARS AND 8 MONTHS		

<sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

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**ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (Continued)**

<b>THEN</b> ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE MUST =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER <b>OR</b>
	26	EXPENSES INCURRED PRIOR TO COVERAGE <b>OR</b>
	27	EXPENSES INCURRED AFTER COVERAGE TERMINATED <b>OR</b>
	30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS <b>OR</b>
	31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED <b>OR</b>
	32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED <b>OR</b>
	33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE <b>OR</b>
	34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS <b>OR</b>
	62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION <b>OR</b>
	141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
<b>2-300-18R</b> IF ENROLLMENT/HEALTH PLAN CODE =	X	FOREIGN ADASM
<b>THEN</b> HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF <b>OR</b>
	T	FOREIGN MILITARY MEMBER
<b>AND</b> HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY <b>OR</b>
	G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) <b>OR</b>
	J	ACADEMY STUDENT <b>OR</b>
	N	NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) <b>OR</b>
	S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) <b>OR</b>
	V	RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS)

<sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

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**ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (2-301)**

**VALIDITY EDITS**

**2-301-01V** MUST BE A VALID HCDP PLAN COVERAGE CODE LISTED IN [ADDENDUM L](#).

**2-301-02V** IF FILING DATE ≥ 09/01/2007

<b>AND</b> HCDP PLAN COVERAGE CODE =	109	TRICARE USFHP DIRECT CARE COVERAGE FOR ADMFs <b>OR</b>
	114	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b>
	115	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b>
	118	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR RETIRED SPONSORS AND FAMILY MEMBERS <b>OR</b>
	119	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR RETIRED SPONSORS AND FAMILY MEMBERS <b>OR</b>
	133	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR TRANSITIONAL SURVIVORS OR ACTIVE DUTY DECEASED SPONSORS <b>OR</b>
	138	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS <b>OR</b>
	139	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS

**THEN** THE TOTAL OF ALL OCCURRENCES/LINEITEMS OF AMOUNT ALLOWED BY PROCEDURE CODES MUST = ZERO

**RELATIONAL EDITS**

**2-301-01R** IF HCDP PLAN COVERAGE CODE =

	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
	402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
	405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
	406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
	407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
	408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE <b>OR</b>
	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE <b>OR</b>
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE <b>OR</b>
	412	TRS SURVIVOR NEW FAMILY COVERAGE <b>OR</b>

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<b>ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (2-301) (Continued)</b>		
	413	TRS MEMBER-ONLY COVERAGE <b>OR</b>
	414	TRS MEMBER AND FAMILY COVERAGE
<b>THEN</b> ENROLLMENT/HEALTH PLAN CODE MUST =	T	TRICARE STANDARD <b>OR</b>
	V	TRICARE EXTRA <b>OR</b>
	FE	TFL - EXTRA <b>OR</b>
	FS	TFL - STANDARD <b>OR</b>
	PS	TSRx <b>OR</b>
	SR	HCP-REFERRED CARE
<b>2-301-02R</b> IF HCDP PLAN COVERAGE CODE =	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
	402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
	405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
	406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
	407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
	408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE <b>OR</b>
	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE <b>OR</b>
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE <b>OR</b>
	412	TRS SURVIVOR NEW FAMILY COVERAGE <b>OR</b>
	413	TRS MEMBER-ONLY COVERAGE <b>OR</b>
	414	TRS MEMBER AND FAMILY COVERAGE
<b>THEN NO</b> OCCURRENCE OF SPECIAL PROCESSING CODE CAN =	PF	ECHO

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

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**ELEMENT NAME: SPECIAL PROCESSING CODE (2-305)**

**VALIDITY EDITS**

<b>2-305-01V</b>	OCCURRENCE NUMBER 1--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8)
<b>2-305-02V</b>	OCCURRENCE NUMBER 2--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8)
<b>2-305-03V</b>	OCCURRENCE NUMBER 3--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8)
<b>2-305-04V</b>	OCCURRENCE NUMBER 4--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8)
<b>2-305-05V</b>	A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).
<b>2-305-06V</b>	SPECIAL PROCESSING CODE OCCURRENCES MUST BE LEFT JUSTIFIED.
<b>2-305-07V</b>	<ul style="list-style-type: none"> <li>SHCP REFERRED/NON-REFERRED</li> </ul>
	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	AN SHCP - NON-MTF-REFERRED CARE <b>OR</b>
	AR SHCP - REFERRED CARE
	<b>THEN</b> BEGIN DATE OF CARE MUST BE < 06/01/2004
<b>2-305-08V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	GF TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	<b>THEN</b> BEGIN DATE OF CARE MUST BE < 09/01/2002
<b>2-305-10V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	MN TSP - NON-NETWORK <b>OR</b>
	MS TSP - NETWORK
	<b>THEN</b> BEGIN DATE OF CARE MUST BE < 12/31/2001
<b>2-305-11V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	SN TSS - NON-NETWORK <b>OR</b>
	SS TSS - NETWORK
	<b>THEN</b> BEGIN DATE OF CARE MUST BE < 12/31/2002
<b>2-305-14V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	ST SPECIALIZED TREATMENT
	<b>THEN</b> BEGIN DATE OF CARE MUST BE < 10/01/2004

**RELATIONAL EDITS**

<b>2-305-02R</b>	IF CA/NAS EXCEPTION REASON =	6	RESOURCE SHARING
	<b>THEN</b> AT LEAST ONE SPECIAL PROCESSING CODE MUST =	S	RESOURCE SHARING - EXTERNAL
<b>2-305-08R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF	ECHO
	<b>THEN NO</b> OCCURRENCE OF SPECIAL PROCESSING CODE =	6	HHC <b>OR</b>
		A	PARTNERSHIP PROGRAM <b>OR</b>
		E	HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP) <b>OR</b>
		S	RESOURCE SHARING - EXTERNAL <b>OR</b>
		CM	ICMP <b>OR</b>
		CT	CCTP <b>OR</b>
		RI	RESOURCE SHARING - INTERNAL

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**ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)**

<b>2-305-12R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	U	BRAC MEDICARE PHARMACY
	<b>THEN</b> TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	<b>AND</b> BEGIN DATE OF CARE MUST BE < 04/01/2001		
<b>2-305-13R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	16	AMBULATORY SURGERY FACILITY CHARGE
	<b>THEN</b> PRICING RATE CODE MUST =	0	PRICING NOT APPLICABLE (DENIED SERVICE/ SUPPLIES AND ALLOWED DRUGS) <b>OR</b>
		1	PRICED MANUALLY <b>OR</b>
		C	AMBULATORY SURGERY FACILITY PAYMENT RATE <b>OR</b>
		D	DISCOUNTED AMBULATORY SURGERY - FACILITY PAYMENT RATE <b>OR</b>
		E	AMBULATORY SURGERY-PAID AS BILLED <b>OR</b>
		P	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-FACILITY PAYMENT RATE <b>OR</b>
		Q	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, DISCOUNTED AMBULATORY SURGERY-FACILITY PAYMENT RATE <b>OR</b>
		R	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-PAID AS BILLED <b>OR</b>
		V	MEDICARE REIMBURSEMENT RATE <b>OR</b>
		P1	OPPS <b>OR</b>
		P2	OPPS WITH COST OUTLINER <b>OR</b>
		P3	OPPS WITH DISCOUNT
<b>2-305-14R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PO	TRICARE PRIME - POINT OF SERVICE
	<b>THEN</b> ENROLLMENT/HEALTH PLAN CODE MUST =	U	TRICARE PRIME, CIVILIAN PCM <b>OR</b>
		Z	TRICARE PRIME, MTF/PCM <b>OR</b>
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM <b>OR</b>
		XF	FOREIGN ADFM
<b>2-305-22R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
		AR	SHCP - REFERRED CARE <b>OR</b>
		CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM <b>OR</b>
		SC	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
		SE	SHCP - TRICARE ELIGIBLE <b>OR</b>
		SM	SHCP - EMERGENCY
	<b>THEN</b> ENROLLMENT/HEALTH PLAN CODE MUST =	SN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>

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<b>ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)</b>		
	SO	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
	SR	SHCP - REFERRED CARE <b>OR</b>
	ST	SHCP - TRICARE ELIGIBLE <b>OR</b>
	SU	SHCP - REFERRAL DESIGNATION UNKNOWN
<b>2-305-24R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	E HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP)
	<b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 03/15/1999	
	<b>AND</b> AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	CM ICMP
<b>2-305-26R</b>	• TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001. FOR EACH OCCURRENCE/LINE ITEM WHERE DATE OF CARE IS < 10/01/2001, THE OCCURRENCE/LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.	
	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	FF TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) <b>OR</b>
		FG TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b>
		FS TFL (SECOND PAYOR)
	ELSE IF BEGIN DATE OF CARE IS < 10/01/2001	
	<b>THEN</b> ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAILED LINE MUST =	15 PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER <b>OR</b>
		26 EXPENSES INCURRED PRIOR TO COVERAGE <b>OR</b>
		27 EXPENSES INCURRED AFTER COVERAGE TERMINATED <b>OR</b>
		30 PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS <b>OR</b>
		31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED <b>OR</b>
		32 OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED <b>OR</b>
		33 CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE <b>OR</b>
		34 CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS <b>OR</b>
		62 PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION <b>OR</b>
		141 CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
<b>2-305-30R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF ECHO

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Non-Institutional Edit Requirements (ELN 300 - 399)

**ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)**

<b>THEN</b> HCDP PLAN COVERAGE CODE MUST ≠		
	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
	402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
	405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
	406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
	407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
	408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE <b>OR</b>
	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE <b>OR</b>
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE <b>OR</b>
	412	TRS SURVIVOR NEW FAMILY COVERAGE <b>OR</b>
	413	TRS MEMBER-ONLY COVERAGE <b>OR</b>
	414	TRS MEMBER AND FAMILY COVERAGE

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Non-Institutional Edit Requirements (ELN 300 - 399)

<b>ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) SPECIAL ENTITLEMENT CODE (2-306)</b>		
<b>VALIDITY EDITS</b>		
<b>2-306-01V</b>	MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE (REFER TO <a href="#">SECTION 2.5</a> )	
<b>RELATIONAL EDITS</b>		
NONE		
<b>ELEMENT NAME: CA/NAS NUMBER (2-310)</b>		
<b>VALIDITY EDITS</b>		
<b>2-310-01V</b>	IF CA/NAS NUMBER IS NOT BLANK <b>THEN</b> MUST BE 1 TO 11 <b>OR</b> 1 TO 15 ALPHANUMERIC CHARACTERS.	
<b>RELATIONAL EDITS</b>		
<b>NO ERROR</b>	IF TYPE OF SUBMISSION =	C COMPLETE CANCELLATION <b>OR</b> D COMPLETE DENIAL
<b>THEN</b> BYPASS ALL CA/NAS NUMBER RELATIONAL EDITING.		
<b>NO ERROR</b>	IF BEGIN DATE OF CARE IS OLDER THAN 6 YEARS	
<b>THEN</b> DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA		
<b>NO ERROR</b>	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 <b>OR</b> T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b> AN SHCP - NON-MTF-REFERRED CARE <b>OR</b> AR SHCP - REFERRED CARE <b>OR</b> CE SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM <b>OR</b> PF ECHO RS MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b> SC SHCP - NON-TRICARE ELIGIBLE <b>OR</b> SE SHCP - TRICARE ELIGIBLE <b>OR</b> SM SHCP - EMERGENCY <b>OR</b> ST SPECIALIZED TREATMENT <b>OR</b> WR MENTAL HEALTH WRAP AROUND
<b>THEN</b> BYPASS ALL CA/NAS NUMBER EDITING.		
<b>NO ERROR</b>	IF ENROLLMENT/HEALTH PLAN CODE =	U TRICARE PRIME, CIVILIAN PCM <b>OR</b> W TPR ADSM - USA <b>OR</b> X FOREIGN ADSM <b>OR</b> Y CHCBP - STANDARD <b>OR</b> Z TRICARE PRIME, MTF/PCM <b>OR</b> AA CHCBP - EXTRA <b>OR</b> BB TSP <b>OR</b>
<sup>1</sup> CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.		

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Non-Institutional Edit Requirements (ELN 300 - 399)

<b>ELEMENT NAME: CA/NAS NUMBER (2-310) (Continued)</b>			
	FE	TFL - EXTRA	<b>OR</b>
	FS	TFL - STANDARD	<b>OR</b>
	PS	TSRx	<b>OR</b>
	SN	SHCP - NON-MTF-REFERRED CARE	<b>OR</b>
	SR	SHCP - REFERRED CARE	<b>OR</b>
	WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM	
<b>THEN</b> BYPASS ALL CA/NAS NUMBER EDITING.			
<b>NO ERROR</b>	IF HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER
<b>THEN</b> BYPASS ALL CA/NAS NUMBER EDITING.			
<b>NO ERROR</b>	IF ANY OCCURRENCE OF ADJUSTMENT/ DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER <b>OR</b>
		26	EXPENSES INCURRED PRIOR TO COVERAGE <b>OR</b>
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED <b>OR</b>
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS <b>OR</b>
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED <b>OR</b>
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED <b>OR</b>
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE <b>OR</b>
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS <b>OR</b>
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION <b>OR</b>
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
<b>THEN</b> BYPASS ALL CA/NAS NUMBER EDITING			
<b>NO ERROR</b>	IF AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO		
<b>THEN</b> NO CA/NAS IS REQUIRED -- BYPASS ALL CA/NAS NUMBER EDITING.			
<b>NO ERROR</b>	IF HCDP PLAN COVERAGE CODE =	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
		405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
		406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
<sup>1</sup> CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.			

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Non-Institutional Edit Requirements (ELN 300 - 399)

<b>ELEMENT NAME: CA/NAS NUMBER (2-310) (Continued)</b>	
407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE <b>OR</b>
410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE <b>OR</b>
411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE <b>OR</b>
412	TRS SURVIVOR NEW FAMILY COVERAGE <b>OR</b>
413	TRS MEMBER-ONLY COVERAGE <b>OR</b>
414	TRS MEMBER AND FAMILY COVERAGE

**2-310-02R** IF CA/NAS EXCEPTION REASON ≠ BLANK  
**THEN** CA/NAS NUMBER MUST = BLANK

**2-310-03R** • MENTAL HEALTH CHECK  
 IF CA/NAS EXCEPTION REASON = BLANK

**AND** TYPE OF SERVICE (FIRST POSITION) = I INPATIENT

**AND** PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316

**AND** PATIENT ZIP CODE IS IN AN MTF CATCHMENT AREA<sup>1</sup>

**THEN** CA/NAS NUMBER MUST BE CODED

**UNLESS** ANY OCCURRENCE OF OVERRIDE CODE = C GOOD FAITH PAYMENT

**THEN** CA/NAS NUMBER MUST = BLANK

**2-310-04R** IF CA/NAS NUMBER IS CODED

**THEN** CA/NAS EXCEPTION REASON MUST = BLANK

<sup>1</sup> CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.

**ELEMENT NAME: CA/NAS REASON FOR ISSUANCE (2-315)**

**VALIDITY EDITS**

**2-315-01V** VALUE MUST A VALID CA/NAS REASON FOR ISSUANCE.

**RELATIONAL EDITS**

**2-315-02R** IF CA/NAS NUMBER = BLANK

**THEN** CA/NAS REASON FOR ISSUANCE MUST = BLANK.

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Non-Institutional Edit Requirements (ELN 300 - 399)

**ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320)**

**VALIDITY EDITS**

**2-320-01V** VALUE MUST BE A VALID CA/NAS EXCEPTION REASON.

**RELATIONAL EDITS**

**NO ERROR** IF TYPE OF SUBMISSION = C COMPLETE CANCELLATION **OR**  
D COMPLETE DENIAL

**THEN** BYPASS ALL CA/NAS EXCEPTION REASON EDITING.

**NO ERROR** IF BEGIN DATE OF CARE IS OLDER THAN 6 YEARS

**THEN** DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA

**NO ERROR** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = R MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NOT A MEDICARE BENEFIT) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**

T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR-NOT A MEDICARE BENEFIT) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**

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

AR SHCP - REFERRED CARE **OR**

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

PF ECHO

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

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

SE SHCP - TRICARE ELIGIBLE **OR**

SM SHCP - EMERGENCY **OR**

ST SPECIALIZED TREATMENT **OR**

WR MENTAL HEALTH WRAP AROUND

**THEN** BYPASS ALL CA/NAS EXCEPTION REASON EDITING.

**NO ERROR** IF ENROLLMENT/HEALTH PLAN CODE = U TRICARE PRIME, CIVILIAN PCM **OR**

W TPR ADSM - USA **OR**

X FOREIGN ADSM **OR**

Y CHCBP - STANDARD **OR**

Z TRICARE PRIME, MTF/PCM **OR**

AA CHCBP - EXTRA **OR**

BB TSP **OR**

FE TFL - EXTRA **OR**

FS TFL - STANDARD **OR**

PS TSRx **OR**

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

SR SHCP - REFERRED CARE **OR**

WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM

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Non-Institutional Edit Requirements (ELN 300 - 399)

**ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320) (Continued)**

**THEN** BYPASS ALL CA/NAS EXCEPTION REASON EDITING.

**NO ERROR** IF HCC MEMBER CATEGORY CODE = T FOREIGN MILITARY MEMBER

**THEN** BYPASS ALL CA/NAS EXCEPTION REASON EDITING.

**NO ERROR** IF ANY OCCURRENCE OF ADJUSTMENT/  
DENIAL REASON CODE FOR THAT DETAIL  
OCCURRENCE =

15 PAYMENT ADJUSTED BECAUSE THE SUBMITTED  
AUTHORIZATION NUMBER IS MISSING, INVALID, OR  
DOES NOT APPLY TO THE BILLED SERVICES OR  
PROVIDER **OR**

26 EXPENSES INCURRED PRIOR TO COVERAGE **OR**

27 EXPENSES INCURRED AFTER COVERAGE TERMINATED  
**OR**

30 PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT  
MET THE REQUIRED ELIGIBILITY, SPEND DOWN,  
WAITING, OR RESIDENCY REQUIREMENTS **OR**

31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED  
AS OUR INSURED **OR**

32 OUR RECORDS INDICATE THAT THIS DEPENDENT IS  
NOT AN ELIGIBLE DEPENDENT AS DEFINED **OR**

33 CLAIM DENIED. INSURED HAS NO DEPENDENT  
COVERAGE **OR**

34 CLAIM DENIED. INSURED HAS NO COVERAGE FOR  
NEWBORNS **OR**

62 PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR  
EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION **OR**

141 CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS  
ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE

**THEN** BYPASS ALL CA/NAS EXCEPTION REASON EDITING

**NO ERROR** IF AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO

**THEN** NO CA/NAS IS REQUIRED -- BYPASS ALL CA/NAS EXCEPTION REASON EDITING

**NO ERROR** IF HCDP PLAN COVERAGE CODE =

401 TRS TIER 1 MEMBER-ONLY COVERAGE  
(CONTINGENCY OPERATIONS) **OR**

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**

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Non-Institutional Edit Requirements (ELN 300 - 399)

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**ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320) (Continued)**

---

412 TRS SURVIVOR NEW FAMILY COVERAGE **OR**

---

413 TRS MEMBER-ONLY COVERAGE **OR**

---

414 TRS MEMBER AND FAMILY COVERAGE

---

**2-320-04R** IF PATIENT ZIP CODE IS IN AN MTF CATCHMENT AREA

---

**AND** TYPE OF SERVICE (FIRST POSITION) = I INPATIENT

---

**AND** PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316

---

**AND** CA/NAS NUMBER NOT CODED

---

**THEN** CA/NAS EXCEPTION REASON MUST BE CODED

---

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Non-Institutional Edit Requirements (ELN 300 - 399)

<b>ELEMENT NAME: PRICING RATE CODE (2-325)</b>		
<b>VALIDITY EDITS</b>		
<b>2-325-01V</b>	VALUE MUST A VALID NON-INSTITUTIONAL PRICING RATE CODE.	
<b>RELATIONAL EDITS</b>		
<b>2-325-01R</b>	IF PRICING RATE CODE =	C AMBULATORY SURGERY FACILITY PAYMENT RATE <b>OR</b>
		D DISCOUNTED AMBULATORY SURGERY FACILITY PAYMENT RATE <b>OR</b>
		E AMBULATORY SURGERY-PAID AS BILLED <b>OR</b>
		P CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-FACILITY PAYMENT RATE <b>OR</b>
		Q CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, DISCOUNTED AMBULATORY SURGERY-FACILITY PAYMENT RATE <b>OR</b>
		R CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-PAID AS BILLED
	<b>THEN</b> ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	16 AMBULATORY SURGERY FACILITY CHARGE
<b>2-325-02R</b>	IF ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM IS A CODE LISTED IN <a href="#">ADDENDUM G, FIGURE 2.G-1</a> .	
	<b>THEN</b> PRICING RATE CODE MUST =	0 PRICING NOT APPLICABLE (DENIED SERVICE/ SUPPLIES AND ALLOWED DRUGS)
<b>2-325-03R</b>	IF PRICING RATE CODE FOR THAT OCCURRENCE/LINE ITEM =	0 PRICING NOT APPLICABLE (DENIED SERVICE/ SUPPLIES AND ALLOWED DRUGS)
	<b>THEN</b> AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO	
	<b>UNLESS</b> TYPE OF SERVICE (SECOND POSITION) =	B RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS <b>OR</b>
		M MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	<b>OR</b> TYPE OF SUBMISSION =	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>
		E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR)
<b>2-325-04R</b>	IF PRICING RATE CODE =	V MEDICARE REIMBURSEMENT RATE
	<b>THEN</b> ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	16 AMBULATORY SURGERY FACILITY CHARGE <b>OR</b>
		T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b>
		FS TFL (SECOND PAYOR) <b>OR</b>
		MN TSP - NON-NETWORK <b>OR</b>
		MS TSP - NETWORK
<b>2-325-05R</b>	IF PRICING RATE CODE =	U SHCP CLAIM OR ACTIVE DUTY MEMBER TPR PAID OUTSIDE NORMAL LIMITS
	<b>THEN</b> ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AR SHCP - REFERRED CARE <b>OR</b>
		AN SHCP - NON-MTF-REFERRED CARE <b>OR</b>

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Non-Institutional Edit Requirements (ELN 300 - 399)

<b>ELEMENT NAME: PRICING RATE CODE (2-325) (Continued)</b>		
	CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM <b>OR</b>
	GU	ADSM ENROLLED IN TPR <b>OR</b>
	SC	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
	SE	SHCP - TRICARE ELIGIBLE <b>OR</b>
	SM	SHCP - EMERGENCY
<b>OR</b> ENROLLMENT/HEALTH PLAN CODE MUST =	SN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
	SR	SHCP - REFERRED CARE
<b>2-325-06R</b> IF PRICING RATE CODE =	W	PRICED OVER CMAC
<b>AND</b> ENROLLMENT/HEALTH PLAN CODE =	T	TRICARE STANDARD PROGRAM
<b>AND</b> AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE =	NE	OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM
<b>AND</b> BEGIN DATE OF CARE ≥ 09/14/2001 <b>AND</b> < 11/01/2008		
<b>THEN</b> PROVIDER PARTICIPATING INDICATOR MUST =	N	NO
<b>2-325-08R</b> IF PRICING RATE CODE =	P1	OPPS <b>OR</b>
	P2	OPPS WITH COST OUTLIER <b>OR</b>
	P3	OPPS WITH DISCOUNT <b>OR</b>
	P5	PARTIAL HOSPITALIZATION - PAID AS OPPS
<b>THEN</b> APC CODE MUST ≠ BLANK <b>OR</b> ZEROES.		
<b>2-325-09R</b> IF PRICING RATE CODE =	CA	CAH REIMBURSEMENT
<b>THEN</b> PROVIDER STATE OR COUNTRY CODE MUST =	AK	ALASKA
<b>AND</b> BEGIN DATE OF CARE MUST BE ≥ 07/01/2007		

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Non-Institutional Edit Requirements (ELN 300 - 399)

**ELEMENT NAME: AMBULATORY PAYMENT CLASSIFICATION (APC) CODE (2-330)**

**VALIDITY EDITS**

**2-330-01V** MUST BE A VALID APC CODE AS LISTED ON TMA'S OPPTS WEB SITE AT [HTTP://WWW.TRICARE.MIL/OPPS](http://www.tricare.mil/opps), BLANK, **OR** ALL ZEROES

**UNLESS** AMOUNT ALLOWED BY PROCEDURE CODE = ZERO

**RELATIONAL EDITS**

**2-330-01R** IF APC CODE = BLANK **OR** ZEROES.

<b>THEN</b> PRICING RATE CODE ≠	P1	OPPS <b>OR</b>
	P2	OPPS WITH COST OUTLIER <b>OR</b>
	P3	OPPS WITH DISCOUNT <b>OR</b>
	P5	PARTIAL HOSPITALIZATION - PAID AS OPPTS

**ELEMENT NAME: OPPTS PAYMENT STATUS INDICATOR CODE (2-331)**

**VALIDITY EDITS**

**2-331-01V** MUST BE A VALID OPPTS PAYMENT STATUS INDICATOR CODE (REFER TO [SECTION 2.6](#)) **OR** BLANK.

**RELATIONAL EDITS**

**2-331-01R** IF OPPTS PAYMENT STATUS INDICATOR CODE = BLANK

**THEN** APC CODE MUST = ALL ZEROES **OR** BLANK.

**ELEMENT NAME: AMOUNT NETWORK PROVIDER DISCOUNT (2-335)**

**VALIDITY EDITS**

**2-335-01V** MUST BE NUMERIC AND ≥ ZERO

**RELATIONAL EDITS**

<b>2-335-01R</b> IF TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED (HCSR) DATA <b>OR</b>
	C	COMPLETE CANCELLATION <b>OR</b>
	D	COMPLETE DENIAL <b>OR</b>
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA <b>OR</b>
	O	ZERO GOVERNMENT TED RECORD DUE TO 100% OHI

**THEN** AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO

<b>2-335-02R</b> IF PROVIDER NETWORK STATUS INDICATOR =	2	NON-NETWORK PROVIDER
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**THEN** AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO

<b>2-335-03R</b> IF REGION INDICATOR =	BLANK <b>OR</b>
	OC OVERSEAS CONTRACT

**THEN** AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO

- END -