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TRICARE
MANAGEMENT ACTIVITY

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**CHANGE 3
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JUNE 10, 2008**

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

The TRICARE Management Activity has authorized the following addition(s)/revision(s) to 7950.2-M, issued February 2008.

CHANGE TITLE: CONSOLIDATED PACKAGE

PAGE CHANGE(S): See pages 2 and 3.

SUMMARY OF CHANGE(S): This change includes several revisions/clarifications to existing requirements. Included in Chapter 1, Section 1.1 of this package is: clarification of requirements for use of "TestTrack Pro" software; clarification of the Information Assurance Vulnerability Management (IAVM) requirements; and updated policy references for personnel security ADP/IT requirements.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TOM, Change No. 3, Feb 2008 TPM, Change No. 3, and Feb 2008 TRM, Change No. 3.


**Reta Michak
Chief, Purchased Care Systems
Integration Branch**

**ATTACHMENT(S): 146 PAGES
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- Review data correction issues and corrective actions to be taken (e.g., catastrophic cap effort--review, research and adjustments).
- Monitor results of contractor testing efforts.
- Other activities as appropriate.

TMA provides a standing agenda for the teleconference with the meeting announcement. Additional subjects for the meetings are identified as appropriate. Contractors are required to ensure representatives participating in the calls are subject matter experts for the identified agenda items and are able to provide the current status of activities for their organization. It is also the responsibility of the contractor to ensure testing activities are completed within the scheduled time frames and any problems experienced during testing are reported via "TestTrack Pro" for review and corrective action by TMA or their designee. Upon the provision of a corrective action strategy or implementation of a modification to a software application by TMA (to correct the problem reported by the contractor), the contractor is responsible for retesting the scenario to determine if the resolution is successful. Retesting shall be accomplished within the agreed upon time frame. Contractors are required to update "TestTrack Pro" upon completion of retesting activities.

TMA will also document system issues and deficiencies into "TestTrack Pro" related to testing and production analysis of the contractors systems and processes. Upon the provision of a corrective action strategy or implementation of a modification to a software application by the contractor (to correct the problem reported by TMA), the contractor is responsible for retesting the scenario to determine if the resolution is successful. Retesting shall be accomplished within the agreed upon time frame. The contractor shall correct internal system problems that negatively impact their interface with the Business to Business (B2B) Gateway, Military Health System (MHS), DMDC, etc. and or the transmission of data, at their own expense.

Each organization identified shall provide two Point of Contacts (POCs) to TMA to include telephone and e-mail contact and will be used for call back purposes, notification of planned and unplanned outages and software releases. POCs will be notified via e-mail in the event of an unplanned outage using the POC notification list, so it is incumbent upon the organizations to notify TMA of changes to the POC list.

3.0 ADP REQUIREMENTS

It is the responsibility of the contractor to employ adequate hardware, software, personnel, procedures, controls, contingency plans, and documentation to satisfy TMA data processing and reporting requirements. Items requiring special attention are listed below.

3.1 Continuity of Operations Plan (COOP)

3.1.1 The contractor shall develop a single plan, deliverable to the TMA CO on an annual basis that ensures the continuous operation of their Information Technologies (IT) systems and data support of TRICARE. The plan shall provide information specific to all actions that will be taken by the prime and subcontractors in order to continue operations should an actual disaster be declared for their region. The COOP shall ensure the availability of the system and associated data in the event of hardware, software and/or communications failures. The COOP shall also include prime

and subcontractor's plans for relocation/recovery of operations, timeline for recovery, and relocation site information in order to ensure compliance with the TOM, [Chapters 1 and 6](#).

Information specific to connection to the B2B Gateway to and from the relocation/recovery site for operations shall also be included in the COOP. For relocation/recovery sites, contractors must ensure all security requirements are met and appropriate processes are followed for B2B Gateway connectivity. The contractor's COOP will enable compliance with all processing standards as defined in the TOM, [Chapter 1](#), and compliance with enrollment processing and Primary Care Manager (PCM) assignment as defined in TOM, [Chapter 6](#). The COOP should include restoration of critical functions such as claims and enrollment within five days of the disaster. The government reserves the right to re-prioritize the functions and system interactions proposed in the COOP during the review and approval process for the COOP.

3.2 Annual Disaster Recovery Tests

3.2.1 The prime contractor will coordinate annual disaster recovery testing of the COOP with its subcontractor(s) and the government. Coordination with the government will begin no later than 90 days prior to the requested start date of the disaster recovery test. Each prime contractor will ensure all aspects of the COOP are tested and coordinated with any contractors responsible for the transmission of TRICARE data. Each prime contractor must ensure major TRICARE functions are tested.

3.2.2 Annual disaster recovery tests will evaluate and validate that the COOP sufficiently ensures continuation of operations and the processing of TRICARE data in accordance with the TOM, [Chapters 1 and 6](#). At a minimum, annual disaster recovery testing will include the processing of:

- TRICARE Prime enrollments in the DEERS contractor test region to demonstrate the ability to update records of enrollees and disenrollees using the government furnished system application, DOES.
- Referrals and Non-Availability Statements (NAS)
- Preauthorizations/authorizations
- Claims
- Claims and catastrophic cap inquiries will be made against production DEERS and the Catastrophic Cap And Deductible Database (CCDD) from the relocation/recovery site. Contractors will test their ability to successfully submit claims inquiries and receive DEERS claim responses and catastrophic cap inquiries and responses. Contractors shall not perform catastrophic cap updates in the CCDD and DEERS production for test claims.
- To successfully demonstrate the ability to perform catastrophic cap updates and the creation of newborn placeholder records on DEERS, the contractor shall process a number of claims using the DEERS contractor test region.
- TED records will be created for every test claims processed during the claims processing portion of the disaster recovery test. The contractor will demonstrate the

ability to process provider, institutional and non-institutional claims. These test claims will be submitted to the TMA TED benchmark area.

3.2.3 Contractors shall maintain static B2B Gateway connections or other government approved connections at relocation/recovery sites that can be activated in the event a disaster is declared for their region.

3.2.4 In all cases, the results of the review and/or test results shall be reported to the TMA Contract Management Division within 10 days of the conclusion of the test. The contractor's report shall include if any additional testing is required or if corrective actions are required as a result of the disaster recovery test. The notice of additional testing requirements or corrective actions to be taken should be submitted along with the proposed date for retesting and the completion date for any corrective actions required. Upon completion of the retest, a report of the results of the actions taken should be provided to the CO within 10 business days of completion.

3.3 DoD Information Assurance Certification And Accreditation Process (DIACAP) Requirements

Contractor Information Systems (IS)/networks involved in the operation of systems of records in support of the MHS requires obtaining, maintaining, and using sensitive and personal information strictly in accordance with controlling laws, regulations, and DoD policy.

3.3.1 Certification and Accreditation (C&A) Process

Contractors shall achieve C&A of all IS that access, process, display, store or transmit DoD Sensitive Information (SI). C&A must be achieved as specified in the contract. Failure to achieve C&A will result in additional visits by assessment teams until C&A is achieved, after which, visits will occur on an annual basis. Return visits by the assessment team may prompt the government to exercise its rights in reducing the contract price. Contract price reductions will reflect costs incurred by the government for each re-assessment of the contractor's information systems, as allowed under contract clause 52.246-4, Inspection of Services-Fixed Price, if deemed appropriate by the CO.

3.3.1.1 The contractor shall safeguard SI through the use of a mixture of administrative, procedural, physical, communications, emanations, computer and personnel security measures that together achieve the requisite level of security established for a Mission Assurance Category III (MAC III) Confidentiality Level (CL) Sensitive system. The contractor shall provide a level of trust which encompasses trustworthiness of systems/networks, people and buildings that ensure the effective safeguarding of SI against unauthorized modifications, disclosure, destruction and denial of service.

3.3.1.2 The contractor shall provide a phased approach to completing the DoD C&A process in accordance with DoD Instruction **8510.01**, "DoD Information Assurance Certification and Process (DIACAP)," dated **November 28, 2007**, within 10 months following the contract award date. C&A requirements apply to all DoD and contractors' ISs that access, process, display, store or transmit DoD information. Contractor shall maintain the MAC III CL Sensitive, Information Assurance (IA) controls defined in reference DoDI 8500.2

The contractor's IS'/networks shall comply with the C&A process established under the DIACAP, or as otherwise specified by the government that meet appropriate DoD IA requirements for safeguarding DoD SI accessed, processed, displayed, maintained, stored or transmitted and used in the operation of systems of records under this contract. The C&A requirements shall be met before the contractor's system is authorized access DoD data or interconnect with any DoD IS or network.

Note: Although the DITSCAP has been superseded by the DIACAP, it should be noted there are no differences in the evaluation criteria. The difference between the processes is specific to reporting requirements by the Information Assurance evaluation team.

Certification is the determination of the appropriate level of protection required for contractor IS'/networks. Certification also includes a comprehensive evaluation of the technical and non-technical security features and countermeasures required for each contractor system/network.

3.3.1.3 Accreditation is the formal approval by the government for the contractor's IS' to operate in a particular security mode using a prescribed set of safeguards at an acceptable level of risk. In addition, accreditation allows IS to operate within the given operational environment with stated interconnections; and with appropriate levels of information assurance security controls. The C&A requirements apply to all DoD IS/networks and contractor's IS/networks that access, manage, store, or manipulate electronic SI data.

3.3.1.4 The contractor shall comply with C&A requirements, as specified by the government that meet appropriate DoD IA requirements. The C&A requirements shall be met before the contractor's system is authorized to access DoD data or interconnect with any DoD IS. The contractor shall initiate the C&A process by providing the CO, not later than 30 days prior to the start of C&A testing, the required documentation necessary to receive an Approval to Operate (ATO). The contractor shall make their IS' available for testing, and initiate the C&A testing four months (120 business days) in advance of accessing DoD data or interconnecting with DoD IS'. The contractor shall ensure the proper contractor support staff is available to participate in all phases of the C&A process. They include, but are not limited to: (a) attending and supporting C&A meetings with the government; (b) supporting/conducting the vulnerability mitigation process; and (c) supporting the C&A team during system security testing and evaluation.

3.3.1.5 Contractors must ensure that their system baseline configuration remains static during initial testing by the C&A team. Contractor's IS' must also remain static for mitigation assessment scans and testing periods. Any reconfiguration or changes to the contractor's information system during the C&A evaluation and testing process may require revision to the system baseline, documentation of system changes and may negatively impact the C&A timeline. Confirmation of the system baseline configuration shall be agreed upon during the definition of the C&A boundary, be signed by the government and the contractor and documented as part of the contractor's System Identification Profile (SIP) and artifacts. Upon completion of all testing and assessments by the C&A team, contractors must notify the IA Directorate, via the CO, of any proposed changes to their IS configuration for review and approval by IA prior to implementation. In order to validate implementation of approved changes does not negatively impact the vulnerability level of a contractor's IS', the C&A team may conduct additional testing and evaluation. During the actual baseline and mitigation assessment scans, the information system must remain frozen. The freeze is only in place during the actual testing periods. Changes between baseline testing and mitigation testing must be coordinated and approved by the MHS IA Program Office prior to implementation.

Any reconfiguration or changes in the system during the C&A testing process may require a rebaselining of the system and documentation of system changes. This could result in a negative impact to the C&A timeline.

3.3.1.6 The C&A process will include the review of compliance with personnel security ADP/IT requirements. The C&A team will review trustworthiness determinations (Background Checks) for personnel accessing DoD sensitive information.

3.3.1.7 Vulnerabilities identified by the government during the C&A process must be mitigated in accordance with the timeline identified by the government. The contractor shall also comply with the MHS DIACAP Checklist. Reference materials may be obtained at http://www.tricare.osd.mil/tmis_new/ia.htm. After contract award date, and an ATO is granted to the contractor, reaccreditation is required every three years or when significant changes occur that impact the security posture of the contractors' information system. An annual review shall be conducted by the TMA IA Office that comprehensively evaluates existing contractor system security posture in accordance with **DoD Instruction 8510.01, "DoD Information Assurance Certification and Process (DIACAP),"** date November 28, 2007.

3.3.2 Information Assurance Vulnerability Management (IAVM)

The TMA IAVM program provides electronic security notification against known threats and vulnerabilities. The contractor shall comply with the IAVM program requirements to ensure an effective security posture is maintained.

The contractor shall acknowledge receipt of Information Assurance Vulnerability Alerts (IAVA) and Information Assurance Vulnerability Bulletins (IAVB). The contractor shall inform the TMA IAVM Coordinator of applicability or non-applicability of IAVA. The contractor shall implement patch or mitigations strategy and report compliance as specified in IAVA to TMA IAVM Coordinator, if IAVA applies. The contractor shall develop and submit a Plan of Action and Milestones (POA&M) for approval, if IAVA applies, but cannot be mitigated within the compliance time frame. The contractor shall ensure that all required risk mitigation actions are implemented in accordance with associated time line, once POA&M is approved. The contractor shall respond to all TMA IAVM Coordinator queries as to compliance status. The contractor shall ensure TMA IAVM program compliance by their subcontractors.

3.3.3 Disposing of Electronic Media

Contractors shall follow the DoD standards, procedures and use approved products to dispose of unclassified hard drives and other electronic media, as appropriate, in accordance with DoD Memorandum, "Disposition of Unclassified Computer Hard Drives," June 4, 2001. DoD guidance on sanitization of other internal and external media components are found in DoDI 8500.2, "Information Assurance (IA) Implementation," February 6, 2003 (see PECS-1 in Enclosure 4, Attachment 5) and DoD 5220.22-M, "Industrial Security Program Operating Manual (NISPOM)," Chapter 8).

4.0 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

On the contract start-work date, the contractor shall be in compliance with the HIPAA Privacy and Security Rules (45 CFR Parts 160 and 164).

Additionally, the contractor shall follow the requirements set forth in the DoD Regulation 6025.18-R, dated January 2003, and the Health Affairs (HA) Policy 06-010, dated June 27, 2006. Contractors shall also establish procedures to ensure the confidentiality, integrity and availability of all beneficiary and provider information in accordance with the requirements of the TOM, [Chapter 20, Sections 3 and 4](#) and the provisions of this Manual and its supporting references.

4.1 Data Use Agreements (DUAs)

The contractor shall enter into a Data Use Agreement (DUA) with TMA in order to be compliant with DoD and HIPAA regulations annually or until their contract is no longer valid. Subcontractors or agents working on behalf of the primary contractor that require the use of, or access to individually identifiable data or protected health information under the provisions of their contract must separately comply, (in coordination with the primary contractor), with referenced DoD and HIPAA regulations and the TMA manuals.

Primary contractors and subcontractors requiring access or use of MHS data must also complete an Account Authorization Request From (AARF) and have an ADP / IT-II. Refer to section 7.3 for Access Requirements.

4.2 Protected Health Information Management Tool (PHIMT)

Contractors shall comply with the HIPAA Privacy Rule requiring covered entities to maintain a history of disclosures of PHI of eligible beneficiaries. Contractors shall also comply with the requirements for the accounting of disclosures and complaint management as specified in DoD 6025.18-R, Sections C7 and C14.4. The PHIMT, a TMA disclosure tracking tool, shall be used by contractors to meet the provisions of the HIPAA Privacy Rule and Privacy Act of 1974. The PHIMT stores information regarding disclosures, complaints, authorizations, restrictions, and confidential communications that are made about or requested by a patient. Contractors and their subcontractors will follow the procedures as outlined in the PHIMT User Guide located on the TMA web site: (<http://www.tricare.osd.mil/tmaprivacy/>) for disclosure and complaint management and the generation of administrative summary reports. The disclosure management function shall be used to track disclosure requests, disclosure restrictions; accounting for disclosures; authorizations; PHI amendments; Notice of Privacy Practices distribution management; and confidential communications. The complaint management function shall be used to store privacy complaint data. The administrative summary report function shall be used to generate reports and track information found in the disclosure management and complaint management section of the PHIMT. Situation reports may be required to address complaints, inquiries, or unique events related to the disclosure accounting responsibility.

5.0 PRIVACY IMPACT ASSESSMENT (PIA)

Contractors are responsible for the employment of practices that satisfy the requirements and regulations of the E-Government Act of 2002 (Public Law (PL) 107-347, 44 USC CH36 - Section 208); the E-Government Memorandum 03-22 (September 26, 2003) and current DoD PIA Guidance Memorandum at <http://www.tricare.mil/TMAPrivacy/Info-Papers-PIAs.cfm>.

The PIA is an analysis of how information is handled: (1) to ensure handling conforms to applicable legal, regulatory, and policy requirements regarding privacy, (2) to determine the risks and effects of collecting, maintaining, and disseminating information in identifiable form in an

electronic information system, and (3) to examine and evaluate protections and alternative processes for handling information to mitigate potential privacy and security risks. The PIA is a due diligence exercise in which organizations identify and address potential privacy risks that may occur during the various stages of a system's lifecycle.

Contractors and their subcontractors shall follow the guidance outlined within the TMA PIA policy and the TMA Privacy Impact Procedures located on the TMA Privacy web site: <http://www.tricare.osd.mil/TMAPrivacy/PIA-Submittal-Process.cfm>.

Contractors shall initiate a PIA and notify TMA Privacy Office within 10 days of the development, or procurement of information technology systems or projects that collect, maintain, or disseminate information in identifiable form from or about members of the public totaling at least 10 individuals. For existing systems, contractors shall identify systems and develop a plan for completing PIAs, and submit to the TMA Privacy Office within two months following contract award date. Contractors shall use the results of the PIA to identify and mitigate any risks associated with the collection of personal information from the public. Contractors shall submit the PIA using the DoD PIA format and the TMA PIA Completion Procedures to the TMA Privacy Office within 10 days of completion.

The TMA Privacy Office will review and approve the PIA summary submitted by the contractor and make it available to the public upon request via the TMA Privacy web site. The TMA Privacy Office will not publish any PIA summaries that would raise security issues, other concerns or reveal information of a proprietary nature to the contractors. Upon completion of review by the TMA Privacy Office, contractors will be notified of any required corrections. Corrective actions to be provided within time frame designated in notification. The contractors are to review and update PIAs, in coordination with the TMA Privacy Office, if there are system modifications or changes in the way information is handled that increase privacy risk.

6.0 PHYSICAL SECURITY REQUIREMENTS

The contractor shall employ physical security safeguards for IS/networks involved in the operation of its systems of records to prevent the unauthorized access, disclosure, modification, destruction, use, etc., of DoD SI and to otherwise protect the confidentiality and ensure the authorized use of SI. In addition, the contractor shall support a Physical Security Assessment performed by the government of its internal information management infrastructure using the criteria from the Physical Security Assessment Matrix. The contractor shall correct any deficiencies of its physical security posture required by the government. The Physical Security Audit Matrix can be accessed via the Policy and Guidance/Security Matrices section at http://www.tricare.osd.mil/tmis_new/ia.htm.

7.0 PERSONNEL SECURITY ADP/IT REQUIREMENTS

7.1 Policy References

Personnel to be assigned to an ADP/IT position must undergo a successful security screening before being granted access to DoD IT resources. Prior to an employee being granted interim access to DoD sensitive information, the organization must receive notification that the Office of Personnel Management (OPM) has scheduled the employee's investigation. The references and specific guidance below were provided to TMA by the Under Secretary of Defense for Intelligence

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(USDI) and the OPM safeguard against inappropriate use and disclosure.

- DoD Directive 8500.1E, "Information Assurance (IA)," October 24, 2002
- DoDI 8500.2, "Information Assurance (IA) Implementation," February 6, 2003
- DoD 5200.2-R, "DoD Personnel Security Program," January 1987
- DoDI 8510.01, "DoD Information Assurance Certification and Accreditation Process (DIACAP)," November 28, 2007
- DoDI 8551.1, "Ports, Protocols, and Services Management (PPSM)," August 13, 2004
- DoD I 8520.2, "Public Key Infrastructure (PKI) and Public Key (PK) Enabling," April 1, 2004
- Defense Information Systems Agency (DISA), "Security Technical Implementation Guides"
- DoD 5200.08-R, "Physical Security Program," April 9, 2007
- DoD Assistant Secretary of Defense Health Affairs (ASD (HA)) Memorandum, "Interim Policy Memorandum on Electronic Records and Electronic Signatures for Clinical Documentation," August 4, 2005
- DoD Assistant Secretary of Defense (ASD) Networks and Information Integration (NII) Memorandum "Department of Defense (DoD) Guidance on Protecting Personally Identifiable Information (PII)," August 18, 2006
- "DISA Computing Services Security Handbook", Version 3, Change 1, December 1, 2000
- "Health Insurance Portability and Accountability Act (HIPAA), Security Standards, Final Rule," February 20, 2003
- Military Health System (MHS) Physical Security Assessment Matrix, August 15, 2004
- Military Health System (MHS) DIACAP Checklist, August 2006
- Military Health System (MHS) Security Incident Checklist, September 2005
- Military Health System (MHS) Information Assurance Policy Guidance, March 27, 2007
- MHS IA Implementation Guide No. 2, "Sanitization and Disposal of Electronic Storage Media and IT Equipment Procedures," July 19, 2005
- MSH IA Implementation Guide No. 3, "Incident Reporting and Response Program," March 27, 2007
- MHS IA Implementation Guide No. 5, "Physical Security," July 19, 2005

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- MHS IA Implementation Guide No. 6, "Wireless Local Area Networks (WLANs)," July 19, 2005
- MHS IA Implementation Guide No. 7, "Data Integrity" March 27, 2007
- MHS IA Implementation Guide No. 8, "Certification and Accreditation (C&A)," March 27, 2007
- MHS IA Implementation Guide No. 9, "Configuration Management - Security," July 19, 2005
- MHS IA Implementation Guide No. 10, "System Lifecycle Management," July 19, 2005
- MHS IA Implementation Guide No. 11, "DoD Public Key Infrastructure (PKI) and Public Key Enabling (PKE)," July 19, 2005
- MHS IA Implementation Guide No. 12, "Information Assurance Vulnerability Management (IAVM) Program," March 27, 2007
- MHS IA Implementation Guide No. 15, "Identity Protection (IdP)," September 14, 2006
- Federal Information Process Standard 140-3, "Draft Security Requirements for Cryptographic Modules," July 13, 2007
- NIST SP 800-34 Contingency Planning Guidance for Information Technology Systems, June 2002
- Privacy Act of 1974
- Health Insurance Portability and Accountability Act (HIPAA) of 1996
- DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 2003
- DoD 5220.22-M, "National Industrial Security Program Operating Manual" (NISPOM), January 1995 (Change 2, May 1, 2000)
- DoD 5400.11-R " Department of Defense Privacy Program (May 14, 2007)".

The requirements above shall be met by contractors, subcontractors and any others who have access to information systems containing TMA/DoD data protected by the Privacy Act of 1974 and protected health information under HIPAA. Background checks shall be conducted for all ADP/IT contractor personnel who receive, process, store, display, or transmit DoD SI to or from a DoD IS/network prior to being granted access.

7.2 Formal Designations Required

All contractor personnel in positions requiring access to DoD systems or networks, DoD/TMA data, Contractor Owned-Contractor Operated (COCO) systems or networks that contain DoD/TMA data, DEERS, or the B2B Gateway, must be designated as either ADP/IT-I, or ADP/IT-II. ADP / ITs are

Public Trust Positions for which the background investigations result in Trustworthiness Determinations. They are not security clearances. For the purposes of TRICARE contracts, ADP/IT-III trustworthiness certifications are not sufficient for contractor personnel to be granted access to DoD systems or networks, DoD/TMA data, COCO systems or networks that contain DoD/TMA data, DEERS, or the B2B Gateway.

Only TRICARE contractors are permitted to submit ADP/IT background checks in accordance with this policy. Military Service and MTF contractors are not to use this guidance.

7.3 Access Requirements

7.3.1 All contractor personnel accessing the DEERS database or the B2B Gateway must have and use a DoD issued Common Access Card (CAC). In addition, the most current version of the DD 2875 (SAAR) must be completed for each contractor employee requiring access to the B2B Gateway, in accordance with [paragraph 10.3](#). New employees hired by contractors may apply for a CAC upon successful completion of the Federal Bureau of Investigation (FBI) Criminal Background Fingerprint check and receipt of the Investigation Schedule Notice (ISN) from the TMA Privacy Office.

7.3.2 Contractors must notify the TMA Privacy Office via fax or secure e-mail of the submission of the SF 85Ps and the FD 258 (Fingerprint card) for new hires and the date submitted to OPM. The notification should include the Name, Social Security Number (SSN), ADP designation, date submitted to OPM, company name, and the contract for which the employee works.

7.3.3 Contractors are required to respond timely to OPM, the Defense Industrial Security Clearance Office (DISCO) or the Defense Office of Hearings and Appeals (DOHA) requests for additional information required during the investigation process. Failure to respond timely to the OPM/DISCO/DOHA will result in the revocation of the CAC by the TMA Sponsor, discontinuation/termination of the investigation by OPM, and Denial of Access by DOHA. Additionally, contractors must notify the TMA Privacy Office on special issues that require contact with OPM, DISCO, and DOHA.

7.3.4 Contractors are required to ensure personnel viewing data obtained from DEERS or the B2B Gateway, or viewing Privacy Act protected data follow contractor established procedures as required by the TOM, [Chapter 1](#) to assure confidentiality of all beneficiary and provider information.

7.4 ADP/IT Category Guidance

In establishing the categories of positions, a combination of factors may affect the determination. Unique characteristics of the system or the safeguards protecting the system permit position category placement based on the agency's judgment. Guidance on ADP/IT categories is:

ADP/IT-I - Critical Sensitive Position. A position where the individual is responsible for the development and administration of MHS IS/network security programs and the direction and control of risk analysis and/or threat assessment. The required investigation is equivalent to a Single-Scope Background Investigation (SSBI). Responsibilities include:

- Significant involvement in life-critical or mission-critical systems.

- Responsibility for the preparation or approval of data for input into a system, which does not necessarily involve personal access to the system, but with relatively high risk for effecting severe damage to persons, properties or systems, or realizing significant personal gain.
- Relatively high risk assignments associated with or directly involving the accounting, disbursement, or authorization for disbursement from systems of (1) dollar amounts of \$10 million per year or greater; (2) lesser amounts if the activities of the individuals are not subject to technical review by higher authority in the ADP/IT-I category to insure the integrity of the system.
- Positions involving major responsibility for the direction, planning, design, testing, maintenance, operation, monitoring and or management of systems hardware and software.
- Other positions as designated by the Designated Approving Authority (DAA) that involve a relatively high risk for causing severe damage to persons, property or systems, or potential for realizing a significant personal gain.

ADP/IT-II - Non-critical-Sensitive Position. A position where an individual is responsible for systems' design, operation, testing, maintenance and/or monitoring that is carried out under technical review of higher authority in the ADP/IT-I category, includes but is not limited to: (1) access to and/or processing of proprietary data, information requiring protection under the Privacy Act of 1974, or Government-developed privileged information involving the award of contracts; (2) accounting, disbursement, or authorization for disbursement from systems of dollar amounts less than \$10 million per year.

Other positions are designated by the DAA that involve a degree of access to a system that creates a significant potential for damage or personal gain less than that in ADP/IT-I positions. The required investigation for ADP/IT-II positions is equivalent to a National Agency Check with Law Enforcement and Credit Checks (NACLCL).

Note: ADP/ITs submitted as a NAC to DSS prior to 2000 were approved as ADP/IT-II/III. Effective 2000, OPM took over the investigation process for TMA. The submission requirements for ADP/IT levels were upgraded as follows: ADP/IT-III is a NAC; ADP/IT-II is a NACLCL and; an ADP/IT-I is an SSBI. Investigations submitted before 2000 for a NAC (ADP/IT-II/III) will need to submit a new SF85P User Form and fingerprint card for a NACLCL to be upgraded to an ADP/IT-II.

ADP/IT-III - Non-sensitive Position. All other positions involved in Federal computer activities. The required investigation is equivalent to a National Agency Check (NAC). This designation is insufficient for granting contractor employee access to DoD IS/Networks, COCO IS/Networks, data and/or DEERS.

Note: The definition of ADP/IT-III is provided for informational purposes only. As previously stated, contractor personnel with ADP/IT-III trustworthiness certifications must be upgraded to an ADP/IT-II NLT October 1, 2004 in order to maintain access to the DEERS database and/or the B2B Gateway.

7.5 Additional ADP/IT Level I Designation Guidance

All TMA contractor companies requiring ADP/IT-I Trustworthiness Determinations for their personnel are required to submit a written request for approval to the TMA Privacy Office prior to submitting applications to OPM. The justification will be submitted to the TMA Privacy Officer, Skyline Five, 5111 Leesburg Pike, Suite 810, Falls Church, Virginia, 22041, on the letterhead of the applicant's contracting company. The request letter must be signed by, at a minimum, the company security officer or other appropriate executive, include contact information for the security officer or other appropriate executive, and a thorough job description which justifies the need for the ADP/IT-I Trustworthiness Determination. Contractor employees shall not apply for an ADP/IT-I Trustworthiness Determination unless specifically authorized by the TMA Privacy Officer.

7.5.1 Required Forms

Each contractor employee shall be required to complete and submit the Standard Form (SF) 85P (Questionnaire for Public Trust Positions), FD 258 (Fingerprint Form), and other documentation as may be required by the OPM to open and complete investigations. Additional information may be requested while the investigation is in progress. This information must be provided in the designated time frame or the investigation will be closed/discontinued, and access granted while investigation is underway will be revoked. The contractor will capture the fingerprint data using a fingerprint capture device that complies with the requirements contained in the Department of Justice Federal Bureau of Investigation Criminal Justice Information Services Electronic Fingerprint Transmission Specifications, Appendix F "IAFIS Image Quality Specifications" and submit the fingerprints to OPM electronically, Instructions and codes for the coversheet will be provided to the contractor by the TMA Privacy Office after contract award. All contractor employees that are prior military should include Copy 4 of the DD214 (Certificate of Release or Discharge from Active Duty) with their original submission. Forms and guidance can be found at <http://www.opm.gov/extra/investigate>.

Note: The appropriate billing codes will be provided following contract award. Contractors should contact the TMA Privacy Office to obtain the PIPS Form 12 when applying for a Submitting Office Number (SON). The application and billing information must be requested from the TMA Privacy Office. Each primary contracting company is responsible for the submission of the SF 85P for its subcontracting company's employees.

7.5.2 Interim Access (U.S. Citizens Working In The U.S. Only)

All contractor personnel who are U.S. Citizens will receive an OPM ISN from the TMA Privacy Office once the OPM has scheduled the investigation. The TMA Privacy Office sends the ISN to the contracting security officer as validation for interim access after the FBI Criminal Fingerprint check is successfully completed. The contractor security officer may use receipt of the ISN as their authority to grant interim access to DoD/TMA data until a Trustworthiness Determination is made. A contractor employee can apply for a CAC only after the ISN is received.

7.5.3 Temporary Access (U.S. Citizens Only)

Temporary employees include intermittent employees, volunteers, and seasonal workers. Contractors shall obtain an ADP/IT-II Trustworthiness Determination for those positions requiring access to systems containing DoD sensitive information. Interim access is allowed as outlined in

[paragraph 7.5.2.](#)

7.5.4 Preferred/Partnership Providers Outside of the Continental United States (OCONUS) MHS Facilities (U.S. Citizens Only)

To obtain an ADP Trustworthiness Determination for a preferred/partnership provider the Security Officer of the MTF will contact the TMA Privacy Officer for instructions and guidance on completing and submitting the SF85P User Form, fingerprint cards and system access. The TMA Privacy Officer will provide guidance on system access upon contact by the Security Officer of the MTF.

7.5.5 ADP/IT Level Trustworthiness Determination Upgrades

Contact the TMA Privacy Office if a higher ADP/IT level is required than what was submitted for an employee. In addition, the contractor's security officer must contact the OPM Federal Investigations Processing Center, Status Line, to determine the status of the investigation. OPM can upgrade the level of investigation only if the investigation has not been closed/completed. If the investigation is pending, you may fax a written request to OPM, Attention: Corrections Technician, to upgrade the NACLCL to an SSBI. You must provide the name, SSN, and Case Number on your request (Case Number can be found on the ISN). If the SF85P User Form is missing information, the Correction Technician will call the requester for missing information. Addresses for each organization are shown below.

- TMA Privacy Office, Skyline Five, 5111 Leesburg Pike, Suite 810, Falls Church, Virginia, 22041
- OPM Federal Investigations Processing Center, P.O. Box 618, Boyers, Pennsylvania, 16018-0618
- OPM Corrections Department, Federal Investigations Processing Center, P.O. Box 618, Boyers, Pennsylvania, 16018-0618

If the investigation has been closed/completed, the original SF85P Agency User Form (coversheet) must be submitted for the higher ADP/IT level. The SF85P may be re-used within 120 days of the case closed date, with corrected ADP level code O8B. The letter "I" must be inserted in the Codes box located above C and D on the SF85P Agency User Form and no fingerprint card is needed. The contractor's Security Officer must update the SF85P Agency User Form, re-sign and re-date the form in Block P. The individual must line through any obsolete information, replacing it with corrected information and initial all changes made to the SF85P. The individual must then re-sign and re-date the certification section of the form.

If it is beyond the 120 day period, the old SF85P may be used if all the information is updated and the certification part of the form is re-dated, and re-signed by the individual. A new SF85P Agency User Form (coversheet) showing the correct ADP/IT level code 30C is required at this time. Each correction/change made to the form must be initialed and dated by the individual.

7.6 Access for Non-U.S. Citizens

7.6.1 Policy

Interim access at Continental United States (CONUS) locations for non-U.S. citizens is not authorized. Non-U.S. citizen contractor employee investigations are not being adjudicated for any Trustworthiness positions, therefore, interim access to DoD ITs/networks is not authorized.

7.6.2 Non-U.S. Citizens/Local Nationals Working At OCONUS MHS Facilities

Non-U.S. Citizens/Local Nationals employed by DoD organizations overseas, whose duties do not require access to classified information, shall be the subject of record checks that include host-government law enforcement and security agency checks at the city, state (province), and national level, whenever permissible by the laws of the host government, initiated by the appropriate Military Department investigative organization prior to employment.

7.7 Transfers Between TRICARE Contractor Organizations

7.7.1 When contractor employees transfer employment from one TRICARE contract to another, while their investigation for ADP/IT Trustworthiness Determination is in process, the investigation being conducted for the previous employer may be applied to the new employing contractor. The new contracting company shall provide the TMA Privacy Office the following information on each new employee from another TRICARE contracting company. This data must be appropriately secured (e.g., secured transmission, registered mail, etc.).

- Name
- SSN
- Name of the former contracting company
- ADP/IT level applied for
- Effective date of the transfer/employment

TMA will verify the status of the Trustworthiness Determination/scheduled investigation for the employee(s) being transferred. If the investigation has not been completed, the TMA Privacy Office will notify OPM to transfer the investigation from the old SON (submitting office number) to the new SON. If the investigation has been completed, OPM cannot affect the transfer. If the Trustworthiness Determination has been approved, the TMA Privacy Office will verify the approval of the Trustworthiness Determination and send a copy to the new contracting company's office.

7.7.2 When a new contractor employee indicates they have a current ADP/IT Trustworthiness Determination (e.g., transfers from another TRICARE contract), the new contracting company shall provide the TMA Privacy Office the following information on the employee. This data must be appropriately secured (e.g., secured transmission, registered mail, etc.).

- Name
- SSN
- Name of the former contracting company
- ADP/IT level
- Effective date of the transfer/employment with the current company

The TMA Privacy Office will verify the status of the individual's ADP/IT Trustworthiness status; if the clearance is current, the TMA Privacy Office will provide the information to the gaining contracting company. If not current, the company will be instructed to begin the ADP investigation process.

7.8 New Contractor Personnel With Recent Secret Clearance

New contractor personnel who have had an active secret clearance within the last two years should not submit a SF85P to OPM. The contracting company must contact the TMA Privacy Office for verification of previous investigation results.

7.9 Notification Of Submittal And Termination

Contracting companies shall notify the TMA Privacy Office when the Security Officer has submitted the SF85P to OPM for new employees. Upon termination of a contractor employee from the TRICARE Contract, contracting companies must notify the TMA Privacy Office and OPM. The contracting company shall provide the TMA Privacy Office and OPM the following information on the employee. This data must be appropriately secured (e.g., secured transmission, registered mail, etc.).

- Name
- SSN
- Name of the contracting company
- Termination date

Upon receipt of a denial letter from the TMA Privacy Office, the company security officer shall immediately terminate that contractor's direct access to all MHS information systems, and if the employee was issued a CAC, obtain the CAC from the employee, and confirm to the TMA Privacy Office in writing within one week of the date of the letter that this action has been taken.

8.0 DOD/MHS INFRASTRUCTURE SECURITY, PORTS, PROTOCOLS AND RISK MITIGATION STRATEGIES

Contractors will comply with DoD guidance regarding allowable ports, protocols and risk mitigation strategies. The Joint Task Force for Global Network Operations (JTF-GNO) is the responsible proponent for the security of the DoD/MHS Infrastructure. Upon identification of security risks, the JTF-GNO issues JTF-GNO Warning Orders notifying users of scheduled changes for access to the DoD/MHS Infrastructure. TMA will provide contractors with JTF-GNO Warning Orders for review and identification of impacts to their connections with the DoD/MHS. Contractors are required to review Warning Orders upon receipt and provide timely responses to TMA indicating whether the change will or will not affect their connection.

Upon identification of an impact by the contractor, the contractor shall develop a mitigation strategy to identify the required actions, schedule for implementation and anticipated costs for implementation. The mitigation strategy must be submitted to TMA for review and approval by the JTF-GNO.

When connectivity requirements that are designated by the Government for the fulfillment of contract requirements are affected by DoD guidance and/or JTF-GNO Warning Orders, mitigation strategies will be developed by the governing agencies.

9.0 PUBLIC KEY INFRASTRUCTURE (PKI)

The DoD has initiated a PKI policy to support enhanced risk mitigation strategies in support of the protection of DoD's system infrastructure and data. DoD's implementation of PKI requirements are specific to the identification and authentication of users and systems within DoD (DoDD 8190.3 and DoDI 8520.2). The following paragraphs provide current DoD PKI requirements.

9.1 User Authentication

9.1.1 All contractor personnel accessing DoD applications and networks are required to obtain PKI enabled and Personal Identity Verification (PIV) compliant Government accepted credentials. Such credentials must follow the PIV trust model (FIPS 201) and be acceptable to the government. Currently, to meet this requirement, contractors shall obtain Government-issued CACs. PIV compliant credentials are required for access to DoD systems and networks. They also allow encryption and digital signatures for information transmitted electronically that includes DoD/TMA data covered by the Privacy Act, HIPAA and SI and network requirements.

9.1.2 Process to Obtain a CAC

9.1.2.1 Contractors shall ensure that all users for whom CACs are requested have initiated the appropriate ADP/IT Personnel Security Requirements, including completion of required Government forms (SF85P and FD 258). The fingerprint check must have been submitted and returned as favorable, and the ISN must be received by the TMA Privacy Office before they can be issued a CAC.

9.1.2.2 In order to obtain a CAC, contractor personnel must first be sponsored by an authorized government representative (sponsor). This representative must be either an active military service member or a federal civilian employee.

9.1.2.3 The contractor shall provide requests for new CACs to the sponsor. These requests shall include necessary personal and employment documentation for all personnel requiring CACs. The contractor may submit this information to the sponsor as a file attachment in XML (eXtensible Markup Language) format for initial startup if the number of employees exceeds 20.

9.1.2.4 The sponsor provides an access code and password to each individual contractor employee (hereinafter "individual") to the Contractor Verification System (CVS). CVS is a web-based application for the electronic data entry of information into DEERS for approved CAC (contractor and specific non-DoD Federal) applicants.

9.1.2.5 The individual then verifies personal information in CVS, makes corrections as necessary, and enters any missing personal information into CVS (automated DD 1172-2).

9.1.2.6 The sponsor then reviews the application. If upon review, the sponsor does not approve the application, the sponsor will notify the individual and the appropriate contractor company

representative. Once the sponsor approves the individual's application, the sponsor will notify the contractor that he/she can go and obtain his/her CAC.

9.1.2.7 When an individual is notified that their application has been approved, they will go to the nearest Real-Time Automated Personnel Identification System (RAPIDS) location to obtain their CAC. Individuals must bring two forms of identification with them—at least one must be a Government Issued identification card with a photograph (i.e., drivers license/passport). RAPIDS site locations may be obtained at www.dmdc.osd.mil/rsl. The Verifying Official (VO) will verify the identification and capture the biometric data that will be encoded on the CAC

9.1.3 Reverification

CAC cards for contractors are effective for three years or until the contract end date, whichever is shorter. The sponsor is required to reverify all CAC holders every six months from the date access was granted to each user. To support this requirement, the contractor shall review their personnel lists monthly and submit updated information to the designated Government Official within 10 calendar days of completion. The specific date for the report may be specified by the sponsor.

9.1.4 Lost or Damaged CACs

Lost CACs must be reported to the government representative within 24 hours after the loss is identified. Damaged CACs must be returned to the government. Replacement CACs are obtained from the nearest RAPIDS location.

9.1.5 Termination of Employment

Upon resignation or termination of a user's employment with the contract, the CAC must be surrendered to the designated government representative. CACs must also be surrendered if the individual employee changes positions and no longer has a valid need for access to DoD systems or networks.

9.1.6 Personal Identification Number (PIN) Resets

Should an individual's CAC become locked after attempting three times to access it, the PIN will have to be reset at a RAPIDS facility or by designated individuals authorized CAC PIN Reset (CPR) applications. These individuals may be contractor personnel, if approved by the government representative. PIN resets cannot be done remotely. The government will provide CPR software licenses and initial training for the CPR process; the contractor is responsible for providing the necessary hardware for the workstation (PC, Card Readers, Fingerprint capture device). It is recommended that the CPR workstation not be used for other applications, as the government has not tested the CPR software for compatibility. The CPR software must run on the desktop and cannot be run from the Local Area Network (LAN). The contractor shall install the CPR hardware and software, and provide the personnel necessary to run the workstation.

9.1.7 E-Mail Address Change

The User Maintenance Portal (UMP) is an available web service that allows current CAC holders to change e-mail signing and e-mail encryption certificates in the event of a change in e-

mail addresses. This service is accessible from a local workstation via web services.

9.1.8 System Requirement for CAC Authentication

Contractors shall procure, install, and maintain desktop level CAC readers and middleware. The middleware software must run on the desktop and cannot be run from the LAN. Technical Specifications for CACs and CAC readers may be obtained at www.dmdc.osd.mil/smartcard.

9.1.9 Contractors shall ensure that CACs are only used by the individual to whom the CAC was issued. Individuals must protect their PIN and not allow it to be discovered or allow the use of their CAC by anyone other than him/herself. Contractors are required to ensure access to DoD systems and applications is only provided to individuals who have been issued a CAC and whose CAC has been validated by the desktop middleware, including use of a card reader. Sharing of CACs, PINs, and other access codes is expressly prohibited.

9.1.10 The contractor shall provide the contractor locations and approximate number of personnel at each site that will require the issuance of a CAC upon contract award.

9.1.11 The contractor shall identify to Purchased Care Systems Branch (PCSB) and DMDC the personnel that require access to the DMDC Contractor Test environment and/or the Benchmark Test environment.

9.2 System Authentication

The contractor is required to obtain DoD acceptable PKI server certificates for identity and authentication of the servers upon direction of the CO. These interfaces include, but are not limited to, the following:

- Contractor systems for inquiries and responses with DEERS
- Contractor systems and the TED Processing Center

10.0 TELECOMMUNICATIONS

10.1 MHS Demilitarized Zone (DMZ) Managed Partner Care B2B Gateway

10.1.1 For all non-DMDC web applications, the contractor will connect to a DISA-established Web DMZ. For all DMDC web applications, the contractor will connect to DMDC.

10.1.2 In accordance with contract requirements, contractors shall connect to the B2B gateway via a contractor procured Internet Service Provider (ISP) connection. Contractors will assume all responsibilities for establishing and maintaining their connectivity to the B2B Gateway. This will include acquiring and maintaining the circuit to the B2B Gateway and acquiring a Virtual Private Network (VPN) device compatible with the MHS VPN device.

10.1.3 Contractors will complete a current version of the DISA B2B gateway questionnaire providing information specific to their connectivity requirements, proposed path for the connection and last mile diagram. The completed questionnaire shall be submitted to DISA for review and scheduling of an initial technical specifications meeting.

10.2 Contractor Provided IT Infrastructure

10.2.1 Platforms shall support HyperText Transfer (Transport) Protocol (HTTP), HyperText Transfer (Transport) Protocol Secure (HTTPS), Web derived Java Applets, secure File Transfer Protocol (FTP), and all software that the contractor proposes to use to interconnect with DoD facilities.

10.2.2 Contractors shall configure their networks to support access to government systems (e.g., configure ports and protocols for access).

10.2.3 Contractors shall provide full time connections to a TIER 1 or TIER 2 ISP. Dial-up ISP connections are not acceptable.

10.3 System Authorization Access Request (SAAR) Defense Department (DD) Form 2875

All contractors that use the DoD gateways to access government IT systems must submit the most current version of DD Form 2875 found on the DISA web site: <http://www.dlis.dls.mil/PDFs/DD2875.pdf> in accordance with CO guidance. A DD Form 2875 is required for each contractor employee who will access any system on a DoD network. The DD Form 2875 must clearly specify the system name and justification for access to that system.

Contractors shall complete and submit to the TMA Privacy Office the DD Form 2875 for verification of ADP Designation (see [paragraph 5.0](#)). The TMA Privacy Office will verify that the contractor employee has the appropriate background investigation completed/or a request for background investigation has been submitted to the OPM. Acknowledgement from OPM that the request for a background investigation has been received and that an investigation has been scheduled will be verified by the TMA Privacy Officer prior to access being approved.

The TMA Privacy Office will forward the DD Form 2875 to the TIMPO for processing; TIMPO will forward DD Form 2875s to DISA. DISA will notify the user of the ID and password via e-mail upon the establishment of a user account. User accounts will be established for individual use and may not be shared by multiple users or for system generated access to any DoD application. Misuse of user accounts by individuals or contractor entities will result in termination of system access for the individual user account.

Contractors shall conduct a monthly review of all contractor employees who have been granted access to DoD IS'/networks to verify that continued access is required. Contractors shall provide the TMA Privacy Office with a report of the findings of their review by the 10th day of the month following the review. Reports identifying changes to contractor employee access requirements shall include the name, SSN, Company, IS/network for which access is no longer required and the date access should be terminated.

10.4 MHS Systems Telecommunications

10.4.1 The primary communication links shall be via Secure Internet Protocol (IPSEC) VPN tunnels between the contractor's primary site and the MHS B2B Gateway.

10.4.2 The contractor shall place the VPN appliance device outside the contractor's firewalls and shall allow full management access to this device (e.g., in router access control lists) to allow Central

VPN Management services provided by the DISA or other source of service as designated by the MHS to remotely manage, configure, and support this VPN device as part of the MHS VPN domain.

10.4.3 For backup purposes, an auxiliary VPN device for contractor locations shall also be procured and configured for operation to minimize any downtime associated with problems of the primary VPN.

10.4.4 The MHS VPN management authority (e.g., DISA) will remotely configure the VPN once installed by the contractor.

10.4.5 Maintenance and repair of contractor procured VPN equipment shall be the responsibility of the contractor. Troubleshooting of VPN equipment shall be the responsibility of the government.

10.5 Contractors Located On MTFs

10.5.1 Contractors located on a military installation who require direct access to government systems shall coordinate/obtain these connections with the local MTF and Base/Post/Camp communication personnel. These connections will be furnished by the government.

10.5.2 Contractors located on military installations that require direct connections to their networks shall provide an isolated IT infrastructure. They shall coordinate with the Base/Post/Camp communications personnel and the MTF in order to get approval for a contractor procured circuit to be installed and to ensure the contractor is within compliance with the respective organizational security policies, guidance and protocols.

Note: In some cases, the contractor may not be allowed to establish these connections due to local administrative/security requirements.

10.5.3 The contractor shall be responsible for all security certification documentation as required to support DoD IA requirements for network interconnections. Further, the contractor shall provide, on request, detailed network configuration diagrams to support DIACAP accreditation requirements. The contractor shall comply with DIACAP accreditation requirements. All network traffic shall be via TCP/IP using ports and protocols in accordance with current Service security policy. All traffic that traverses MHS, DMDC, and/or military Service Base/Post/Camp security infrastructure is subject to monitoring by security staff using Intrusion Detection Systems.

10.6 TMA/TED

10.6.1 Primary Site

The TED primary processing site is currently located in Oklahoma City, OK, and operated by the Defense Enterprise Computing Center (DECC), Oklahoma City Detachment of the DISA.

Note: The location of the primary site may be changed. The contractor shall be advised should this occur.

10.6.2 General

The common means of administrative communication between government representatives and the contractor is via telephone and e-mail. An alternate method may be approved by TMA, as validated and authorized by TMA. Each contractor on the telecommunication network is responsible for furnishing to TMA at the start-up planning meeting (and update when a change occurs), the name, address, and telephone number of the person who will serve as the technical POC. Contractors shall also furnish a separate computer center (Help Desk) number to TMA which the TMA computer operator can use for resolution of problems related to data transmissions.

10.6.3 TED-Specific Data Communications Technical Requirements

The contractor shall communicate with the government's TED Data Center through the MHS B2B Gateway.

10.6.3.1 Communication Protocol Requirements

10.6.3.1.1 File transfer software shall be used to support communications with the TED Data Processing Center. CONNECT:Direct is the current communications software standard for TED transmissions. The contractor is expected to upgrade/comply with any changes to this software. The contractor shall provide this product and a platform capable of supporting this product with the TCP/IP option included. Details on this product can be obtained from:

Sterling Commerce
4600 Lakehurst Court
P.O. Box 8000
Dublin, OH 43016-2000 USA
<http://www.sterlingcommerce.com/solutions/products/ebi/connect/direct.html>
Phone: 614-793-7000
Fax: 614-793-4040

10.6.3.1.2 For Ports and Protocol support, TCP/IP communications software incorporating the TN3270 emulation shall be provided by the contractor.

10.6.3.1.3 Transmission size is limited to any combination of 400,000 records at one time.

10.6.3.1.4 "As Required" Transfers

Ad hoc movement of data files shall be coordinated through and executed by the network administrator or designated representative at the source file site. Generally speaking, the requestor needs only to provide the point of contact at the remote site, and the source file name. Destination file names shall be obtained from the network administrator at the site receiving the data. Compliance with naming conventions used for recurring automated transfers is not required. Other site specific requirements, such as security constraints and pool names are generally known to the network administrators.

10.6.3.1.5 File Naming Convention

10.6.3.1.5.1 All files received by and sent from the TMA data processing site shall comply with the following standard when using CONNECT:Direct:

POSITION(S)	CONTENT
1 - 2	"TD"
3 - 8	YYMMDD Date of transmission
9 - 10	Contractor number
11 - 12	Sequence number of the file sent on a particular day. Ranges from 01 to 99. Reset with the first file transmission the next day.

10.6.3.1.5.2 All files sent from the TMA data processing site shall be named after coordination with receiving entities in order to accommodate specific communication requirements for the receivers.

10.6.3.1.6 Timing

Under most circumstances, the source file site shall initiate automated processes to cause transmission to occur. With considerations for timing and frequency, activation of transfers for each application shall be addressed on a case by case basis.

10.6.3.1.6.1 Alternate Transmission

Should the contractor not be able to transmit their files through the normal operating means, the contractor should notify TMA (EIDS Operations) to discuss alternative delivery methods.

10.7 TMA/MHS Referral And Authorization System

The MHS Referral and Authorization System is to be determined. Interim processes are discussed in the TOM.

10.8 TMA/TRICARE Duplicate Claims System

The DCS is planned to operate as a web application. The contractor is responsible for providing internal connectivity to the public Internet. The contractor is responsible for all systems and operating system software needed internally to support the DCS. (See the TOM, [Chapter 9](#) for DCS Specifications.)

- END -

Chapter 2

TRICARE Encounter Data (TED)

Section/Addendum	Subject/Addendum Title
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1.2	Data Reporting - Provider File Record Submission
2.1	Data Requirements - Overview
2.2	Data Requirements - Data Element Layout
2.3	Data Requirements - Header Record Data
2.4	Data Requirements - Institutional/Non-Institutional Record Data Elements (A - D)
2.5	Data Requirements - Institutional/Non-Institutional Record Data Elements (E - L)
2.6	Data Requirements - Institutional/Non-Institutional Record Data Elements (M - O)
2.7	Data Requirements - Institutional/Non-Institutional Record Data Elements (P)
2.8	Data Requirements - Institutional/Non-Institutional Record Data Elements (Q - S)
2.9	Data Requirements Institutional/Non-Institutional Record Data Elements (T - Z)
2.10	Data Requirements - Provider Record Data
3.1	General Edit Requirements - Overview
4.1	Header Edit Requirements (ELN 000 - 099)
5.1	Institutional Edit Requirements (ELN 000 - 099)
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5.5	Institutional Edit Requirements (ELN 400 - 499)
6.1	Non-Institutional Edit Requirements (ELN 000-099)
6.2	Non-Institutional Edit Requirements (ELN 100 - 199)
6.3	Non-Institutional Edit Requirements (ELN 200 - 299)
6.4	Non-Institutional Edit Requirements (ELN 300 - 399)

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Chapter 2, TRICARE Encounter Data (TED)

Section/Addendum	Subject/Addendum Title
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7.2	Provider Edit Requirements (ELN 100 - 199)
8.1	Financial Edit Requirements
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B	Data Requirements - State Codes Figure 2.B-1 State Codes Figure 2.B-2 medicare State Codes
C	Data Requirements - Provider's Major Specialty Codes Figure 2.C-1 Provider Major Specialty Codes For Use On Non-Institutional TED Records For Outpatient Hospital Care
D	Data Requirements - Type Of Institution Codes Figure 2.D-1 Type Of Institution
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F	Data Requirements - Place Of Service/Type Of Service Allowable Relationships Figure 2.F-1 Place Of Service Codes Figure 2.F-2 Place Of Service Values Figure 2.F-3 Type Of Service Second Position Values
G	Data Requirements - Adjustment/Denial Reason Codes Figure 2.G-1 Denial Codes Figure 2.G-2 Denial/Adjustment Codes Figure 2.G-3 Adjustment/Remark Codes
H	Data Requirements - Revenue Codes
I	Data Requirements - Contract Area Of Responsibility Figure 2.I-1 Contract Areas Of Responsibility Awarded Prior To TBD ¹ Figure 2.I-2 Contract Areas Of Responsibility Awarded After TBD ¹
J	Data Requirements - Pay Plan Code Valid Values
K	Data Requirements - Dependent Elements & Values For Rank Code, Sponsor Pay Category
L	Data Requirements - Health Care Delivery Program (HCDP) Plan Coverage Code Values
M	Data Requirements - Default Values For Complete Claims Denials Figure 2.M-1 Common Elements Figure 2.M-2 Institutional-Specific Elements Figure 2.M-3 Non-Institutional-Specific elements

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Section/Addendum	Subject/Addendum Title
N	UB-04/UB-92 Conversion Table - To Be Used For Reporting Non-Institutional TED Records
O	Data Requirements - MTF Enrolling DMIS-IDs
	Figure 2.O-1 North Contract Enrolling DMIS-IDs
	Figure 2.O-2 West Contract Enrolling DMIS-IDs
	Figure 2.O-3 South Contract Enrolling DMIS-IDs

Data Reporting - TRICARE Encounter Data Record Submission

1.0 GENERAL

1.1 TRICARE Encounter Data (TED) records provide detailed information for each treatment encounter and are required for the TRICARE Management Activity (TMA) health care and financial reporting. A TED record is submitted as either an institutional or non-institutional record.

1.1.1 Institutional TED records usually reflect a treatment encounter created by the formal acceptance of a hospital or other authorized institutional provider of a TRICARE beneficiary for the purpose of occupying a bed with the reasonable expectation that the patient will remain on inpatient status at least 24 hours with a registration and assignment of an inpatient number or designation. Institutional TED records may also reflect outpatient care in a Hospice or Home Health Program.

1.1.2 Non-institutional TED records reflect either inpatient or outpatient health care services exclusive of inpatient institutional facility services, including institutional care in connection with ambulatory surgery.

1.2 All elements of the TED records must be maintained in the contractor's claims history file. The claims history will reflect the data submitted to the TMA on the TED record including initial submissions, resubmissions, adjustments, and cancellations. Claims history will also contain all data necessary to reproduce a TED record as required by this manual and to reproduce an Explanation Of Benefits (EOB), if required.

1.3 There are three types of TED records:

- Initial Submission
- Adjustment/Cancellation Submission
- Resubmission

1.4 These types of records are discussed in the following paragraphs. Complete record layouts and data requirements by Element Locator Number (ELN) are detailed in [Sections 2.4](#) through [2.9](#). Edit criteria are detailed in [Sections 5.1](#) through [6.4](#), and [8.1](#).

1.5 TED records within a day's cycle are processed by TMA first in **Processed to Completion Date Order**, then by TYPE OF SUBMISSION (I, O, D, R first; A, B, C, E second).

2.0 INITIAL SUBMISSION OF TED RECORDS

Initial submission applies only to the first submission of a new TED record. Initial submissions

are identified by TYPE OF SUBMISSION codes 'I', 'D', and 'O' on the TED record.

2.1 All data indicated as "required" in the data element definition must be reported. If not received in the treatment encounter data, this data must be developed.

2.2 All signed numeric data elements on the initial submission must be reported as positive values.

2.3 When institutional TED records are reported for other than the complete inpatient hospital stay, the TED records must be reported to TMA in the sequence that the care was provided (FREQUENCY CODES, 2-Initial, 3-Interim or 4-Final). Refer to [paragraph 7.0](#) for requirements on submitting interim bills for institutional claims.

3.0 SUBMISSION OF ADJUSTMENT/CANCELLATION TED RECORDS

3.1 Adjustment and cancellation TED records correct records with claims processing errors, or update prior data on the record with more current/accurate information. For contracts awarded prior to July 1, 2007, adjustment records also corrected relational errors that were provisionally accepted on the TMA database.

3.2 For contracts awarded prior to July 1, 2007, the TED RECORD CORRECTION INDICATOR (ELNs 1-374 and 2-139) will have been coded on adjustments and cancellations reported under those contracts. This data element identifies whether the adjustment or cancellation was to: 1) correct provisional errors only, 2) correct claims processing errors or update prior data, or 3) correct both provisional errors and claims processing errors or update prior data. This data element does not apply, and should be blank, for TED records reported under contracts awarded on or after July 1, 2007.

3.3 Adjustments and cancellations to complete denial or cancellation TED records are not permitted. Denied or cancelled TED records that require further processing activity must be submitted as new, initial submissions.

3.4 Adjustments and cancellations TED records must be submitted on the same header type (batch or voucher) as the original submission.

3.5 Adjustments and cancellations to TED records are identified by TYPE OF SUBMISSION codes 'A', 'B', 'C', and 'E' on the TED record. Adjustments and cancellations to non-TED records must be reported using TYPE OF SUBMISSION codes 'B' or 'E'. The use of the proper TYPE OF SUBMISSION code is essential for accurate processing of adjustments.

3.6 Adjustment and cancellation conditions include, but are not limited to, the following:

- Error in information received from the provider or beneficiary
- Late submission of data from providers
- Error in processing by current or prior contractor (if applicable)
- Patient liability corrections
- Successful recoupment of monies, or receipt of a refund from the provider, beneficiary, or third party
- Stale dated payment checks

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Data Requirements - Data Element Layout

5.0 TRANSMISSION RECORDS

5.1 The requirement for all electronic transmissions will incorporate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated standards wherever feasible.

5.2 The first record in each transmission to TRICARE Management Activity (TMA), whether by teleprocessing or magnetic tape, will be a transmission header, using the following format. Where value is specified under comments, the value must be reported exactly as shown.

TRANSMISSION HEADER RECORD FORMAT

POSITION(S)	DESCRIPTION	CONTENT	COMMENT
1-8	Alpha	Data Type	Must be "TED Data".
9-10	**	Delimiter	Must be **.
11-22	Alphanumeric	File Name	Must be named in accordance with Chapter 1, Section 1.1, paragraph 10.6.3.1.5 .
23-24	**	Delimiter	Must be **
25-29	Alpha		Must be "FSIZE"
30-Variable	Numeric	File Size	Includes the total number of batch/voucher header records, provider, pricing and TED records (variable length). Includes transmission header, excludes transmission trailer.
Variable (2 positions)	**	Delimitier	Must be **.
Variable (6 positions)	Alpha	Record Type	Must be "RTYPEV".
Variable (2 positions)	**	Delimiter	Must be **.
Variable (7 positions)	Alpha		Must be "MAXRLEN".
Variable	Numeric	Maximum Record Length	Length of the longest variable length record within the transmission. Must be > 0.
Variable (2 positions)	**	Delimiter	Must be **.
Variable - 80	Blank	Reserved	Must be HEX 40.

5.3 Appended to the end of each transmission to TMA, whether by teleprocessing or magnetic tape, will be a transmission trailer record. The format for the transmission trailer record follows:

TRANSMISSION TRAILER RECORD FORMAT

POSITION(S)	DESCRIPTION	CONTENT	COMMENT
1	Alpha	Record ID	Must be "@" sign.
2-3	Alphanumeric	Contractor Number	TMA-assigned Contractor number.
4-10	Alphanumeric	Transmission Date	Enter in YYYYDDD format.
11-14	Numeric	Batch Count	Number of batches and/or vouchers in the transmission.

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Data Requirements - Data Element Layout

TRANSMISSION TRAILER RECORD FORMAT (CONTINUED)

POSITION(S)	DESCRIPTION	CONTENT	COMMENT
15-20	Numeric	Record Count	Includes the total number of batch/voucher header records, provider, pricing and variable length TED records. Excludes transmission header and transmission trailer.
21-80	Blank	Reserved	Must be HEX 40.

5.4 Transmissions will be returned to the contractor, with appropriate error codes appended, if any of the following occur:

ERROR CODE	ERROR TYPE	VALIDATION RULE
1200	Transmission header record not found	First record of the file must be a Transmission Header (first position is 'T').
1201	No records found in Transmission file	Byte count of the file = 0.
1202	Data Type is incorrect	Data Type must be "TED Data" - upper/lower case as shown is required. Cannot be all lower or all upper case.
1203	Second transmission header found	Second Transmission Header (first position is 'T') must not be found.
1207	Value of MAXRLEN in transmission header is not possible	MAXRLEN must be a valid value based on the combinations of record lengths included. Compare against all possible record lengths for Header (1), Inst (450), Non-Inst (99), and Provider (1) records.
1210	Transmission trailer record not found	A record must be found with first position = '@'.
1220	Second record is not a batch or voucher header record	Second record of the transmission must be batch/voucher record (record type = 0 or 5).
1240	Header record error in FSIZE, Record Type, or MAXRLEN fields)	'FSIZE', 'RTYPEV' and 'MAXRLEN' literals must be found in Transmission Header record and value of MAXRLEN must be > 0 and < 25535.
1250	Record type other than 0, 1, 2, 3, 4,5, T, or @ is invalid)	Record Type (first position of the record) must be 0, 1, 2, 3, 4, 5, 6, 9, T, or @.
1260	Extraneous data found after transmission trailer record	No record should be found after Trailer Record of the transmission file.
1290	Count of batch/voucher headers on trailer not equal headers read	Count of batch/voucher headers on trailer must match count of batch/vouchers.
1291	Batch/voucher Identifier code invalid	Batch/voucher identifier must be = 3, 4, or 5.
1295	Total record count on transmission trailer record not in balance.	Record count of transmission trailer must match total record count (except transmission header and trailer) of the file.
1296	Contractor number in trailer record does not match batch/voucher contract number	The contractor number (positions 2-3) in the transmission trailer record must correspond with the contractor number (ELN 0-010) in the batch/voucher header record(s) in the transmission file.
1299	Transmission header file-size not in possible in file	Transmission Header file size (FSIZE) must match total record count (except transmission header) of the file.
1998	Invalid non-printable character	Transmission file must not contain invalid non-printable characters (ASCII Values 0-9, 11-31, 127-255)

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Data Requirements - Data Element Layout

ERROR CODE	ERROR TYPE	VALIDATION RULE
1999	Invalid printable character	Transmission file must not contain invalid printable characters (e.g., binary values, >, <, :, ;, \, ", , etc.). The only acceptable characters are A-Z (uppercase only), 0-9, ', @, *, #, and blank.

6.0 PRINT/REPORT TRANSMISSIONS

6.1 All errors in batch/voucher, TED, and TEPRV records detected by the TMA editing system will be reported to the contractor in 133-byte record print image format. Except for special situations, error files will be teleprocessed to the contractor the day of processing. The format of the error records returned to the contractor will be:

ERRORS RECORDS RETURNED FORMAT

DESCRIPTION	POSITION	
	FROM	THRU
Number of errors on this TED record	1	3
Batch/Voucher, TED, or TEPRV data as submitted	4	Variable
Error code number (occurs 1 to 500 times based on number of errors above)	Variable	Variable

6.2 The format of the error code number is 10 characters:

ERROR CODE FORMAT

DESCRIPTION	POSITION
ELN (Element Locator Number)	1 to 4
Edit error number within ELN	5 to 6
Validity/Relational/Financial edit indicator	7 to 7
Line item/occurrence number from TED record if applicable	8 to 10

6.3 The associated error reports will list each edit incurred on each batch/voucher, TED or TEPRV record. A brief description of the edit condition is included. If the edit is a relational edit or financial edit, the ELNs and element names for the elements that are involved in the edit condition will be included, along with the values reported by the contractor for those elements.

- END -

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Chapter 2, Section 2.4

Data Requirements - Institutional/Non-Institutional Record Data Elements (A - D)

DATA ELEMENT DEFINITION

ELEMENT NAME: AMOUNT INTEREST PAYMENT

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
Institutional	1-145	1	No
Non-Institutional	2-112	1	No

PRIMARY PICTURE (FORMAT) Nine (9) signed numeric digits including two (2) decimal places.

DEFINITION The interest field is used by the contractor to report/record any dollar amounts associated with the delivery of health care that could not otherwise be reported in existing TED records fields. This amount shall be reported on both financially underwritten and non-financially underwritten payments (batch/voucher). (Refer to the financial provisions of the contract.)

CODE/VALUE SPECIFICATIONS N/A

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

This amount is not part of the AMOUNT PAID BY GOVERNMENT CONTRACTOR field on the TED record. However, it is to be included in the TOTAL AMOUNT PAID field in the header record. Interest shall not be reported or paid on MOP claims (Type of Service, second position = M)

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Chapter 2, Section 2.4

Data Requirements - Institutional/Non-Institutional Record Data Elements (A - D)

DATA ELEMENT DEFINITION

ELEMENT NAME: AMOUNT NETWORK PROVIDER DISCOUNT

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
Institutional	1-377	1	Yes ¹
Non-Institutional	2-335	Up to 99	Yes ¹

PRIMARY PICTURE (FORMAT) Nine (9) signed numeric digits including two (2) decimals.

DEFINITION Institutional: Amount of network provider discount for all services reported on the TED record. The amount will be the difference between the network provider's negotiated or discounted rate and the DRG amount, the mental health per diem, or any other TRICARE payment determined through a TMA-approved reimbursement methodology.

Non-Institutional: Amount of network provider discount for service(s) on this occurrence/line item. The amount will be the difference between the network provider's negotiated or discounted rate and the CMAC, prevailing charge, billed charges or any other TRICARE payment determined through a TMA-approved reimbursement methodology.

CODE/VALUE SPECIFICATIONS N/A

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

¹ **Applicable** to the North, South, and West Region contracts only. Excludes claims when TRICARE is secondary payer and the OHI has made payment(s).

For Contract Numbers MDA90602C0013, MDA90603C0019, MDA90603C0009, MDA90603C0010, MDA90603C0011, and MDA90603C0015, the TED system will set the transaction value of this element to zeroes.

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Data Requirements - Institutional/Non-Institutional Record Data Elements (P)

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER TAXONOMY (SPECIALTY)

		RECORDS/LOCATOR NUMBERS	
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-255	Up to 99	Yes
PRIMARY PICTURE (FORMAT) Ten (10) alphanumeric characters.			
DEFINITION Code describing the provider's specialty.			
CODE/VALUE SPECIFICATIONS Refer to http://www.wpc-edi.com/codes for Provider Specialty Codes. Refer to Addendum C, Figure 2.C-1 as a reference when assigning Provider Major Specialty Codes to Outpatient Hospital Non-Institutional TED records.			
ALGORITHM N/A			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		GROUP	
N/A		N/A	
NOTES AND SPECIAL INSTRUCTIONS:			
This data element must be '183500000X' for MOP and '333600000X' for Retail Pharmacy.			

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Data Requirements - Institutional/Non-Institutional Record Data Elements (P)

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER STATE OR COUNTRY CODE			
RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-195	1	Yes
Non-Institutional	2-235	Up to 99	Yes
PRIMARY PICTURE (FORMAT) Three (3) alphanumeric characters.			
DEFINITION Code assigned to identify the state or foreign country in which the care was received. State Code must be left justified and blank fill to right.			
CODE/VALUE SPECIFICATIONS Addendum A and Addendum B .			
ALGORITHM N/A			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE	GROUP		
N/A	N/A		
NOTES AND SPECIAL INSTRUCTIONS:			
N/A			

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Data Requirements - Provider Record Data

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER MAJOR SPECIALTY/TYPE OF INSTITUTION

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-090	1	Yes
PRIMARY PICTURE (FORMAT) Ten (10) alphanumeric characters.			
DEFINITION	Code describing a provider's major specialty for non-institutional TEDs or a code describing the type of institution for institutional TEDs. Type of Institution must be left justified and blank filled to the right.		
CODE/VALUE SPECIFICATIONS	Refer to http://www.wpc-edi.com/codes for non-institutional provider specialty codes. Refer to Addendum D, Figure 2.D-1 for type of institution codes for Institutional TEDs. Refer to Addendum C, Figure 2.C-1 for assistance when assigning Provider Specialty Codes to Outpatient Hospital non-institutional provider records.		
ALGORITHM	N/A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE	GROUP		
N/A	N/A		

NOTES AND SPECIAL INSTRUCTIONS:

Autism Demonstration EIA Supervisors will be assigned Provider Taxonomy Code 101YS0200X, School Counselor, if other Provider Taxonomy Codes have not already been assigned by CMS or the MCSC.

Autism Demonstration Tutors or Tutors-in-Training will be assigned Provider Taxonomy Code 390200000X, Student in an Organized Health Care Education/Training Program, if other Provider Taxonomy Codes have not already been assigned by CMS or the MCSC.

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Chapter 2, Section 2.10

Data Requirements - Provider Record Data

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER NAME

		RECORDS/LOCATOR NUMBERS	
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-035	1	Yes
PRIMARY PICTURE (FORMAT)	Forty (40) alphanumeric characters.		
DEFINITION	Name of provider.		
CODE/VALUE SPECIFICATIONS	Must be left justified and blank filled. If this field is a person's name, it should be in the form of last name, first name, middle initial (each name should be separated by a comma with no space between the name). Do not use articles such as 'the,' 'A,' 'An,' etc. Use standard abbreviations such as 'St.' for Saint, 'Comm' for community, 'Hosp' for hospital, etc.		
ALGORITHM	N/A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE			GROUP
N/A			N/A
NOTES AND SPECIAL INSTRUCTIONS:			
N/A			

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 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)
RELATIONAL EDITS			
0-001-01R	IF HEADER TYPE INDICATOR =	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)
	THEN BATCH/VOUCHER IDENTIFIER MUST =	5	INSTITUTIONAL/NON-INSTITUTIONAL (BATCH/VOUCHER)
0-001-02R	IF CONTRACT NUMBER = (NEW FOREIGN CONTRACT)		
	THEN BYPASS THIS EDIT		
	ELSE IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE OR
		6	VOUCHER HEADER ADMIN CLAIM RATE-ELIGIBLE
	AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN ADJUSTMENT KEY MUST =	5	VOUCHER
0-001-03R	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) OR
		9	BATCH HEADER (INSTITUTIONAL/NON-INSTITUTIONAL AT-RISK ADMIN CLAIM RATE ELIGIBLE RED RECORDS)

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.

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Header Edit Requirements (ELN 000 - 099)

ELEMENT NAME: HEADER TYPE INDICATOR (0-001) (Continued)			
	AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	AND BATCH/VOUCHER IDENTIFIER =	5	INSTITUTIONAL/NON-INSTITUTIONAL
	THEN ADJUSTMENT KEY MUST =	0	BATCH
0-001-04R	IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE OR
		6	VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE
	AND TYPE OF SUBMISSION =	D	COMPLETE DENIAL OR
		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 OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO		
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.			

ELEMENT NAME: CONTRACT NUMBER (0-010)			
VALIDITY EDITS			
0-010-01V	MUST BE A VALID VALUE FOUND ON THE TMA DATABASE.		
RELATIONAL EDITS			
0-010-01R	IF CONTRACT NUMBER =	TBD	TPHARM
	AND BATCH/VOUCHER INDICATOR =	5	INSTITUTIONAL/NON-INSTITUTIONAL
	THEN ALL OCCURRENCES OF RECORD TYPE INDICATOR MUST =	2	NON-INSTITUTIONAL
	AND ALL OCCURRENCES OF TYPE OF SERVICE (POSITION 2) MUST =	M	MOP
	OR ALL OCCURRENCES OF TYPE OF SERVICE (POSITION 2) MUST =	B	RETAIL PHARMACY

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Chapter 2, Section 4.1

Header Edit Requirements (ELN 000 - 099)

ELEMENT NAME: BATCH/VOUCHER IDENTIFIER (0-015)			
VALIDITY EDITS			
0-015-01V	MUST =	3	PROVIDER OR
		5	INSTITUTIONAL/NON-INSTITUTIONAL
RELATIONAL EDITS			
0-015-01R	IF BATCH/VOUCHER IDENTIFIER =	5	INSTITUTIONAL/NON-INSTITUTIONAL
	THEN RECORD TYPE (FOR EVERY TED RECORD IN THE BATCH/VOUCHER)		
	MUST =	1	INSTITUTIONAL OR
		2	NON-INSTITUTIONAL
0-015-02R	IF BATCH/VOUCHER IDENTIFIER =	3	PROVIDER
	THEN RECORD TYPE (FOR EVERY TED RECORD IN THE BATCH/VOUCHER)		
	MUST =	3	PROVIDER
NOTE: IF THIS EDIT FAILS FOR ANY TED RECORD, THE ENTIRE BATCH/VOUCHER FAILS.			

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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 ¹ .		
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 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 CONTRACT IDENTIFIER MUST BE A UNIQUE (KEY) COMBINATION OF CONTRACT NUMBER, BATCH/VOUCHER IDENTIFIER AND BATCH/VOUCHER NUMBER WITHIN THIS TMA PROCESSING CYCLE.		
¹ TMA DATABASE.		

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Header Edit Requirements (ELN 000 - 099)

ELEMENT NAME: BATCH/VOUCHER ASAP ACCOUNT NUMBER (0-025)

VALIDITY EDITS

0-025-01V MUST BE ALPHANUMERIC.

RELATIONAL EDITS

0-025-01R IF HEADER TYPE INDICATOR = 0 BATCH HEADER (USED ON ALL PROVIDER BATCHES, AND FOR INSTITUTIONAL/NON-INSTITUTIONAL FINANCIALLY UNDERWRITTEN NON-ADMIN CLAIM RATE ELIGIBLE TED RECORDS) **OR**

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

THEN BATCH/VOUCHER ASAP ACCOUNT NUMBER MUST BE ZERO.

0-025-02R IF HEADER TYPE INDICATOR = 5 VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE **OR**

6 VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE

AND BATCH/VOUCHER RESUBMISSION NUMBER = ZERO

THEN ASAP ACCOUNT NUMBER MUST BE VALID¹ **AND** ACTIVE² FOR THE CONTRACT NUMBER ON THE TED BATCH/VOUCHER RECORD.

0-025-05R IF CONTRACT NUMBER = (NEW TDEFIC CONTRACT) **OR**

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 BYPASS THIS EDIT

ELSE IF HCDP PLAN COVERAGE CODE = 000 NO HEALTH CARE COVERAGE PLAN **OR**

121 CHCBP STANDARD - INDIVIDUAL COVERAGE **OR**

122 CHCBP EXTRA - FAMILY COVERAGE **OR**

401 TRS TIER 1 MEMBER-ONLY **OR**

402 TRS TIER 1 MEMBER AND FAMILY **OR**

403 TOBACCO CESSATION DEMONSTRATION PROGRAM **OR**

404 WEIGHT MANAGEMENT DEMONSTRATION PROGRAM **OR**

405 TRS TIER 2 MEMBER-ONLY **OR**

406 TRS TIER 2 MEMBER AND FAMILY **OR**

407 TRS TIER 3 MEMBER-ONLY **OR**

408 TRS TIER 3 MEMBER AND FAMILY **OR**

409 TRS SURVIVOR CONTINUING INDIVIDUAL COVERAGE **OR**

¹ TMA DATABASE.

² DEFINED IN THE TRICARE OPERATIONS MANUAL (TOM), [CHAPTER 3](#). IF CONTRACTOR REQUIRES THE ABILITY TO SUBMIT 'INITIAL SUBMISSIONS' ON A CLOSED BATCH/VOUCHER CLIN/ASAP ACCOUNT, THEN CONTACT TMA, CRM FOR INSTRUCTIONS ON HOW TO PROCEED.

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Header Edit Requirements (ELN 000 - 099)

ELEMENT NAME: BATCH/VOUCHER ASAP ACCOUNT NUMBER (0-025) (Continued)		
	410	TRS SURVIVOR CONTINUING FAMILY COVERAGE OR
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRS SURVIVOR NEW FAMILY COVERAGE OR
	413	TRS MEMBER-ONLY COVERAGE OR
	414	TRS MEMBER AND FAMILY COVERAGE
OR ENROLLMENT/HEALTH PLAN CODE =	Y	CHCBP STANDARD - INDIVIDUAL COVERAGE OR
	AA	CHCBP EXTRA - FAMILY COVERAGE OR
	SN	SHCP NON-REFERRED CARE OR
	SR	SHCP REFERRED CARE
OR SPECIAL PROCESSING CODE =	AN	SHCP NON-MTF REFERRED CARE OR
	AR	SHCP MTF REFERRED CARE
OR HCC MEMBER CATEGORY CODE =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD ACTIVE > 30 DAYS; AGR CODE A-H OR
	J	ACADEMY STUDENT, NOT OCS OR
	N	NATIONAL GUARD NOT ACTIVE OR < 31 DAYS OR
	S	RESERVE MEMBER ACTIVE > 30 DAYS OR
	T	FOREIGN MILITARY OR
	V	RESERVE MEMBER NOT ACTIVE OR < 31 DAYS OR
	Y	SERVICE AFFILIATES (ROTC, MERCHANT MARINE)
AND HCC MEMBER RELATIONSHIP CODE =	A	SELF
THEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER APPROPRIATION TYPE FOUND IN CORAMS MUST ≠	TF	TRUST/ACCRUAL FUND
ELSE IF OTHER GOVERNMENT PROGRAM TYPE CODE =	A	MEDICARE PART A OR
	C	MEDICARE PART A & B OR
	I	MEDICARE PART A & D OR
	L	MEDICARE PART A, B AND D
AND OTHER GOVERNMENT PROGRAM BEGIN REASON CODE ≠	N	NOT ELIGIBLE FOR MEDICARE
AND HCDP PLAN COVERAGE CODE =	004	DIRECT CARE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	005	TRICARE STANDARD FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	016	DIRECT CARE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	017	TRICARE STANDARD FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR

¹ TMA DATABASE.

² DEFINED IN THE TRICARE OPERATIONS MANUAL (TOM), [CHAPTER 3](#). IF CONTRACTOR REQUIRES THE ABILITY TO SUBMIT 'INITIAL SUBMISSIONS' ON A CLOSED BATCH/VOUCHER CLIN/ASAP ACCOUNT, THEN CONTACT TMA, CRM FOR INSTRUCTIONS ON HOW TO PROCEED.

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Header Edit Requirements (ELN 000 - 099)

ELEMENT NAME: BATCH/VOUCHER ASAP ACCOUNT NUMBER (0-025) (Continued)		
	021	TFL FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	023	TFL FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	110	TRICARE PRIME FOR INDIVIDUAL COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	111	TRICARE PRIME FAMILY COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	114	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	115	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	136	TRICARE PRIME INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	137	TRICARE PRIME FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	138	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	139	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	143	TRICARE PLUS COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	144	TRICARE PLUS WITH CHC COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	148	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	149	TRICARE PLUS COVERAGE WITH CHC COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	151	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS
OR HCC MEMBER CATEGORY CODE =	F	FORMER MEMBER OR
	H	MEDAL OR HONOR RECIPIENT OR
	R	RETIRED OR
	W	FORMER SPOUSE
THEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER APPROPRIATION TYPE FOUND IN CORAMS MUST =	TF	TRUST/ACCRUAL FUND

¹ TMA DATABASE.
² DEFINED IN THE TRICARE OPERATIONS MANUAL (TOM), [CHAPTER 3](#). IF CONTRACTOR REQUIRES THE ABILITY TO SUBMIT 'INITIAL SUBMISSIONS' ON A CLOSED BATCH/VOUCHER CLIN/ASAP ACCOUNT, THEN CONTACT TMA, CRM FOR INSTRUCTIONS ON HOW TO PROCEED.

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Header Edit Requirements (ELN 000 - 099)

ELEMENT NAME: BATCH/VOUCHER ASAP ACCOUNT NUMBER (0-025) (Continued)		
ELSE BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER APPROPRIATION TYPE FOUND IN CORAMS MUST ≠	TF	TRUST/ACCRUAL FUND
0-025-06R IF ANY OCCURRENCE OF TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN BYPASS THIS EDIT		
ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD	TRICARE DOMESTIC
AND CONTRACT NUMBER =		<i>T3 NORTH</i>
AND BEGIN DATE OF CARE ≥		<i>START OF CONTRACT</i>
THEN ENROLLMENT CODE/HEALTH PLAN CODE MUST =	SN	SHCP NON-MTF REFERRED CARE OR
	SR	SHCP REFERRED CARE
OR HCDP PLAN COVERAGE CODE MUST=	000	CARE DELIVERED TO INELIGIBLES OR
	121	CHCBP STANDARD - INDIVIDUAL COVERAGE OR
	122	CHCBP EXTRA - FAMILY COVERAGE OR
	401	TRS TIER 1 MEMBER-ONLY OR
	402	TRS TIER 1 MEMBER AND FAMILY OR
	403	TOBACCO CESSATION DEMONSTRATION PROGRAM OR
	404	WEIGHT MANAGEMENT DEMONSTRATION PROGRAM OR
	405	TRS TIER 2 MEMBER-ONLY OR
	406	TRS TIER 2 MEMBER AND FAMILY OR
	407	TRS TIER 3 MEMBER-ONLY OR
	408	TRS TIER 3 MEMBER AND FAMILY OR
	409	TRS SURVIVOR CONTINUING INDIVIDUAL COVERAGE OR
	410	TRS SURVIVOR CONTINUING FAMILY COVERAGE OR
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRS SURVIVOR NEW FAMILY COVERAGE OR
	413	TRS MEMBER-ONLY COVERAGE OR
	414	TRS MEMBER AND FAMILY COVERAGE OR
	999	UNVERIFIED NEWBORN
OR SPECIAL PROCESSING CODE MUST =	AN	SHCP NON-MTF REFERRED CARE OR
	AR	SHCP REFERRED CARE OR

¹ TMA DATABASE.
² DEFINED IN THE TRICARE OPERATIONS MANUAL (TOM), [CHAPTER 3](#). IF CONTRACTOR REQUIRES THE ABILITY TO SUBMIT 'INITIAL SUBMISSIONS' ON A CLOSED BATCH/VOUCHER CLIN/ASAP ACCOUNT, THEN CONTACT TMA, CRM FOR INSTRUCTIONS ON HOW TO PROCEED.

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Header Edit Requirements (ELN 000 - 099)

ELEMENT NAME: BATCH/VOUCHER ASAP ACCOUNT NUMBER (0-025) (Continued)

	AU	AUTISM DEMONSTRATION OR
	CL	CLINICAL TRIALS OR
	CM	INDIVIDUAL CASE MANAGEMENT OR
	CT	CUSTODIAL CARE
OR HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD > 30 DAYS OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD < 30 DAYS OR
	S	RESERVE > 30 DAYS OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE < 30 DAYS OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN
0-025-07R IF ANY OCCURRENCE OF TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN BYPASS THIS EDIT		
ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD	TRICARE DOMESTIC
AND CONTRACT NUMBER =		T3 SOUTH
AND BEGIN DATE OF CARE ≥		START OF CONTRACT
THEN ENROLLMENT CODE/HEALTH PLAN CODE MUST =	Y	CHCBP OR
	AA	CHCBP - EXTRA OR
	SN	SHCP NON-MTF REFERRED CARE OR
	SR	SHCP REFERRED
OR HCDP PLAN COVERAGE CODE MUST =	000	CARE DELIVERED TO INELIGIBLES OR
	121	CHCBP STANDARD - INDIVIDUAL COVERAGE OR
	122	CHCBP EXTRA - FAMILY COVERAGE OR
	401	TRS TIER 1 MEMBER-ONLY OR
	402	TRS TIER 1 MEMBER AND FAMILY OR
	403	TOBACCO CESSATION DEMONSTRATION PROGRAM OR
	404	WEIGHT MANAGEMENT DEMONSTRATION PROGRAM OR

¹ TMA DATABASE.
² DEFINED IN THE TRICARE OPERATIONS MANUAL (TOM), [CHAPTER 3](#). IF CONTRACTOR REQUIRES THE ABILITY TO SUBMIT 'INITIAL SUBMISSIONS' ON A CLOSED BATCH/VOUCHER CLIN/ASAP ACCOUNT, THEN CONTACT TMA, CRM FOR INSTRUCTIONS ON HOW TO PROCEED.

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Header Edit Requirements (ELN 000 - 099)

ELEMENT NAME: BATCH/VOUCHER ASAP ACCOUNT NUMBER (0-025) (Continued)	
	405 TRS TIER 2 MEMBER-ONLY OR
	406 TRS TIER 2 MEMBER AND FAMILY OR
	407 TRS TIER 3 MEMBER-ONLY OR
	408 TRS TIER 3 MEMBER AND FAMILY OR
	409 TRS SURVIVOR CONTINUING INDIVIDUAL COVERAGE OR
	410 TRS SURVIVOR CONTINUING FAMILY COVERAGE OR
	411 TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412 TRS SURVIVOR NEW FAMILY COVERAGE OR
	413 TRS MEMBER-ONLY COVERAGE OR
	414 TRS MEMBER AND FAMILY COVERAGE OR
	999 UNVERIFIED NEWBORN
OR SPECIAL PROCESSING CODE MUST =	AN SHCP NON-MTF REFERRED CARE OR
	AR SHCP REFERRED CARE OR
	AU AUTISM DEMONSTRATION OR
	CL CLINICAL TRIALS OR
	CM INDIVIDUAL CASE MANAGEMENT OR
	CT CUSTODIAL CARE
OR HCC MEMBER CATEGORY CODE MUST =	A ACTIVE DUTY OR
	G NATIONAL GUARD > 30 DAYS OR
	J ACADEMY STUDENT OR
	N NATIONAL GARD < 30 DAYS OR
	S RESERVE > 30 DAYS OR
	T FOREIGN MILITARY MEMBER OR
	V RESERVE < 30 DAYS OR
	Z UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A SELF OR
	Z UNKNOWN
0-025-08R IF ANY OCCURRENCE OF TYPE OF SUBMISSION =	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN BYPASS THIS EDIT	
ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD TRICARE DOMESTIC
AND CONTRACT NUMBER =	T3 WEST

¹ TMA DATABASE.
² DEFINED IN THE TRICARE OPERATIONS MANUAL (TOM), [CHAPTER 3](#). IF CONTRACTOR REQUIRES THE ABILITY TO SUBMIT 'INITIAL SUBMISSIONS' ON A CLOSED BATCH/VOUCHER CLIN/ASAP ACCOUNT, THEN CONTACT TMA, CRM FOR INSTRUCTIONS ON HOW TO PROCEED.

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Header Edit Requirements (ELN 000 - 099)

ELEMENT NAME: BATCH/VOUCHER ASAP ACCOUNT NUMBER (0-025) (Continued)	
AND BEGIN DATE OF CARE ≥	START OF CONTRACT
THEN SPECIAL PROCESSING CODE MUST =	AN SHCP NON-MTF REFERRED CARE OR
	AR SHCP REFERRED CARE OR
	AU AUTISM DEMONSTRATION OR
	CL CLINICAL TRIALS OR
	CM INDIVIDUAL CASE MANAGEMENT OR
	CT CUSTODIAL CARE
OR ENROLLMENT/HEALTH PLAN CODE MUST =	SN SHCP NON-MTF REFERRED CARE OR
	SR SHCP REFERED CARE
OR HCDP PLAN COVERAGE CODE MUST =	000 CARE DLEIVIER TO INELIGIBLES OR
	401 TRS TIER 1 MEMBER-ONLY OR
	402 TRS TIER 1 MEMBER AND FAMILY OR
	403 TOBACCO CESSATION DEMONTRATION PROGRAM OR
	404 WEIGHT MANAGEMENT DEMONSTRATION PROGRAM OR
	405 TRS TIER 2 MEMBER-ONLY OR
	406 TRS TIER 2 MEMBER AND FAMILY OR
	407 TRS TIER 3 MEMBER-ONLY OR
	408 TRS TIER 3 MEMBER AND FAMILY OR
	409 TRS SURVIVOR CONTINUING INDIVIDUAL COVERAGE OR
	410 TRS SURVIVOR CONTINUING FAMILY COVERAGE OR
	411 TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412 TRS SURVIVOR NEW FAMILY COVERAGE OR
	413 TRS MEMBER-ONLY COVERAGE OR
	414 TRS MEMBER AND FAMILY COVERAGE OR
	999 UNVERIFIED NEWBORN
OR PATIENT ZIP CODE IS IN ALASKA	
OR PCM DMIS ID STATE = ALASKA	
OR HCC MEMBER CATEGORY CODE MUST =	A ACTIVE DUTY OR
	G NATIONAL GUARD > 30 DAYS OR
	J ACADEMY STUDENT OR
	N NATIONAL GUARD < 30 DAYS OR
	S RESERVE > 30 DAYS OR
	T FOREIGN MILITARY MEMBER OR

¹ TMA DATABASE.

² DEFINED IN THE TRICARE OPERATIONS MANUAL (TOM), [CHAPTER 3](#). IF CONTRACTOR REQUIRES THE ABILITY TO SUBMIT 'INITIAL SUBMISSIONS' ON A CLOSED BATCH/VOUCHER CLIN/ASAP ACCOUNT, THEN CONTACT TMA, CRM FOR INSTRUCTIONS ON HOW TO PROCEED.

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Header Edit Requirements (ELN 000 - 099)

ELEMENT NAME: BATCH/VOUCHER ASAP ACCOUNT NUMBER (0-025) (Continued)		
	V	RESERVE < 30 DAYS OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN
0-025-09R IF ANY OCCURRENCE OF TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN BYPASS THIS EDIT		
ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TC	TRICARE CIVILIAN PRIME
AND CONTRACT NUMBER =		<i>T3 NORTH, SOUTH & WEST</i>
THEN ENROLLMENT CODE/HEALTH PLAN CODE MUST =	U	TRICARE PRIME CIVILIAN PCM
AND BEGIN DATE OF CARE MUST BE ≥ START DATE OF HEALTH CARE DELIVERY		
0-025-10R IF ANY OCCURRENCE OF TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN BYPASS THIS EDIT		
ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TN	TRICARE NON-CIVILIAN PRIME
AND CONTRACT NUMBER =		<i>T3 NORTH, SOUTH & WEST</i>
THEN ENROLLMENT CODE/HEALTH PLAN CODE MUST =	T	TRICARE STANDARD PROGRAM OR
	V	TRICARE EXTRA OR
	Z	TRICARE PRIME, MTF/PCM OR
	WF	TRICARE PRIME REMOTE ADFM
AND BEGIN DATE OF CARE MUST BE ≥ START DATE OF HEALTHCARE DELIVERY		
0-025-11R IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE- ELIGIBLE OR
	6	VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE
AND CONTRACT NUMBER =	TBD	TPHARM
AND POSITION 1 THRU 4 OF THE CLIN/ASAP NUMBER = 'MIPR'		
THEN ALL OCCURRENCES OF TYPE OF SERVICE (POSITION 2) MUST =	M	MOP
0-025-12R IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE- ELIGIBLE OR
	6	VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE

¹ TMA DATABASE.
² DEFINED IN THE TRICARE OPERATIONS MANUAL (TOM), CHAPTER 3. IF CONTRACTOR REQUIRES THE ABILITY TO SUBMIT 'INITIAL SUBMISSIONS' ON A CLOSED BATCH/VOUCHER CLIN/ASAP ACCOUNT, THEN CONTACT TMA, CRM FOR INSTRUCTIONS ON HOW TO PROCEED.

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Header Edit Requirements (ELN 000 - 099)

ELEMENT NAME: BATCH/VOUCHER ASAP ACCOUNT NUMBER (0-025) (Continued)

AND TYPE OF SERVICE (POSITION 2) = M MOP

THEN POSITION 1 THRU 4 OF THE CLIN/ASAP NUMBER MUST = 'MIPR'

0-025-13R IF HEADER TYPE INDICATOR = 5 VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE **OR**

6 VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE

AND CONTRACT NUMBER = TBD TPHARM

AND POSITION 1 THRU 4 OF THE CLIN/ASAP NUMBER ≠ 'MIPR'

THEN ALL OCCURRENCES OF TYPE OF SERVICE (POSITION 2) MUST = B RETAIL PHARMACY

¹ TMA DATABASE.

² DEFINED IN THE TRICARE OPERATIONS MANUAL (TOM), [CHAPTER 3](#). IF CONTRACTOR REQUIRES THE ABILITY TO SUBMIT 'INITIAL SUBMISSIONS' ON A CLOSED BATCH/VOUCHER CLIN/ASAP ACCOUNT, THEN CONTACT TMA, CRM FOR INSTRUCTIONS ON HOW TO PROCEED.

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Header Edit Requirements (ELN 000 - 099)

ELEMENT NAME: BATCH/VOUCHER DATE (0-030)

VALIDITY EDITS

0-030-01V MUST BE A VALID JULIAN DATE AND CANNOT BE > TMA CURRENT SYSTEM DATE.

0-030-02V BATCH/VOUCHER DATE MUST BE ≥ CONTRACT BEGIN DATE¹

AND BATCH/VOUCHER DATE MUST BE ≤ CONTRACT END DATE¹

RELATIONAL EDITS

0-030-01R IF HEADER TYPE INDICATOR = 5 VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE **OR**

6 VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE

AND BATCH/VOUCHER RESUBMISSION NUMBER = 00

AND BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =

TD TRICARE DOMESTIC **OR**

TF TRICARE FOREIGN **OR**

TT TRICARE TARGET

AND TYPE OF SUBMISSION = D COMPLETE DENIAL **OR**

I INITIAL SUBMISSION **OR**

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

R RESUBMISSION

0-030-02R IF HEADER TYPE INDICATOR = 5 VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE **OR**

6 VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE

THEN BATCH/VOUCHER DATE IN HEADER MUST NOT BE LESS THAN THE ASAP BEGIN DATE ON THE TMA DATABASE.

0-030-03R IF BATCH/VOUCHER RESUBMISSION NUMBER = 00

THEN BATCH/VOUCHER DATE MUST ≠ 09/29/XXXX **OR**
09/30/XXXX

UNLESS BATCH/VOUCHER IDENTIFIER = 3 PROVIDER (BATCH ONLY)

0-030-04R IF BATCH/VOUCHER RESUBMISSION NUMBER = 00

AND TRANSMISSION FILE RECEIVED TIME/DATE STAMP > 10:00 AM 09/28/(CURRENT YEAR)

AND BATCH/VOUCHER IDENTIFIER = 5 INSTITUTIONAL/NON-INSTITUTIONAL (BATCH/VOUCHER)

THEN BATCH/VOUCHER DATE MUST NOT BE < 10/01/(CURRENT YEAR)

0-030-05R IF HEADER TYPE INDICATOR = 5 VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE **OR**

6 VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE

AND BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =

TC TRICARE CIVILIAN PRIME **OR**

TN TRICARE NON-CIVILIAN PRIME

¹ CONTRACT DATES ON THE TMA DATABASE. THESE DATES ARE TAKEN FROM THE TMA CONTRACTS.

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Header Edit Requirements (ELN 000 - 099)

ELEMENT NAME: BATCH/VOUCHER DATE (0-030) (Continued)

THEN BEGIN DATE OF CARE MUST BE EQUAL TO OR WITHIN ASAP BEGIN AND END DATES ON THE TMA DATABASE

¹ CONTRACT DATES ON THE TMA DATABASE. THESE DATES ARE TAKEN FROM THE TMA CONTRACTS.

ELEMENT NAME: BATCH/VOUCHER SEQUENCE NUMBER (0-035)

VALIDITY EDITS

0-035-01V MUST BE NUMERIC **AND** > ZERO.

RELATIONAL EDITS

NONE

ELEMENT NAME: BATCH/VOUCHER RESUBMISSION NUMBER (0-040)

VALIDITY EDITS

0-040-01V MUST BE NUMERIC

AND IF BATCH/VOUCHER IDENTIFIER = 5 INSTITUTIONAL/NON-INSTITUTIONAL

THEN MUST BE 1 GREATER THAN THE PRIOR SUBMISSION NUMBER UNDER THE SAME CONTRACT IDENTIFIER¹.

RELATIONAL EDITS

NONE

¹ TMA DATABASE.

ELEMENT NAME: TOTAL NUMBER OF RECORDS (0-045)

VALIDITY EDITS

0-045-01V MUST BE NUMERIC.

0-045-02V MUST EQUAL NUMBER OF TED RECORDS IN THE BATCH/VOUCHER.

0-045-03V TOTAL RECORDS MUST > 0

RELATIONAL EDITS

0-045-01R IF BATCH/VOUCHER IDENTIFIER = 5 INSTITUTIONAL/NON-INSTITUTIONAL

AND BATCH/VOUCHER RESUBMISSION NUMBER > ZERO

THEN NUMBER OF RECORDS IN THE BATCH/VOUCHER MUST = NUMBER OUTSTANDING RECORDS¹.

¹ TMA DATABASE.

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Header Edit Requirements (ELN 000 - 099)

ELEMENT NAME: TOTAL AMOUNT PAID (0-050)

VALIDITY EDITS

0-050-01V MUST BE NUMERIC.

RELATIONAL EDITS

0-050-01R IF BATCH/VOUCHER IDENTIFIER = 5 INSTITUTIONAL/NON-INSTITUTIONAL

THEN TOTAL AMOUNT PAID MUST = THE ACCUMULATED TOTAL OF AMOUNTS PAID BY GOVERNMENT CONTRACTOR **AND** AMOUNT OF INTEREST PAYMENT FOR ALL TED RECORDS IN THE BATCH/VOUCHER.

0-050-02R IF BATCH/VOUCHER IDENTIFIER = 3 PROVIDER **OR**

THEN TOTAL AMOUNT PAID MUST EQUAL ZERO.

0-050-03R IF HEADER TYPE INDICATOR = 5 VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE **OR**

6 VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE

AND BATCH/VOUCHER IDENTIFIER = 5 INSTITUTIONAL/NON-INSTITUTIONAL

AND BATCH/VOUCHER RESUBMISSION NUMBER > ZERO

THEN TOTAL AMOUNT PAID MUST BE EQUAL TO THE VOUCHER BALANCE¹.

¹ TMA DATABASE.

ELEMENT NAME: INITIAL TRANSMISSION DATE (TMA DERIVED) (0-055)

VALIDITY EDITS

NONE

RELATIONAL EDITS

NONE

ELEMENT NAME: TMA BATCH/VOUCHER PROCESSING DATE (TMA DERIVED) (0-060)

VALIDITY EDITS

NONE

RELATIONAL EDITS

NONE

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Header Edit Requirements (ELN 000 - 099)

ELEMENT NAME: FUND ACCOUNTING (0-065)

VALIDITY EDITS

0-065-01V MUST BE NUMERIC.

RELATIONAL EDITS

0-065-01R IF CONTRACT NUMBER = MDA906-02-C-0013 (MOP)

AND BATCH/VOUCHER IDENTIFIER = 5 INSTITUTIONAL/NON-INSTITUTIONAL

THEN THE FUND ACCOUNTING MUST = THE ACCUMULATED TOTALS OF AMOUNT ALLOWED BY PROCEDURE CODE MINUS AMOUNT BILLED BY PROCEDURE CODE FOR ALL TED RECORDS IN THIS VOUCHER.

0-065-02R IF CONTRACT NUMBER = MDA906-02-C-0013 (MOP)

AND HEADER TYPE INDICATOR = 5 VOUCHER HEADER NON-ADMIN CLAIM RATE ELIGIBLE **OR**

6 VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE

AND BATCH/VOUCHER IDENTIFIER = 5 INSTITUTIONAL/NON-INSTITUTIONAL

AND BATCH/VOUCHER RESUBMISSION NUMBER > ZERO

THEN THE FUND ACCOUNTING MUST BE EQUAL TO THE VOUCHER BALANCE¹.

¹ TMA DATABASE.

- END -

Institutional Edit Requirements (ELN 000 - 099)

ELEMENT NAME: RECORD TYPE INDICATOR (1-001)			
VALIDITY EDITS			
1-001-01V	RECORD TYPE INDICATOR MUST =	1	INSTITUTIONAL
RELATIONAL EDITS			
1-001-01R	IF TYPE OF SUBMISSION	A	ADJUSTMENT OR
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		C	COMPLETE CANCELLATION OR
		D	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
AND MATCH IS FOUND ON THE TMA DATABASE			
THEN THE RECORD TYPE FOR THE TED ON THE DATABASE MUST EQUAL THE RECORD TYPE ON THE ADJUSTMENT/CANCELLATION TED BEING SUBMITTED.			

ELEMENT NAME: FILING DATE (1-015)			
VALIDITY EDITS			
1-015-01V	MUST BE A VALID JULIAN DATE AND CANNOT BE > TMA CURRENT SYSTEM DATE.		
1-015-02V	IF CONTRACT NUMBER = MDA90603C0015		
	THEN FILING DATE MUST BE < 07/01/2008		
RELATIONAL EDITS			
1-015-01R	FILING DATE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION		

ELEMENT NAME: FILING STATE/COUNTRY CODE (1-020)			
VALIDITY EDITS			
1-020-01V	IF TYPE OF SUBMISSION =	D	COMPLETE DENIAL OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION
THEN MUST BE A VALID STATE/COUNTRY CODE. (REFER TO ADDENDUM A AND ADDENDUM B).			
RELATIONAL EDITS			
1-020-01R	IF PRICING RATE CODE =	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I	TRICARE DRG REIMBURSEMENT WITH COST OUTLIER OR
		J	TRICARE DRG REIMBURSEMENT WITH NO OUTLIER
THEN FILING STATE/COUNTRY CODE MUST NOT BE A FOREIGN COUNTRY EXCEPT FOR PUERTO RICO (PRI).			

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Chapter 2, Section 5.1

Institutional Edit Requirements (ELN 000 - 099)

ELEMENT NAME: SEQUENCE NUMBER (1-025)

VALIDITY EDITS

1-025-01V THE FIRST FIVE CHARACTERS MUST BE A COMBINATION OF ALPHABETIC OR NUMERIC CHARACTERS THE LAST TWO CHARACTERS MUST = BLANK.

NOTE: THE FIRST FIVE CHARACTERS CANNOT BE SPACES OR SPECIAL CHARACTERS

RELATIONAL EDITS

NONE

ELEMENT NAME: TIME STAMP (1-030)

VALIDITY EDITS

1-030-01V MUST BE NUMERIC

RELATIONAL EDITS

1-030-01R IF FILING DATE IS \geq 02/01/1995

THEN TIME STAMP MUST BE $>$ ZERO

ELEMENT NAME: ADJUSTMENT KEY (1-035)

VALIDITY EDITS

1-035-01V MUST BE ALPHA, '0' OR '5'

RELATIONAL EDITS

NONE

ELEMENT NAME: DATE TED RECORD PROCESSED TO COMPLETION (1-040)

VALIDITY EDITS

1-040-01V MUST BE VALID GREGORIAN DATE AND CANNOT BE $>$ CURRENT SYSTEM DATE.

RELATIONAL EDITS

1-040-01R DATE TED RECORD PROCESSED TO COMPLETION MUST BE \leq BATCH/VOUCHER DATE.

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Chapter 2, Section 5.2

Institutional Edit Requirements (ELN 100 - 199)

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

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Chapter 2, Section 5.2

Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: PROVIDER STATE OR COUNTRY CODE (1-195)

VALIDITY EDITS

1-195-01V VALUE MUST BE A VALID STATE **OR** COUNTRY CODE (REFER TO [ADDENDUM A](#) OR [ADDENDUM B](#))

RELATIONAL EDITS

1-195-01R PROVIDER STATE/COUNTRY CODE MUST MATCH THE CORRESPONDING RECORD¹ IN THE PROVIDER FILE
UNLESS AMOUNT ALLOWED (TOTAL) ≤ ZERO

OR ADJUSTMENT/DENIAL REASON
 CODE =

38 SERVICES NOT PROVIDED OR AUTHORIZED BY
 DESIGNATED (NETWORK) PROVIDERS **OR**

52 THE REFERRING/PRESCRIBING/RENDERING PROVIDER
 IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/
 PERFORM THE SERVICE BILLED **OR**

B7 THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE
 PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE
 OF SERVICE

OR ANY OCCURRENCE OF SPECIAL
 PROCESSING CODE =

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

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

FS TFL (SECOND PAYOR) **OR**

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

THEN DO NOT CHECK FOR MATCH ON PROVIDER FILE

¹ "CORRESPONDING RECORD" ON PROVIDER FILE IS BASED ON INSTITUTIONAL TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER ZIP CODE, AND TYPE OF **INSTITUTION**. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (1-200-02R).

- END -

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Chapter 2, Section 5.4

Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: REVENUE CODE (1-385) (Continued)		
	0656	GENERAL INPATIENT CARE - NON-RESPITE OR
	0657	PHYSICIAN SERVICES OR
	0659	OTHER HOSPICE
THEN	TYPE OF INSTITUTION MUST =	78 NON-HOSPITAL BASED HOSPICE OR
		79 HOSPITAL BASED HOSPICE
UNLESS AMOUNT ALLOWED (TOTAL) = ZERO		
1-385-11R	IF REVENUE CODE =	0023 HHA PPS
AND BEGIN DATE OF CARE ≥ 06/01/2004		
THEN	TYPE OF INSTIUTION MUST =	70 HHA
ELEMENT NAME: UNITS OF SERVICE BY REVENUE CODE (1-390)		
VALIDITY EDITS		
1-390-01V	VALUE MUST BE SIGNED NUMERIC, 0 TO 9,999,999.	
UNLESS	TYPE OF SUBMISSION =	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN	VALUE MUST BE SIGNED NUMERIC, -9,999,999 TO 9,999,999	
RELATIONAL EDITS		
1-390-01R	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	UNITS OF SERVICE BY REVENUE CODE MUST BE > ZERO FOR ALL OCCURRENCES/LINE ITEMS	
EXCLUDING REVENUE CODE 0001 AND 0023.		
1-390-02R	IF UNITS OF SERVICE BY REVENUE CODE = 0	
AND	TYPE OF SUBMISSION ≠	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN	TOTAL CHARGE BY REVENUE CODE MUST ALSO = 0 (FOR THAT OCCURRENCE/LINE ITEM)	
EXCEPT FOR REVENUE CODE 0001 OR 0022		
1-390-03R	IF UNITS OF SERVICE BY REVENUE CODE > 0	
AND	TYPE OF SUBMISSION ≠	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN	TOTAL CHARGE BY REVENUE CODE MUST ALSO > 0 (FOR THAT OCCURRENCE/LINE ITEM)	
UNLESS	REVENUE CODE =	0022 SNF PPS
OR	REVENUE CODE =	0023 HHA PPS
AND THE OCCURRENCE/LINE ITEM CONTAINS AN ADJUSTMENT/DENIAL REASON CODE LISTED IN ADDENDUM G, FIGURE 2.G-1 OR FIGURE 2.G-2 .		
1-390-04R	IF REVENUE CODE = 0001	

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Chapter 2, Section 5.4

Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: UNITS OF SERVICE BY REVENUE CODE (1-390) (Continued)

THEN UNITS OF SERVICE BY REVENUE CODE MUST = ZERO.

1-390-05R	IF REVENUE CODE =	0023	HHA PPS
	AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

THEN UNITS OF SERVICE BY REVENUE CODE MUST = 1

UNLESS THE OCCURRENCE/LINE ITEM CONTAINS AN ADJUSTMENT/DENIAL REASON CODE LISTED IN [ADDENDUM G, FIGURE 2.G-1](#) OR [FIGURE 2.G-2](#).

THEN UNITS OF SERVICE BY REVENUE CODE MUST = 0 **OR** 1

ELEMENT NAME: TOTAL CHARGE BY REVENUE CODE (1-395)

VALIDITY EDITS

1-395-01V	IF TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

THEN MUST BE - 999,999.99 TO 999,999.99

UNLESS REVENUE CODE = 0001

THEN MUST BE - 9,999,999.99 TO 9,999,999.99

ELSE MUST BE 0 TO 999,999.99

UNLESS REVENUE CODE = 0001

THEN MUST BE 0 TO 9,999,999.99

RELATIONAL EDITS

1-395-01R	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 TOTAL CHARGE BY REVENUE CODE MUST BE > ZERO ON EACH OCCURRENCE/LINE ITEM (EXCLUDING REVENUE CODE 0022 AND 0023)

1-395-02R' THE SUM OF ALL TOTAL CHARGE BY REVENUE CODE FOR REVENUE CODES OTHER THAN 0001 MUST EQUAL THE TOTAL CHARGE BY REVENUE CODE FOR REVENUE CODE 0001.

- END -

Non-Institutional Edit Requirements (ELN 000-099)

ELEMENT NAME: RECORD TYPE INDICATOR (2-001)	
VALIDITY EDITS	
2-001-01V	RECORD TYPE INDICATOR MUST = 2 NON-INSTITUTIONAL
RELATIONAL EDITS	
2-001-01R	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
AND A MATCH IS FOUND ON THE TMA DATABASE	
THEN THE RECORD TYPE FOR THE TED ON THE DATABASE MUST = THE RECORD TYPE ON THE ADJUSTMENT/CANCELLATION TED BEING SUBMITTED.	

ELEMENT NAME: FILING DATE (2-015)	
VALIDITY EDITS	
2-015-01V	MUST BE A VALID JULIAN DATE AND CANNOT BE > TMA CURRENT SYSTEM DATE.
2-015-02V	IF CONTRACT NUMBER = MDA90603C0015
	THEN FILING DATE MUST BE < 07/01/2008
RELATIONAL EDITS	
2-015-01R	FILING DATE MUST BE ≤DATE TED RECORD PROCESSED TO COMPLETION

ELEMENT NAME: FILING STATE/COUNTRY CODE (2-020)	
VALIDITY EDITS	
2-020-01V	IF TYPE OF SUBMISSION =
	D COMPLETE DENIAL OR
	I INITIAL SUBMISSION OR
	O ZERO PAYMENT WITH 100% OHI/TPL OR
	R RESUBMISSION
THEN MUST BE A VALID STATE/COUNTRY CODE (REFER TO ADDENDUM A AND ADDENDUM B .)	
RELATIONAL EDITS	
NONE	

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Non-Institutional Edit Requirements (ELN 000-099)

ELEMENT NAME: SEQUENCE NUMBER (2-025)

VALIDITY EDITS

2-025-01V THE FIRST FIVE CHARACTERS MUST BE A COMBINATION OF ALPHABETIC OR NUMERIC CHARACTERS, LAST TWO CHARACTERS MUST BE BLANK.

NOTE: THE FIRST FIVE CHARACTERS CANNOT BE SPACES OR SPECIAL CHARACTERS.

RELATIONAL EDITS

NONE

ELEMENT NAME: TIME STAMP (2-030)

VALIDITY EDITS

2-030-01V MUST BE NUMERIC.

RELATIONAL EDITS

2-030-01R IF FILING DATE IS \geq 02/01/1995

THEN TIME STAMP MUST BE $>$ ZERO

ELEMENT NAME: ADJUSTMENT KEY (2-035)

VALIDITY EDITS

2-035-01V MUST BE ALPHA, '0', OR '5'

RELATIONAL EDITS

NONE

ELEMENT NAME: DATE TED RECORD PROCESSED TO COMPLETION (2-040)

VALIDITY EDITS

2-040-01V MUST BE A VALID GREGORIAN DATE AND CANNOT BE $>$ TMA CURRENT SYSTEM DATE.

RELATIONAL EDITS

2-040-01R DATE TED RECORD PROCESSED TO COMPLETION MUST BE \leq BATCH/VOUCHER DATE

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Chapter 2, Section 6.2

Non-Institutional Edit Requirements (ELN 100 - 199)

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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Chapter 2, Section 6.2

Non-Institutional Edit Requirements (ELN 100 - 199)

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: 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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Chapter 2, Section 6.3

Non-Institutional Edit Requirements (ELN 200 - 299)

ELEMENT NAME: PROVIDER TAXPAYER NUMBER (2-240) (Continued)

2-240-04R IF ANY OCCURRENCE OF OVERRIDE CODE = NC NON-CERTIFIED PROVIDER

THEN THE NON-CERTIFIED PROVIDER MUST MATCH THE PROVIDER ON THE PROVIDER FILE USING THE FOLLOWING:

NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER

AND PROVIDER MAJOR SPECIALTY

AND PROVIDER ZIP CODE¹

AND PROVIDER SUB-IDENTIFIER

AND ACCEPTANCE AND TERMINATION DATES MUST = ZEROES

AND PROVIDER CONTRACT AFFILIATION CODE MUST = '5' (NON-CERTIFIED PROVIDER)

IF NO OCCURRENCE OF OVERRIDE CODE = NC NON-CERTIFIED PROVIDER

THEN THE CERTIFIED PROVIDER MUST MATCH THE PROVIDER ON THE PROVIDER FILE USING THE FOLLOWING:

NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER

AND PROVIDER MAJOR SPECIALTY

AND PROVIDER ZIP CODE¹

AND PROVIDER SUB-IDENTIFIER

¹ ONLY THE FIRST FIVE DIGITS OF THE PROVIDER ZIP CODE IS USED IN THE MATCH.

ELEMENT NAME: PROVIDER SUB-IDENTIFIER (2-245)

VALIDITY EDITS

2-245-01V MUST BE FOUR CHARACTERS
FIRST CHARACTER ALPHANUMERIC, LAST THREE CHARACTERS NUMERIC

OR FIRST TWO CHARACTERS ALPHANUMERIC, LAST TWO CHARACTERS NUMERIC

OR ALL FOUR NUMERIC

RELATIONAL EDITS

NONE

ELEMENT NAME: PROVIDER ZIP CODE (2-250)

VALIDITY EDITS

2-250-01V MUST BE NINE DIGITS **OR** FIVE DIGITS WITH FOUR BLANKS

MUST BE A VALID ZIP CODE (BASED ON BEGIN DATE OF CARE) IN THE GOVERNMENT PROVIDED ELECTRONIC ZIP CODE FILE **OR**

MUST BE A THREE CHARACTER FOREIGN COUNTRY CODE (BASED ON THE COUNTRY CODES TABLE¹) FOLLOWED BY SIX BLANKS

RELATIONAL EDITS

NONE

¹ WHEN FOREIGN COUNTRY CODES ARE SUBMITTED, THE FIRST THREE CHARACTERS WILL BE EDITED AGAINST [ADDENDUM A](#).

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Chapter 2, Section 6.3

Non-Institutional Edit Requirements (ELN 200 - 299)

ELEMENT NAME: PROVIDER TAXONOMY (SPECIALTY) (2-255)

VALIDITY EDITS

2-255-01V THIS FIELD MUST BE A VALID PROVIDER SPECIALTY (REFER TO [HTTP://WWW.WPC-EDI.COM/CODES](http://www.wpc-edi.com/codes)).

RELATIONAL EDITS

2-255-03R IF PROVIDER SPECIALTY = 333600000X (SUPPLIERS/PHARMACY)

THEN TYPE OF SERVICE (SECOND POSITION) =

B RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS

2-255-04R IF PROVIDER SPECIALTY = 183500000X (PHARMACY SERVICE PROVIDERS/PHARMACIST)

THEN TYPE OF SERVICE (SECOND POSITION) =

M MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS

ELEMENT NAME: PROVIDER PARTICIPATION INDICATOR (2-260)

VALIDITY EDITS

2-260-01V MUST BE A VALID PROVIDER PARTICIPATION INDICATOR.

RELATIONAL EDITS

NONE

ELEMENT NAME: PROVIDER NETWORK STATUS INDICATOR (2-265)

VALIDITY EDITS

2-265-01V PROVIDER NETWORK STATUS INDICATOR MUST =

1 NETWORK PROVIDER **OR**

2 NON-NETWORK PROVIDER

RELATIONAL EDITS

NONE

ELEMENT NAME: PHYSICIAN REFERRAL NUMBER (2-270)

VALIDITY EDITS

NONE

RELATIONAL EDITS

NONE

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Chapter 2, Section 7.1

Provider Edit Requirements (ELN 000 - 099)

ELEMENT NAME: PROVIDER MAJOR SPECIALTY/TYPE OF INSTITUTION (3-090)

VALIDITY EDITS

NONE

RELATIONAL EDITS

3-090-01R IF INSTITUTIONAL/NON-INSTITUTIONAL INDICATOR = I INSTITUTIONAL
THEN MUST BE VALID PROVIDER MAJOR SPECIALTY/TYPE OF INSTITUTION (REFER TO [ADDENDUM D, FIGURE 2.D-1](#)).

3-090-02R IF INSTITUTIONAL/NON-INSTITUTIONAL INDICATOR = N NON-INSTITUTIONAL
THEN MUST BE A VALID PROVIDER MAJOR SPECIALTY/TYPE OF INSTITUTION (REFER TO [HTTP://WWW.WPC-EDI.COM/CODES](http://www.wpc-edi.com/codes)).

3-090-03R IF PROVIDER MAJOR SPECIALTY/TYPE INSTITUTION = 183500000X (PHARMACY SERVICE PROVIDERS/ PHARMACIST)
THEN CONTRACTOR NUMBER MUST = 02 TMOP **OR**
 70 TPHARM

ELEMENT NAME: TYPE OF INSTITUTION TERM INDICATOR CODE (3-095)

VALIDITY EDITS

3-095-01V MUST BE A VALID TYPE OF INSTITUTION TERM INDICATOR CODE.

RELATIONAL EDITS

3-095-01R IF TYPE OF INSTITUTION CODE TERM INDICATOR = L LONG-TERM **OR**
 S SHORT-TERM
THEN INSTITUTIONAL/NON-INSTITUTIONAL INDICATOR MUST = I INSTITUTIONAL

- END -

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Chapter 2, Section 8.1

Financial Edit Requirements

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL (1-000) (Continued)		
	110	TRICARE PRIME FOR INDIVIDUAL COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	111	TRICARE PRIME FAMILY COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	114	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	115	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	136	TRICARE PRIME INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	137	TRICARE PRIME FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	138	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	139	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	143	TRICARE PLUS COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	144	TRICARE PLUS WITH CHC COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	148	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	149	TRICARE PLUS COVERAGE WITH CHC FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	151	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS
OR HCC MEMBER CATEGORY CODE =	F	FORMER MEMBER OR
	H	MEDAL OF HONOR RECIPIENT OR
	R	RETIRED OR
	W	DOD BENEFICIARY
THEN BATCH/VOUCHER ASAP ACCOUNT NUMBER APPROPRIATION TYPE FOUND IN CORAMS MUST =	TF	TRUST/ACCRUAL FUND
ELSE BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER APPROPRIATION TYPE FOUND IN CORAMS MUST ≠	TF	TRUST/ACCRUAL FUND
1-000-02F	• NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - NORTH CONTRACT	
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR

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Financial Edit Requirements

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL (1-000) (Continued)

	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) = ZERO		
THEN BYPASS THIS EDIT		
ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD	TRICARE DOMESTIC
AND CONTRACT NUMBER =	MDA906-03-C-0011	(NORTH)
AND BEGIN DATE OF CARE ≥ 09/01/2004		
THEN SPECIAL PROCESSING CODE MUST =	AN	SHCP NON-MTF REFERRED CARE OR
	AR	SHCP - REFERRED CARE OR
	AU	AUTISM DEMONSTRATION OR
	CL	CLINICAL TRIALS OR
	CM	INDIVIDUAL CASE MANAGEMENT OR
	CT	CUSTODIAL CARE
OR ENROLLMENT/HEALTH PLAN CODE MUST =	SN	SHCP NON-MTF REFERRED CARE OR
	SR	SHCP - REFERRED CARE
OR HCDP PLAN COVERAGE CODE MUST =	000	CARE DELIVERED TO INELIGIBLES OR
	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR
	402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRS SURVIVOR NEW FAMILY COVERAGE OR
	413	TRS MEMBER-ONLY COVERAGE OR
	414	TRS MEMBER AND FAMILY COVERAGE OR

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ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL (1-000) (Continued)

	999	UNVERIFIED NEWBORN
OR HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD > 30 DAYS OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD < 30 DAYS OR
	S	RESERVE > 30 DAYS OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE < 30 DAYS OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN
1-000-03F	• NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - SOUTH CONTRACT	
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) = ZERO		
THEN BYPASS THIS EDIT		
ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD	TRICARE DOMESTIC
AND CONTRACT NUMBER =	MDA906-03-C-0010 (SOUTH)	
AND BEGIN DATE OF CARE ≥ 11/01/2004		
THEN ENROLLMENT CODE/HEALTH PLAN CODE MUST =	Y	CHCBP OR
	AA	CHCBP - EXTRA OR
	SN	SHCP NON-MTF REFERRED CARE OR
	SR	SHCP - REFERRED CARE
OR HCDP PLAN COVERAGE CODE MUST =	000	CARE DELIVERED TO INELIGIBLES OR
	121	CHCBP STANDARD - INDIVIDUAL COVERAGE OR
	122	CHCBP EXTRA - FAMILY COVERAGE OR
	401	TRS TIER 1 MEMBER-ONLY COVERAGE OR
	402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR

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Financial Edit Requirements

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL (1-000) (Continued)		
	406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRS SURVIVOR NEW FAMILY COVERAGE OR
	413	TRS MEMBER-ONLY COVERAGE OR
	414	TRS MEMBER AND FAMILY COVERAGE OR
	999	UNVERIFIED NEWBORN
OR SPECIAL PROCESSING CODE MUST =	AN	SHCP NON-MTF REFERRED CARE OR
	AR	SHCP - REFERRED CARE OR
	AU	AUTISM DEMONSTRATION OR
	CL	CLINICAL TRIALS OR
	CM	INDIVIDUAL CASE MANAGEMENT OR
	CT	CUSTODIAL CARE
OR HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD > 30 DAYS OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD < 30 DAYS OR
	S	RESERVE > 30 DAYS OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE < 30 DAYS OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN
1-000-04F • NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - WEST CONTRACT		
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR 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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Financial Edit Requirements

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL (1-000) (Continued)

OR AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) = ZERO

THEN BYPASS THIS EDIT

ELSE IF BATCH/VOUCHER CLIN/ASAP
ACCOUNT NUMBER ASAP DESCRIPTION
FOUND IN CORAMS =

TD TRICARE DOMESTIC

AND CONTRACT NUMBER = MDA906-03-C-0009 (WEST)

AND BEGIN DATE OF CARE ≥ 10/01/2004

THEN SPECIAL PROCESSING CODE
MUST =

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

AR SHCP - REFERRED CARE **OR**

AU **AUTISM DEMONSTRATION OR**

CL CLINICAL TRIALS **OR**

CM INDIVIDUAL CASE MANAGEMENT **OR**

CT CUSTODIAL CARE

OR ENROLLMENT/HEALTH PLAN
CODE =

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

SR SHCP - REFERRED CARE

OR HCDP PLAN COVERAGE CODE
MUST =

000 CARE DELIVERED TO INELIGIBLES **OR**

401 TRS TIER 1 MEMBER-ONLY COVERAGE **OR**

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

405 TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED
QUALIFICATIONS) **OR**

406 TRS TIER 2 MEMBER AND FAMILY COVERAGE
(CERTIFIED QUALIFICATIONS) **OR**

407 TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE
AGREEMENT) **OR**

408 TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE
AGREEMENT) **OR**

409 TRS SURVIVOR CONTINUING WITH INDIVIDUAL
COVERAGE **OR**

410 TRS SURVIVOR CONTINUING WITH FAMILY
COVERAGE **OR**

411 TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR**

412 TRS SURVIVOR NEW FAMILY COVERAGE **OR**

413 TRS MEMBER-ONLY COVERAGE **OR**

414 TRS MEMBER AND FAMILY COVERAGE **OR**

999 UNVERIFIED NEWBORN

OR PATIENT ZIP CODE IS IN ALASKA

OR PCM DMIS ID STATE = ALASKA

OR HCC MEMBER CATEGORY CODE
MUST =

A ACTIVE DUTY **OR**

G NATIONAL GUARD > 30 DAYS **OR**

J ACADEMY STUDENT **OR**

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Financial Edit Requirements

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL (1-000) (Continued)

	N	NATIONAL GUARD < 30 DAYS OR
	S	RESERVE > 30 DAYS OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE < 30 DAYS OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN

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Financial Edit Requirements

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - NON-INSTITUTIONAL (2-000) (Continued)

THEN BYPASS THIS EDIT

ELSE IF BATCH/VOUCHER CLIN/ASAP
ACCOUNT NUMBER ASAP DESCRIPTION
FOUND IN CORAMS =

TD TRICARE DOMESTIC

AND CONTRACT NUMBER = MDA906-03-C-0011 (NORTH)

AND BEGIN DATE OF CARE ≥ 09/01/2004

THEN SPECIAL PROCESSING CODE
MUST =

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

AR SHCP - REFERRED CARE **OR**

AU **AUTISM DEMONSTRATION OR**

CL CLINICAL TRIALS **OR**

CM INDIVIDUAL CASE MANAGEMENT **OR**

CT CUSTODIAL CARE

OR ENROLLMENT/HEALTH PLAN
CODE MUST =

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

SR SHCP - REFERRED CARE

OR HCDP PLAN COVERAGE CODE
MUST =

000 CARE DELIVERED TO INELIGIBLES **OR**

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

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

405 TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED
QUALIFICATIONS) **OR**

406 TRS TIER 2 MEMBER AND FAMILY COVERAGE
(CERTIFIED QUALIFICATIONS) **OR**

407 TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE
AGREEMENT) **OR**

408 TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE
AGREEMENT) **OR**

409 TRS SURVIVOR CONTINUING WITH INDIVIDUAL
COVERAGE **OR**

410 TRS SURVIVOR CONTINUING WITH FAMILY
COVERAGE **OR**

411 TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR**

412 TRS SURVIVOR NEW FAMILY COVERAGE **OR**

413 TRS MEMBER-ONLY COVERAGE **OR**

414 TRS MEMBER AND FAMILY COVERAGE **OR**

999 UNVERIFIED NEWBORN

OR HCC MEMBER CATEGORY CODE
MUST =

A ACTIVE DUTY **OR**

G NATIONAL GUARD > 30 DAYS **OR**

J ACADEMY STUDENT **OR**

N NATIONAL GUARD < 30 DAYS **OR**

S RESERVE > 30 DAYS **OR**

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Financial Edit Requirements

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - NON-INSTITUTIONAL (2-000) (Continued)		
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE < 30 DAYS OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN
2-000-03F • NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - SOUTH CONTRACT		
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/ VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/ VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE = ZERO		
THEN BYPASS THIS EDIT		
ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD	TRICARE DOMESTIC
AND CONTRACT NUMBER =	MDA906-03-C-0010 (SOUTH)	
AND BEGIN DATE OF CARE ≥ 11/01/2004		
THEN ENROLLMENT CODE/HEALTH PLAN CODE MUST =	Y	CHCBP OR
	AA	CHCBP - EXTRA OR
	SN	SHCP NON-MTF REFERRED CARE OR
	SR	SHCP - REFERRED CARE
OR HCDP PLAN COVERAGE CODE MUST =	000	CARE DELIVERED TO INELIGIBLES OR
	121	CHCBP STANDARD - INDIVIDUAL COVERAGE OR
	122	CHCBP EXTRA - FAMILY COVERAGE OR
	401	TRS TIER 1 MEMBER-ONLY COVERAGE 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

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ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - NON-INSTITUTIONAL (2-000) (Continued)		
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRS SURVIVOR NEW FAMILY COVERAGE OR
	413	TRS MEMBER-ONLY COVERAGE OR
	414	TRS MEMBER AND FAMILY COVERAGE OR
	999	UNVERIFIED NEWBORN
OR SPECIAL PROCESSING CODE MUST =	AN	SHCP NON-MTF REFERRED CARE OR
	AR	SHCP - REFERRED CARE OR
	AU	AUTISM DEMONSTRATION OR
	CL	CLINICAL TRIALS OR
	CM	INDIVIDUAL CASE MANAGEMENT OR
	CT	CUSTODIAL CARE
OR HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD > 30 DAYS OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD < 30 DAYS OR
	S	RESERVE > 30 DAYS OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE < 30 DAYS OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN
2-000-04F	• NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - WEST CONTRACT	
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE = ZERO		
THEN BYPASS THIS EDIT		
ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD	TRICARE DOMESTIC

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Financial Edit Requirements

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - NON-INSTITUTIONAL (2-000) (Continued)

AND CONTRACT NUMBER =	MDA906-03-C-0009 (WEST)
AND BEGIN DATE OF CARE ≥ 10/01/2004	
THEN SPECIAL PROCESSING CODE MUST =	AN SHCP NON-MTF REFERRED CARE OR
	AR SHCP - REFERRED CARE OR
	AU AUTISM DEMONSTRATION OR
	CL CLINICAL TRIALS OR
	CM INDIVIDUAL CASE MANAGEMENT OR
	CT CUSTODIAL CARE
OR ENROLLMENT/HEALTH PLAN CODE MUST =	SN SHCP NON-MTF REFERRED CARE OR
	SR SHCP - REFERRED CARE
OR HCDP PLAN COVERAGE CODE MUST =	000 CARE DELIVERED TO INELIGIBLES OR
	401 TRS TIER 1 MEMBER-ONLY COVERAGE OR
	402 TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405 TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406 TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407 TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408 TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409 TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410 TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411 TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412 TRS SURVIVOR NEW FAMILY COVERAGE OR
	413 TRS MEMBER-ONLY COVERAGE OR
	414 TRS MEMBER AND FAMILY COVERAGE OR
	999 UNVERIFIED NEWBORN
OR PATIENT ZIP CODE IS IN ALASKA	
OR PCM DMIS ID STATE = ALASKA	
OR HCC MEMBER CATEGORY CODE MUST =	A ACTIVE DUTY OR
	G NATIONAL GUARD > 30 DAYS OR
	J ACADEMY STUDENT OR
	N NATIONAL GUARD < 30 DAYS OR
	S RESERVE > 30 DAYS OR
	T FOREIGN MILITARY MEMBER OR
	V RESERVE < 30 DAYS OR
	Z UNKNOWN

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Financial Edit Requirements

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - NON-INSTITUTIONAL (2-000) (Continued)

AND HCC MEMBER

RELATIONSHIP CODE MUST =

A SELF **OR**

Z UNKNOWN

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Financial Edit Requirements

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055)

VALIDITY EDITS

REFER TO [SECTION 6.1](#).

RELATIONAL EDITS

2-055-11F • TPR [ADSM]

IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE OR
	6	VOUCHER HEADER ADMIN CLAIM RATE-ELIGIBLE
AND ENROLLMENT/HEALTH PLAN CODE =	W	TPR ADSM - USA OR
	WA	TPR FOREIGN ADSM
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	GU	ADSM ENROLLED IN TPR
AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
AND THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE ≠ ZERO		
THEN SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
	O	NOAA OR
	Z	NOT PROVIDED FROM DEERS
AND HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR
	S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	V	RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN

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Financial Edit Requirements

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (Continued)

2-055-20F • SHCP VOUCHERS (ADSM CLAIMS ONLY)

IF ENROLLMENT/HEALTH PLAN CODE =	SR	SHCP - REFERRED CARE (EFFECTIVE 10/01/1999)
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AR	SHCP REFERRED
OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) = ZERO		
THEN BYPASS THIS EDIT		
ELSE IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE OR
	6	VOUCHER HEADER ADMIN CLAIM RATE-ELIGIBLE
AND ENROLLMENT/HEALTH PLAN CODE =	X	FOREIGN ADSM OR
	SO	SHCP - NON-TRICARE ELIGIBLE OR
	ST	SHCP - TRICARE ELIGIBLE OR
	SU	SHCP - REFERRAL DESIGNATION UNKNOWN
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
	SC	SHCP - NON-TRICARE ELIGIBLE OR
	SE	SHCP - TRICARE ELIGIBLE OR
	SM	SHCP - EMERGENCY
THEN SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
	O	NOAA OR
	Z	NOT PROVIDED FROM DEERS OR
	1	FOREIGN ARMY OR
	2	FOREIGN NAVY OR
	3	FOREIGN MARINE CORPS OR
	4	FOREIGN AIR FORCE
AND HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR

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Financial Edit Requirements

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (Continued)		
	S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN
2-055-30F • NAVY LINE OF DUTY CLAIMS		
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
THEN BYPASS THIS EDIT		
ELSE IF HEADER TYPE INDICATOR =	5	NON-CLAIM RATE VOUCHER OR
	6	CLAIM RATE VOUCHER
AND CONTRACT NUMBER =	MDA906-03-0010 (SOUTH)	
AND BATCH/VOUCHER ASAP ACCOUNT NUMBER POSITION 8 = 5		
THEN SERVICE BRANCH CLASSIFICATION CODE MUST =	N	NAVY OR
	Z	UNKNOWN
2-055-31F • MARINE LINE OF DUTY CLAIMS		
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
THEN BYPASS THIS EDIT		
ELSE IF HEADER TYPE INDICATOR =	5	NON-CLAIM RATE VOUCHER OR
	6	CLAIM RATE VOUCHER
AND CONTRACT NUMBER =	MDA906-03-0010 (SOUTH)	
AND BATCH/VOUCHER ASAP ACCOUNT NUMBER POSITION 8 = 6		
THEN SERVICE BRANCH CLASSIFICATION CODE MUST =	M	MARINE OR
	Z	UNKNOWN
2-055-32F • SHCP NON-MTF REFERRED VOUCHER (ADSM CLAIMS ONLY)		
IF TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) = ZERO		
THEN BYPASS THIS EDIT		

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Financial Edit Requirements

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (2-055) (Continued)

ELSE IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE OR
	6	VOUCHER HEADER ADMIN CLAIM RATE ELIGIBLE
AND ENROLLMENT/HEALTH PLAN CODE =	SN	SHCP NON-MTF REFERRED CARE
OR ANY OCCURRENCE OF SPECIAL PROCESING CODE =	AN	SHCP NON-MTF REFERRED CARE
THEN SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A	ARMY OR
	C	COAST GUARD OR
	F	AIR FORCE OR
	H	PUBLIC HEALTH SERVICE OR
	M	MARINES OR
	N	NAVY OR
	O	NOAA OR
	Z	NOT PROVIDED FROM DEERS OR
	1	FOREGIN ARMY OR
	2	FOREIGN NAVY OR
	3	FOREIGN MARINE CORPS OR
	4	FOREIGN AIR FORCE
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN

ELEMENT NAME: AGR SERVICE LEGAL AUTHORITY CODE (2-056)

VALIDITY EDITS

REFER TO [SECTION 6.1](#)

RELATIONAL EDITS

NONE

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Financial Edit Requirements

ELEMENT NAME: ADMINISTRATIVE CLIN (2-108)

VALIDITY EDITS

REFER TO [SECTION 5.2](#)

RELATIONAL EDITS

2-108-02F • NO DUPLICATE CLINs ON TED RECORD

IF CONTRACT NUMBER NOT =	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 BYPASS THIS EDIT

ELSE IF HEADER TYPE INDICATOR =	6	VOUCHER HEADER (USED ONLY FOR INSTITUTIONAL/ NON-INSTITUTIONAL NON-FINANCIALLY UNDERWRITTEN ADMIN CLAIM RATE ELIGIBLE TED RECORDS) OR
	9	BATCH HEADER (INSTITUTIONAL/NON- INSTITUTIONAL FINANCIALLY UNDERWRITTEN ADMIN CLAIM RATE ELIGIBLE TED RECORDS)

THEN ANY OCCURRENCE OF ADMINISTRATIVE CLIN (POSITIONS 3-6) MUST HAVE NO DUPLICATE IN ANY OCCURRENCES (DUPLICATE BLANK ADMINISTRATIVE CLIN OCCURRENCES ARE ALLOWED)

2-108-11F • NO BASE ADMINISTRATIVE PAYMENT FOR DENIAL OF SERVICES

IF CONTRACT NUMBER NOT =	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 BYPASS THIS EDIT

ELSE IF HEADER TYPE INDICATOR =	6	VOUCHER HEADER (USED ONLY FOR INSTITUTIONAL/ NON-INSTITUTIONAL NON-FINANCIALLY UNDERWRITTEN ADMIN CLAIM RATE ELIGIBLE TED RECORDS) OR
	9	BATCH HEADER (INSTITUTIONAL/NON- INSTITUTIONAL FINANCIALLY UNDERWRITTEN ADMIN CLAIM RATE ELIGIBLE TED RECORDS)

AND CONTRACT NUMBER = MDA906-02-C-0002 (TMOP)

AND TYPE OF SUBMISSION = D COMPLETE DENIAL

THEN RATE TYPE FOR CLIN IN THE
TMA DATABASE MUST ≠ D DISPENSING FEE

THIS DATA ELEMENT ONLY APPLIES TO THE FOLLOWING CONTRACT NUMBERS: MDA906-02-C-0013, MDA906-03-C-0009, MDA906-03-C-0010, MDA906-03-C-0011, MDA906-03-C-0015, AND MDA906-03-C-0019.

ADMINISTRATIVE CLIN EDIT ERRORS ARE NOT COUNTED AGAINST THE CONTRACTOR'S PERFORMANCE STANDARDS. THE EDITS ARE DESIGNED TO INFORM THE CONTRACTOR WHEN REQUEST FOR AN ADMINISTRATIVE PAYMENT HAS BEEN DENIED BY TMA, CRM AND HOW TO CORRECT THE ERROR.

¹ BYPASS EDIT 2-108-17F IF RECORD FAILS 2-108-16F.

BYPASS EDIT 2-108-18F IF RECORD FAILS 2-108-16F.

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 2, Section 8.1

Financial Edit Requirements

ELEMENT NAME: ADMINISTRATIVE CLIN (2-108) (Continued)

2-108-16F¹ • OPTION PERIOD

IF CONTRACT NUMBER NOT =	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 BYPASS THIS EDIT	
ELSE IF HEADER TYPE INDICATOR =	6 CLAIM RATE VOUCHER OR
	9 CLAIM RATE BATCH
AND CLIN FIELD ON TED RECORD NOT = BLANK	
AND NET MASTER VALUE OF DERIVED ADMIN CLAIM COUNT FIELD = 0	
THEN IF TYPE OF SUBMISSION =	A ADJUSTMENT OR
	B ADJUSTMENT NON-TED RECORD (HCSR) DATA OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN THE CLIN MUST BE VALID IN THE CURRENT OR PRIOR OPTION PERIOD FOR THAT CONTRACT ON THE TMA DATABASE	
ELSE THE CLIN MUST BE VALID IN THE CURRENT OPTION PERIOD FOR THAT CONTRACT ON THE TMA DATABASE.	

2-108-17F¹ • CLIN MATCHES APPROPRIATION TYPE

IF CONTRACT NUMBER NOT =	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 BYPASS THIS EDIT	
ELSE IF HEADER TYPE INDICATOR =	6 CLAIM RATE VOUCHER OR
	9 CLAIM RATE BATCH
AND CLIN FIELD ON TED RECORD NOT = BLANK	
AND NET MASTER VALUE OF DERIVED ADMIN CLAIM COUNT FIELD = 0	
THEN THE APPROPRIATION ASSOCIATED WITH THE ADMINISTRATIVE CLIN CLAIMED ON THE TED RECORD MUST MATCH THE APPROPRIATION ASSOCIATED WITH THE BATCH/VOUCHER ASAP NUMBER ASSIGNED BY TMA/CRM AND USED IN THE VOUCHER HEADER.	
THE APPROPRIATION ASSOCIATED WITH THE ADMINISTRATIVE CLIN CLAIMED ON THE TED RECORD MUST MATCH THE APPROPRIATION ASSOCIATED WITH THE BATCH/VOUCHER ASAP NUMBER ASSIGNED BY TMA/CRM AND USED IN THE VOUCHER HEADER.	

THIS DATA ELEMENT ONLY APPLIES TO THE FOLLOWING CONTRACT NUMBERS: MDA906-02-C-0013, MDA906-03-C-0009, MDA906-03-C-0010, MDA906-03-C-0011, MDA906-03-C-0015, AND MDA906-03-C-0019.

ADMINISTRATIVE CLIN EDIT ERRORS ARE NOT COUNTED AGAINST THE CONTRACTOR'S PERFORMANCE STANDARDS. THE EDITS ARE DESIGNED TO INFORM THE CONTRACTOR WHEN REQUEST FOR AN ADMINISTRATIVE PAYMENT HAS BEEN DENIED BY TMA, CRM AND HOW TO CORRECT THE ERROR.

¹ BYPASS EDIT 2-108-17F IF RECORD FAILS 2-108-16F.

BYPASS EDIT 2-108-18F IF RECORD FAILS 2-108-16F.

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 2, Section 8.1

Financial Edit Requirements

ELEMENT NAME: ADMINISTRATIVE CLIN (2-108) (Continued)

2-108-18F¹ • CLIN VS. CLAIM FORM TYPE

IF CONTRACT NUMBER NOT =		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 BYPASS THIS EDIT		
ELSE IF HEADER TYPE INDICATOR =	6	CLAIM RATE VOUCHER OR
	9	CLAIM RATE BATCH
AND CLIN FIELD ON TED RECORD NOT = BLANK		
AND NET MASTER VALUE OF DERIVED ADMIN CLAIM COUNT FIELD = 0		
THEN THE RATE TYPE FOR THAT CLIN IN THE TMA DATABASE MUST =	D	DISPENSING FEE OR
	S	SINGLE
OR IF THE RATE TYPE FOR THAT CLIN IN THE TMA DATABASE =	E	ELECTRONIC
THEN THE CLAIM FORM TYPE/EMC INDICATOR ON THE TED RECORD MUST =	G	ELECTRONIC INSTITUTIONAL CLAIM SUBMISSION OR
	H	ELECTRONIC NON-INSTITUTIONAL CLAIM SUBMISSION OR
	I	ELECTRONIC DRUG CLAIM SUBMISSION
OR IF RATE TYPE FOR THAT CLIN IN THE TMA DATABASE =	P	PAPER
THEN THE CLAIM FORM TYPE/ EMC INDICATOR ON THE TED RECORD MUST =	B	DD FORM 2642 OR
	C	HCFA/CMS 1500 OR
	F	UB-04/UB-92 OR
	J	OTHER
OR IF RATE TYPE FOR THAT CLIN IN THE TMA DATABASE =	F	FOREIGN
THEN THE BATCH/VOUCHER ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN THE TMA DATA BASE MUST =	BA	BATCH OR
	TF	TRICARE FOREIGN

THIS DATA ELEMENT ONLY APPLIES TO THE FOLLOWING CONTRACT NUMBERS: MDA906-02-C-0013, MDA906-03-C-0009, MDA906-03-C-0010, MDA906-03-C-0011, MDA906-03-C-0015, AND MDA906-03-C-0019. ADMINISTRATIVE CLIN EDIT ERRORS ARE NOT COUNTED AGAINST THE CONTRACTOR'S PERFORMANCE STANDARDS. THE EDITS ARE DESIGNED TO INFORM THE CONTRACTOR WHEN REQUEST FOR AN ADMINISTRATIVE PAYMENT HAS BEEN DENIED BY TMA, CRM AND HOW TO CORRECT THE ERROR.

¹ BYPASS EDIT 2-108-17F IF RECORD FAILS 2-108-16F.
 BYPASS EDIT 2-108-18F IF RECORD FAILS 2-108-16F.

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 2, Section 8.1

Financial Edit Requirements

ELEMENT NAME: ADMINISTRATIVE CLIN (2-108) (Continued)

2-108-19F • ONLY ONE BASE ADMINISTRATIVE PAYMENT PER EPISODE OF CARE (EOC)

IF CONTRACT NUMBER NOT =	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 BYPASS THIS EDIT	
ELSE IF CONTRACT NUMBER =	MDA906-02-C-0013 (TMOP) OR
	MDA906-03-C-0019 (TRRx)
AND HEADER TYPE INDICATOR =	9 CLAIM RATE ELIGIBLE BATCH
AND CLIN NOT = BLANK	
THEN RATE TYPE FOR THAT CLIN IN THE TMA DATABASE MUST ≠	D DISPENSING FEE OR
	E ELECTRONIC OR
	P PAPER

2-108-20F • ONLY ONE BASE ADMINISTRATIVE PAYMENT PER EOC

IF CONTRACT NUMBER NOT =	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 BYPASS THIS EDIT	
ELSE IF CONTRACT NUMBER =	MDA906-02-C-0013 (TMOP) OR
	MDA906-03-C-0019 (TRRx)
AND HEADER TYPE INDICATOR =	6 CLAIM RATE ELIGIBLE VOUCHER
THEN RATE TYPE FOR THAT CLIN IN THE TMA DATABASE MUST ≠	S SINGLE RATE

2-108-21F • CLAIM SUBMITTED UNDER WRONG HEADER TYPE INDICATOR

IF CONTRACT NUMBER NOT =	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)

THIS DATA ELEMENT ONLY APPLIES TO THE FOLLOWING CONTRACT NUMBERS: MDA906-02-C-0013, MDA906-03-C-0009, MDA906-03-C-0010, MDA906-03-C-0011, MDA906-03-C-0015, AND MDA906-03-C-0019.

ADMINISTRATIVE CLIN EDIT ERRORS ARE NOT COUNTED AGAINST THE CONTRACTOR'S PERFORMANCE STANDARDS. THE EDITS ARE DESIGNED TO INFORM THE CONTRACTOR WHEN REQUEST FOR AN ADMINISTRATIVE PAYMENT HAS BEEN DENIED BY TMA, CRM AND HOW TO CORRECT THE ERROR.

¹ BYPASS EDIT 2-108-17F IF RECORD FAILS 2-108-16F.

BYPASS EDIT 2-108-18F IF RECORD FAILS 2-108-16F.

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 2, Section 8.1

Financial Edit Requirements

ELEMENT NAME: ADMINISTRATIVE CLIN (2-108) (Continued)

THEN BYPASS THIS EDIT

ELSE IF HEADER TYPE INDICATOR = 6 CLAIM RATE VOUCHER **OR**

9 CLAIM RATE BATCH

THEN AT LEAST ONE OCCURRENCE OF ADMINISTRATIVE CLIN MUST **NOT** = BLANK

THIS DATA ELEMENT ONLY APPLIES TO THE FOLLOWING CONTRACT NUMBERS: MDA906-02-C-0013, MDA906-03-C-0009, MDA906-03-C-0010, MDA906-03-C-0011, MDA906-03-C-0015, AND MDA906-03-C-0019.

ADMINISTRATIVE CLIN EDIT ERRORS ARE NOT COUNTED AGAINST THE CONTRACTOR'S PERFORMANCE STANDARDS. THE EDITS ARE DESIGNED TO INFORM THE CONTRACTOR WHEN REQUEST FOR AN ADMINISTRATIVE PAYMENT HAS BEEN DENIED BY TMA, CRM AND HOW TO CORRECT THE ERROR.

¹ BYPASS EDIT 2-108-17F IF RECORD FAILS 2-108-16F.

BYPASS EDIT 2-108-18F IF RECORD FAILS 2-108-16F.

ELEMENT NAME: AMOUNT INTEREST PAYMENT (2-112)

VALIDITY EDITS

REFER TO [SECTION 2.4](#).

RELATIONAL EDITS

NONE

ELEMENT NAME: AMOUNT PATIENT COST-SHARE (2-200)

VALIDITY EDITS

REFER TO [SECTION 2.4](#).

RELATIONAL EDITS

NONE

- END -

Data Requirements - Country And/Or Islands Codes

REGION ¹	TRS REGION ⁴	TRICARE COUNTRY AND/OR ISLAND	CODE
13	20	Afghanistan	AFG
13	20	Aland Islands	ALA
13	20	Albania	ALB
13	20	Algeria	DZA
14	21	American Samoa	ASM
13	20	Andorra	AND
13	20	Angola	AGO
15	22	Anguilla	AIA
14	21	Antarctica	ATA
15	22	Antigua and Barbuda	ATG
15	22	Argentina	ARG
13	20	Armenia	ARM
15	22	Aruba	ABW
14	21	Australia	AUS
13	20	Austria	AUT
13	20	Azerbaijan	AZE
15	22	Bahamas	BHS
13	20	Bahrain	BHR
14	21	Bangladesh	BGD
15	22	Barbados	BRB
13	20	Belarus	BLR
13	20	Belgium	BEL
15	22	Belize	BLZ
13	20	Benin	BEN
15	22	Bermuda	BMU
14	21	Bhutan	BTN
15	22	Bolivia	BOL
13	20	Bosnia and Herzegowina	BIH

In accordance with HIPAA requirements, TRICARE utilizes the International Organization for Standardization (ISO) 3166 for country and island code determination. The ISO 3166 can also be used if more detailed information is required to assign territories and islands into these countries.

¹ OCONUS Region: Region 13 = Europe, Region 14 = Pacific, and Region 15 = Latin America.

² The TRICARE Southeast (Region 3)/Latin America & Canada (Region 15 and Region 22) Regional Director (RD) is responsible for health care support for beneficiaries residing in Canada (CA), as well as for beneficiaries residing in Puerto Rico and the Virgin Islands.

³ Edits 1-020-01 and 2-020-01 use this table to check validity.

⁴ OCONUS TRICARE Reserve Select Region: Region 20 = Europe, Region 21 = Pacific, and Region 22 = Latin America.

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Chapter 2, Addendum A

Data Requirements - Country And/Or Islands Codes

REGION ¹	TRS REGION ⁴	TRICARE COUNTRY AND/OR ISLAND	CODE
13	20	Botswana	BWA
13	20	Bouvet Island	BVT
15	22	Brazil	BRA
14	21	British Indian Ocean Territory	IOT
15	22	British Virgin Islands	VGB
15	22	Brunei Darussalam	BRN
13	20	Bulgaria	BGR
13	20	Burkina Faso (formerly Upper Volta)	BFA
13	20	Burundi	BDI
14	21	Cambodia (formerly Khmer Republic/Kampuchea, Democratic)	KHM
13	20	Cameroon	CMR
15	22	Canada ²	CAN
13	20	Cape Verde	CPV
15	22	Cayman Islands	CYM
13	20	Central African Republic	CAF
13	20	Chad	TCD
15	22	Chile	CHL
14	21	China	CHN
14	21	Christmas Island	CXR
14	21	Cocos (Keeling) Islands	CCK
15	22	Colombia	COL
13	20	Comoros	COM
13	20	Congo (formerly Zaire)	COG
13	20	Congo, the Democratic Republic of the	COD
14	21	Cook Islands	COK
15	22	Costa Rica	CRI
13	20	Cote D'Ivoire	CIV
15	22	Cuba	CUB
13	20	Croatia	HRV
13	20	Cyprus	CYP
13	20	Czech Republic	CZE
13	20	Denmark	DNK
13	20	Djibouti (formerly French Afars and Issass)	DJI
15	22	Dominica	DMA

In accordance with HIPAA requirements, TRICARE utilizes the International Organization for Standardization (ISO) 3166 for country and island code determination. The ISO 3166 can also be used if more detailed information is required to assign territories and islands into these countries.

¹ OCONUS Region: Region 13 = Europe, Region 14 = Pacific, and Region 15 = Latin America.

² The TRICARE Southeast (Region 3)/Latin America & Canada (Region 15 and Region 22) Regional Director (RD) is responsible for health care support for beneficiaries residing in Canada (CA), as well as for beneficiaries residing in Puerto Rico and the Virgin Islands.

³ Edits 1-020-01 and 2-020-01 use this table to check validity.

⁴ OCONUS TRICARE Reserve Select Region: Region 20 = Europe, Region 21 = Pacific, and Region 22 = Latin America.

Data Requirements - Provider's Major Specialty Codes

FIGURE 2.C-1 PROVIDER MAJOR SPECIALTY CODES FOR USE ON NON-INSTITUTIONAL TED RECORDS FOR OUTPATIENT HOSPITAL CARE

TYPE OF INSTITUTION		PROVIDER MAJOR SPECIALTY	
CODE	DESCRIPTION	CODE	DESCRIPTION
10	General Medical and Surgical	282N00000X	General Acute Care Hospital
11	Hospital unit of an institution (prison hospital, college infirmary etc.)	See below.	See below.
	Prison	261QP2400X	Prison Health
	College infirmary	261QS1000X	Student Health
12	Hospital unit within an institution for the mentally retarded	315P00000X	Intermediate Care Facility, Mentally
22	Psychiatric hospital or unit	283Q00000X	Retarded
		273R00000X	Psychiatric Hospital
33	Tuberculosis and other respiratory diseases	281P00000X	Psychiatric Unit
44	Obstetrics and Gynecology	282NW0100X	Chronic Disease Hospital
45	Eye, Ear, Nose, and Throat	284300000X	Women (General Acute Care Hospital - main category)
46	Rehabilitation	283X00000X	Special Hospital
47	Orthopedic	284300000X	Rehabilitation Hospital
48	Chronic Disease	281P00000X	Special Hospital
49	Other Specialty	284300000X	Chronic Disease Hospital
50	Children's General	282NC2000X	Special Hospital
51	Children's Hospital Unit of an Institution	282NC2000X	Children General Acute Care Hospital
		283Q00000X	Children General Acute Care Hospital
52	Children's Psychiatric Hospital or Unit of	273R00000X	Psychiatric Hospital
		281PC2000X	Psychiatric Unit
53	Children's tuberculosis and other respiratory disease	281PC2000X	Psychiatric Unit
55	Children's eye, ear, nose, and throat	284300000X	Children Chronic Disease Hospital
56	Children's rehabilitation	273Y00000X	Special Hospital
57	Children's Orthopedic	284300000X	Rehabilitation Unit
58	Children's Chronic	281PC2000X	Special Hospital
59	Children's Other Specialty	284300000X	Children Chronic Disease Hospital
62	Institution for Mental Retardation	320600000X	Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities

This table should be used as a reference when assigning Provider Major Specialty Codes to Outpatient Hospital Non-Institutional Provider Records and Outpatient Hospital Non-Institutional TED records.

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Chapter 2, Addendum C

Data Requirements - Provider's Major Specialty Codes

FIGURE 2.C-1 PROVIDER MAJOR SPECIALTY CODES FOR USE ON NON-INSTITUTIONAL TED RECORDS FOR OUTPATIENT HOSPITAL CARE (CONTINUED)

TYPE OF INSTITUTION		PROVIDER MAJOR SPECIALTY	
CODE	DESCRIPTION	CODE	DESCRIPTION
70	Home Health Agency	251E00000X	Home Health Agency
71	Specialized Treatment Facility	284300000X	Special Hospital
72	Residential Treatment Center	322D00000X	Residential Treatment Facility, Emotionally Disturbed Children
73	Extended Care Facility	313M00000X	Nursing Facility/Intermediate Care Facility
74	Christian Science Facility	287300000X	Christian Science Sanitarium (hospital services)
75	Hospital-Based Ambulatory Surgery Center	261QA1903X	Ambulatory Surgical
76	Skilled Nursing Facility	314000000X	Skilled Nursing Facility
78	Non-Hospital-Based Hospice	251G00000X	Hospice Care, Community Based
79	Hospital-Based Hospice	315D00000X	Hospice, Inpatient
82	Substance Use Disorders Rehabilitation Facility (SUDRF)	276400000X	Rehabilitation, Substance Use Disorder Unit
90	Cancer	284300000X	Special Hospital
91	Sole Community	282N00000X	General Acute Care Hospital
92	Freestanding Ambulatory Surgery Center	261QA1903X	Ambulatory Surgical

This table should be used as a reference when assigning Provider Major Specialty Codes to Outpatient Hospital Non-Institutional Provider Records and Outpatient Hospital Non-Institutional TED records.

- END -

Data Requirements - Place Of Service/Type Of Service Allowable Relationships

FIGURE 2.F-1 PLACE OF SERVICE CODES

PLACE OF SERVICE CODE	TYPE OF SERVICE CODE(S) ALLOWED (SECOND POSITION VALUES)
03	1, 2, 3, 4, 5, 7, 9, A, B, F, H, K, L
04	1, H
05	1, 2, 3, 4, 5, 6, 7, 8, 9, A, B, C, D, E, F, G, H, J, K, L
06	1, 2, 3, 4, 5, 6, 7, 8, 9, A, B, C, D, E, F, G, H, J, K, L
07	1, 2, 3, 4, 5, 6, 7, 8, 9, A, B, C, D, E, F, G, H, J, K, L
08	1, 2, 3, 4, 5, 6, 7, 8, 9, A, B, C, D, E, F, G, H, J, K, L
09	1, 2, 3, 4, 5, 6, 7, 8, 9, A, B, C, D, E, F, G, H, I, J, K, L, M
11	1, 2, 3, 4, 5, 6, 7, 9, A, C, E, F, G, H, J, K, L
12	1, 2, 3, 4, 5, 6, 7, 8, 9, A, D, F, J, H, K, L
13	1, 2, I, H, K
14	1, 2, I, H, K
15	1, 2, 3, 4, 5, 6, 7, 9, A, C, E, F, G, H, J, K, L
19	B, M
20	1, 2, 3, 4, 5, 6, 7, 9, A, C, E, F, G, H, J, K, L
21	1, 2, 3, 4, 5, 6, 7, 8, 9, E, F, G, H, K, L
22	1, 2, 3, 4, 5, 6, 7, 8, 9, A, C, E, F, G, H, I, J, K, L
23	1, 2, 3, 4, 5, 6, 7, 9, A, C, E, F, G, H, J, K, L
24	1, 2, 3, 4, 5, 6, 7, 8, 9, A, C, F, G, H, K
25	1, 2, 3, 4, 5, 7, 9, F
26	1, 2, 3, 4, 5, 6, 7, 8, 9, A, C, E, F, G, H, I, J, K, L
31	1, 2, 3, 4, 5, 9, A, E, H, J, K, L
32	1, 2, 3, 4, 5, 9, A, E, H, J, K, L
33	1, 2, 3, 4, 5, 9, A, E, H, J, K, L
34	1, 2, 3, 9, A, D
41	1, 9, A, F, I, J
42	1, 9, A, I
49	1, 2, 3, 4, 5, 6, 7, 9, A, C, D, E, F, G, H, J, K, L
50	1, 2, 3, 4, 5, F, H
51	1, 2, 3, 4, 5, 7, 9, H, K, L
52	1, 3, 4, 5, 9, H, J, K, L
53	1, 3, 4, 5, 9, H, K, L

This table is used in edit 2-275-01V.

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 2, Addendum F

Data Requirements - Place Of Service/Type Of Service Allowable Relationships

FIGURE 2.F-1 PLACE OF SERVICE CODES (CONTINUED)

PLACE OF SERVICE CODE	TYPE OF SERVICE CODE(S) ALLOWED (SECOND POSITION VALUES)
54	1, 2, 3, 4, 5, 9, A, H, J, K, L
55	1, 3, 4, 5, 9, H, J, K, L
56	1, 3, 9, H, K, L
57	1, 3, 5, 9, H
60	1, 9, B
61	1, 2, 3, 4, 5, 9, A, B, H, J, K, L
62	1, 2, 3, 4, 5, 9, A, H, J, K, L
65	1, 2, 3, 4, 5, 6, 9, A, E, J
71	1, 2, 3, 4, 5, 6, 7, 8, 9, E, F, G, H, J, K, L
72	1, 2, 3, 4, 5, 6, 7, 8, 9, E, F, G, H, J, K, L
81	1, 2, 4, 5, 9, F
99	1, 2, 3, 4, 5, 6, 7, 8, 9, A, B, C, D, E, F, G, H, J, K, L

This table is used in edit 2-275-01V.

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 2, Addendum G

Data Requirements - Adjustment/Denial Reason Codes

FIGURE 2.G-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
136	Failure to follow prior payer's coverage rules.
138	Appeal procedures not followed or time limits not met.
140	Patient/Insured health identification number and name do not match.
141	Claim spans eligible and ineligible periods of coverage.
146	Diagnosis was invalid for the date(s) of service reported.
147	Provider contracted/negotiated rate expired or not on file.
148	Information from another provider was not provided or was insufficient/incomplete.
149	Benefit maximum for this time period or occurrence has been reached.
155	Patient refused the service/procedure.
166	These services were submitted after this payers responsibility for processing claims under this plan ended.
167	This (these) diagnosis(es) is (are) not covered.
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.
170	Payment is denied when performed/billed by this type of provider.
171	Payment is denied when performed/billed by this type of provider in this type of facility.
174	Service was not prescribed prior to delivery.
175	Prescription is incomplete.
176	Prescription is no current.
177	Patient has not met the required eligibility requirements.
181	Procedure code was invalid on the date of service.
182	Procedure modifier was invalid on the date of service.
183	The referring provider is not eligible to refer the service billed.
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.
185	The rendering provider is not eligible to perform the service billed.
188	This product/procedure is only covered when used according to FDA recommendations.
191	Not a work related injury/illness and thus not the liability of the Worker's Compensation carrier.
196	Claim/service denied based on prior payer's coverage determination.
199	Revenue code and procedure code do not match.
200	Expenses incurred during lapse in coverage.
201	Worker's Compensation (WC) case settled. Patient is responsible for amount of this claim/ service through WC "Medicare set aside arrangement" or other agreement.
202	Non-covered personal comfort or convenience services.
204	Payment adjusted for discontinued or reduced service.
206	National Provider Identifier - missing.
207	National Provider Identifier - Invalid format.
208	National Provider Identifier - Not matched.
213	Non-compliance with the physician self-referral prohibition legislation or payer policy.
214	Worker's Compensation claim adjudicated as non-compensable.

HIPAA Adjustment Reason Codes Release 11/05/2007.

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 2, Addendum G

Data Requirements - Adjustment/Denial Reason Codes

FIGURE 2.G-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
220	The applicable fee schedule does not contain the billed code.
A1	Claim/service denied.
A6	Prior hospitalization or 30 day transfer requirement not met.
A8	Ungroupable DRG.
B1	Non-covered visits.
B5	Coverage/program guidelines were not met or were exceeded.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B9	Patient is enrolled in a Hospice.
B12	Services not documented in patients' medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Only one visit or consultation per physician per day is covered.
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
B18	This procedure code and modifier were invalid on the date of service.
B20	Procedure/service was partially or fully furnished by another provider.
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.
D1	Claim/service denied. Level of subluxation is missing or inadequate.
D2	Claim lacks the name, strength, or dosage of the drug furnished.
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.
D4	Claim/service does not indicate the period of time for which this will be needed.
D5	Claim/service denied. Claim lacks individual lab codes included in the test.
D6	Claim/service denied. Claim did not include patient's medical record for the service.
D7	Claim.service denied. Claim lacks date of patient's most recent physician visit.
D8	Claim/service denied. Claim lacks indicator that 'x-ray is available for review.'
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.
D10	Claim/service denied. Completed physician financial relationship form not on file.
D11	Claim lacks completed pacemaker registration form.
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test of the amount you were charged for the test.
D13	Claim/service denied. Performed by the facility/supplier in which the ordering/referring physician has a financial interest.
D14	Claim lacks indication that plan of treatment is on file.
D15	Claim lacks indication that service was supervised or evaluated by a physician.
D16	Claim lacks prior payer payment information.

HIPAA Adjustment Reason Codes Release 11/05/2007.

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 2, Addendum G

Data Requirements - Adjustment/Denial Reason Codes

FIGURE 2.G-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
D17	Claim/Service has invalid non-covered days.
D18	Claim/Service has missing diagnosis information.
D19	Claim/Service lacks Physician/Operative or other supporting documentation.
D20	Claim/Service missing service/product information.
D21	This (these) diagnosis(es) is (are) missing or are invalid.

HIPAA Adjustment Reason Codes Release 11/05/2007.

TRICARE Systems Manual 7950.2-M, February 1, 2008

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Data Requirements - Adjustment/Denial Reason Codes

FIGURE 2.G-2 DENIAL/ADJUSTMENT CODES

ADJUST/DENIAL REASON CODE	DESCRIPTION
23	The impact of prior payer(s) adjudication including payments and/or adjustments.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
59	Processed based on multiple or concurrent procedure rules.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
63	Correction to prior claim.
65	Procedure code was incorrect. This payment reflects the correct code.
78	Non-Covered days/Room charge adjustment.
93	No Claim Level Adjustments.
95	Plan procedures not followed.
108	Rent/purchase guidelines were not met.
117	Transportation is only covered to the closest facility that can provide the necessary care.
120	Patient is covered by a managed care plan.
125	Submission/billing error(s).
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
150	Payer deems the information submitted does not support this level of services.
151	Payer deems the information submitted does not support this many services.
152	Payer deems the information submitted does not support this length of service.
153	Payer deems the information submitted does not support this dosage.
154	Payer deems the information submitted does not support this day's supply.
157	Service/procedure was provided as a result of an act of war.
158	Service/procedure was provided outside of the United States.
159	Service/procedure was provided as a result of terrorism.
160	Injury/illness was the result of an activity that is a benefit exclusion.
163	Attachment referenced on the claim was not received.
164	Attachment referenced on the claim was not received in a timely fashion.
165	Referral absent or exceeded.
169	Alternate benefit has been provided.
172	Payment is adjusted when performed/billed by a provider of this specialty.
173	Service was not prescribed by a physician.
178	Patient has not met the required spend down requirements.
179	Patient has not met the required waiting requirements.
180	Patient has not met the required residency requirements.
186	Level of care change adjustment.
189	Not otherwise classified or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.

HIPAA Adjustment Reason Codes Release 11/05/2007.

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Data Requirements - Adjustment/Denial Reason Codes

FIGURE 2.G-2 DENIAL/ADJUSTMENT CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
193	Original payment decision is being maintained. This claim was processed properly the first time.
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.
195	Refund issued to an erroneous priority payer for this claim/service.
197	Precertification/authorization/notification absent.
198	Precertification/authorization exceeded.
203	Discontinued or reduced service.
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected.
210	Payment adjusted because precertification/authorization not received in a timely fashion.
211	National Drug Codes (NDCs) not eligible for rebate, are not covered.
212	Administrative surcharges are not covered.
215	Based on subrogation of a third party settlement.
216	Based on the findings of a review organization.
217	Based on the payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
218	Based on the entitlement to benefits.
219	Based on extent of injury.
221	Worker's Compensation claim is under investigation.
A3	Medicare Secondary Payer liability met.
B4	Late filing penalty.
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.
B8	Alternative services were available, and should have been utilized.
B16	'New Patient' qualifications were not met.
B19	Claim/Service adjusted because of the finding of a Review Organization.
B21	The charges were reduced because the service/care was partially furnished by another physician.
B22	This payment is adjusted based on the diagnosis.
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence.

HIPAA Adjustment Reason Codes Release 11/05/2007.

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Data Requirements - Adjustment/Denial Reason Codes

FIGURE 2.G-3 ADJUSTMENT/REMARK CODES

ADJUST/DENIAL REASON CODE	DESCRIPTION
1	Deductible amount
2	Coinsurance amount
3	Copayment amount
36	Balance does not exceed copayment amount.
37	Balance does not exceed deductible.
41	Discount agreed to in Preferred Provider contract.
42	Charges exceed our fee schedule or maximum allowable amount.
43	Gramm-Rudman reduction.
44	Prompt-pay discount.
45	Charges exceed fee schedule/maximum allowable or contracted/ legislated fee arrangement.
61	Penalty for failure to obtain second surgical opinion.
64	Denial reversed per Medical Review.
66	Blood Deductible.
67	Lifetime reserve days. (Handled in QTY, QTY01=LA)
68	DRG weight. (Handled in CLP12)
69	Day outlier amount.
70	Cost outlier amount - Adjustment to compensate for additional costs.
71	Primary Payer amount.
72	Coinsurance day. (Handled in QTY, QTY01=CD)
73	Administrative days.
74	Indirect Medical Education (IDME) Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
77	Covered days. (Handled in QTY, QTY01=CA)
79	Cost Report days. (Handled in MIA15)
80	Outlier days. (Handled in QTY, QTY01=OU)
81	Discharges.
82	PIP days.
83	Total Visits.
84	Capital Adjustment. (Handled in MIA)
85	Patient Interest Adjustment.
86	Statutory Adjustment.
87	Transfer amount.
88	Adjustment amount represents collection against receivable created in prior overpayment.
90	Ingredient cost adjustment.
91	Dispensing fee adjustment.
92	Claim Paid in full.
94	Processed in Excess of charges.

HIPAA Adjustment Reason Codes Release 11/05/2007.

Data Requirements - Revenue Codes

CODES	MAJOR/SUB-CATEGORY
0001	Total Charge
001X	RESERVED
002X	Health Insurance - Prospective Payment System (HIPPS)
	Subcategory
	2 Skilled Nursing Facility (SNF PPS)
	3 Home Health Agency (HHA PPS)
	4 Inpatient Rehab Facility (REHAB PPS) (Effective 10/16/2003)
003X TO 006X	RESERVED for National Assignment
007X TO 009X	RESERVED for National Assignment
010X	All Inclusive Rate
	Flat fee charge incurred on either a daily basis or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.
	Subcategory
	0 All-Inclusive Room and Board Plus Ancillary
	1 All-Inclusive Room and Board
011X	Room and Board - Private Medical or General
	Routine service charges for single bed rooms.
	Subcategory
	0 General Classification
	1 Medical/Surgical/Gyn
	2 OB
	3 Pediatric
	4 Psychiatric
	5 Hospice
	6 Detoxification
	7 Oncology
	8 Rehabilitation
	9 Other

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Data Requirements - Revenue Codes

CODES	MAJOR/SUB-CATEGORY (CONTINUED)
012X	Room and Board - Semi-Private Two Bed (Medical or General)
	Routine service charges incurred for accommodations with two beds.
	Subcategory
	0 General Classification
	1 Medical/Surgical/Gyn
	2 OB
	3 Pediatric
	4 Psychiatric
	5 Hospice
	6 Detoxification
	7 Oncology
	8 Rehabilitation
	9 Other
013X	Semi-Private - Three and Four Beds
	Routine service charges incurred for accommodations with three and four beds.
	Subcategory
	0 General Classification
	1 Medical/Surgical/Gyn
	2 OB
	3 Pediatric
	4 Psychiatric
	5 Hospice
	6 Detoxification
	7 Oncology
	8 Rehabilitation
	9 Other
014X	Private (Deluxe)
	Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.
	Subcategory
	0 General Classification
	1 Medical/Surgical/Gyn
	2 OB
	3 Pediatric
	4 Psychiatric
	5 Hospice
	6 Detoxification
	7 Oncology
	8 Rehabilitation
	9 Other

Data Requirements - MTF Enrolling DMIS-IDs

FIGURE 2.0-1 NORTH CONTRACT ENROLLING DMIS-IDS

DMIS-ID	MILITARY TREATMENT FACILITY	STATE	REGION	BRANCH OF SERVICE
0035	NACC GROTON	RI	NORTH	NAVY
0036	436TH MED GRP - DOVER	DE	NORTH	USAF
0037	WALTER REED ARMY MEDICAL CENTER	DC	NORTH	ARMY
0055	375TH MED GRP - SCOTT	IL	NORTH	USAF
0056	NH GREAT LAKES	IL	NORTH	NAVY
0060	BLANCHFIELD ACH	KY	SOUTH	ARMY
0061	IRELAND ACH	KY	NORTH	ARMY
0066	89TH MED GRP - ANDREWS	MD	NORTH	USAF
0067	NNMC BETHESDA	MD	NORTH	NAVY
0068	NMCL PATUXENT RIVER	MD	NORTH	NAVY
0069	KIMBROUGH AMBULATORY CARE CENTER	MD	NORTH	ARMY
0081	PATTERSON AHC	NJ	NORTH	ARMY
0086	KELLER ACH	NY	NORTH	ARMY
0089	WOMACK AMC	NC	NORTH	ARMY
0090	4TH MED GRP - SEYMOUR JOHNSON	NC	NORTH	USAF
0091	NH CAMP LEJUENE	NC	NORTH	NAVY
0092	NH CHERRY POINT	NC	NORTH	NAVY
0095	54TH MED GRP - WRIGHT PATTERSON	OH	NORTH	USAF
0100	NACC NEWPORT	RI	NORTH	NAVY
0120	1ST MED GRP - LANGLEY	VA	NORTH	USAF
0121	MCDONALD ACH	VA	NORTH	ARMY
0122	KENNER AHC	VA	NORTH	ARMY
0123	DEWITT ACH	VA	NORTH	ARMY
0124	NMC PORTSMOUTH	VA	NORTH	NAVY
0255	MCNAIR AHC	DC	NORTH	ARMY
0256	DILORENZO TRICARE HEALTH CLINIC	DC	NORTH	ARMY
0259	NBMC NRL WASHINGTON	MD	NORTH	NAVY
0290	ROCK ISLAND ARSENAL AHC	IL	NORTH	ARMY
0296	BLUE GRASS DEPOT AHC	KY	NORTH	ARMY
0298	NBMC WINTER HARBOR	RI	NORTH	NAVY
0299	NBMC NAS BRUNSWICK	RI	NORTH	NAVY
0301	NBMC INDIAN HEAD	MD	NORTH	NAVY
0302	NBMC CARDEROCK	MD	NORTH	NAVY

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Data Requirements - MTF Enrolling DMIS-IDs

FIGURE 2.O-1 NORTH CONTRACT ENROLLING DMIS-IDS (CONTINUED)

DMIS-ID	MILITARY TREATMENT FACILITY	STATE	REGION	BRANCH OF SERVICE
0306	NMCL ANNAPOLIS	MD	NORTH	NAVY
0308	KIRK AHC	MD	NORTH	ARMY
0309	AHC FT. DETRICK	MD	NORTH	ARMY
0310	66TH MED GRP - HANSCOM	MA	NORTH	USAF
0311	NATICK AHC	MA	NORTH	ARMY
0313	SELFRIIDGE AHC	MI	NORTH	ARMY
0321	NACC PORTSMOUTH NH	RI	NORTH	NAVY
0322	NBMC COLTS NECK EARLE	MD	NORTH	NAVY
0325	PICATINNY ARESNAL AHC	NJ	NORTH	ARMY
0326	305TH MED GRP - MCGUIRE	NJ	NORTH	USAF
0328	NBMC BALLSTON SPA	RI	NORTH	NAVY
0329	AHC WATERVLIT	NY	NORTH	ARMY
0330	GUTHRIE AHC	NY	NORTH	ARMY
0333	NBMC MCAS NEW RIVER	NC	NORTH	NAVY
0335	43RD MED GRP - POPE AFB	NC	NORTH	ARMY
0344	NBMC PHILADELPHIA NAVAL BUSINESS CENTER	MD	NORTH	NAVY
0347	NBMC WILLOW GROVE	MD	NORTH	NAVY
0348	NBMC MECHANICSBURG	MD	NORTH	NAVY
0350	INDIANTOWN GAP AHC	PA	NORTH	ARMY
0351	LETTERKENNY ARMY DEPOT AHC	PA	NORTH	ARMY
0352	DUNHAM AHC	PA	NORTH	ARMY
0353	TOBYHANNA ARMY DEPOT AHC	PA	NORTH	ARMY
0372	MONROE AHC	VA	NORTH	ARMY
0373	AHC DEF GEN SUP CNTR	VA	NORTH	ARMY
0374	AHC FT. PICKETT	VA	NORTH	ARMY
0375	AP HILL AHC	VA	NORTH	ARMY
0378	NBMC LITTLE CREEK	VA	NORTH	NAVY
0380	NBMC NSY NORFOLK	VA	NORTH	NAVY
0381	NBMC YORK TOWN	VA	NORTH	NAVY
0382	NBMC DAM NECK	VA	NORTH	NAVY
0385	NMCL QUANTICO	VA	NORTH	NAVY
0386	NBMC DAHLGREN	MD	NORTH	NAVY
0387	NBMC OCEANA	VA	NORTH	NAVY
0390	ANDREW RADER AHC	VA	NORTH	ARMY
0401	NBMC LAKEHURST	MD	NORTH	NAVY
0404	NBMC SUGAR GROVE	MD	NORTH	NAVY
0413	11TH MED GRP - BOLLING	DC	NORTH	USAF
0438	HAMILTON AINESWORTH AHC	NY	NORTH	ARMY
0441	NEW CUMBERLAND ARMY DEPOT AHC	PA	NORTH	ARMY

Interface Overview

1.0 OPERATIONAL POLICIES AND CONSTRAINTS

The Defense Enrollment Eligibility Reporting System (DEERS) and its interfacing systems operate under the following policies and constraints:

- Standard Provider, Payer, and Patient IDs will be used, as legislated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) when these IDs are mandated for implementation.

2.0 SYSTEM DESCRIPTION

2.1 Interface

DEERS supports various interfaces to systems within the Military Health System (MHS) and outside the MHS including the Center For Medicare and Medicaid Services (CMS) and the state Medicaid agencies.

Major communities that DEERS interfaces with include:

- Composite Health Care System (CHCS)
- DoD service personnel systems
- MHS clinical systems
- Clinical Data Repository (CDR)
- Managed Care Support Contractors (MCSCs)/claims processors
- Uniformed Services Family Health Plan (USFHP) Providers
- Beneficiary Services Officers worldwide via the General Inquiry of DEERS (GIQD) application
- Pharmacy Data Transaction System (PDTS)
- Continued Health Care Benefit Program (CHCBP) administrator
- TRICARE Dental contractors
- Department of Veterans Affairs (DVA)
- TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC)
- Other organizations as identified

2.2 DEERS Operational Environment and Characteristics

The DEERS system environment consists of a Relational Database Management System (RDBMS), rules-based applications processing DoD entitlements and eligibility, a Transmission Control Protocol/Internet Protocol (TCP/IP) sockets listener, application servers that enforce business rules, and web servers.

DEERS provides applications, web applications, web services, and system to system interfaces.

2.2.1 Web Requirements

All Defense Manpower Data Center (DMDC) web-based applications require Microsoft® Internet Explorer 6.0 or higher using https. They are all government furnished equipment.

The contractor shall use the applications for their intended use only. The contractor shall not utilize screen scraping, html stripping, and any other technology or approach to manipulate or alter the intended use of the application or the application architecture.

The DEERS Online Enrollment System (DOES) supports enrollment activities and allows entry of fee information. DOES will show all fee payments for an existing policy, as well as for policies that have ended within the last 18 months.

PCM Research Application (PCMRS) allows users to view PCMs, their capacities, and their enrolled counts.

PCM Panel Reassignment (PCMRA) allows MCSCs to reassign beneficiaries by group to other PCMs. MTFs also use PCMRA to set up group moves for execution by the MCSCs.

General Inquiry of DEERS (GIQD) is used for research and customer service to display demographics, coverage and PCM assignment information. It also allows address updates.

The Catastrophic Cap and Deductible Research and Enrollment Fee Payment Transaction Research Application (CCD Web Research) supports research **and allows limited updates** on the history of CC&D and enrollment fee payment transactions posted to DEERS and stored on-line (current plus previous **four** fiscal years).

The OHI Maintenance Application is used by MCSCs, USFHP, pharmacy, and CHCS. It allows add, update, and cancellation of OHI policies as well as Standard Insurance Table (SIT) carrier adds, updates, cancellations and deactivations.

The SIT Verification Application is used exclusively by the TRICARE Management Activity (TMA) Uniform Business Office Verification Point of Contact (VPOC). The application queues all SIT transactions entered through the OHI Maintenance Application for review and verification by the VPOC.

The Security application is used by the MCSC/USFHP site security manager to establish users and grant access to applications and other privileges. The MCSC/USFHP is responsible for designating a primary site security manager and one backup to manage all users and their access to DEERS applications. The appointed Site Security Manager (SSM) and alternate are required to complete an on-line training certification at initial appointment and yearly thereafter. All SSMs are required to remove access to all DEERS systems immediately upon departure of an employee from performing the function.

The DMDC Support Office Web Request (DWR) application is used by the MCSCs/USFHP to report potential data problems or request historical enrollment corrections that cannot be

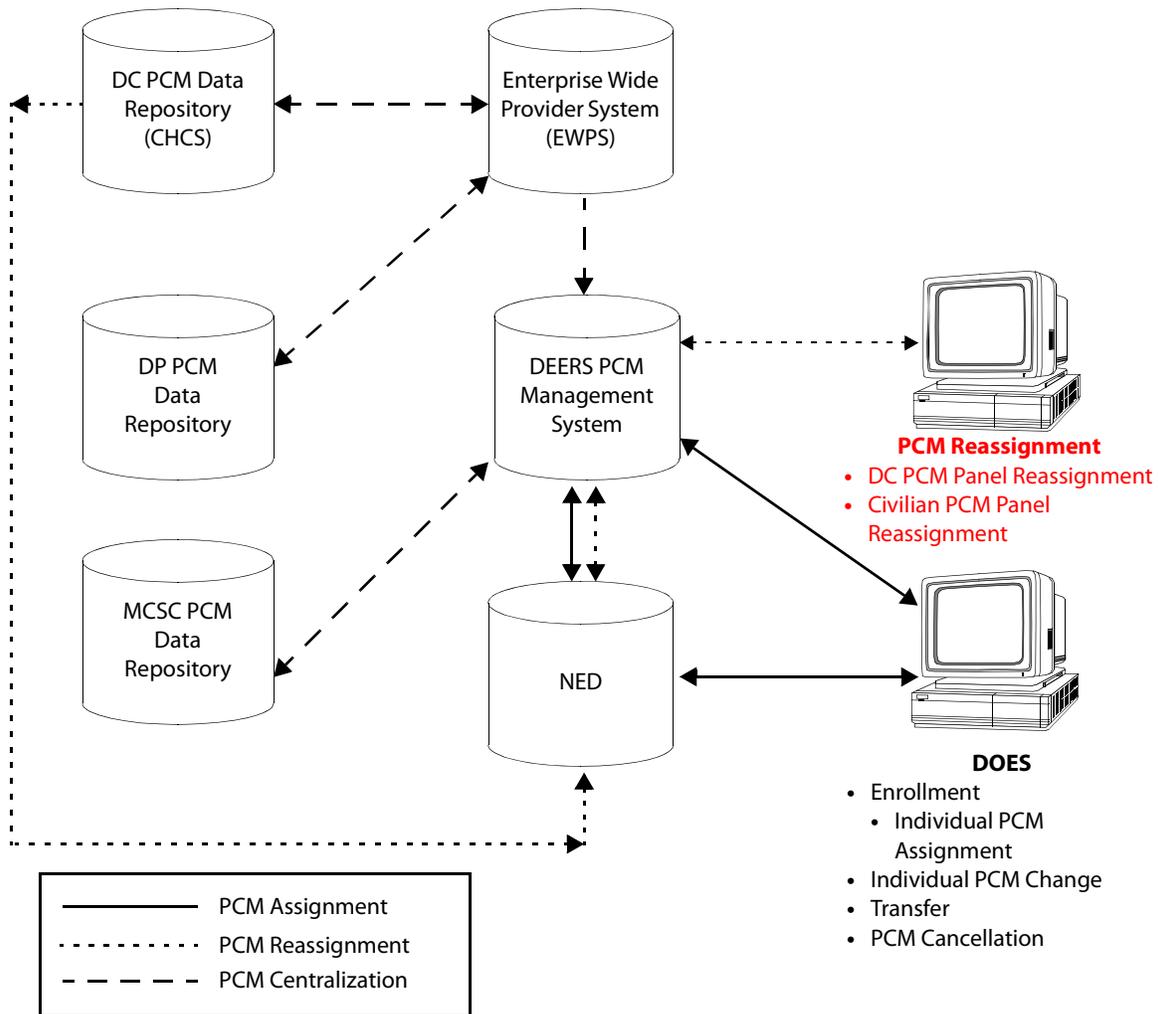
Panel changes that cross Composite Health Care System (CHCS) platforms must be coordinated not only with the contractor but with the designated TRICARE Management Activity (TMA) Representative and DEERS.

Emergency moves may be coordinated by the MTF with the MCSC by the best available means, including phone, fax, or secure e-mail.

1.2.7.2.2 Civilian Panel Reassignment

DMDC provides a web application to allow contractors to perform mass reassignments of a civilian PCM's enrollees. There is an option to suppress the PCM change letters for civilian PCM panel reassignments.

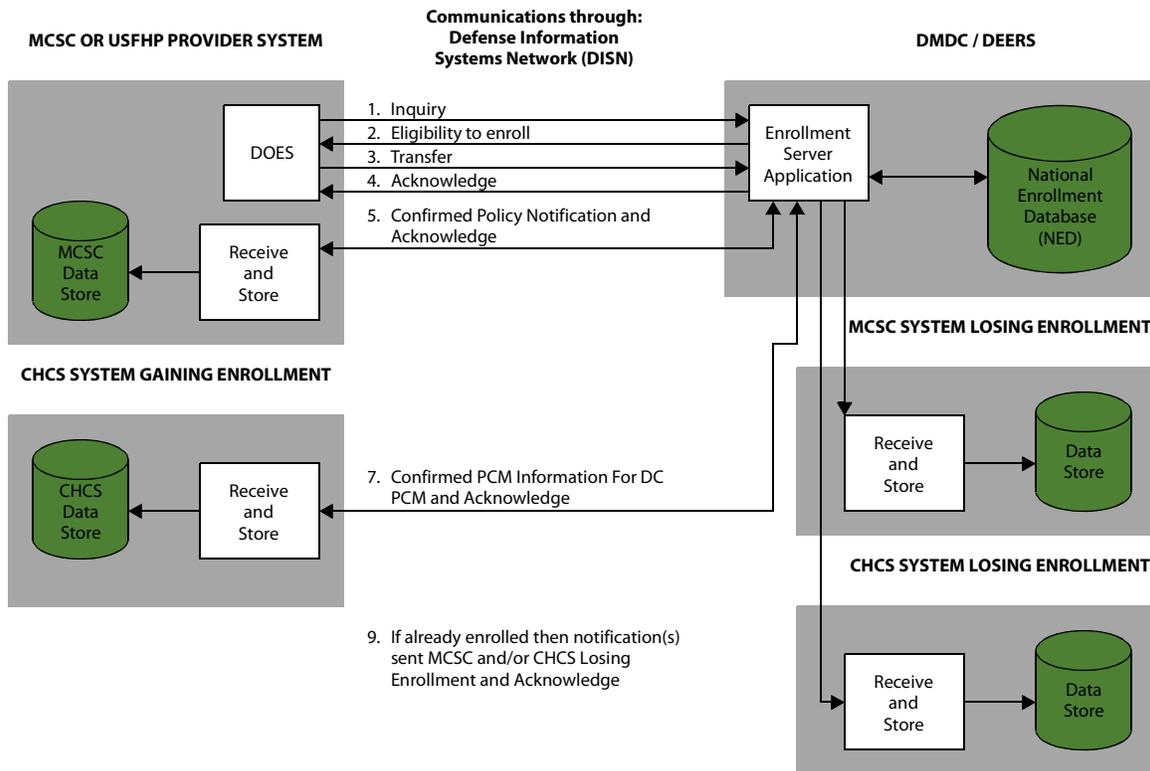
FIGURE 3.1.4-6 PCM ASSIGNMENT PROCESS



1.2.7.3 Transfer Of Enrollment And Transfer Cancellation

A transfer of enrollment moves the enrollment from one contract to another and thus moves the responsibility for the administration of the enrollment to the gaining contractor. DEERS supports transfers within plans (e.g., TRICARE Prime). A transfer may include a change to the Health Care Coverage (HCC) plan in some cases, such as TRICARE Prime for ADSMs to TPR for ADSMs. DEERS will enforce when such transfers are allowed.

FIGURE 3.1.4-7 ENROLLMENT TRANSFER PROCESS



If an enrollment transfer is performed in error, a transfer cancellation may be performed. This action results in reinstatement of the enrollment with the previous enrolling organization and the previous PCM.

1.2.7.4 Enrollment Period Change

This event is used to update an enrollee's begin or end date. Modifications can only be performed by the enrolling organization responsible for managing the enrollment. A contractor may change the enrollment end date only after performing a disenrollment. If the enrollment end date is the same as the loss of eligibility date, the user is not allowed to change the end date to a later date. DEERS changes the date range for the applicable PCM selection and policy to correspond with the new end dates if necessary.

If a person's eligibility in DEERS changes and affects an enrollment because the eligibility

period is either greater or less than originally stated, DEERS updates the enrollment period and pushes the PCM and policy changes to the appropriate systems managing the enrollment.

1.2.7.5 Enrollment End Reason Change

Disenrollments can be done for various reasons and are mostly done by enrolling organizations. If a disenrollment is performed by an enrolling organization using an incorrect end reason code, the end reason code can be updated. Enrolling organizations enter an end date that precedes the date of loss of eligibility.

1.2.7.6 Enrollment/Disenrollment Cancellation

1.2.7.6.1 Enrollment cancellations can only be performed by the enrolling organization. An enrollment cancellation completely removes the enrollment from DEERS and it will not be shown on subsequent inquiries. Assuming that the beneficiary is still eligible, the prior enrollment and PCM will be reinstated if there was a contiguous change of plan (family to individual or Prime to TPR).

1.2.7.6.2 Disenrollment cancellations can only be performed by the enrolling organization. A disenrollment cancellation removes the disenrollment event and reinstates the enrollment and PCM assignment as if the disenrollment never occurred.

1.2.8 Enrollment Fees And Enrollment Fee Waivers

DEERS records and displays enrollment fee payment information and returns accumulated enrollment fee payment information by policy for the enrollment year in DOES.

DEERS provides a number of applications to support enrollment-fee-related transactions:

- Enrollment Fee Payment (Fee/CCDD Web Research application and Fee Interface)
- Update an enrollee's free-rider code (DOES)
- Terminate Policy For Failure To Pay Fees (DOES and Fee Interface)

DEERS will automatically set enrollment fee waivers for a policy based on the following events:

- Sponsor served in Bosnia
- One or more enrollees have Medicare Parts A and B
- The family has met their catastrophic cap
- Mid-month retiree enrollment

Fee waivers are stored at the family level. DEERS will provide the reason for fee waiver, whether it applies to one enrollee in the policy or more than one enrollee, and the begin and end dates, a status code, and status date associated to that waiver on the PNT. The status code indicates whether the waiver is active or inactive. Inactive waivers reflect waiver information that is no longer applicable because there has been a change to the fee waiver entitlement. Inactive waivers do not have an effect on the determination of fees due for the policy and are for audit purposes only. **A fee waiver that indicates that a family has met their fiscal year catastrophic cap limit will be considered inactive if the fee waiver end date is not September 30th of the fiscal year for which the waiver**

exists. All waiver data is displayed in the Fee/CCDD Web Research application.

1.2.8.1 Enrollment Fee Payment

Enrollment fees may be paid monthly, quarterly, or annually. The beneficiary specifies this payment option during enrollment and the contractor shall enter the fee information in the fee interface as part of the enrollment transaction. Contractors shall update DEERS with all subsequent enrollment fee payments and shall update a fee paid-through date for each. They shall transmit this information, including any credits to DEERS within one business day. With the exception of claims recoupments, all monetary receipts from beneficiaries must be treated as fee payments and reported to DEERS either as fee payments or credits, unless they are refunded to the beneficiary. There is no option to retain such records in the contractor's system. The contractor's system shall be able to process fee refunds as necessary.

DEERS will automatically apply any fee payments and adjustments posted through DOES or the Enrollment Fee Payment interface to the beneficiary's catastrophic cap. For individual policies, the beneficiary will be credited with the fee amount; for family policies, the fee will be posted under the sponsor's catastrophic cap. If the catastrophic cap is locked at the time the fee payment is sent, DEERS will reject the fee payment. The contractor shall resend the fee amount to DEERS daily until it is accepted. If the record remains locked longer than 48 hours, the contractor should contact the claims processor that placed the lock to determine the reason for the lock and when it will be released.

The enrollment fee payment interface perform edits against the submitted fee data. The contractor shall research and correct any data discrepancies identified by DEERS (both warnings and errors) within three business days.

DEERS records both the enrollment fee payment date and the enrollment fee paid-through date. The enrollment fee payment date reflects the date the fee was received by the contractor. The enrollment fee paid-through date reflects the last date for which coverage is paid. The purpose of tracking the paid-through date is to ensure portability. On an enrollment transfer, DEERS includes the fee information from the enrollee's policy on the notification to the new contractor.

DEERS does not prorate fees, determine the amount of the next enrollment fee payment, determine the date of the next enrollment fee payment, send enrollment fee payment due notifications, or identify which entity is responsible for enrollment fee payments. These actions are the responsibility of the enrolling organization. Additionally, the enrolling organization must be able to accommodate policies that are less than 12 months in length and prorate enrollment fees appropriately.

DEERS will automatically apply any fee payments posted through the Enrollment Fee Payment interface to the catastrophic cap.

1.2.8.2 Fee Payments Interface

The contractor will send enrollment fee payment information to DEERS through a system-to-system interface. This interface includes new payments, payment adjustments, and updates to paid-through dates. Contractors must correct and resubmit enrollment fee payments rejected by

DEERS or research, correct and resubmit fee payments for which DEERS has provided a warning within three business days of the error.

1.2.8.3 TRICARE Reserve Select (TRS) Premium Payments

For the TRS Program, DEERS will accept premium payment paid through dates. Contractors are required to submit paid through dates to DEERS upon receipt of premium payments. Contractors will refund all overpayments of premiums to the TRS member. In the event the TRS member moves from one region to another region, billings for premiums shall be initiated on the first day of the next month with coverage effective the first day following the previous paid through date. In the event of a delinquent account, billing notification and delinquency actions may be required of the gaining contractor prior to the next billing cycle. Transfers shall not be initiated except upon notification by the TRS member of an address change to the contractor.

At a date to be determined later, contractors shall submit premium payment amounts received, including any overpayments, to DEERS. As with any other enrollment fee or premium payment, overpayments are considered part of the fee or premium amount that must be reported to DEERS.

Note: TRS premium payments are not applicable to the FY Catastrophic Cap.

1.2.8.4 Enrollment Fee Waivers

DEERS will automatically maintain fee waiver entitlement data for families. Multiple fee waiver entitlements may exist at the same time (i.e., the family has a waiver for Medicare at the same time that they have met the catastrophic cap for part of a fiscal year). DEERS will supply all fee waiver entitlements, and the contractor is responsible for calculating fees due based on all waiver entitlement data.

When new enrollments are processed, certain fee waiver entitlements will be immediately available on the enrollment PNT. Under certain circumstances (i.e., mid-month enrollments), the enrollment data will be processed and a PNT is sent prior to the calculation of the fee waiver entitlements. In such cases, a subsequent PNT will be sent immediately after the fee waiver entitlement recalculation that will include the updated waiver data.

When primary data changes in DEERS that affect fee waivers, the corresponding entitlement periods will be recalculated. If a fee waiver entitlement affects the current or future fiscal years for an active policy, DEERS will send an unsolicited notification to the most recent contractor.

Additionally, if primary data in DEERS changes that makes an existing entitlement invalid (i.e., the family going back under the catastrophic cap), the existing entitlement will be marked inactive and an unsolicited PNT will be sent to the contractor if it affects an active policy's current or future fiscal years.

1.3 Address, Telephone Number, and E-Mail Address Updates

1.3.1 Addresses

DEERS receives address information from a number of source systems. Although most systems only update the residence address, DEERS actually maintains multiple addresses for each person. The contractor shall update the residential and mailing addresses through DOES or other DEERS applications (e.g., GIQD) whenever possible. These addresses shall not reflect unit, MTF, or MCSC addresses unless provided directly by the beneficiary. The mailing address captured on DEERS is primarily used to mail the enrollment card and other correspondence. The residential address is used to determine enrollment jurisdiction at the Zip Code level. DOES uses a commercial product to validate address information received online and from batch sources.

1.3.2 Telephone Numbers

DEERS has several types of telephone numbers for a person (e.g., home, work, and fax). Contractors shall make reasonable efforts to add or update telephone numbers.

1.3.3 E-mail Addresses

DEERS can store an e-mail address for each person. Contractors shall make reasonable efforts to add or update this e-mail address.

1.4 Notifications

Notifications are sent to contractor for various reasons and reflect the most current enrollment information for a beneficiary. The contractor must accept, apply, and store the data contained in the notification as sent from DEERS. Notifications may be sent due to new enrollments or updates to existing enrollments. If the contractor does not have the information contained in the notification, the contractor shall add it to their system. If the contractor already has enrollment information for the beneficiary, the contractor shall apply all information contained in the notification to their system. The contractor shall use the DEERS ID to match the notification to the correct beneficiary in their system. There are also circumstances where a contractor may receive a notification that does not appear to be updating the information that the contractor already has for the enrollee. Such notifications shall not be treated as errors by the contractor system and must be applied. The contractor is expected to acknowledge all notifications sent by DEERS. If DEERS does not receive an acknowledgement, the notification will continue to be sent until acknowledgement is received. The following information details examples of events that trigger DEERS to send notifications to a contractor.

1.4.1 Notifications Resulting From Enrollment Actions

DEERS sends notifications to the contractor detailing any enrollment update performed in the DOES or BWE application. This includes address updates made for enrollees. Additionally, DOES supports a feature for the contractor to request a notification to be sent without updating any address or enrollment information. The purpose of this request is to re-sync the contractor systems with the latest DEERS enrollment data.

Notifications sent as a result of enrollments, transfers, or PCM changes in BWE will indicate a pending status. The contractor shall apply all pending PNTs received, as well as reviewing and either confirming, rejecting or modifying the enrollment as needed. A second notification is sent when the action is confirmed in DOES. If the DOES operator modified the enrollment or PCM data, the second notification will contain the corrected data in a non-pending status.

During transfers in BWE, one non-pending disenrollment notification is sent to the losing contractor. There is no subsequent notification sent to the losing contractor when the enrollment information is confirmed in DOES. If the transfer is cancelled before the gaining contractor approves it, the losing contractor will receive a cancellation of the disenrollment.

1.4.2 Unsolicited Notifications

Unsolicited notifications result from updates to a sponsor or family member's information made by an entity other than the enrolling contractor. Unsolicited notifications may result from various types of updates made in DEERS:

- Change to eligibility. As updates are made in DEERS that affect a beneficiary's entitlements to TRICARE benefits, DEERS modifies policy data based on those changes and sends notifications to the contractor and to CHCS, if appropriate. One example of this type of notification is notification of loss of eligibility.
- Extended Eligibility. For example, in the case of a 21-year old child that shows proof of being a full-time student, eligibility may be extended until the 23rd birthday.
- SSN, name, and date of birth changes. Updates to an enrolled sponsor or beneficiary's SSN, name, or date of birth are communicated via unsolicited notification to the contractor.
- Address changes. The notification also includes information as to which type of entity made the update. Address changes performed by CHCS are also sent to the contractor.
- Data corrections made by the DMDC Support Office (DSO) or the DOES Help Desk. If a contractor requests the DSO to make a data correction for a current or future enrollment that the contractor cannot make themselves, notification detailing the update is sent to the contractor, and to CHCS, if appropriate.
- Automatic approvals of BWE actions. DEERS will send unsolicited notifications for all BWE actions approved without contractor action in DOES.

1.5 Patient ID Merge

Occasionally, incomplete or inaccurate person data is provided to DEERS and a single person may be temporarily assigned two patient IDs. When DEERS identifies this condition, DEERS makes this information available online for all contractors. The contractor is responsible for retrieving and applying this information on a weekly basis. The merge brings the data gathered under the two IDs under only one of the IDs and discards the other. Although DEERS retains both IDs for an indefinite period, from that point on only the one remaining ID shall be used by the contractor for that person

and for subsequent interaction with DEERS and other MHS systems. If there are enrollments under both records being merged that overlap, the enrolling organizations are responsible for correcting the enrollments. The contractor shall also update the catastrophic cap that has been posted for these records if necessary. DEERS merges OHI by assigning the last updates of OHI active policies (not cancelled or systematically terminated) to the remaining Patient ID.

1.6 Enrollment Cards And Letter Production

The contractor is responsible for processing all mail returned for bad addresses and shall research the address, correct it on DEERS, and re-mail the correspondence to the beneficiary.

1.6.1 DEERS is responsible for producing the TRICARE universal beneficiary card for both Continental United States (CONUS) and Outside the Continental United States (OCONUS). The cards are produced for beneficiaries enrolled in all TRICARE Prime programs or TRICARE Reserve Select. Enrollment cards are not produced for enrollments to USFHPs.

New enrollment cards are automatically sent upon a new enrollment or an enrollment transfer to a new region, unless the enrollment operator specifies in DOES not to send an enrollment card. A contractor may request a replacement enrollment card for an enrollee at any time. DEERS sends enrollment card request information in a notification to the contractor indicating the last date an enrollment card was generated for the enrollee.

1.6.2 In addition to the enrollment card, DEERS sends a letter to the beneficiary indicating their PCM selection, if applicable. This letter is sent even if no card is generated. PCM change letters may be suppressed through both DOES and PCM Panel Reassignment (PCMRS).

DEERS also sends a letter to a beneficiary upon disenrollment. If the disenrollment is due to loss of eligibility for all MHS medical benefits, DEERS will send a Certificate of Creditable Coverage (CoCC) instead of the disenrollment letter. DEERS will send appropriate letters when the loss of eligibility is due to death of the beneficiary. The contractor shall not send additional letters that duplicate those already provided by DEERS.

1.7 Claims, Catastrophic Cap, And Deductible Data

DEERS is the system of record for eligibility and enrollment information. As such, in the process of claims adjudication, the contractor shall query DEERS to determine eligibility and/or enrollment status for a given period of time. The contractor shall use DEERS as the database of record for:

- Person Identification
- Eligibility
- Enrollment and PCM information
- Enrollment and FY to date totals for CC&D amounts
- Other Government Programs (OGP)

The contractor shall not override this data with information from other sources.

Although DEERS is not the database of record for address, it is a centralized repository that is reliant on numerous organizations to verify, update and add to at every opportunity. The address

data received as part of the claims inquiry shall be used as part of the claims adjudication process. If the contractor has evidence of additional or more current address information they shall process claims using the additional or more current information and update DEERS within two business days.

Although DEERS is not the database of record for OHI, it is a centralized repository of OHI information that is reliant on the MHS organizations to verify, update and add to at every opportunity. The OHI data received as part of the claims inquiry shall be used as part of the claims adjudication process. If the contractor has evidence of additional or more current OHI information they shall process claims using the additional or more current information. After the claims adjudication process is complete, the contractor shall send the updated or additional OHI information to DEERS within two business days.

DEERS stores enrollment and FY CC&D data in a central repository. DEERS stores the current and the four prior enrollment and FY CC&D totals. The purpose of the DEERS CCDD repository is to maintain and provide accurate CC&D amounts, making them universally accessible to DoD claims processors.

1.7.1 Data Events: Inquiries And Responses

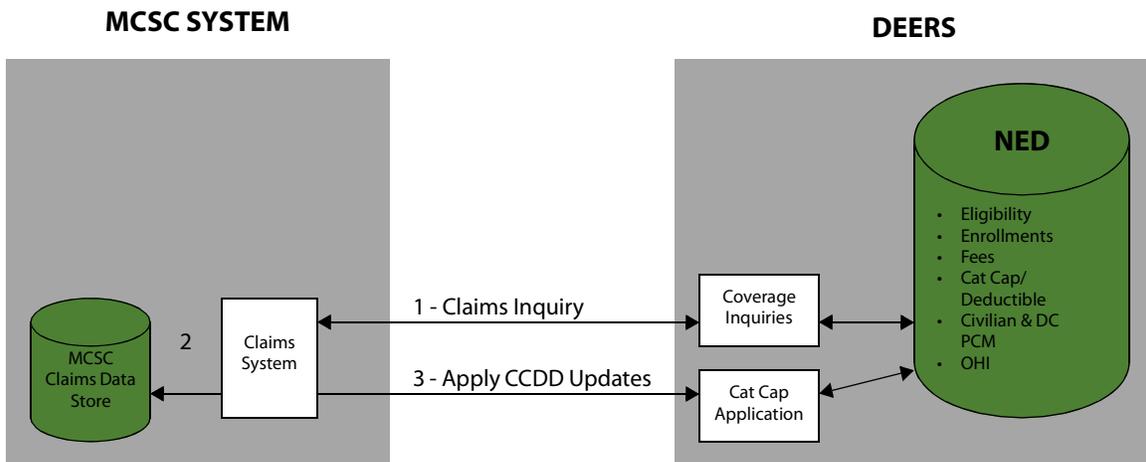
This section identifies the main events, including the inquiries and responses between the contractors and DEERS, associated with CCDD transactions. The main events to support processing this information include:

- HCC Inquiry for Claims
- CCDD Totals Inquiry
- CCDD Amounts Update
- CCDD Transaction History Request

1.7.1.1 HCC Inquiry For Claims

The contractor shall install a prepayment eligibility verification system into its TRICARE operation that results in a query against DEERS for TRICARE claims and adjustments. The interface should be conducted early in the claims processing cycle to assure extensive development/claims review is not done on claims for ineligible beneficiaries. The DEERS HCC Inquiry for Claims supports business events associated with HCC and CCDD data for processing medical claims. This inquiry may also be used for general customer service requests or for referrals and authorizations.

FIGURE 3.1.4-8 CLAIMS INQUIRY TO DEERS



The contractor must use the eligibility, enrollment, OGP (e.g., Medicare), and the PCM information returned on the DEERS response to process the claim. The contractor must use CCDD information either from this DEERS response or from a totals inquiry completed immediately prior to adjudication. The contractor may use address and OHI information from any source but must update DEERS with any differing information within two business days if the information is more current.

There are multiple options for inquiring about coverage information while including CCDD information. These different inquiry options allow the inquirer to receive coverage information and CCDD totals with or without locking the CCDD information for the family. A coverage inquiry and lock of the CCDD accumulations is necessary prior to updating this data on DEERS.

For audit and performance review purposes, the contractor is required to retain a copy of every transaction and response sent and received for claims adjudication procedures. This information is to be retained for the period required by the TRICARE Policy Manual (TPM) or TRICARE Operations Manual (TOM).

Unless authorized by the contracting officer, the contractor may not bypass the query/response process. If either DEERS or the contractor is down for 24 hours or any other extended period of time the contractor shall work directly with DEERS and TMA to develop a mutually agreeable method and schedule for processing the backlog or implementing their disaster recovery processes.

1.7.1.1.1 Exceptions To The DEERS Eligibility Query Process

Claims processing adjudication requires a query to DEERS except in cases where a claim contains only services that will be totally denied and no monies are to be applied to the CCDD. No query is needed for:

- Another claim or adjustment for the same beneficiary that is being processed at

the same time.

- Negative Adjustments
- Total Cancellations

1.7.1.1.2 Information Required For A HCC Inquiry For Claims

The information needed to perform this type of coverage inquiry includes:

- Person identification information, including person or family transaction type
- Begin and end dates for the inquiry period

1.7.1.1.3 Person Identification

A beneficiary's information is accessed with the coverage inquiry using the identification information from the claim. DEERS performs the identification of the individual and returns the system identifiers (DEERS ID and Patient ID). The DEERS IDs shall be used for subsequent communications on this claim.

1.7.1.1.4 Inquiry Options: Person Or Family

The inquirer must specify if the coverage inquiry is for a person or the entire family. The person inquiry option should be used when specific person identification is known. If person information is incomplete, the family inquiry mode can be used. In family inquiries, the Inquiry Person Type Code is required to indicate if the SSN, Foreign ID, or Temporary ID is for the sponsor or family member. In such inquiries, DEERS returns both sponsor and family member information. If there is more than one person or family match, DEERS will return a partial match response. The contractor shall select the correct person and resend the coverage inquiry.

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Chapter 3, Section 1.4

DEERS Functions

FIGURE 3.1.4-9 INQUIRY PERSON TYPE CODE

PERSONS TO RETURN	WHAT INFORMATION IS AVAILABLE FROM THE CLAIM	VALUES TO SET	USAGE
RETURN ONLY A SINGLE SPONSOR/FAMILY MEMBER (PNF_TXN_TYP_CD = P)	SPONSOR INFORMATION IS PROVIDED (INQ_PN_TYPE_CD=S)	<u>INQUIRY SPONSOR INFO SECTION:</u> SPN_INQ_PN_ID SPN_INQ_PN_ID_TYP_CD SPN_PN_LST_NM SPN_PN_1ST_NM SPN_PN_BRTH_DT <u>INQUIRY PERSON INFO SECTION:</u> INQ-PN_ID INQ-PN_ID_TYP_CD and/or PN-LST-NM PN-1ST_NM PN_BRTH_DT	R R O O O S S NA S S
RETURN ONLY A SINGLE PERSON SINGLE SPONSOR/ FAMILY MEMBER (PNF_TXN_TYP_CD=P)	NO SPONSOR INFORMATION IS PROVIDED** (INQ_PN_TYP_CD=P)	<u>INQUIRY SPONSOR INFO SECTION:</u> <u>INQUIRY PERSON INFO SECTION:</u> INQ_PN_ID INQ_PN_ID_TYP_CD PN_LST_NM PN_1ST_NM PN_BRTH_DT	NA R R O O O
RETURN THE WHOLE FAMILY (PNF_TXN_TYP_CD=F)	SPONSOR INFORMATION PROVIDED (INQ_PN_TYP_CD=S)	<u>INQUIRY SPONSOR INFO SECTION:</u> SPN_INQ_PN_ID SPN_NQ_PN_ID_TYP_CD SPN_PN_LST_NM SPN_PN_1ST_NM SPN_PN_BRTH_DT <u>INQUIRY PERSON INFO SECTION:</u>	R R O O O NA

LEGEND: R - Required; O - Optional; S - Situational

Note: * The Inquiry Person information section on a family member inquiry must either have the INQ_PN_ID and INQ_PN_TYP_CD OR if none is available then at least a PN_1ST_NM and PN_BRTH_DT.

**The period of time required for this type of inquiry to DEERS is significantly longer than for a family member based inquiry using a sponsor and should be used only infrequently when NO sponsor PN_ID information is provided on the claim.

The HICN (H) is only valid in the Person Inquiry section, not in the sponsor section and only on PERSON pulls (leave sponsor section blank).

1.7.1.1.5 Inquiry Period

In addition to identifying the correct person or family, the inquirer must supply the inquiry period. The inquiry period may either be a single day or can span multiple days. Historical dates are valid, as long as the requested dates are within five years. The inquirer queries DEERS for information about the coverage plans in effect during that inquiry period for the sponsor and/or family member. The reply may include one or more coverage plans in effect during the specified period. For claims, the contractor shall use the dates of service on the claim.

1.7.1.1.6 Lock indicator

The contractor chooses whether to lock Catastrophic Cap Deductible (CCD) totals. If the contractor intends to update the CCD amounts, the contractor must lock the totals.

1.7.1.2 Information Returned In The HCC Inquiry For Claims

The DEERS ID is returned in response to a coverage inquiry. The contractor shall store the DEERS ID for use in subsequent CCD update transactions for this claim. In addition, the Patient ID is returned in the coverage response. The contractor shall store the Patient ID. The contractor must put the Patient ID and DEERS ID on the TRICARE Encounter Data (TED) record.

When implementing applications that use system to system interfaces that return partial matches (such as claims), those applications must allow the operator to view and select the correct individual, as described above. The partial match response is designed to provide unique identifiers (Patient ID or DEERS ID) that can ensure that subsequent processing will uniquely identify the correct individual or beneficiary.

1.7.1.2.1 Data Returned In A Coverage Inquiry That Repeats For Every Coverage Plan

In response to a HCC Inquiry for Claims, DEERS returns the specified coverage information in effect for the inquiry period. The following list shows the information DEERS returns for each coverage plan in effect during the inquiry period:

- Coverage plan information (assigned or enrolled)
- Coverage plan begin and end dates within the inquiry period
- Sponsor branch of service and family member category and relationship to the sponsor during coverage period

Note: Newborn coverage information will only be reflected after the newborn is added to DEERS. See TOM, [Chapter 3](#).

1.7.1.2.2 Data Returned In A Coverage Inquiry Independently From The Coverage Plan Information

The DEERS coverage response will always return:

- Sponsor Personnel Information: All current personnel segments will be returned, including dual eligible segments. The contractor shall not use this information for claims processing. This information is intended to be used for the TED only.
 - Person information including the mailing address.
 - The residential zip code will be returned for jurisdiction purposes.
- CCDD totals: Both family and individual CCDD accumulations are provided in the coverage response.

- Lock Indicator: The status of the lock on CCDD totals is returned on the coverage response.

The DEERS coverage response may include the following information. If nothing is returned, this means that DEERS does not have this information for the requested inquiry dates.

- Primary care manager information: PCM information is returned for some enrolled coverage plans. No PCM information is present for the DoD assigned coverage plans and some enrolled coverage plans. PCM information provided includes DMIS, the PCM Network Provider Type Code, and individual PCM information if available in DEERS.
- OHI: Limited OHI information is returned.
- OGPs: Complete OGP information is provided in the response.

1.7.1.2.3 HCC Copayment Factor For Coverage Inquiries

The HCC Copayment Factor Code for a beneficiary is determined by DEERS and is returned on a claims inquiry, but may be influenced by treatment information from a claim. The contractor shall use this factor code to determine the actual copayment for the claim.

The different factors are determined by legislation, which considers factors such as pay grade and personnel category, such as retired sponsor or active duty. Although the rates are based on the population to which they pertain, such as retired sponsor, these rates also apply to a sponsor's family members. Examples of copayment factors are:

- Pay Grade Corporal/Sergeant or Petty Officer Third Class and below rate
- Pay Grade Sergeant/Staff Sergeant or Petty Officer Second Class and above rate
- Retiree and Surviving family members of deceased active duty sponsors rate
- Foreign Military rate

The contractor's system should be flexible enough to permit additional rate codes to be added, as required by the DoD.

1.7.1.2.4 Special Entitlements

Congressional legislation may affect deductibles and rates. The Special Entitlement Code and dates if applicable provide information to support this legislation. Effective dates will also be included in the response from DEERS. Note that a person may have multiple special entitlements.

Examples are:

- Special entitlement for participation in Operation Joint Endeavor. This code, when returned from a claims inquiry to DEERS, will waive or reduce the annual deductible charges of the beneficiary for the period indicated by the effective and expiration dates of the special entitlement section of the data returned.

- Special entitlement for participation in Operation Noble Eagle. This code, when returned from a claims inquiry to DEERS, will waive or reduce the annual deductible charges of the beneficiary for the period indicated by the effective and expiration dates of the special entitlement section of the data returned. In addition, non-participating physicians will be paid up to 115% of the CHAMPUS Maximum Allowable Charge (CMAC) or billed charges whichever is less.

1.7.1.3 Multiple Responses To A Single HCC Inquiry for Claims

DEERS may need to send multiple responses to a single HCC Inquiry for Claims if a person has multiple DEERS IDs within the inquiry period. It is necessary for DEERS to capture family member entitlements and benefit coverage corresponding to each instance of the person's DEERS ID. For example, in a joint service marriage, a child may be covered by the mother from January through May (DEERS ID #1) and covered by the father from June through December (DEERS ID #2). These responses are returned in a single transaction. (Note: multiple responses are returned only when an individual inquiry is submitted.) Family inquiries will not produce multiple responses. Upon receiving a multiple response, the contractor shall select the correct beneficiary and resubmit a properly configured claims inquiry.

Contractors shall deny a claim (either totally or partially) if the services were received partially or entirely outside any period of eligibility.

If the contractor is unable to select a patient from the family listing provided by DEERS, the contractor shall check the patient's date of birth. If the date of birth is within 365 days of the date of the query (i.e., a newborn less than **one** year old), the contractor shall release the claim for normal processing.

CHAMPVA claims shall be forwarded to Health Administration Center, CHAMPVA Program, PO Box 65024, Denver CO 80206-5024.

A list of key DSO personnel and the Joint Uniformed Services Personnel Advisory Committee (JUSPAC) and the Joint Uniformed Services Medical Advisory Committee (JUSMAC) Members is provided at the TMA web site at <http://www.tricare.osd.mil>. These individuals are designated by the TMA to assist DoD beneficiaries on issues regarding claims payments. In extreme cases the DSO may direct the claims processor to override the DEERS information; however, in most cases the DSO is able to correct the database to allow the claim to be reprocessed appropriately. The procedure the contractor shall use to request data corrections is in [Section 1.5](#).

Any overrides issued by the DSO will be in writing detailing the information needed to process the claim. Overrides cannot be processed verbally, and overrides are not allowed in cases where correction of the data is the appropriate action. Only in cases of aged data that can not be corrected will DSO authorize an override. The contractor will provide designated Point Of Contact (POC) for the DSO personnel and the JUSPAC/JUSMAC members identified on the TMA web site.

1.7.1.4 CCDD Totals Inquiry

The CCDD Totals Inquiry is used to obtain CCDD balances for the year(s) that correspond to the requested inquiry period. The contractor must inquire and lock CCDD totals before updating DEERS CCDD amounts.

Note: A catastrophic cap record is not required for persons who are authorized benefits but are not on DEERS or eligible for medical benefits, such as prisoners or government employees. The purpose of the catastrophic cap is to benefit those beneficiaries who are eligible for MHS benefits. Those persons that are authorized benefits who would not under any other circumstances be eligible, are not subject to catastrophic cap requirements.

1.7.1.4.1 Information Required To Inquire For Totals

The following information details the data required to inquire for CCDD totals.

1.7.1.4.1.1 Person Information

The contractor must use the DEERS ID for the beneficiary whose claim is being processed for this inquiry. The DEERS ID is returned by DEERS on the policy notification or coverage response. Even though only one person's DEERS ID is used, both individual and family totals will be returned in the response.

1.7.1.4.1.2 CCDD Totals Inquiry Period

The inquiry period used for the CCDD Totals Inquiry may be a single date or a date range, not more than five years in the past (current FY and four prior FYs). Future dates are not valid.

1.7.1.4.1.3 Lock Indicator

If the contractor intends to update the CCDD amounts, the contractor must lock the CCDD totals.

1.7.1.4.2 Response To CCDD Totals Inquiry

The following information details the information returned from a CCDD totals and inquiry.

1.7.1.4.2.1 CCDD Totals

DEERS sends a response showing year-to-date CCDD totals for each FY, based on the inquiry dates requested. Dates must be within the current FY or four prior FYs. Both individual and family totals are displayed. If there are no CCDD totals accumulated for any FY in the inquiry period requested, DEERS will show a zero value for that fiscal year.

If the inquiry period spans multiple FYs, the CCDD totals would repeat multiple times. For example, if the inquiry dates are September 1, 2007 through October 25, 2007, there would be two sets of CCDD totals, one for FY 2007 and one for FY 2008.

1.7.1.4.2.2 Lock Information

- If a contractor inquires for CCDD totals and does not request a lock on the totals, DEERS returns any totals accumulated for the inquiry period and any lock information if the totals were already locked.

- If a contractor inquires for totals with a request to lock and the totals were not already locked, DEERS would return the accumulated totals and the lock information, including the locking organization, the lock date, and the lock time.
- If an contractor inquires and requests a lock for a beneficiary whose totals are already locked, only the locking organization, the lock date, and the lock time will be returned. No totals will be returned in this situation.

1.7.1.5 Updating CCDD Amounts

The CCDD total can be updated online for the current and four prior FYs. This update transaction requires the DEERS ID, which may be obtained from a coverage or CCDD totals inquiry. Only the same organization that placed the lock may update the locked record and remove the lock. DEERS validates that the updating organization is the same as the organization that placed the lock. If there is a discrepancy, DEERS does not allow the update and sends a response that the update was not successful. If there are more claims outstanding for the same family, the contractor may choose not to remove the lock. In this case, the record would remain locked until the 48-hour time period expires, or the lock is removed, whichever comes first.

Each transaction should only include updates for one claim. CCDD amounts for multiple claims should be sent in separate transactions. In the split claim situation, multiple transactions must be sent for the same claim. For example, if a claim spans FYs and is split, updates for FY 2000 and FY 2001 must be sent in two transactions using the claim extension identifier to distinguish the two updates from one another. If a claim does not span multiple fiscal or enrollment years, the claim extension identifier should be set to '000'. Split claims will use a unique claim extension identifier for each FY in which the claim occurs.

If cost-shares, copays or deductibles are collected, these amounts must be posted to CCDD, even if the catastrophic cap has been met. If cost-shares, copays or deductibles were reduced or waived based on the CCDD totals returned, those amounts shall also be posted to DEERS even if the catastrophic cap has been met. If the catastrophic cap is exceeded, the contractor shall refund the overage to the beneficiary.

Do not send CCDD updates for programs for which they do not apply (e.g., Extended Care Health Option (ECHO)). See the TPM.

1.7.1.5.1 Information Required To Update CCDD Amounts

The contractor must provide the following information to update the CCDD amounts:

- DEERS ID: This identifies the beneficiary for whom the update is applied.
- Catastrophic cap, deductible, and/or point of service dollar amount. The contractor sends DEERS the CCDD amount for the beneficiary. DEERS knows to which family the beneficiary belongs and rolls up the totals for the correct family using the DEERS ID.
- Identifier for the claim, enrollment fee, or adjustment.

Note: If there is a discrepancy between the identifier used for locking and the identifier used for updating, DEERS does not allow the update.

- Claim extension identifier. When a claim spans FYs, the claim extension is used to identify a split claim. These claims should have the same claim identifier with a different claim extension identifier. Splitting the claim is the responsibility of the claims processor, who splits the claim, adds the claim extension, and sends this information to DEERS.
- Lock information (remove or do not remove lock).
- Dates provided for the catastrophic cap and/or deductible update. The dates shall include the date(s) of service for the claim (both begin and end date). These dates are necessary for accumulating the CCDD totals for the correct time period and HCDP.

1.7.1.5.2 Types Of CCDD Updates

DEERS supports CCDD update functionality including adding, adjusting, and canceling amounts. Adds, adjustments, and cancellations may be made for the current and previous four FYs.

1.7.1.5.2.1 Adds

The contractor utilizes the CCDD update to add new CCDD amounts to the DEERS CCDD repository.

1.7.1.5.2.2 Adjustments

The contractor utilizes the CCDD update to adjust posted CCDD amounts. The same claim identifier as the original claim must be provided for the adjustment. The appropriate negative or positive amount should be entered, in order to correct the net amount. In order to adjust a claim, a contractor must provide the same information for updating a claim as outlined in the previous section. For example, a contractor updates a claim with a \$50 catastrophic cap amount, then two weeks later discovers that the claim was incorrectly adjudicated and the catastrophic cap amount should have been \$35. The contractor would then update the beneficiary's catastrophic cap for the same claim number with an amount of -\$15. The DEERS catastrophic cap balance would then show \$35 for that claim. To cancel a catastrophic cap amount, adjust the claims to zero out the previous amount applied for that claim.

1.7.1.5.2.3 The 48-Hour Rule

If a contractor places a lock on a record and fails to update that record within the specified 48-hour time period, the contractor will be unable to update CCDD amounts, because the lock will have expired. To remove a lock, a contractor shall perform a CCDD update specifying to remove the lock. In this case, the contractor would send no catastrophic cap or deductible amounts, only an indication of the removal of the lock.

1.7.1.5.2.4 Add Newborn

CCDD amounts for a newborn are posted to DEERS by using the CCDD update transaction and setting the Newborn Addition Indicator Code to 'Y'. The 'Y' code indicates that a newborn placeholder is to be added. If DEERS returns an error code on a newborn add indicating that the person is already on the database, the contractor shall query to determine if this is actually the same person. If so, then the contractor shall use the returned information to apply the CCDD to the existing record. Contractors shall not create duplicate newborn placeholders within the same family; special care should be taken when the newborn may have multiple sponsors. (E.g, the child of two active duty sponsors should be tracked only under one of the two sponsors if at all possible.)

The CCDD update transaction shall include both the newborn information and the CCDD amounts. After the newborn has been added to DEERS, the CCDD update will be posted to the database (provided that the family record is not locked). In the event that the CCDD update was unable to be posted, it is the contractor's responsibility to query DEERS to verify that the newborn has been created. The contractor is then to resend the CCDD update transaction, setting the Newborn Addition Indicator Code to 'N'.

Adding the newborn in DEERS via CCDD updates will not generate eligibility for the newborn, but the newborn will show in GIQD and in claims responses. Once the sponsor "adds" the newborn in DEERS through the Real-Time Automated Personnel Identification System (RAPIDS), the newborn will be eligible like any other beneficiary.

1.7.2 CCDD Transaction History Request

CCDD transaction history information is useful for customer service requests, for auditing purposes, or for researching any problems associated with CCDD updates in relation to a particular claim. DEERS maintains a record of each update transaction applied toward CCDD information. This detailed transaction information is available through the CCDD web application.

1.8 SIT Program

The SIT program supports the MHS billing and collection process. The SIT is validated by the TMA Uniform Business Office (UBO) through the DoD Verification Point of Contact (VPOC). The VPOC is ultimately responsible for maintaining the SIT in DEERS, which is the system of record for SIT information. The SIT provides uniform billing information for reimbursement of medical care costs covered through commercial policies held by the DoD beneficiary population. MHS personnel use the SIT to obtain other payer information in a standardized format.

The Health Insurance Carrier (HIC) Identifier (ID) is the unique identifier for a carrier. Once a standard national health plan identifier is adopted by the Secretary, Health and Human Services (HHS), DEERS and MHS trading partners will migrate to that identifier.

All systems identified as trading partners will request an initial full SIT subscription from DEERS. See the Technical Specification, "Health Insurance Carrier/Other Health Insurance" for subscription procedures. In addition, holders of the SIT shall subscribe to DEERS at least daily in order to receive subsequent updates of the SIT.

Field users perform five actions with the SIT:

- Inquiry actions can be performed on the OHI/SIT web application or through the local SIT file.
- An add action to report a new SIT entry for validation by the DoD VPOC.
- An update action to report an updated SIT entry for validation by the DoD VPOC.
- The cancellation of a carrier add sent to the SIT for verification by the DoD VPOC.

Note: Only the organization requesting a carrier to be added can cancel the request.

- A request to deactivate a verified HIC previously sent to the SIT for verification by the DoD VPOC.

1.8.1 SIT Inquiry

Local holders of the SIT cannot perform system-to-system inquiries against the central SIT maintained on DEERS.

1.8.2 SIT Add

When MHS personnel add a complete OHI record to a person or patient, they will need the HIC ID from the SIT. The HIC ID represents the identifier assigned to insurance carriers in the SIT provided by DEERS. The HIC ID Status Code identifies the ID as standard or temporary. See the "Technical Specifications for the HIC SIT and the OHI" for detailed information about the data elements required for the SIT add process.

When a HIC is not on the SIT, the user may send a request to add it to the SIT on DEERS. DEERS responds with a HIC ID, a HIC Status Code with the designation of "temporary," and a HIC Verification Status Code of "unverified". Unverified carriers are made available to all local holders of the SIT through the daily subscription process to prevent duplicate requests requiring VPOC validation. OHI may be assigned to unverified carriers. When the DoD VPOC validates the SIT, the HIC Verification Status Code will be changed from "unverified" to "verified."

1.8.3 SIT Update

For updates to an existing SIT record, the existing HIC ID must be sent with the update. These updates are sent to all subscribers through the daily subscription process. Rejection of SIT updates by the DoD VPOC is reported to all local holders of the SIT. DEERS does not allow an update to a HIC when the HIC has a Verification Status Code of "unverified."

1.8.4 SIT Add Cancellation

The MHS personnel may need to cancel a previously submitted "add" to the SIT. A cancel can only be done by the system that submitted the "add" and only if the "add" has not yet been verified by the DoD VPOC. DEERS cancels any OHI policy on the DEERS database associated with the cancelled "unverified" HIC. After the "add" request is cancelled, DEERS will provide the

cancellations to all local holders of the SIT through the daily subscription process.

1.8.5 Validation Of HIC Information

Validation of a SIT update includes verifying the name, mailing address, and telephone number information for the HIC. In addition, the DoD VPOC assigns the HIC Status Code of "Standard" to validated HICs. If the DoD VPOC determines that the requested update is not correct, the DoD VPOC assigns a HIC Status Code of "rejected". Rejected updates are returned to all local holders of the SIT.

If a SIT "add" or "update" request is rejected by the DoD VPOC, DEERS cancels any OHI policy on the DEERS database associated with the rejected HIC. All SIT additions and updates that are validated by the DoD VPOC are made available to all systems identified to DEERS as authorized holders of a local copy of the SIT.

1.8.6 Deactivation of a HIC

MHS organizations can request the DoD VPOC to deactivate any HIC on the SIT. DEERS does not allow a deactivation of a HIC with a HIC Status Code of "temporary" and/or a HIC Verification Status Code of "unverified", until validated by the DoD VPOC. DEERS deactivates any OHI policy on the DEERS database associated with the deactivated HIC. DEERS reports the deactivation of the HIC to all local holders of the SIT.

1.9 OHI

OHI identifies non-DoD health insurance held by a beneficiary. The requirements for OHI are validated by the TMA Uniform Business Office (UBO). OHI information includes:

- OHI policy and carrier
- Policyholder
- Type of coverage provided by the additional insurance policy
- Employer information offering coverage, if applicable
- Effective period of the policy

OHI transactions allow adding, updating, canceling, or viewing all OHI policy information. OHI policy updates can accompany enrollments or be performed alone. OHI information can be added to DEERS or updated on DEERS through multiple mechanisms. At the time of enrollment the contractor will determine the existence of OHI. The contractor can add or update minimal OHI data through the DOES application used by the contractor to enter enrollments into DEERS. In addition, DEERS will accept OHI updates from a claims processor through a system to system interface. Other MHS systems can add or update the OHI through the OHI/SIT Web application provided by DEERS. The presence of an OHI Policy discovered during routine claims processing shall be updated on DEERS within two business days of receipt of the required information.

The minimum information necessary to add OHI to a person record is:

- Policy Identifier (policy number)
- OHI Effective Date
- HIPAA Insurance Type Code

- HIPAA Person Association Code
- Claim Filing Code
- OHI Coverage Type Code
- OHI Coverage Payer Type Code
- OHI Coverage Effective Date
- OHI Policy Coverage Precedence Code
- HIC Name or HIC ID
- Health Insurance Coverage Type Code
- Health Insurance Payer Type Code

Note: There are additional data elements necessary if the policy being added is a Group Employee policy.

If only the minimum required data is entered by the contractor, the contractor is required to fully develop the remaining OHI data necessary to complete the OHI record within 15 business days. Detailed requirements for the exchange of OHI information are contained in the "Technical Specifications for the Health Insurance Carriers Standard Insurance Table (SIT) and the Other Health Insurance (OHI) Carriers." HIC information is validated against the SIT which maintains the valid insurance carrier information on DEERS.

DEERS requires the contractor to perform an OHI Inquiry before attempting to add or update an OHI policy. The MHS organizations are reliant on the individual beneficiary to provide accurate OHI information and DEERS is reliant on the MHS organizations for the accurate assignment of policy information to the individual record. DEERS is not the system of record for OHI information. Performing an OHI Inquiry on a person before adding or attempting to update an OHI policy helps ensure that the proper policy is updated based on the most current information on the person.

Examples of OHI coverages are:

- Comprehensive Medical coverage (Plans with multiple coverage types)
- Medical coverage
- Inpatient coverage
- Outpatient coverage
- Pharmacy coverage
- Dental coverage
- Long-term care coverage
- Mental health coverage
- Vision coverage
- Partial hospitalization coverage
- Skilled nursing care coverage

The default coverage will be Comprehensive Medical Coverage unless another of the above coverages is selected. The indication of Comprehensive Medical Coverage presumes medical coverage, inpatient coverage, outpatient coverage, and pharmacy coverage. The MCSC must develop the OHI within 15 days but is not responsible for development of pharmacy. The pharmacy contractor is expected to develop pharmacy OHI.

In addition, each OHI policy carries a code indicating whether the policy is active, inactive, or deactivated. The deactivation of an OHI policy only occurs when the DoD VPOC at TMA deactivates

the HIC on the SIT. DEERS retains OHI policy data for five years after an OHI policy expires or is deactivated or terminated.

1.9.1 OHI Policy Inquiry

1.9.1.1 Person Identification For OHI Policy Inquiry

OHI information is requested using the Patient ID, which is person-level identification. Person identification is used for the sponsor or family member. If the Patient ID is unknown, a coverage inquiry to DEERS can be performed to obtain it.

1.9.1.2 OHI Person Inquiry

The OHI data is by person. A system-to-system OHI inquiry is only for individual person requests. The OHI/SIT web application allows a family OHI inquiry. DEERS allows multiple OHI policies for each person. DEERS does not support an inquiry that shows all insured persons in a particular policy.

1.9.1.3 OHI Information

In addition, queries may be filtered by the HIC ID or the HIC Name, the OHI Policy ID or the OHI Coverage Type Code.

The HIC ID represents the identifier assigned to insurance carriers in the SIT provided by the DoD VPOC to DEERS. A requester can seek information on a specific coverage for a beneficiary by using the OHI Coverage Type Code in the OHI inquiry sent to DEERS, or for a specific insurance carrier by using the HIC Name. If a requestor is unsure about a specific OHI Policy, a time period should be specified for the inquiry to return the OHI Policy information in effect.

1.9.1.4 Information Returned In The OHI Inquiry Response

The DEERS response returns all OHI policies in effect during the specified time period for the beneficiary. OHI policies that are inactive or deactivated are returned if the OHI policies were in effect for any portion of the OHI inquiry period. If a specific coverage type is selected in the inquiry, only policies having that coverage type are included in the DEERS response.

The OHI/SIT web application will return OHI for a requested beneficiary or a sponsor and family. OHI is displayed one person at a time. If DEERS cannot find OHI information, DEERS does not return any OHI policies for the requested OHI inquiry period. When the Patient ID is included in the OHI inquiry, the Patient ID is returned in the response.

1.9.2 OHI Policy Add

DEERS allows the MHS and contractor systems to add an OHI policy for a person when information is presented to them. An OHI Inquiry should be done prior to updating an OHI policy. This ensures that updates are performed with the most current information. Following the OHI Inquiry, the OHI data can be added as necessary. OHI data can be added during an enrollment via the DOES application. OHI can be updated any time after enrollment through the web application provided by DEERS, or through the system to system interface. The presence of an OHI Policy

discovered during routine claims processing shall be entered on DEERS within two business days. Within 15 business days, the contractor shall provide all OHI data not initially entered.

The fields required to add an OHI policy for a person are:

- Patient ID
- HIC ID
- OHI Policy ID
- OHI Effective Calendar Date
- HIPAA Insurance Type Code
- HIPAA Person Association Code
- OHI Claims Filing Code
- OHI Policy Coverage Effective Date
- OHI Policy Coverage Precedence Code
- HIC Coverage Type Code
- HIC Coverage Payer Type Code
- OHI Coverage Type Code
- OHI Carrier Coverage Payer Type Code

When the MHS organization enters the HIC ID DEERS will check it against the SIT for validation of the HIC information. If the HIC ID is not on the SIT, the MHS organization may add a new HIC and Coverage. If the insurance carrier is not known, the MHS organization shall use the carrier "Placeholder HIC ID", which is the placeholder entry on the SIT. The HIC "Placeholder HIC ID" has an assigned HIC ID of "UNKVA0001" with a coverage type of "XM". For "Placeholder HIC ID" OHI policies, the default coverage indicator is "comprehensive medical"; however, any coverage indicator can be assigned to it. The single placeholder OHI policy can be used to indicate that an OHI policy exists for a beneficiary. The enrolling entity or updating system is responsible for obtaining the complete OHI information and updating the placeholder OHI policy in DEERS within 15 business days.

Pharmacy placeholder policies will be developed by the pharmacy contractor, regardless of which organization created the placeholder. All other placeholder policies will be developed by the contractor, regardless of which organization created the placeholder. MHS organizations will not normally enter placeholder policies but would develop them if they created them.

A person can have multiple types of OHI coverage for one policy. For example, to add an OHI policy that covers medical and vision, two OHI coverage types, one for medical coverage and one for vision coverage, would be sent to DEERS.

A person can have multiple OHI policies. Multiple OHI policies may have the same or different HICs, and/or the same or different OHI policy effective periods.

The HIC ID, OHI Policy ID, and OHI Effective Date cannot be updated once an OHI policy has been added to DEERS. These attributes, along with the person identification, uniquely associate an OHI Policy to a person. All messages sent to DEERS are acknowledged as either accepted or rejected.

1.9.3 OHI Policy Update

DEERS allows the MHS systems to update existing OHI policy and coverage information for a person when policy change information is presented. Policy and coverage updates include modifications to existing policy and coverage information. Updates can also be used to terminate an existing policy or coverage, that is when the policy or coverage no longer applies to the person. An OHI Inquiry must be done prior to updating an OHI policy. Following the OHI Inquiry, the OHI data can be updated as necessary.

If OHI is identified during routine claims processing or other contract activities, the contractor shall send the OHI information to DEERS within two business days.

1.9.4 OHI Policy Cancellation

Cancellation of an OHI policy is used to remove a policy that was erroneously associated to a person. The OHI Policy Cancellation is not used to terminate an existing policy (see OHI Policy Update above). An OHI policy cancellation completely removes the policy. DEERS verifies that the cancellation is performed by the entity that added or last updated the OHI policy.

Note: Terminations do not remove the policy from a person's record.

When canceling an OHI policy, an OHI Policy Inquiry must be done to verify the information necessary to perform a cancellation. Canceling an OHI policy requires the following data elements:

- Patient ID
- HIC ID
- OHI Policy ID
- OHI Effective Calendar Date
- OHI Expiration Calendar Date
- OHI End Reason Code

1.10 Medicare Data

DEERS performs a match with the Centers for Medicare and Medicaid Services (CMS) to obtain Medicare data and incorporates the Medicare data into the DEERS database as OGP's entitlement information. This information includes Medicare Parts A, B, C, and D eligibility along with the effective dates. The match includes all potential Medicare-eligible beneficiaries.

DEERS sends Medicare Parts A and B information to the TDEFIC. The TDEFIC sends the information to the CMS Fiscal Intermediaries for identification of Medicare eligibles during claims adjudication.

- END -

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Appendix A

Acronyms And Abbreviations

FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GBL	Government Bill of Lading
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
H/E	Health and Environment
HAC	Health Administration Center
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly Healthcare Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy

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HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDL	Hardware Description Language
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HepB-Hib	Hepatitis B and Hemophilus influenza B
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HHC/CM	Home Health Care/Case Management
HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
HIV	Human Immunodeficiency Virus
HL7	Health Level 7
HLA	Human Leukocyte Antigen
HMAC	Hash-Based Message Authentication Code
HMO	Health Maintenance Organization
HNPCC	Hereditary Nonpolypsis Colorectal Cancer
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRG	Health Resource Group
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy
HSCRC	Health Services Cost Review Commission
HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVB	Information Assurance Vulnerability Bulletin
IAVM	Information Assurance Vulnerability Management

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IAW	In accordance with
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IE	Interface Engine Internet Explorer
IEP	Individualized Educational Program
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IGCE	Independent Government Cost Estimate
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Intramuscular
IND	Investigational New Drugs
INR	Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPN	Intraperitoneal Nutrition
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary

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IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVF	In Vitro Fertilization
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LOC	Letter of Consent
LOD	Letter of Denial/Revocation
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial
LSN	Location Storage Number

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LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RS	Medical Benefits and Reimbursement Systems
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index
MDR	MHS Data Repository
MDS	Minimum Data Set
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MMA	Medicare Modernization Act
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy

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MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MS	Microsoft®
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCF	National Conversion Factor
NCI	National Cancer Institute
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System

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NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLT	No Later Than
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCONUS	Outside of the Continental United States

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OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OD	Optical Disk
OGC	Office of General Counsel
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PCMBN	PCM By Name
PCMRS	PCM Reassignment System
PC	Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCM	Primary Care Manager
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application)

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PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Permanent Change of Station
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PPPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PL	Public Law
PLS	Preschool Language Scales

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PM-DRG	Pediatric Modified-Diagnosis Related Group
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion

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PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Remittance Advice
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI Outcomes and Assessment Information Set Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center

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RUG	Resource Utilization Group
RV	Residual Volume
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAO	Security Assistant Organizations
SAP	Special Access Program
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stell Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Status Indicator
SIDS	Sudden Infant Death Syndrome
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number

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SOR	Statement of Reasons
SP	Special Processing Code
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCP/IP	Transmission Control Protocol/Internet Protocol
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEFRA	Tax Equity and Fiscal Responsibility Act

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TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TNEX	TRICARE Next Generation (MHS Systems)
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)

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TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRPB	TRICARE Retail Pharmacy Benefits
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
UAE	Uterine Artery Embolization
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
URF	Unremarried Former Spouses
URL	Universal Resource Locator
US	United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office

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USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veteran Affairs (hospital) Veteran Administration
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thoroscopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome

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Acronyms And Abbreviations

XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

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