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TRICARE
MANAGEMENT ACTIVITY

PCSIB

CHANGE 4
7950.2-M
NOVEMBER 7, 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 CHANGE

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change brings this Manual up-to-date with published changes to the Aug 2002 TRICARE Systems Manual (TSM), 7950.1-M. Included are Changes 62, 63, 64, 65, and 67. This change also removes the requirement that contractors capture fingerprint data using a fingerprint capture device (Chapter 1, Section 1.1, paragraph 7.5.1); updates Public Key Infrastructure (PKI) requirements (Chapter 1, Section 1.1, paragraph 9.0); and includes numerous editing changes to bring the Manual up-to-date with the TRICARE Encounter Data (TED) production system (Chapter 2).

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

This change is made in conjunction with Feb 2008 TOM, Change No. 4, Feb 2008 TPM, Change No. 4, and Feb 2008 TRM, Change No. 4.

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Chief, Purchased Care Systems
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General Automated Data Processing/Information Technology (ADP/IT) Requirements

- 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 (NACLC).

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 NACLC 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 NACLC 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. 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 NACL 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, networks and data 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, networks and data. **Alternate sign on access will not be granted.** 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 (**level I or II**), 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. **If 20 or more employees require CACS, the contractor may submit this information electronically to the sponsor. The electronic submission must be protected with a TMA-approved encryption method, and the information provided** as a file attachment in XML (eXtensible Markup Language) format for initial startup.

9.1.2.4 The sponsor **will provide** 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.

Since the above process will not be used for data submitted electronically, the contractor must insure the data in the XML file is correct prior to submission. The access code and password must be provided the CAC holder in a secure manner, e.g., directly provided to user in a written or verbal format.

9.1.2.5 The individual **will then verify** personal information in CVS, **making** corrections as necessary, and **entering** any missing personal information into CVS (automated DD 1172-2).

9.1.2.6 The sponsor will then review the application and verify the individual employee's ADP/IT status. CAC applications will not be approved if the individual either does not have a current ADP/IT status or has not successfully completed the FBI fingerprint check and/or the TMA Privacy Office has not received the NAC from OPM. 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., driver's 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 Initial Contract Start Up

9.1.3.1 When 200 or more contractor employees require CAC issuance, the government may produce the CACs at a Central Issuing Facility (CIF). In order to facilitate the CAC issuance process, the government may also deploy a mobile RAPIDS station to the contractor's site to verify individual employee identity and obtain the biometric data required for the CAC. The site for the mobile RAPIDS station will be determined by the government. Information obtained by the mobile RAPIDS station will be forwarded to the CIF for production of the CAC.

9.1.3.2 The contractor will designate two individuals for the CAC distribution process. The first individual shall be the designated recipient for the CACs that are produced by the CIF; the second will be the recipient for the CAC PINs. Each individual will be responsible for separately distributing the CAC or the PIN, as determined by the responsibility assigned by the contractor.

9.1.4 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.

9.1.5 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.

9.1.6 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.

9.1.7 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.

9.1.8 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.

9.1.9 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.

9.1.10 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 applications **and data** 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.

9.1.11 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.

9.1.12 The contractor shall identify to Purchased Care Systems **Integration** Branch (PCSIB) and DMDC the personnel that require access to the DMDC Contractor Test environment and/or the Benchmark Test environment **in advance of the initiation of testing activities**.

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.dtic.mil/whs/directives/infomgt/forms/forminfo/forminfo3211.html> 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 -

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Chapter 2, TRICARE Encounter Data (TED)

Section/Addendum	Subject/Addendum Title
N	UB-04/UB-92 Conversion Table - To Be Used For Reporting Non-Institutional TED Records

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Data Requirements - Data Element Layout

2.0 INSTITUTIONAL DATA ELEMENT (CONTINUED)

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
1-135	AMOUNT PATIENT COST-SHARE	S9(7)V99	247	255
1-136	HEALTH CARE COVERAGE COPAYMENT FACTOR CODE	X	256	256
1-140	AMOUNT PAID BY GOV'T CONTRACTOR (TOTAL)	S9(7)V99	257	265
1-145	AMOUNT INTEREST PAYMENT	S9(7)V99	266	274
1-150	REASON FOR INTEREST PAYMENT	X(2)	275	276
1-155	PROCESSING INFORMATION		277	313
1-160	OVERRIDE CODE	X(6)	277	282
1-165	TYPE OF SUBMISSION	X	283	283
1-170	CA/NAS NUMBER	X(15)	284	298
1-175	CA/NAS REASON FOR ISSUANCE	X	299	299
1-180	CA/NAS EXCEPTION REASON	X(2)	300	301
1-185	SPECIAL PROCESSING CODE	X(8)	302	309
1-186	HEALTH CARE DELIVERY PROGRAM SPECIAL ENTITLEMENT CODE	X(2)	310	311
1-190	PRICING RATE CODE	X(2)	312	313
1-195	PROVIDER STATE OR COUNTRY CODE	X(3)	314	316
1-200	PROVIDER TAXPAYER NUMBER	X(9)	317	325
1-205	PROVIDER SUB-IDENTIFIER	X(4)	326	329
	FILLER	X(10)	330	339
1-215	PROVIDER ORGANIZATIONAL NPI NUMBER (TYPE 2)	X(10)	340	349
1-220	PROVIDER ZIP CODE	X(9)	350	358
1-225	PROVIDER PARTICIPATION INDICATOR	X	359	359
1-230	PROVIDER NETWORK STATUS INDICATOR	X	360	360
1-235	TYPE OF INSTITUTION	X(2)	361	362
1-240	CLAIM FORM TYPE/EMC INDICATOR	X	363	363
1-245	TYPE OF BILL		364	365
1-250	FREQUENCY CODE	X	364	364
1-255	TYPE OF ADMISSION	X	365	365
1-260	SOURCE OF ADMISSION	X	366	366
1-265	ADMISSION DATE	YYYYMMDD	367	374
1-270	PATIENT STATUS	X(2)	375	376
1-275	BEGIN DATE OF CARE	YYYYMMDD	377	384
1-280	END DATE OF CARE	YYYYMMDD	385	392
1-283	ADMINISTRATIVE CLIN	X(18)	393	410
1-285	COVERED DAYS	S9(3)	411	413
1-290	DRG NUMBER	X(3)	414	416
1-292	HIPPS CODE	X(5)	417	421
1-295	ADMISSION DIAGNOSIS	X(6)	422	427
1-300	PRINCIPAL TREATMENT DIAGNOSIS	X(6)	428	433
1-305	SECONDARY TREATMENT DIAGNOSIS-1	X(6)	434	439

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Data Requirements - Data Element Layout

2.0 INSTITUTIONAL DATA ELEMENT (CONTINUED)

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
1-310	SECONDARY TREATMENT DIAGNOSIS-2	X(6)	440	445
1-315	SECONDARY TREATMENT DIAGNOSIS-3	X(6)	446	451
1-320	SECONDARY TREATMENT DIAGNOSIS-4	X(6)	452	457
1-325	SECONDARY TREATMENT DIAGNOSIS-5	X(6)	458	463
1-330	SECONDARY TREATMENT DIAGNOSIS-6	X(6)	464	469
1-333	SECONDARY TREATMENT DIAGNOSIS-7	X(6)	470	475
1-335	SECONDARY TREATMENT DIAGNOSIS-8	X(6)	476	481
1-337	SECONDARY TREATMENT DIAGNOSIS-9	X(6)	482	487
1-340	SECONDARY TREATMENT DIAGNOSIS-10	X(6)	488	493
1-342	SECONDARY TREATMENT DIAGNOSIS-11	X(6)	494	499
1-345	PRINCIPAL OPERATION/NON-SURGICAL PROCEDURE CODE	X(5)	500	504
1-350	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-1	X(5)	505	509
1-353	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-2	X(5)	510	514
1-355	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-3	X(5)	515	519
1-358	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-4	X(5)	520	524
1-360	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-5	X(5)	525	529
1-362	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-6	X(5)	530	534
1-364	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-7	X(5)	535	539
1-365	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-8	X(5)	540	544
1-368	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-9	X(5)	545	549
1-370	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-10	X(5)	550	554
1-373	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-11	X(5)	555	559
1-374	TED RECORD CORRECTION INDICATOR	X(1)	560	560
1-375	TOTAL OCCURRENCE/LINE ITEM COUNT	9(3)	561	563
1-377	AMOUNT NETWORK PROVIDER DISCOUNT	S9(7)V99	564	572
1-378	ADJUSTMENT SEQUENCE NUMBER	X(3)	573	575
	FILLER	X(7)	576	582
1-380	OCCURRENCE/LINE ITEM NUMBER (OCCURS 1 TO 450 TIMES)	9(3)	583	585
1-385	REVENUE CODE	X(4)	586	589
1-390	UNITS OF SERVICE BY REVENUE CODE	S9(10)	590	599
1-395	TOTAL CHARGE BY REVENUE CODE	S9(7)V99	600	608
1-400	ADJUSTMENT/DENIAL REASON CODE	X(5)	609	613
	FILLER	X(20)	614	633

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3.0 NON-INSTITUTIONAL DATA ELEMENT

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
2-001	RECORD TYPE INDICATOR	X	1	1
2-005	TED RECORD INDICATOR		2	25
2-010	INTERNAL CONTROL NUMBER (ICN)		2	18
2-015	FILING DATE	YYYYDDD	2	8
2-020	FILING STATE/COUNTRY CODE	X(3)	9	11
2-025	SEQUENCE NUMBER	X(7)	12	18
2-030	TIME STAMP	X(6)	19	24
2-035	ADJUSTMENT KEY	X	25	25
2-040	DATE TED RECORD PROCESSED TO COMPLETION	YYYYMMDD	26	33
2-045	DATE ADJUSTMENT IDENTIFIED	YYYYMMDD	34	41
2-050	PERSON IDENTIFIER (SPONSOR)	X(9)	42	50
2-051	PERSON IDENTIFIER TYPE CODE (SPONSOR)	X	51	51
2-055	SERVICE BRANCH CLASSIFICATION CODE (SPONSOR)	X	52	52
2-056	AGR SERVICE LEGAL AUTHORITY CODE	X	53	53
2-060	PERSON NAME (PATIENT)		54	148
2-061	PERSON LAST NAME (PATIENT)	X(35)	54	88
2-062	PERSON FIRST NAME (PATIENT)	X(25)	89	113
2-063	PERSON MIDDLE NAME (PATIENT)	X(25)	114	138
2-064	PERSON CADENCY NAME (PATIENT)	X(10)	139	148
2-065	PERSON IDENTIFIER (PATIENT)	X(9)	149	157
2-066	PERSON IDENTIFIER TYPE CODE (PATIENT)	X	158	158
2-070	PERSON BIRTH CALENDAR DATE (PATIENT)	YYYYMMDD	159	166
2-075	DEERS DEPENDENT SUFFIX	X(2)	167	168
2-080	PATIENT IDENTIFIER (DOD)	X(10)	169	178
2-082	DEERS IDENTIFIER (PATIENT)	X(11)	179	189
2-085	PERSON SEX (PATIENT)	X	190	190
2-090	PATIENT ZIP CODE	X(9)	191	199
2-095	OVERRIDE CODE	X(6)	200	205
2-100	TYPE OF SUBMISSION	X	206	206
2-105	CLAIM FORM TYPE/EMC INDICATOR	X	207	207
2-108	ADMINISTRATIVE CLIN	X(18)	208	225
2-110	PCM LOCATION DMIS-ID (ENROLLMENT) CODE	X(4)	226	229
2-112	AMOUNT INTEREST PAYMENT	S9(7)V99	230	238
2-113	REASON FOR INTEREST PAYMENT	X(2)	239	240
2-115	PRINCIPAL TREATMENT DIAGNOSIS	X(6)	241	246
2-120	SECONDARY TREATMENT DIAGNOSIS-1	X(6)	247	252
2-125	SECONDARY TREATMENT DIAGNOSIS-2	X(6)	253	258
2-127	SECONDARY TREATMENT DIAGNOSIS-3	X(6)	259	264
2-130	SECONDARY TREATMENT DIAGNOSIS-4	X(6)	265	270

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Data Requirements - Data Element Layout

3.0 NON-INSTITUTIONAL DATA ELEMENT (CONTINUED)

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
2-132	SECONDARY TREATMENT DIAGNOSIS-5	X(6)	271	276
2-135	SECONDARY TREATMENT DIAGNOSIS-6	X(6)	277	282
2-137	SECONDARY TREATMENT DIAGNOSIS-7	X(6)	283	288
2-139	TED RECORD CORRECTION INDICATOR	X(1)	289	289
2-140	TOTAL OCCURRENCE/LINE ITEM COUNT	9(3)	290	292
2-141	ADJUSTMENT SEQUENCE NUMBER	X(3)	293	295
	FILLER	X(6)	296	301
2-145	OCCURRENCE/LINE ITEM NUMBER (OCCURS 1 TO 99 TIMES)	9(3)	302	304
2-150	BEGIN DATE OF CARE	YYYYMMDD	305	312
2-155	END DATE OF CARE	YYYYMMDD	313	320
2-160	PROCEDURE CODE	X(5)	321	325
2-165	PROCEDURE CODE MODIFIER	X(8)	326	333
2-170	NATIONAL DRUG CODE	X(11)	334	344
2-175	NUMBER OF SERVICES	S9(3)	345	347
2-180	AMOUNT BILLED BY PROCEDURE CODE	S9(7)V99	348	356
2-185	AMOUNT ALLOWED BY PROCEDURE CODE	S9(7)V99	357	365
2-190	AMOUNT PAID BY OTHER HEALTH INSURANCE	S9(7)V99	366	374
2-191	OTHER GOVERNMENT PROGRAM TYPE CODE	X	375	375
2-192	OTHER GOVERNMENT PROGRAM BEGIN REASON CODE	X	376	376
2-195	AMOUNT APPLIED TOWARD DEDUCTIBLE	S9(3)V99	377	381
2-200	AMOUNT PATIENT COST-SHARE	S9(7)V99	382	390
2-201	HEALTH CARE COVERAGE COPAYMENT FACTOR CODE	X	391	391
2-205	AMOUNT PAID BY GOV'T CONTRACTOR BY PROCEDURE CODE	S9(7)V99	392	400
2-220	ADJUSTMENT/DENIAL REASON CODE	X(5)	401	405
2-225	PROVIDER INDIVIDUAL NPI NUMBER (TYPE 1)	X(10)	406	415
2-230	PROVIDER ORGANIZATIONAL NPI NUMBER (TYPE 2)	X(10)	416	425
2-235	PROVIDER STATE OR COUNTRY CODE	X(3)	426	428
2-240	PROVIDER TAXPAYER NUMBER	X(9)	429	437
2-245	PROVIDER SUB-IDENTIFIER	X(4)	438	441
2-250	PROVIDER ZIP CODE	X(9)	442	450
2-255	PROVIDER TAXONOMY SPECIALTY	X(10)	451	460
2-260	PROVIDER PARTICIPATION INDICATOR	X	461	461
2-265	PROVIDER NETWORK STATUS INDICATOR	X	462	462
2-270	PHYSICIAN REFERRAL NUMBER	X(13)	463	475
2-275	PLACE OF SERVICE	X(2)	476	477
2-280	TYPE OF SERVICE	X(2)	478	479
2-285	HEALTH CARE COVERAGE MEMBER CATEGORY CODE	X	480	480
2-291	PAY GRADE CODE (SPONSOR)	X(2)	481	482
2-292	PAY PLAN CODE (SPONSOR)	X(5)	483	487

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Data Requirements - Data Element Layout

3.0 NON-INSTITUTIONAL DATA ELEMENT (CONTINUED)

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
2-295	HEALTH CARE COVERAGE MEMBER RELATIONSHIP CODE	X	488	488
2-300	ENROLLMENT/HEALTH PLAN CODE	X(2)	489	490
2-301	HEALTH CARE DELIVERY PROGRAM PLAN COVERAGE CODE	X(3)	491	493
2-303	REGION INDICATOR	X(2)	494	495
2-305	SPECIAL PROCESSING CODE	X(8)	496	503
2-306	HEALTH CARE DELIVERY PROGRAM SPECIAL ENTITLEMENT CODE	X(2)	504	505
2-310	CA/NAS NUMBER	X(15)	506	520
2-315	CA/NAS REASON FOR ISSUANCE	X	521	521
2-320	CA/NAS EXCEPTION REASON	X(2)	522	523
2-325	PRICING RATE CODE	X(2)	524	525
2-330	AMBULATORY PAYMENT CLASSIFICATION CODE	X(5)	526	530
2-331	OPPS PAYMENT STATUS INDICATOR CODE	X(2)	531	532
2-335	AMOUNT NETWORK PROVIDER DISCOUNT	S9(7)V99	533	541
	FILLER	X(4)	542	545

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4.0 PROVIDER FILE RECORD

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
3-001	RECORD TYPE INDICATOR	X	1	1
3-005	PROVIDER TAXPAYER NUMBER	X(9)	2	10
3-010	PROVIDER SUB-IDENTIFIER	X(4)	11	14
3-015	PROVIDER TAXPAYER NUMBER IDENTIFIER	X	15	15
3-020	CONTRACTOR NUMBER	X(2)	16	17
3-025	PROVIDER CONTRACT AFFILIATION CODE	X	18	18
3-030	INSTITUTIONAL/NON-INSTITUTIONAL INDICATOR	X	19	19
3-035	PROVIDER NAME	X(40)	20	59
3-040	PROVIDER ADDRESS		60	119
3-045	PROVIDER STREET ADDRESS	X(30)	60	89
3-050	PROVIDER CITY	X(18)	90	107
3-055	PROVIDER STATE OR COUNTRY CODE	X(3)	108	110
3-060	PROVIDER ZIP CODE	X(9)	111	119
3-065	PROVIDER BILLING ADDRESS		120	179
3-070	PROVIDER BILLING STREET ADDRESS	X(30)	120	149
3-075	PROVIDER BILLING CITY	X(18)	150	167
3-080	PROVIDER BILLING STATE OR COUNTRY CODE	X(3)	168	170
3-085	PROVIDER BILLING ZIP CODE	X(9)	171	179
3-090	PROVIDER MAJOR SPECIALTY/TYPE OF INSTITUTION	X(10)	180	189
3-095	TYPE OF INSTITUTION TERM INDICATOR CODE	X	190	190
3-100	AMERICAN HOSPITAL ASSOCIATION ID NUMBER	X(9)	191	199
3-105	AHA MULTI-HOSPITAL SYSTEM CODE	X(4)	200	203
3-110	MEDICARE NUMBER	X(8)	204	211
3-115	PROVIDER ACCEPTANCE DATE	YYYYMMDD	212	219
3-120	PROVIDER TERMINATION DATE	YYYYMMDD	220	227
3-125	RURAL/URBAN INDICATOR	X	228	228
3-130	IDME RATIO	9V9(4)	229	233
3-135	IDME RATIO EFFECTIVE DATE	YYYYMMDD	234	241
3-140	AREA WAGE INDEX	9V9(4)	242	246
3-145	AREA WAGE INDEX EFFECTIVE DATE	YYYYMMDD	247	254
3-150	DRG EXEMPT/NONEXEMPT INDICATOR	X	255	255
3-155	DRG EXEMPT/NONEXEMPT EFFECTIVE DATE	YYYYMMDD	256	263
3-160	TRANSACTION CODE	X	264	264
3-165	RECORD EFFECTIVE DATE	YYYYMMDD	265	272
	FILLER	X(17)	273	289

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

DATA ELEMENT DEFINITION

ELEMENT NAME: ADJUSTMENT SEQUENCE NUMBER

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
Institutional	1-378	1	Yes
Non-Institutional	2-141	1	Yes

PRIMARY PICTURE (FORMAT) Three (3) alphanumeric characters.

DEFINITION Identifies the processing order of adjustment and cancellation records.

CODE/VALUE SPECIFICATIONS N/A

ALGORITHM Set Adjustment Sequence Number on the initial TED (Type of Submission = I, O, and D) to 000 (zeroes) and increment by one (1) with each adjustment/cancellation transaction (Type of Submission = A and C). Do **not** increment for TED record resubmissions. If the adjustment/cancellation is for a TED record initially submitted by a previous contractor then set the Adjustment Sequence Number to 001 and increment by one (1) for each subsequent adjustment.

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

For all adjustment/cancellations to original HCSR records (Type of Submission B and E) set the Adjustment Sequence Number to 000 (zeroes).

For Contract Numbers MDA90602C0013, MDA90603C0019, MDA90603C0009, MDA90603C0010, MDA90603C0011, and MDA90603C0015, the TED system will set the transaction value of this element to 000 (zeroes).

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

DATA ELEMENT DEFINITION

ELEMENT NAME: AMINISTRATIVE CLIN

RECORD NAME	RECORDS/LOCATOR NUMBERS		
	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-283	3	Yes ¹
Non-Institutional	2-108	3	Yes ¹

PRIMARY PICTURE (FORMAT) Three (3) occurrences of six (6) alphanumeric characters.

DEFINITION Request for government administrative fee. Shall be provided by contractor.

CODE/VALUE SPECIFICATIONS N/A

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

¹ To be reported on contracts awarded prior to 08/2007. Must be blank filled for all others. Can report from 1 to 3 CLINs, left justify and blank fill. Do not duplicate. Each occurrence consists of six characters.

Note: Identifies the Contract Line Item Number (CLIN) on the contract for which the contractor is requesting an administrative fee payment.

Note: Administrative CLIN cannot change on an adjustment if the Admin Rate has been paid.

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

DATA ELEMENT DEFINITION

ELEMENT NAME: ADMISSION DATE

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-265	1	Yes
PRIMARY PICTURE (FORMAT) Eight (8) alphanumeric characters, YYYYMMDD.			
DEFINITION Date the patient was first admitted to the institution for this episode of care.			
CODE/VALUE SPECIFICATIONS			
	YYYY	4 digit calendar year	
	MM	2 digit calendar month	
	DD	2 digit calendar day	
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 - Institutional/Non-Institutional Record Data Elements (A - D)

DATA ELEMENT DEFINITION

ELEMENT NAME: ADMISSION DIAGNOSIS

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-295	1	Yes
PRIMARY PICTURE (FORMAT) Six (6) alphanumeric characters.			
DEFINITION ICD-9-CM Code to identify the diagnosis under which patient was admitted to institution.			
CODE/VALUE SPECIFICATIONS Refer to Internal Classification of Diseases, Ninth Edition, Clinical Modification, (ICD-9-CM), Volume 1 for valid ICD-9-CM codes. Must code the most detailed subcategory or subclassification. Left justify including leading zeroes and blank fill. Do not fill with zeroes. Do not code the decimal point.			
ALGORITHM N/A			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE			GROUP
N/A			N/A

NOTES AND SPECIAL INSTRUCTIONS:

The primary diagnosis may be coded as the admission diagnosis if the admission diagnosis is not available.

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

DATA ELEMENT DEFINITION

ELEMENT NAME: AGR SERVICE LEGAL AUTHORITY CODE

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
Institutional	1-065	1	Yes
Non-Institutional	2-056	1	Yes

PRIMARY PICTURE (FORMAT) One (1) alphanumeric character

DEFINITION The code that represents the source of the legal authority for Active Guard and Reserve service. Download field from DEERS.

CODE/VALUE SPECIFICATIONS		
A	AGR under 10 USC 10301 (reference (b))	
B	AGR under 10 USC 10211 (reference (b))	
C	AGR under 10 USC 12301 (d) (reference (b))	
D	AGR under 10 USC 12310 (reference (b))	
E	AGR under 10 USC 12501 (reference (b))	
F	AGR under 10 USC 3015/3019/8019 (reference (b))	
G	AGR under 10 USC 3033/8033 (reference (b))	
H	AGR under 10 USC 3496/8496 (reference (b))	
I	AGR: 14 USC 276	
J	AGR under 32 USC 502(f) (reference (m))	
K	AGR under 32 USC 503 (reference (m))	
L	AGR under 32 USC 708 (reference (m))	
X	AGR: Other	
Z	Unknown/Not Applicable	

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

If the DEERS response does not return an AGR SERVICE LEGAL AUTHORITY CODE, report 'Z' in this field.
 If the person is not on DEERS but claim is payable (i.e., government liability), report 'Z' in this field.

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

DATA ELEMENT DEFINITION

ELEMENT NAME: AMBULATORY PAYMENT CLASSIFICATION (APC) CODE			
RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-330	Up to 99	Yes ¹
PRIMARY PICTURE (FORMAT) Five (5) alphanumeric characters.			
DEFINITION Grouping that categorizes outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed when paid under the Outpatient Prospective Payment System (OPPS).			
CODE/VALUE SPECIFICATIONS Refer to TMA's OPPS web site at http://www.tricare.mil/opp s. Must be left justified and blank filled.			
ALGORITHM N/A			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE			GROUP
N/A			N/A
NOTES AND SPECIAL INSTRUCTIONS:			
¹ Required on all TED records reimbursed under the OPPS.			

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

DATA ELEMENT DEFINITION

ELEMENT NAME: AMOUNT ALLOWED (TOTAL)			
RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-125	1	Yes
PRIMARY PICTURE (FORMAT) Nine (9) signed numeric digits including two (2) decimal places.			
DEFINITION	Total amount allowed for all authorized services on the TED record. For reporting data relating to External Resource Sharing Encounters, refer to Section 1.1, paragraph 8.0 .		
CODE/VALUE SPECIFICATIONS	N/A		
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 - Institutional/Non-Institutional Record Data Elements (A - D)

DATA ELEMENT DEFINITION

ELEMENT NAME: AMOUNT ALLOWED BY PROCEDURE CODE

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-185	Up to 99	Yes ¹
PRIMARY PICTURE (FORMAT) Nine (9) signed numeric digits including two (2) decimal places.			
DEFINITION Total amount allowed for this (these) service(s)/supply(ies).			
CODE/VALUE SPECIFICATIONS N/A			
ALGORITHM N/A			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		GROUP	
N/A		N/A	

NOTES AND SPECIAL INSTRUCTIONS:

¹ If the procedure is denied this amount must be zero.

Note: For Mail Order Pharmacy (MOP) records the AMOUNT ALLOWED BY PROCEDURE CODE the acquisition cost of the drug or supply.

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

DATA ELEMENT DEFINITION

ELEMENT NAME: AMOUNT APPLIED TOWARD DEDUCTIBLE

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-institutional	2-195	Up to 99	Yes
PRIMARY PICTURE (FORMAT) Five (5) signed numeric digits including two (2) decimal places.			
DEFINITION Portion of Amount Allowed which is applied toward the person or family deductible for the fiscal year for the services reported on the occurrence/line item.			
CODE/VALUE SPECIFICATIONS N/A			
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 - Institutional/Non-Institutional Record Data Elements (A - D)

DATA ELEMENT DEFINITION

ELEMENT NAME: AMOUNT BILLED (TOTAL)

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-120	1	Yes
PRIMARY PICTURE (FORMAT) Nine (9) signed numeric digits including two (2) decimal places.			
DEFINITION	Total amount billed for all services reported on the TED record. For reporting data relating to External Resource Sharing Encounters, refer to Section 1.1, paragraph 8.0 .		
CODE/VALUE SPECIFICATIONS	N/A		
ALGORITHM	Must be sum total charge per revenue code (institutional record) fields.		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE	GROUP		
N/A	N/A		
NOTES AND SPECIAL INSTRUCTIONS:			
N/A			

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

DATA ELEMENT DEFINITION

ELEMENT NAME: AMOUNT BILLED BY PROCEDURE CODE

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-180	Up to 99	Yes
PRIMARY PICTURE (FORMAT) Nine (9) signed numeric digits including two (2) decimals.			
DEFINITION Amount billed by the provider for this (these) service(s)/supply(ies).			
CODE/VALUE SPECIFICATIONS N/A			
ALGORITHM N/A			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE	GROUP		
N/A	N/A		

NOTES AND SPECIAL INSTRUCTIONS:

For non-cancelled TRICARE Mail Order Pharmacy (TMOP) records the AMOUNT BILLED BY PROCEDURE CODE on the first occurrence/line item must be the Administrative Fee (includes administrative and dispensing cost) and must be \$0.00 on the second occurrence/line item. For cancelled TMOP records the AMOUNT BILLED BY PROCEDURE CODE for all occurrences/line items must be \$0.00 except for lines with Procedure Codes 000MN and 000PA.

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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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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 (A - D)

DATA ELEMENT DEFINITION

ELEMENT NAME: AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL)

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-140	1	Yes ¹
PRIMARY PICTURE (FORMAT) Nine (9) signed numeric digits including two (2) decimal places.			
DEFINITION The total amount paid by government contractor for all services reported on the TED record.			
CODE/VALUE SPECIFICATIONS N/A			
ALGORITHM N/A			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		GROUP	
N/A		N/A	

NOTES AND SPECIAL INSTRUCTIONS:

¹ Reflects the total amount paid regardless of a provider's financial arrangement with the contractor, i.e., "withheld amounts."

Note: This amount does not include interest payments. The amount in this field will be included in the TOTAL AMOUNT PAID field in the header record.

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

DATA ELEMENT DEFINITION

ELEMENT NAME: AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-205	Up to 99	Yes ¹
PRIMARY PICTURE (FORMAT) Nine (9) signed numeric digits including two (2) decimal places.			
DEFINITION The amount paid by the government contractor for the services reported on this occurrence/line item.			
CODE/VALUE SPECIFICATIONS N/A			
ALGORITHM N/A			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		GROUP	
N/A		N/A	

NOTES AND SPECIAL INSTRUCTIONS:

¹ Reflects the total amount paid regardless of a provider's financial arrangement with the contractor, i.e., "withheld amounts."

Note: This amount does not include interest payments. The amount in this field will be included in the TOTAL AMOUNT PAID field in the header record.

Note: For MOP records, the AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE must be the acquisition cost of the drug or supply minus the AMOUNT PATIENT COST-SHARE. It must be only the acquisition cost of the drug or supply on the second occurrence/line item.

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

DATA ELEMENT DEFINITION

ELEMENT NAME: AMOUNT PAID BY OTHER HEALTH INSURANCE (OHI)			
RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-130	1	Yes
Non-Institutional	2-190	Up to 99	Yes
PRIMARY PICTURE (FORMAT) Nine (9) signed numeric digits including two (2) decimal places.			
DEFINITION Institutional: Amount paid by OHI, including TPL, for services reported on this occurrence/line item.			
Non-Institutional: Amount paid by OHI, including TPL, for service(s) on this occurrence/line item.			
CODE/VALUE SPECIFICATIONS N/A			
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 - Institutional/Non-Institutional Record Data Elements (A - D)

DATA ELEMENT DEFINITION

ELEMENT NAME: AMOUNT PATIENT COST-SHARE

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
Institutional	1-135	1	Yes
Non-Institutional	2-200	Up to 99	Yes

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

DEFINITION Institutional: The total amount of money the beneficiary is responsible for paying in connection with covered services, other than any disallowed amounts.

Non-Institutional: The total amount of money the beneficiary is responsible for paying in connection with covered services, other than the annual fiscal year deductible and any disallowed amounts for services reported on this occurrence/line item.

CODE/VALUE SPECIFICATIONS N/A

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

DATA ELEMENT DEFINITION

ELEMENT NAME: BEGIN DATE OF CARE

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-275	1	Yes
Non-Institutional	2-150	Up to 99	Yes
PRIMARY PICTURE (FORMAT) Eight (8) alphanumeric characters, YYYYMMDD.			
DEFINITION Institutional: Earliest date of care reported on this TED record.			
Non-Institutional: The earliest date of care for this procedure.			
CODE/VALUE SPECIFICATIONS	YYYY	4 digit calendar year	
	MM	2 digit calendar month	
	DD	2 digit calendar day	
ALGORITHM	N/A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE	GROUP		
N/A	N/A		

NOTES AND SPECIAL INSTRUCTIONS:

Institutional Record - if the record has a FREQUENCY CODE of '3' Interim, or '4' Final, the BEGIN DATE OF CARE must match the ENDING DATE OF CARE on the previous TED record submitted.

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

DATA ELEMENT DEFINITION

ELEMENT NAME: CA/NAS EXCEPTION REASON

RECORD NAME	RECORDS/LOCATOR NUMBERS		
	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-180	1	Yes ¹
Non-Institutional	2-320	Up to 99	Yes ¹

PRIMARY PICTURE (FORMAT) Two (2) alphanumeric characters².

DEFINITION Code that describes the reason for bypassing the requirement of a CA/NAS.

CODE/VALUE SPECIFICATIONS	LOCATOR#	DESCRIPTION
	1	Enrollment in an insurance plan that provides primary coverage
	2	Emergency medical treatment
	3	Inpatient care in a college infirmary
	5	Residential Treatment Center (RTC)
	6	Resource Sharing
	7	Specialized Treatment Facility (STF), e.g., Alcohol Treatment Facility
	9	TRICARE Demonstration Projects that allow exception to CA/NAS requirements.
	B	Former spouse with pre-existing condition, not on DEERS.
	C	Issuance of Good Faith Payment when the patient cannot be enrolled on DEERS due to death, inability to locate, etc.
	K	Continued Health Care Benefit Program (CHCBP)
	M	Abused Family Member
	Q	Active Duty Claims
	S	Home Health Agency (HHA PPS)

	ORDER ³	CA/NAS EXCEPTION REASON	DESCRIPTION
	1st	9	TRICARE Demonstration Projects
	2nd	2	Emergency medical treatment
	3rd	1	Enrollment in an insurance plan that provides primary coverage
	4th	3	Inpatient care in college infirmary
	5th	5	Residential Treatment Center care
	6th	6	Resource Sharing
	7th	7	Specialized Treatment Facility, e.g., Alcohol Treatment Facility

NOTES AND SPECIAL INSTRUCTIONS:

¹ Required if applicable to TED record as defined in CA/NAS Exception Reason Specifications. If not applicable, report blank.

² When using single digit codes, left justify and blank fill.

³ Reporting sequence to be used if more than one EXCEPTION REASON applies.

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

DATA ELEMENT DEFINITION

ELEMENT NAME: CA/NAS EXCEPTION REASON (Continued)			
	ORDER³	CA/NAS EXCEPTION REASON	DESCRIPTION
CODE/VALUE SPECIFICATIONS (CONTINUED)	8th	B	Former spouse with pre-existing condition, not on DEERS and CA/NAS required
	9th	C	Issuance of Good Faith Payment when the patient cannot be enrolled on DEERS due to death, inability to locate, etc.
	10th	S	HHA PPS
	11th	Q	Active Duty Claims
	12th	K	CHCBP
	13th	M	Abused Family Member
ALGORITHM	N/A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE	GROUP		
N/A	PROCESSING INFORMATION		
NOTES AND SPECIAL INSTRUCTIONS:			
¹ Required if applicable to TED record as defined in CA/NAS Exception Reason Specifications. If not applicable, report blank.			
² When using single digit codes, left justify and blank fill.			
³ Reporting sequence to be used if more than one EXCEPTION REASON applies.			

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

DATA ELEMENT DEFINITION

ELEMENT NAME: CA/NAS REASON FOR ISSUANCE

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
Institutional	1-175	1	Yes ¹
Non-Institutional	2-315	Up to 99	Yes ¹

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

DEFINITION The CA/NAS Reason For Issuance indicates why the care was not or cannot be provided by a MTF.

CODE/VALUE SPECIFICATIONS Download from DEERS.

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	PROCESSING INFORMATION

NOTES AND SPECIAL INSTRUCTIONS:

¹ If not applicable report blanks.

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

DATA ELEMENT DEFINITION

ELEMENT NAME: CAS/NAS NUMBER

RECORD NAME	RECORDS/LOCATOR NUMBERS		
	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-170	1	Yes ¹
Non-Institutional	2-310	Up to 99	Yes ¹

PRIMARY PICTURE (FORMAT) Fifteen (15) alphanumeric characters.

DEFINITION Unique number assigned by the MTF when issuing the CA/NAS. Care authorization is also issued by the MTF.

CODE/VALUE SPECIFICATIONS Download from DEERS.

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	PROCESSING INFORMATION

NOTES AND SPECIAL INSTRUCTIONS:

¹ Must be blank if the record contains treatment data exempt from CA/NAS requirement or services are denied for lack of CA/NAS.

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

DATA ELEMENT DEFINITION

ELEMENT NAME: CLAIM FORM TYPE/EMC INDICATOR			
RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-240	1	Yes
Non-Institutional	2-105	Up to 99	Yes
PRIMARY PICTURE (FORMAT) One (1) alphanumeric character.			
DEFINITION Code associated with the primary claim form submitted.			
CODE/VALUE SPECIFICATIONS	B	DD Form 2642	
	C	HCFA/CMS 1500	
	F	UB-04/UB-92	
	G	Electronic Institutional Claim Submission	
	H	Electronic Non-Institutional Claim Submission	
	I	Electronic Drug Claim Submission	
	J	Other	
ALGORITHM N/A			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE	GROUP		
N/A	N/A		
NOTES AND SPECIAL INSTRUCTIONS:			
This data element must be 'I' for MOP Prescriptions.			
This data element must be 'J' for MOP and Retail Pharmacy Prior Authorizations and Medical Necessity Reviews.			

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

DATA ELEMENT DEFINITION

ELEMENT NAME: COVERED DAYS

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-285	1	Yes
PRIMARY PICTURE (FORMAT)	Three (3) signed numeric digits		
DEFINITION	Number of hospital days authorized by the contractor.		
CODE/VALUE SPECIFICATIONS	For admit through discharge statements, enter the number of hospital days where there was any allowance by the contractor. For initial, interim, or final statements, enter the number of allowed days in the period covered by the TED record.		
ALGORITHM	The day of admission is to be counted as a hospital day. The day of discharge is not to be counted as a hospital day.		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE			GROUP
N/A			N/A
NOTES AND SPECIAL INSTRUCTIONS:			
N/A			

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

DATA ELEMENT DEFINITION

ELEMENT NAME: DATE ADJUSTMENT IDENTIFIED			
RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-045	1	Yes ¹
Non-Institutional	2-045	1	Yes ¹
PRIMARY PICTURE (FORMAT) Eight (8) alphanumeric characters, YYYYMMDD.			
DEFINITION Date the contractor determined an adjustment or cancellation TED record was required.			
CODE/VALUE SPECIFICATIONS			
	YYYY	4 digit calendar year	
	MM	2 digit calendar month	
	DD	2 digit calendar day	
ALGORITHM N/A			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		GROUP	
N/A		N/A	
NOTES AND SPECIAL INSTRUCTIONS:			
¹ Zero fill if TED record is an initial submission record.			

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

DATA ELEMENT DEFINITION

ELEMENT NAME: DATE TED RECORD PROCESSED TO COMPLETION

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
Institutional	1-040	1	Yes
Non-Institutional	2-040	1	Yes

PRIMARY PICTURE (FORMAT) Eight (8) alphanumeric characters, YYYYMMDD.

DEFINITION Date the contractor processed the claim/treatment encounter data to completion. This is when all services and supplies on the claim have been adjudicated, payment has been determined, deductible has been applied, and payment/deductible/denial has been posted to history and the TED record(s). This date does not change for resubmissions (corrections to TED records with edit errors) unless previously coded in error.

CODE/VALUE SPECIFICATIONS		
	YYYY	4 digit calendar year
	MM	2 digit calendar month
	DD	2 digit calendar day

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

DATA ELEMENT DEFINITION

ELEMENT NAME: DEERS DEPENDENT SUFFIX

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
Non-Institutional	2-075	1	No

PRIMARY PICTURE (FORMAT) Two (2) alphanumeric characters.

DEFINITION Code maintained on DEERS database that uniquely identifies the patient within the family. Download field from DEERS.

CODE/VALUE SPECIFICATIONS		
	-	Blank (not reported)
	01-19	Eligible Dependent Children
	20	Sponsor
	30-39	Spouse of Sponsor
	40-44	Mother of Sponsor
	45-49	Father of Sponsor
	50-54	Mother-in-law of Sponsor
	55-59	Father-in-law of Sponsor
	60-69	Other Eligible Family Members (including former spouse)
	70-74	Unknown by DEERS
	75	Pseudo DDS - Unknown by Contractor
	98	Service Secretary Designee

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

This data element CAN ONLY be used for TYPE OF SERVICE (SECOND POSITION) = 'M' (MOP Drugs, Supplies, Prescription Authorizations, and Reviews) and for TYPE OF SUBMISSION 'B' (ADJUSTMENT OF NON-TED RECORD (HCSR) DATA) AND 'E' (COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA).

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

DATA ELEMENT DEFINITION

ELEMENT NAME: DEERS IDENTIFIER (PATIENT)

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
Institutional	1-097	1	Yes
Non-Institutional	2-082	1	Yes

PRIMARY PICTURE (FORMAT) Eleven (11) alphanumeric characters.

DEFINITION A DEERS identifier created from the combination of the DEERS assigned nine digit DEERS family identifier and two digit DEERS Beneficiary Identifier. Download from DEERS.

CODE/VALUE SPECIFICATIONS Positions 1 through 9 = DEERS Family Identifier

ALGORITHM Positions 10 and 11 = DEERS Beneficiary Identifier (Valid Values are 00 through 99).

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

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

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

DATA ELEMENT DEFINITION

ELEMENT NAME: DRG NUMBER

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-290	1	Yes ¹
PRIMARY PICTURE (FORMAT) Three (3) alphanumeric characters.			
DEFINITION Number identifying the Diagnosis Related Group (DRG) determined for this care.			
CODE/VALUE SPECIFICATIONS N/A			
ALGORITHM N/A			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE	GROUP		
N/A	N/A		

NOTES AND SPECIAL INSTRUCTIONS:

¹ Required if TED record is processed under TRICARE DRG reimbursement methodology. See TRICARE Reimbursement Manual (TRM), [Chapter 6](#) for DRG information.

- END -

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Chapter 2, Section 2.7

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

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER SUB-IDENTIFIER

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-205	1	Yes
Non-Institutional	2-245	Up to 99	Yes
PRIMARY PICTURE (FORMAT) Four (4) alphanumeric characters.			
DEFINITION Identification number that uniquely identifies multiple providers using the same TIN.			
CODE/VALUE SPECIFICATIONS Refer to Section 2.10 , ELN 3-010.			
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 - Institutional/Non-Institutional Record Data Elements (P)

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER TAXPAYER NUMBER

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
Institutional	1-200	1	Yes
Non-Institutional	2-240	Up to 99	Yes

PRIMARY PICTURE (FORMAT) Nine (9) alphanumeric characters.

DEFINITION The IRS TIN assigned to the institution/provider supplying the care.

CODE/VALUE SPECIFICATIONS For institutions must be nine digit EIN. For individual providers, should be the nine digit EIN or SSN, if available. If not available, report the contractor-assigned number. (Refer to [Section 2.10 ELN 3-005](#)). Report all nines for transportation services.

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

Claims for care rendered by an **EIA** Tutor must be identified on the TED record using the billing **ACSP** Provider Taxpayer Number.

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Data Requirements - Institutional/Non-Institutional Record Data Elements (Q - S)

DATA ELEMENT DEFINITION

ELEMENT NAME: SPECIAL PROCESSING CODE

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-185	4	Yes ¹
Non-Institutional	2-305	4/Up to 99	Yes ¹
PRIMARY PICTURE (FORMAT) Four occurrences of two (2) alphanumeric characters per occurrence/line item for non-institutional.			
DEFINITION Code indicating care that requires special processing.			
CODE/VALUE SPECIFICATIONS			
	0	Hospice non-affiliated provider	
	1	Medicaid	
	3	Allogeneic bone marrow recipient (Wilford Hall referred only prior to 10/01/1997 and PCM/HCF referred after 12/31/2002)	
	4	Allogeneic bone marrow donor (Wilford Hall referred only prior to 10/01/1997 and PCM/HCF referred after 12/31/2002)	
	5	Liver transplant (effective for care before 03/01/1997, or between 02/20/1998 and 08/31/1999 and after 05/31/2003)	
	6	Home Health Care (non-institutional only)	
	7	Heart Transplant	
	10	Active duty cost-share ambulatory surgery taken from professional claim	
	11	Hospice	
	12	Capitated Arrangements	
	14	Bone marrow transplants - TMA approved	
	16	Ambulatory Surgery Facility charge	
	17	VA medical provider claim (care rendered by a VA provider)	
	A	Partnership Program (internal providers with signed agreements)	
	E	HHC/CM Demonstration (After 03/15/1999, grandfathered into the Individual Case Management Program) ²	
	Q	Active Duty Delayed Deductible	
	R	Medicare/TRICARE Dual Entitlement First Payor - not a Medicare Benefit (Effective 10/01/2001)	
	S	Resource Sharing - External	

NOTES AND SPECIAL INSTRUCTIONS:

- ¹ Required if TED record processing is applicable to special processing conditions. Can report from 0 to 4 codes, left justify and blank fill. Do not duplicate. Each occurrence consists of two characters.
- ² Whenever SPECIAL PROCESSING CODE = 'E' (grandfathered HHC claims) is coded, SPECIAL PROCESSING CODE 'CM' must be present.
- ³ Whenever SPECIAL PROCESSING CODE = 'AU' (AUTISM DEMONSTRATION) is coded, SPECIAL PROCESSING CODE 'PF' (ECHO) must be present.
- ⁴ Whenever SPECIAL PROCESSING CODE = 'RB' (Respite Benefit for Seriously Injured or Ill ADSM) is coded, SPECIAL PROCESSING CODE 'SE' (SHCP- TRICARE Eligible) must be present.

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Data Requirements - Institutional/Non-Institutional Record Data Elements (Q - S)

DATA ELEMENT DEFINITION

ELEMENT NAME: SPECIAL PROCESSING CODE (Continued)		
CODE/VALUE SPECIFICATIONS (CONTINUED)		
	T	Medicare/TRICARE Dual Entitlement (formally normal COB processing (Effective 10/01/2001 process as Second Payor))
	U	BRAC Medicare Pharmacy (Section 702) claim (Terminated 04/01/2001)
	V	Financially underwritten payment by contractor
	W	Non-financially underwritten payment by financially underwritten contractor
	X	Partial hospitalization - provider not contracted with or employed by the partial hospitalization program billing for psychotherapy services in a partial hospitalization program
	Y	Heart-lung transplant
	Z	Kidney transplant
	AB	Abused dependent of discharged or dismissed member (Effective 07/28/1999)
	AD	Foreign active duty claims (Effective 06/30/1996)
	AN	SHCP - Non-MTF-Referral Care (Effective 10/01/1999 through 05/31/2004)
	AR	SHCP - Referred Care (Effective 10/01/1999 through 05/31/2004)
	AU	Autism Demonstration (Effective 03/15/2008) ³
	BD	Bosnia Deductible (Effective 12/08/1995)
	CA	Civil Action Payment (Effective 07/01/1999)
	CE	SHCP - CCEP (Effective 10/01/1999)
	CL	Clinical Trials Demonstration (Enrollment Effective 03/17/2003 through 03/31/2008)
	CM	ICMP claims (Effective 03/15/1999)
	CP	Cancer Clinical Trials (Enrollment Effective on or after 04/01/2008)
	CT	CCTP (Effective 12/28/2001)
	EU	Emergency services rendered by an unauthorized provider (Effective 06/01/1999)
	FF	TFL (First Payor - Not A Medicare Benefit) (Effective 10/01/2001)

NOTES AND SPECIAL INSTRUCTIONS:

- ¹ Required if TED record processing is applicable to special processing conditions. Can report from 0 to 4 codes, left justify and blank fill. Do not duplicate. Each occurrence consists of two characters.
- ² Whenever SPECIAL PROCESSING CODE = 'E' (grandfathered HHC claims) is coded, SPECIAL PROCESSING CODE 'CM' must be present.
- ³ Whenever SPECIAL PROCESSING CODE = 'AU' (AUTISM DEMONSTRATION) is coded, SPECIAL PROCESSING CODE 'PF' (ECHO) must be present.
- ⁴ Whenever SPECIAL PROCESSING CODE = 'RB' (Respite Benefit for Seriously Injured or Ill AD SM) is coded, SPECIAL PROCESSING CODE 'SE' (SHCP- TRICARE Eligible) must be present.

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Data Requirements - Institutional/Non-Institutional Record Data Elements (Q - S)

DATA ELEMENT DEFINITION

ELEMENT NAME: SPECIAL PROCESSING CODE (Continued)

CODE/VALUE SPECIFICATIONS (CONTINUED)		
	FG	TFL (First Payor - No TRICARE Provider Certification, i.e., Medicare benefits have been exhausted) (Effective 10/01/2001)
	FS	TFL (Second Payor) (Effective 10/01/2001)
	GF	TPR for eligible ADFM residing with a TPR Eligible ADSM (Effective 10/30/2000 through 08/31/2002)
	GU	ADSM enrolled in TPR (Effective 10/01/1999)
	KO	Allied Forces - Kosovo (Effective 06/01/1999)
	MH	Mental Health Active Duty Cost- Share
	MN	TSP (Non-Network) (Effective 01/01/1998 through 12/31/2001)
	MS	TSP (Network) (Effective 01/01/1998 through 12/31/2001)
	NE	Operation Noble Eagle/Operation Enduring Freedom (Reservist called to Active Duty under Executive Order 13223) (Effective 09/14/2001 through 10/31/2009)
	PD	Pharmacy Redesign Pilot Program (Effective 07/01/2000 through 04/01/2001)
	PF	ECHO (formerly PFPWD)
	PO	TRICARE Prime - Point of Service
	PS	Specialty Pharmacy Service (MOP Only)
	PV	Retail Network Pharmacy Services for DVA Beneficiaries (TPharm Retail Pharmacies Only)
	RB	Respite Benefit for Seriously Injured or Ill ADSMs ⁴
	RI	Resource Sharing - Internal
	RS	Medicare/TRICARE Dual Entitlement (First Payor - No TRICARE Provider Certification, i.e., Medicare benefits have been exhausted) (Effective 10/01/2001)
	SC	SHCP - Non-TRICARE Eligible (Effective 10/01/1999)
	SE	SHCP - TRICARE Eligible (Effective 10/01/1999)
	SM	SHCP - Emergency (Effective 10/01/1999)
	SN	TSS (Non-Network) (Effective 04/01/2000 through 12/31/2002)
	SP	Special/Emergent Care (Effective 06/01/1999)
	SS	TSS (Network) (Effective 04/01/2000 through 12/31/2002)

NOTES AND SPECIAL INSTRUCTIONS:

- ¹ Required if TED record processing is applicable to special processing conditions. Can report from 0 to 4 codes, left justify and blank fill. Do not duplicate. Each occurrence consists of two characters.
- ² Whenever SPECIAL PROCESSING CODE = 'E' (grandfathered HHC claims) is coded, SPECIAL PROCESSING CODE 'CM' must be present.
- ³ Whenever SPECIAL PROCESSING CODE = 'AU' (AUTISM DEMONSTRATION) is coded, SPECIAL PROCESSING CODE 'PF' (ECHO) must be present.
- ⁴ Whenever SPECIAL PROCESSING CODE = 'RB' (Respite Benefit for Seriously Injured or Ill ADSM) is coded, SPECIAL PROCESSING CODE 'SE' (SHCP- TRICARE Eligible) must be present.

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Data Requirements - Institutional/Non-Institutional Record Data Elements (Q - S)

DATA ELEMENT DEFINITION

ELEMENT NAME: SPECIAL PROCESSING CODE (Continued)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	ST	Specialized Treatment (Effective 03/01/1997 through 05/31/2003)
	WR	Mental Health Wraparound Demonstration (Effective 01/01/1998 through 06/30/2001)
ALGORITHM	N/A	
SUBORDINATE AND/OR GROUP ELEMENTS		
SUBORDINATE	GROUP	
N/A	PROCESSING INFORMATION	
NOTES AND SPECIAL INSTRUCTIONS:		
¹ Required if TED record processing is applicable to special processing conditions. Can report from 0 to 4 codes, left justify and blank fill. Do not duplicate. Each occurrence consists of two characters.		
² Whenever SPECIAL PROCESSING CODE = 'E' (grandfathered HHC claims) is coded, SPECIAL PROCESSING CODE 'CM' must be present.		
³ Whenever SPECIAL PROCESSING CODE = 'AU' (AUTISM DEMONSTRATION) is coded, SPECIAL PROCESSING CODE 'PF' (ECHO) must be present.		
⁴ Whenever SPECIAL PROCESSING CODE = 'RB' (Respite Benefit for Seriously Injured or Ill ADSM) is coded, SPECIAL PROCESSING CODE 'SE' (SHCP- TRICARE Eligible) must be present.		

- END -

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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:			
N/A			

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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			

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Data Requirements - Provider Record Data

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER SUB-IDENTIFIER

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
Provider	3-010	1	Yes

PRIMARY PICTURE (FORMAT) Four (4) alphanumeric characters.

DEFINITION Identification number that uniquely identifies multiple providers using the same Taxpayer Identification Number (TIN).

CODE/VALUE SPECIFICATIONS Must be zero-filled if there are no multiple providers within the TIN and zip code.

For non-institutional providers, including institutions that render non-institutional care (e.g., outpatient), no two Provider Sub-Identifiers may be the same within a TIN and zip code.

For clinics, Provider Sub-Identifier is assigned with an alpha character in the first position or first two positions followed by two or three numeric digits, sequentially assigned with the clinic always assigned 01 or 001. Individual providers within the clinic would then begin with 02 or 002 having the same alpha character(s) in the first position as the clinic record.

For all other non-institutional providers, the Provider Sub-Identifier must be four numeric digits.

Institutional Provider Sub-Identifiers are to be numeric digits and sequentially assigned within the TIN. For requirements on reporting institutional providers as outpatient hospital non-institutional providers, see Provider Sub-Identifier Example 2.

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

PROVIDER SUB-IDENTIFIER EXAMPLE 1

Example: City Wide Clinic with a TIN of 123456789 has three locations in an area. They would be submitted to TMA in the following format:

TIN	ZIP CODE	SUB-ID	NAME	SPEC
123456789	12345	A001	City Wide Clinic 1	193200000X
123456789	12345	A002	Doctor Jones	207KA0200X
123456789	12345	A003	Doctor Smith	208D00000X
123456789	12345	A004	Doctor Brown	207K00000X
123456789	12345	A005	Doctor Doe	207Q00000X
123456789	12345	B001	City Wide Clinic 2	193200000X
123456789	12345	B002	Doctor Watson	208D00000X
123456789	12345	B003	Doctor Allen	207RG0100X
123456789	54321	A00	City Wide Clinic 3	193200000X
123456789	54321	A002	Doctor Peterson	207QA0401X
123456789	54321	A003	Doctor Adams	2084P0802X

PROVIDER SUB-IDENTIFIER EXAMPLE 2

Example: Township Hospital with a TIN of 987654321 provides outpatient services (e.g., emergency room, etc.) and has two affiliated clinics in the area. These provider records should be reported to TMA in the following manner:

TIN	ZIP CODE	I/N-I IND	SUB-ID	NAME	SPEC
987654321	67890	N	0000	Township Hospital	282N00000X
987654321	67890	N	A001	Township Ear Nose & Throat Clinic	193400000X
987654321	67890	N	A002	Dr. Jones	207YX0602X
987654321	67890	N	A003	Dr. Smith	207YP0228X
987654321	69116	N	A001	Township Surgeons Group	193400000X
987654321	69116	N	A002	Dr. Cutter	207XX0004X
987654321	69116	N	A003	Dr. Suture	207XX0005X

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Data Requirements - Provider Record Data

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER TAXPAYER NUMBER

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-005	1	Yes
PRIMARY PICTURE (FORMAT) Nine (9) alphanumeric characters.			
DEFINITION The IRS TIN assigned to the provider supplying the care.			
CODE/VALUE SPECIFICATIONS For institutions must be a nine digit EIN. For individual providers must be a nine digit TIN or SSN if TIN is not applicable. If not available, follow reporting requirements listed below.			
ALGORITHM N/A			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		GROUP	
N/A		N/A	

PROVIDER TAXPAYER NUMBER REPORTING REQUIREMENTS

1. The contractor who is responsible for certifying the provider shall assign an APN as outlined below when the actual TIN of a provider is not available. The use of a contractor-assigned APN is restricted to the following situations:
 - a. The provider is located in a foreign country and does not have a TIN. If a foreign provider has a TIN, it is to be used. Otherwise, an APN is used regardless of whether the claim is to be paid or denied.
 - b. The provider does not meet TRICARE certification requirements or the contractor does not have substantial evidence that the provider meets the TRICARE certification requirements.
 - c. The contractor has substantial evidence that the provider meets the TRICARE certification requirements. In this case, the payment must be made to the beneficiary.
2. When neither the EIN nor the SSN is available for the provider and the provider is located in your contract area¹.
 - a. If the provider is located in a foreign country, the field is coded in the following manner.

Position 1 through 3 - The three character alpha abbreviation of the country in which the provider or institution is located ([Addendum A](#)).

Position 4 through 9 - A six digit sequential contractor assigned number. These numbers are to be permanently assigned to the provider.

Example: The first provider from Mexico will be coded MEX000001.

 - b. If the provider is not an institutional provider and is located in the United States, the field is coded in the following manner.

Position 1 through 3 - The two character abbreviation of the state (left justify and blank fill) in which the provider or facility is located ([Addendum B](#)).

Position 4 through 9 - A six digit sequential contractor assigned number.

Example: The first provider from Maryland would be coded MD b 000001. Refer to instruction below, for exception.

 - c. For ECHO, if the TED record is for transportation via a POV, assign a TIN of all nines and do not submit a provider record.
3. If it is necessary to assign a number for a provider that is outside of your contract area, the number is assigned following all the above rules except the fourth high order digit must be an "A".

Example: If a beneficiary, whose care when traveling outside of your area is your responsibility, received care in Mexico, it will be coded MEXA00001.

NOTES AND SPECIAL INSTRUCTIONS:

¹ Claims for care rendered by an institutional provider located in the United States must be processed with a valid EIN. Contractor-assigned provider numbers will not be allowed.

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Data Requirements - Provider Record Data

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER TAXPAYER NUMBER (Continued)

Note: These numbers, once assigned, will not be reassigned to another provider. Upon receipt of a valid EIN or SSN, inactivate the APN provider record and submit an 'ADD' transaction for the actual TIN. After the TIN record is added, subsequent adjustments to the TED records previously reported using an APN shall be reported with the current TIN and provider information.

NOTES AND SPECIAL INSTRUCTIONS:

¹ Claims for care rendered by an institutional provider located in the United States must be processed with a valid EIN. Contractor-assigned provider numbers will not be allowed.

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Chapter 2, Section 5.2

Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185)

VALIDITY EDITS

1-185-01V OCCURRENCE NUMBER 1--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO [SECTION 2.8](#)).

1-185-02V OCCURRENCE NUMBER 2--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO [SECTION 2.8](#)).

1-185-03V OCCURRENCE NUMBER 3--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO [SECTION 2.8](#)).

1-185-04V OCCURRENCE NUMBER 4--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO [SECTION 2.8](#)).

1-185-05V A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).

1-185-06V SPECIAL PROCESSING CODE OCCURRENCES MUST BE LEFT JUSTIFIED.

1-185-07V IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

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

THEN BEGIN DATE OF CARE MUST BE < 06/01/2004

1-185-08V IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

GF	TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADSM
----	---

THEN BEGIN DATE OF CARE MUST BE < 09/01/2002

1-185-10V IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

MN	TSP - NON-NETWORK OR
MS	TSP - NETWORK

THEN BEGIN DATE OF CARE MUST BE < 12/31/2001

1-185-11V IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

SN	TSS - NON-NETWORK OR
SS	TSS - NETWORK

THEN BEGIN DATE OF CARE MUST BE < 12/31/2002

1-185-14V IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

ST	SPECIALIZED TREATMENT
----	-----------------------

THEN BEGIN DATE OF CARE MUST BE < 10/01/2004

RELATIONAL EDITS

1-185-08R IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

PO	TRICARE PRIME - POINT OF SERVICE
THEN ENROLLMENT/HEALTH PLAN CODE MUST =	
U	TRICARE PRIME (CIVILIAN PCM) OR
Z	TRICARE PRIME, MTF/PCM OR
WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM OR
XF	FOREIGN ADFM

1-185-14R IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

AN	SHCP - NON-MTF-REFERRED CARE OR
AR	SHCP - REFERRED CARE OR
CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
SC	SHCP - NON-TRICARE ELIGIBLE OR
SE	SHCP - TRICARE ELIGIBLE OR

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

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Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)

	SM	SHCP - EMERGENCY
THEN ENROLLMENT/HEALTH PLAN CODE MUST =	SR	SHCP - REFERRED CARE OR
	SN	SHCP - NON-MTF REFERRED CARE OR
	SO	SHCP - NON-TRICARE ELIGIBLE OR
	ST	SHCP - TRICARE ELIGIBLE
1-185-32R IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	E	HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP)
THEN BEGIN DATE OF CARE IS ≥ 03/15/1999		
AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	CM	ICMP
1-185-34R • TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001. IF BEGIN DATE OF CARE IS < 10/01/2001, THE LINE ITEMS MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.		
IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	FF	TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) OR
	FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) OR
	FS	TFL (SECOND PAYOR)
AND TYPE OF INSTITUTION ≠	10	GENERAL MEDICAL AND SURGICAL
THEN BEGIN DATE OF CARE MUST BE ≥ 10/01/2001		
AND ENROLLMENT/HEALTH PLAN CODE MUST =	FE	TFL - EXTRA OR
	FS	TFL - STANDARD
ELSE IF BEGIN DATE OF CARE IS < 10/01/2001		
THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAILED LINE ITEM (EXCEPT LINE CONTAINING REVENUE CODE 0001) MUST =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER OR
	26	EXPENSES INCURRED PRIOR TO COVERAGE OR
	27	EXPENSES INCURRED AFTER COVERAGE TERMINATED OR
	30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS OR
	31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED OR
	32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED OR

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

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Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)

	33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE OR
	34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS OR
	62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION OR
	141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE.
1-185-35R		<ul style="list-style-type: none"> TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001 UNLESS THE BENEFICIARY IS AN INPATIENT AND THE ADMISSION DATE WAS PRIOR TO 10/01/2001, TFL WILL PAY FOR THE ENTIRE HOSPITAL STAY.
IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	FF	TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) OR
	FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, I.E., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) OR
	FS	TFL (SECOND PAYOR)
AND TYPE OF INSTITUTION =	10	GENERAL MEDICAL AND SURGICAL
THEN END DATE OF CARE MUST BE ≥ 10/01/2001		
AND ENROLLMENT/HEALTH PLAN CODE MUST =	FE	TFL - EXTRA OR
	FS	TFL - STANDARD
1-185-39R		IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	PF	ECHO
THEN HCDP PLAN COVERAGE CODE MUST ≠	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR
	402	TRS TIER 1 MEMBER AND FAMILY 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

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

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Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)

414 TRS MEMBER AND FAMILY COVERAGE

1-185-49R IF ANY OCCURRENCE OF SPECIAL
PROCESSING CODE =

AU AUTISM DEMONSTRATION

THEN BEGIN DATE OF CARE MUST BE \geq 03/15/2008

AND AT LEAST ONE OTHER
OCCURRENCE OF SPECIAL
PROCESSING CODE MUST =

PF ECHO

AND PATIENT AGE¹ MUST BE \geq 18 MONTHS

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

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) SPECIAL ENTITLEMENT CODE (1-186)

VALIDITY EDITS

1-186-01V MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE (REFER TO [SECTION 2.5](#)).

RELATIONAL EDITS

NONE

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Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: PRICING RATE CODE (1-190)

VALIDITY EDITS

1-190-01V VALUE MUST BE A VALID INSTITUTIONAL PRICING RATE CODE.

RELATIONAL EDITS

1-190-01R	IF FILING STATE/COUNTRY CODE =	MD	MARYLAND
	THEN PRICING RATE CODE MUST ≠	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I	TRICARE DRG REIMBURSEMENT WITH COST OUTLIER OR
		J	TRICARE DRG REIMBURSEMENT WITH NO OUTLIER
1-190-02R	IF DRG NUMBER IS CODED (OTHER THAN ZERO)		
	THEN PRICING RATE CODE MUST =	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I	TRICARE DRG REIMBURSEMENT WITH COST OUTLIER OR
		J	TRICARE DRG REIMBURSEMENT WITH NO OUTLIER OR
		U	SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS OR
		V	MEDICARE REIMBURSEMENT RATE
1-190-03R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	11	HOSPICE
	THEN PRICING RATE CODE MUST =	D	DISCOUNT RATE AGREEMENT OR
		P	PER DIEM RATE AGREEMENT OR
		U	SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS OR
		V	MEDICARE REIMBURSEMENT RATE
	UNLESS TYPE OF SUBMISSION =	D	COMPLETE DENIAL
	OR AMOUNT ALLOWED (TOTAL) = ZERO		
1-190-04R	IF PRICING RATE CODE =	V	MEDICARE REIMBURSEMENT RATE
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 OR
		FS	TFL (SECOND PAYOR) OR
		MN	TSP - NON-NETWORK OR
		MS	TSP - NETWORK
	OR TYPE OF INSTITUTION =	70	HHA OR
		76	SNF
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

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Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: PRICING RATE CODE (1-190) (Continued)		
	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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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 5.3

Institutional Edit Requirements (ELN 200 - 299)

ELEMENT NAME: DRG NUMBER (1-290) (Continued)			
1-290-23R	IF PRICING RATE CODE =	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I	TRICARE DRG REIMBURSEMENT WITH COST OUTLIER OR COST OUTLIER OR
		J	TRICARE DRG REIMBURSEMENT WITH NO OUTLIER
AND DATE OF ADMISSION ≥ 10/01/2000 AND < 10/01/2001			
THEN DRG NUMBER MUST = 001-213, 216-220, 223-384, 391-437, 439-455, 461-471, 473, 475-511, 600-619, 621-624, 626-628, 630-636, 900-901.			
1-290-24R	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
AND DATE OF ADMISSION ≥ 10/01/2001 AND ≤ 09/30/2002			
THEN DRG NUMBER MUST = 001-111, 113-213, 216-220, 223-384, 391-433, 439-455, 461-471, 473, 475-523, 600-619, 621-624, 626-628, 630-636, 900-901.			
1-290-25R	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
AND DATE OF ADMISSION ≥ 10/01/2002 AND ≤ 09/30/2003			
THEN DRG NUMBER MUST = 001-111, 113-213, 216-220, 223-384, 391-433, 439-455, 461-471, 473, 475-527, 600-619, 621-624, 626-628, 630-636, 900-901.			
1-290-26R	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
AND DATE OF ADMISSION ≥ 10/01/2003 AND < 10/01/2004			
THEN DRG NUMBER MUST = 001-003, 006-111, 113-213, 216-220, 223-230, 232-384, 391-399, 401-433, 439-455, 461-471, 473, 475-513, 515-540, 600-619, 621-624, 626-628, 630-636, 900-901.			
1-290-27R	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
AND DATE OF ADMISSION ≥ 10/01/2004 AND < 10/01/2005			
THEN DRG NUMBER MUST = 001-111, 113-213, 216-220, 223-384, 391-433, 439-455, 461-471, 473, 475-482, 484-513, 515-543, 600-619, 621-624, 626-628, 630-636, 900-901.			
1-290-28R	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
AND DATE OF ADMISSION ≥ 10/01/2005 AND < 10/01/2006			

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Institutional Edit Requirements (ELN 200 - 299)

ELEMENT NAME: DRG NUMBER (1-290) (Continued)

THEN DRG NUMBER MUST = 001-003, 006-106, 108, 110-111, 113-114, 117-208, 210-213, 216-220, 223-230, 232-384, 391-399, 401-433, 439-455, 461-471, 473, 475-477, 479-482, 484-513, 515, 518-525, 528-559, 600-619, 621-624, 626-628, 630-636, 900-901.

1-290-29R	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

AND DATE OF ADMISSION ≥ 10/01/2006 **AND** < 10/01/2007

THEN DRG NUMBER MUST = 001-003, 006-019, 021-023, 026-106, 108, 110-111, 113-114, 117-147, 149-153, 155-208, 210-213, 216-220, 223-230, 232-384, 391-399, 401-414, 417-433, 439-455, 461-471, 473, 476-477, 479-482, 484-513, 515, 518-522, 524-525, 528-579, 600-619, 621-624, 626-628, 630-636, 900-901.

1-290-30R	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

AND DATE OF ADMISSION ≥ 10/01/2007 **AND** < 10/01/2008

THEN DRG NUMBER MUST = 001-003, 006-019, 021-023, 026-106, 108, 110-111, 113-114, 117-147, 149-153, 155-208, 210-213, 216-220, 223-230, 232-341, 344-384, 391-399, 401-414, 417-433, 439-455, 461-471, 473, 476-477, 479-482, 484-513, 515, 518-522, 524-525, 528-580, 600-619, 621-624, 626-628, 630-636, 900-901.

1-290-31R	IF PRICING RATE CODE =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER OR
		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER

AND DATE OF ADMISSION ≤ 10/01/2008

THEN DRG NUMBER MUST = 001-003, 020-042, 052-125, 129-270, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 573-585, 592-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 787-797, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 876, 880-887, 894-896, 898, 899, 901-909, 913-923, 927-929, 933-935, 939-941, 945-951, 955-959, 963-965, 959-970, 974-976, 984-989, 998, 999.

ELEMENT NAME: HIPPS CODE (1-292)

VALIDITY EDITS

1-292-01V MUST BE VALID HIPPS CODES REFER TO [SECTION 2.8](#).

RELATIONAL EDITS

1-292-01R IF HIPPS CODE = BLANK

THEN NO OCCURRENCE OF REVENUE CODE CAN =

0022 SNF **OR**

0023 HHA PPS

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Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: TOTAL OCCURRENCE/LINE ITEM COUNT (1-375)

VALIDITY EDITS

1-375-01V VALUE MUST BE IN RANGE 001-450.

AND MUST EQUAL THE PHYSICAL COUNT OF THE DETAIL LINE ITEMS ON THE TED RECORD

- | | | | |
|------------------|-------------------------|---|---|
| 1-375-02V | IF TYPE OF SUBMISSION = | A | ADJUSTMENT OR |
| | | B | ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR |
| | | C | COMPLETE CANCELLATION OR |
| | | E | COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA |

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

RELATIONAL EDITS

NONE

ELEMENT NAME: AMOUNT NETWORK PROVIDER DISCOUNT (1-377)

VALIDITY EDITS

1-377-01V MUST BE NUMERIC AND \geq ZERO

RELATIONAL EDITS

- | | | | |
|------------------|-------------------------|---|---|
| 1-377-01R | IF TYPE OF SUBMISSION = | B | ADJUSTMENT TO NON-TED (HCSR) DATA OR |
| | | C | COMPLETE CANCELLATION OR |
| | | D | COMPLETE DENIAL OR |
| | | E | COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR |
| | | O | ZERO GOVERNMENT TED RECORD DUE TO 100% OHI |

THEN AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO

1-377-02R IF PROVIDER NETWORK STATUS INDICATOR = 2 NON-NETWORK PROVIDER

THEN AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO

1-377-03R IF REGION INDICATOR = ~~B~~ BLANK **OR** OC OVERSEAS CONTRACT

THEN AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO

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Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: ADJUSTMENT SEQUENCE NUMBER (1-378)¹

VALIDITY EDITS

1-378-01V MUST BE NUMERIC

RELATIONAL EDITS

1-378-01R IF TYPE OF SUBMISSION = D COMPLETE DENIAL **OR**
 I INITIAL SUBMISSION **OR**
 O ZERO PAYMENT WITH 100% OHI/TPL **OR**
 R RESUBMISSION

THEN ADJUSTMENT SEQUENCE NUMBER MUST = 000 (ZEROES)

1-378-02R IF TYPE OF SUBMISSION = A ADJUSTMENT **OR**
 C COMPLETE CANCELLATION

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

1-378-03R IF TYPE OF SUBMISSION = B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
 E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

THEN ADJUSTMENT SEQUENCE NUMBER MUST = 000 (ZEROES)

¹ BYPASS ALL 1-378 EDITS FOR CONTRACT NUMBERS MDA90602C0013, MDA90603C0019, MDA90603C0009, MDA90603C0010, MDA90603C0011, AND MDA90603C0015.

ELEMENT NAME: OCCURRENCE/LINE ITEM NUMBER (1-380)

VALIDITY EDITS

1-380-01V EACH VALUE MUST BE NUMERIC.
1-380-02V OCCURRENCE/LINE ITEM NUMBER MUST BE CODED FOR EACH NUMBER OF OCCURRENCES SPECIFIED BY THE TOTAL OCCURRENCE/LINE ITEM COUNT.
1-380-03V OCCURRENCE/LINE ITEM NUMBER MUST BE REPORTED IN ASCENDING CONSECUTIVE ORDER.

RELATIONAL EDITS

NONE

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Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: REVENUE CODE (1-385)

VALIDITY EDITS

1-385-01V VALUE MUST BE A VALID REVENUE CODE.

UNLESS ADJUSTMENT/DENIAL REASON CODE IS A DENIAL REASON CODE LISTING IN [ADDENDUM G, FIGURE 2.G-1](#) **OR** [FIGURE 2.G-2](#)

NOTE: THE FOLLOWING VALID OUTPATIENT REVENUE CODES ARE ALLOWED ON AN INSTITUTIONAL TED RECORD ONLY WHEN BEING DENIED

049X, 051X-054X, 0630-0635, 064X, 0661, 0662, 082X-085X, 0882, AND 310X.

1-385-02V FIRST DETAILED LINE MUST CONTAIN REVENUE CODE 0001.

RELATIONAL EDITS

1-385-01R ONLY ONE OCCURRENCE OF REVENUE CODE MUST = 0001.

1-385-02R AT LEAST ONE OCCURRENCE OF REVENUE CODE FOR ROOM ACCOMMODATION CHARGES MUST = 010X-021X **OR** 0724

UNLESS ONE OCCURRENCE OF OVERRIDE CODE =

Y NEWBORN IN MOTHER'S ROOM WITHOUT NURSERY CHARGES

OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

11 HOSPICE

OR ANY OCCURRENCE OF REVENUE CODE =

0023 HHA PPS

OR AMOUNT ALLOWED (TOTAL) = ZERO

1-385-03R 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 PROFESSIONAL SERVICE REVENUE CODES = 0901, 0914-0918, **OR** 096X-098X

AND AQUISITION OF BODY PARTS (081X) MUST BE DENIED.

1-385-04R IF ANY REVENUE CODE = 0723

THEN PERSON SEX (PATIENT) MUST = MALE.

1-385-05R IF ANY REVENUE CODE = 072X BUT **NOT** 0723

THEN PERSON SEX (PATIENT) MUST = FEMALE

1-385-06R IF TYPE OF SUBMISSION =

A ADJUSTMENT **OR**

C COMPLETE CANCELLATION

THEN REVENUE CODES MUST OCCUR IN THE SAME ORDER

AND ON THE SAME OCCURRENCE/LINE ITEM NUMBER AS TMA DATABASE.

1-385-07R IF REVENUE CODE =

0022 SNF CHARGE

THEN ADMISSION DATE ≥ 08/01/2003

AND TYPE OF INSTITUTION MUST =

76 SNF

AND HIPPS CODE ≠ BLANK

UNLESS PATIENT AGE IS < 10 YEARS OF AGE ON DATE OF ADMISSION

1-385-09R IF ANY REVENUE CODE =

0650 GENERAL CLASSIFICATION **OR**

0651 ROUTINE HOME CARE **OR**

0652 CONTINUOUS HOME CARE **OR**

0655 INPATIENT RESPITE CARE **OR**

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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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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.
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- END -

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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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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: ADJUSTMENT SEQUENCE NUMBER (2-141)¹

VALIDITY EDITS

2-141-01V MUST BE NUMERIC.

RELATIONAL EDITS

2-141-01R IF TYPE OF SUBMISSION =

D COMPLETE DENIAL **OR**

I INITIAL SUBMISSION **OR**

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

R RESUBMISSION

THEN ADJUSTMENT SEQUENCE NUMBER MUST = 000 (ZEROES)

2-141-02R IF TYPE OF SUBMISSION =

A ADJUSTMENT **OR**

C COMPLETE CANCELLATION

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

2-141-03R IF TYPE OF SUBMISSION =

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

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

THEN ADJUSTMENT SEQUENCE NUMBER MUST = 000 (ZEROES)

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

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

VALIDITY EDITS

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

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

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

RELATIONAL EDITS

NONE

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Non-Institutional Edit Requirements (ELN 100 - 199)

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

OR ANY OCCURRENCE OF SPECIAL
PROCESSING CODE =

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

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

FS TFL (SECOND PAYOR) **OR**

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

THEN DO NOT CHECK PROVIDER FILE

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

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

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Chapter 2, Section 6.2

Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: PROCEDURE CODE (2-160)

VALIDITY EDITS

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

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

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

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

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

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

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

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

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

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

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

RELATIONAL EDITS

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

THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE ≤ZERO

UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

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

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

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

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Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: PROCEDURE CODE (2-160) (Continued)	
	FS TFL (SECOND PAYOR) OR
	GU ADSM ENROLLED IN TPR OR
	MN TSP - NETWORK OR
	MS TSP - NON-NETWORK OR
	SC SHCP - NON-TRICARE ELIGIBLE OR
	SE SHCP - TRICARE ELIGIBLE OR
	SM SHCP - EMERGENCY
OR ENROLLMENT/HEALTH PLAN CODE MUST =	SN SHCP - NON-MTF-REFERRED CARE OR
	SR SHCP - REFERRED CARE
OR FILING STATE AND COUNTRY CODE MUST = A FOREIGN COUNTRY CODE (REFER TO ADDENDUM A)	
2-160-05R	IF PROCEDURE CODE ¹ = A0100, A0110, A0120, A0130, A0140, A0170, E0170 - E0172, E0241- E0245, E0270, E0273, E0625, E0701, E0911, E0912, L3000 - L3003, L3010, L3020, L3030, L3031, L3040, L3050, L3060, L3070, L3080, L3090, L3100, L3160, L3201 - L3207, L3212 - L3219, L3221 - L3223, L3230, L3250 -L3255, L3257, L3265, L3300, L3310, L3320, L3330, L3332, L3334, L3340, L3350, L3360, L3370, L3380, L3390, L3400, L3410, L3420, L3430, L3440, L3450, L3455, L3460, L3465, L3470, L3480, L3485, L3500, L3510, L3520, L3530, L3540, L3550, L3560, L3570, L3580, L3590, L3595, L3630, S1040, S9122 - S9124, OR 99082
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = PF ECHO
UNLESS ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM IS A CODE LISTED IN ADDENDUM G, FIGURE 2.G-1 OR FIGURE 2.G-2	
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AN SHCP - NON-MTF-REFERRED CARE OR
	AR SHCP - REFERRED CARE OR
	CE SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
	GU ADSM ENROLLED IN TPR OR
	MN TSP - NETWORK OR
	MS TSP - NON-NETWORK OR
	SC SHCP - NON-TRICARE ELIGIBLE OR
	SE SHCP - TRICARE ELIGIBLE OR
	SM SHCP - EMERGENCY
OR ENROLLMENT/HEALTH PLAN CODE =	X FOREIGN ADSM OR
	SN SHCP - NON-MTF-REFERRED CARE OR
	SR SHCP - REFERRED CARE OR
	WA TPR - FOREIGN ADSM
2-160-06R	IF TYPE OF SERVICE (FIRST POSITION) = I INPATIENT
THEN PROCEDURE CODE MUST NOT BE FOR OUTPATIENT ONLY CARE (REFER TO ADDENDUM E, FIGURE 2.E-2).	
2-160-08R	IF PROCEDURE CODE ¹ = 98800 FOR DRUGS OR
	00MN PRESCRIPTION MEDICAL NECESSITY REVIEWS OR
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² PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-160-01R.	
³ BYPASS EDIT 2-160-01R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.	

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Non-Institutional Edit Requirements (ELN 100 - 199)

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

	00PA	PRESCRIPTION PRIOR AUTHORIZATIONS
THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS OR
	M	MOP DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS
AND NATIONAL DRUG CODE MUST ≠ BLANK		
UNLESS PROVIDER STATE OR COUNTRY CODE IS A FOREIGN COUNTRY CODE (ADDENDUM A)		
2-160-11R	IF PROCEDURE CODE ¹ = S5108 OR 99080	
THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AU	AUTISM DEMONSTRATION
UNLESS ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM IS A CODE LISTED IN ADDENDUM G , FIGURE 2.G-1 OR FIGURE 2.G-2 .		
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AN	SHCP - NON-MTF-REFERRED CARE OR
	AR	SHCP - REFERRED CARE OR
	CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
	GU	ADSM ENROLLED IN TPR OR
	MN	TSP - NETWORK OR
	MS	TSP - NON-NETWORK OR
	SC	SHCP - NON-TRICARE ELIGIBLE OR
	SE	SHCP - TRICARE ELIGIBLE OR
	SM	SHCP - EMERGENCY
OR ENROLLMENT/HEALTH PLAN CODE =	X	FOREIGN ADSM OR
	SN	SHCP - NON-MTF-REFERRED CARE OR
	SR	SHCP - REFERRED CARE OR
	WA	TPR - FOREIGN ADSM

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

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

ELEMENT NAME: PROCEDURE CODE MODIFIER (2-165)

VALIDITY EDITS

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

RELATIONAL EDITS

NONE

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Chapter 2, Section 6.3

Non-Institutional Edit Requirements (ELN 200 - 299)

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER RELATIONSHIP CODE (2-295)	
VALIDITY EDITS	
2-295-01V	MUST BE A VALID HCC MEMBER RELATIONSHIP CODE (REFER TO SECTION 2.5)
RELATIONAL EDITS	
2-295-03R	IF PATIENT AGE ¹ ≥ 21
	AND PERSON BIRTH CALENDAR DATE (PATIENT) ≠ 19111111
	THEN HCC MEMBER RELATIONSHIP CODE MUST ≠
	C CHILD OR STEPCHILD OR
	D PRE-ADOPTIVE CHILD OR
	E WARD (COURT ORDERED)
	UNLESS ONE OCCURRENCE OF OVERRIDE CODE MUST =
	D PATIENT IS DEPENDENT 21 YEARS OF AGE
2-295-06R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	PF ECHO
	THEN HCC MEMBER RELATIONSHIP CODE MUST =
	B SPOUSE OR
	C CHILD OR STEPCHILD OR
	D PRE-ADOPTIVE CHILD OR
	E WARD (COURT ORDERED) OR
	G SURVIVING SPOUSE
2-295-07R	IF TYPE OF SERVICE (FIRST POSITION) =
	A AMBULATORY SURGERY COST-SHARED AS INPATIENT
	THEN HCC MEMBER RELATIONSHIP CODE MUST =
	A SELF OR
	B SPOUSE OR
	C CHILD OR STEPCHILD OR
	D PRE-ADOPTIVE CHILD OR
	E WARD (COURT ORDERED) OR
	G SURVIVING SPOUSE OR
	Z UNKNOWN
	AND HCC MEMBER CATEGORY CODE ≠
	W FORMER SPOUSE
	UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	SC SHCP - NON-TRICARE ELIGIBLE
2-295-10R	IF HCC MEMBER CATEGORY CODE =
	T FOREIGN MILITARY MEMBER
	AND HCC MEMBER RELATIONSHIP CODE =
	A SELF
	THEN ANY OCCURRENCE OF SPECIAL PROCESSING CODE MUST =
	AN SHCP - NON-REFERRED CARE OR
	AR SHCP - REFERRED CARE OR
	SC SHCP - NON-TRICARE ELIGIBLE OR
	SM SHCP - EMERGENCY
	OR ENROLLMENT/HEALTH PLAN CODE MUST =
	SN SHCP - NON-MTF REFERRED OR
	SO SHCP - NON-TRICARE ELIGIBLE OR

¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN CARE DATE.

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Chapter 2, Section 6.3

Non-Institutional Edit Requirements (ELN 200 - 299)

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER RELATIONSHIP CODE (2-295) (Continued)

SR SHCP - REFERRED **OR**

SU SHCP - REFERRAL DESIGNATION UNKNOWN

UNLESS AMOUNT ALLOWED BY PROCEDURE CODE = ZERO

THEN BYPASS THIS EDIT

¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN CARE DATE.

- END -

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Chapter 2, Section 6.4

Non-Institutional Edit Requirements (ELN 300 - 399)

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

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Chapter 2, Section 6.4

Non-Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: SPECIAL PROCESSING CODE (2-305)

VALIDITY EDITS

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

RELATIONAL EDITS

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

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² PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

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Chapter 2, Section 6.4

Non-Institutional Edit Requirements (ELN 300 - 399)

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

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

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² PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

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Non-Institutional Edit Requirements (ELN 300 - 399)

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

THEN ENROLLMENT/HEALTH PLAN CODE MUST =	SN	SHCP - NON-MTF-REFERRED CARE OR
	SO	SHCP - NON-TRICARE ELIGIBLE OR
	SR	SHCP - REFERRED CARE OR
	ST	SHCP - TRICARE ELIGIBLE OR
	SU	SHCP - REFERRAL DESIGNATION UNKNOWN
2-305-24R IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	E	HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP)
THEN BEGIN DATE OF CARE MUST BE ≥ 03/15/1999		
AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	CM	ICMP
2-305-26R		<ul style="list-style-type: none"> TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001. FOR EACH OCCURRENCE/LINE ITEM WHERE DATE OF CARE IS < 10/01/2001, THE OCCURRENCE/LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.
IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	FF	TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) OR
	FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) OR
	FS	TFL (SECOND PAYOR)
ELSE IF BEGIN DATE OF CARE IS < 10/01/2001		
THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAILED LINE MUST =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER OR
	26	EXPENSES INCURRED PRIOR TO COVERAGE OR
	27	EXPENSES INCURRED AFTER COVERAGE TERMINATED OR
	30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS OR
	31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED OR
	32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED OR
	33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE OR
	34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS OR
	62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION OR

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² PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

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Chapter 2, Section 6.4

Non-Institutional Edit Requirements (ELN 300 - 399)

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

		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
2-305-30R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF	ECHO
	THEN HCDP PLAN COVERAGE CODE MUST ≠	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
2-305-31R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AU	AUTISM DEMONSTRATION
	THEN BEGIN DATE OF CARE MUST BE ≥ 03/15/2008		
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	PF	ECHO
	AND PATIENT AGE ² MUST BE ≥ 18 MONTHS		
2-305-32R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	RB	RESPIRE BENEFIT FOR ADMSs
	THEN BEGIN DATE OF CARE MUST BE ≥ 01/01/2008		
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	SE	SHCP - TRICARE ELIGIBLE
2-305-33R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PS	SPECIALTY PHARMACY SERVICES
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	AND PROCEDURE CODE MUST ≠	000MN	PRESCRIPTION MEDICAL NECESSITY REVIEWS OR

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Non-Institutional Edit Requirements (ELN 300 - 399)

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

		000PA	PRESCRIPTION PRIOR AUTHORIZATIONS
2-305-34R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PV	RETAIL PHARMACY FOR DVA BENEFICIARIES
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	AND PROVIDER NETWORK STATUS INDICATOR MUST =	1	NETWORK PROVIDER
	AND PROCEDURE CODE MUST ≠	000MN	PRESCRIPTION MEDICAL NECESSITY REVIEWS OR
		000PA	PRESCRIPTION PRIOR AUTHORIZATIONS

¹ CPT ONLY © 2006 AMERICAN MEDICAL ASSOCIATION (OR SUCH OTHER DATE OF PUBLICATION OF CPT). ALL RIGHTS RESERVED.

² PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) SPECIAL ENTITLEMENT CODE (2-306)

VALIDITY EDITS

2-306-01V MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE (REFER TO [SECTION 2.5](#))

RELATIONAL EDITS

NONE

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Non-Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: CA/NAS NUMBER (2-310)

VALIDITY EDITS

2-310-01V IF CA/NAS NUMBER IS NOT BLANK **THEN** MUST BE 1 TO 11 **OR** 1 TO 15 ALPHANUMERIC CHARACTERS.

RELATIONAL EDITS

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

THEN BYPASS ALL CA/NAS NUMBER RELATIONAL EDITING.

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

THEN DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA

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

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

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

AR SHCP - REFERRED CARE **OR**

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

PF ECHO

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

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

SE SHCP - TRICARE ELIGIBLE **OR**

SM SHCP - EMERGENCY **OR**

ST SPECIALIZED TREATMENT **OR**

WR MENTAL HEALTH WRAP AROUND

THEN BYPASS ALL CA/NAS NUMBER EDITING.

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

W TPR ADSM - USA **OR**

X FOREIGN ADSM **OR**

Y CHCBP - STANDARD **OR**

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

AA CHCBP - EXTRA **OR**

BB TSP **OR**

FE TFL - EXTRA **OR**

FS TFL - STANDARD **OR**

PS TSRx **OR**

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

SR SHCP - REFERRED CARE **OR**

¹ CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.

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Non-Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: CA/NAS NUMBER (2-310) (Continued)			
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE AD5M
	THEN BYPASS ALL CA/NAS NUMBER EDITING.		
NO ERROR	IF HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER
	THEN BYPASS ALL CA/NAS NUMBER EDITING.		
NO ERROR	IF ANY OCCURRENCE OF ADJUSTMENT/ DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER OR
		26	EXPENSES INCURRED PRIOR TO COVERAGE OR
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED OR
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS OR
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED OR
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED OR
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE OR
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS OR
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION OR
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
	THEN BYPASS ALL CA/NAS NUMBER EDITING		
NO ERROR	IF AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO		
	THEN NO CA/NAS IS REQUIRED -- BYPASS ALL CA/NAS NUMBER EDITING.		
NO ERROR	IF HCDP PLAN COVERAGE CODE =	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
		405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
		406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
		407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
		408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
		409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR

¹ CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.

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Non-Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: CA/NAS NUMBER (2-310) (Continued)

	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

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

2-310-03R • MENTAL HEALTH CHECK
 IF CA/NAS EXCEPTION REASON = BLANK
AND TYPE OF SERVICE (FIRST POSITION) = I INPATIENT
AND PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316
AND PATIENT ZIP CODE IS IN AN MTF CATCHMENT AREA¹
THEN CA/NAS NUMBER MUST BE CODED
UNLESS ANY OCCURRENCE OF OVERRIDE CODE = C GOOD FAITH PAYMENT
THEN CA/NAS NUMBER MUST = BLANK

2-310-04R IF CA/NAS NUMBER IS CODED
THEN CA/NAS EXCEPTION REASON MUST = BLANK

¹ CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.

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

VALIDITY EDITS

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

RELATIONAL EDITS

2-315-02R IF CA/NAS NUMBER = BLANK
THEN CA/NAS REASON FOR ISSUANCE MUST = BLANK.

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Non-Institutional Edit Requirements (ELN 300 - 399)

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

VALIDITY EDITS

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

RELATIONAL EDITS

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

THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING.

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

THEN DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA

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

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

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

AR SHCP - REFERRED CARE **OR**

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

PF ECHO

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

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

SE SHCP - TRICARE ELIGIBLE **OR**

SM SHCP - EMERGENCY **OR**

ST SPECIALIZED TREATMENT **OR**

WR MENTAL HEALTH WRAP AROUND

THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING.

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

W TPR ADSM - USA **OR**

X FOREIGN ADSM **OR**

Y CHCBP - STANDARD **OR**

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

AA CHCBP - EXTRA **OR**

BB TSP **OR**

FE TFL - EXTRA **OR**

FS TFL - STANDARD **OR**

PS TSRx **OR**

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

SR SHCP - REFERRED CARE **OR**

WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM

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Non-Institutional Edit Requirements (ELN 300 - 399)

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

THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING.

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

THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING.

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

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

26 EXPENSES INCURRED PRIOR TO COVERAGE **OR**

27 EXPENSES INCURRED AFTER COVERAGE TERMINATED
OR

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

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

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

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

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

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

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

THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING

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

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

NO ERROR IF HCDP PLAN COVERAGE CODE =

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

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

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

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

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

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

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

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

411 TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR**

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Non-Institutional Edit Requirements (ELN 300 - 399)

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

412 TRS SURVIVOR NEW FAMILY COVERAGE **OR**

413 TRS MEMBER-ONLY COVERAGE **OR**

414 TRS MEMBER AND FAMILY COVERAGE

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

AND TYPE OF SERVICE (FIRST POSITION) = I INPATIENT

AND PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316

AND CA/NAS NUMBER NOT CODED

THEN CA/NAS EXCEPTION REASON MUST BE CODED

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Non-Institutional Edit Requirements (ELN 300 - 399)

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

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Non-Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: PRICING RATE CODE (2-325) (Continued)		
	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
2-325-06R IF PRICING RATE CODE =	W	PRICED OVER CMAC
AND ENROLLMENT/HEALTH PLAN CODE =	T	TRICARE STANDARD PROGRAM
AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE =	NE	OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM
AND BEGIN DATE OF CARE ≥ 09/14/2001 AND < 11/01/2009		
THEN PROVIDER PARTICIPATING INDICATOR MUST =	N	NO
2-325-08R IF PRICING RATE CODE =	P1	OPPS OR
	P2	OPPS WITH COST OUTLIER OR
	P3	OPPS WITH DISCOUNT OR
	P5	PARTIAL HOSPITALIZATION - PAID AS OPPS
THEN APC CODE MUST ≠ BLANK OR ZEROES.		
2-325-09R IF PRICING RATE CODE =	CA	CAH REIMBURSEMENT
THEN PROVIDER STATE OR COUNTRY CODE MUST =	AK	ALASKA
AND BEGIN DATE OF CARE MUST BE ≥ 07/01/2007		

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Non-Institutional Edit Requirements (ELN 300 - 399)

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

VALIDITY EDITS

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

UNLESS AMOUNT ALLOWED BY PROCEDURE CODE = ZERO

RELATIONAL EDITS

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

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

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

VALIDITY EDITS

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

RELATIONAL EDITS

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

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

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

VALIDITY EDITS

2-335-01V MUST BE NUMERIC AND ≥ ZERO

RELATIONAL EDITS

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

THEN AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO

2-335-02R IF PROVIDER NETWORK STATUS INDICATOR =	2	NON-NETWORK PROVIDER
---	---	----------------------

THEN AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO

2-335-03R IF REGION INDICATOR =	BLANK OR
	OC OVERSEAS CONTRACT

THEN AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO

- END -

Financial Edit Requirements

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL (1-000)		
VALIDITY EDITS		
NONE		
RELATIONAL EDITS		
1-000-01F	• BATCH/VOUCHER ASAP ACCOUNT NUMBER VALIDATION - ACCRUAL FUND CHECK	
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER GOVERNMENT CAUSED ERROR
OR CONTRACT NUMBER ≠	MDA906-02-C-0013 (TMOP)	OR
	MDA906-03-C-0009 (WEST)	OR
	MDA906-03-C-0010 (SOUTH)	OR
	MDA906-03-C-0011 (NORTH)	OR
	MDA906-03-C-0019 (TRRx)	
OR AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) = ZERO		
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
	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

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Financial Edit Requirements

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

	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/ACCURAL 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, & D
AND OTHER GOVERNMENT PROGRAM BEGIN REASON CODE ≠	N	NOT ELIGIBLE FOR MEDICARE
AND HEALTH CARE DELIVERY PROGRAM 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
	014	DIRECT CARE FOR TRANSITIONAL 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
	021	TFL FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	023	TFL FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR

Data Requirements - Adjustment/Denial Reason Codes

FIGURE 2.G-1 DENIAL CODES

ADJUST/DENIAL REASON CODE	DESCRIPTION
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
17	Requested information was not provided or was insufficient/incomplete.
18	Duplicate claim/service.
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	This injury/illness is covered by the liability carrier.
21	This injury/illness is the liability of the no-fault carrier.
22	This care may be covered by another payer per coordination of benefits.
24	Charges are covered under a capitation agreement/managed care plan.
25	Payment denied. Your Stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
28	Coverage not in effect at the time the service was provided.
29	The time limit for filing has expired.
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
31	Patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Insured has no dependent coverage.
34	Insured has no coverage for newborns.

HIPAA Adjustment Reason Codes Release 11/05/2007.

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Chapter 2, Addendum G

Data Requirements - Adjustment/Denial Reason Codes

FIGURE 2.G-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
35	Lifetime benefit maximum has been reached.
38	Services not provided or authorized by designated (network) providers.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care.
46	This (these) service(s) is (are) not covered.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
48	This (these) procedure(s) is (are) not covered.
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50	These are non-covered services because this is not deemed a "medical necessity" by the payer.
51	These are non-covered services because this is a pre-existing condition
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case.
55	Procedure/treatment is deemed experimental/investigational by the payer.
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer.
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.
89	Professional fees removed from charges.
96	Non-covered charge(s).
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
98	The hospital must file the Medicare claim form for this inpatient non-physician service.
106	Patient payment option/election not in effect.
107	The related or qualifying claim/service was not identified on this claim.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Service not furnished directly to the patient and/or not documented.
113	Payment denied because service/procedure was provided outside the United States or as a result of war.
114	Procedure/product not approved by the Food and Drug Administration.
115	Procedure postponed, canceled, or delayed.
116	The advance indemnification notice signed by the patient did not comply with requirements.
119	Benefit maximum for this time period has been reached.
128	Newborn's services are covered in the mother's Allowance.
129	Prior processing information appears incorrect.
134	Technical fees removed from charges.

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Data Requirements - Adjustment/Denial Reason Codes

FIGURE 2.G-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
135	Interim bills cannot be processed.
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.

HIPAA Adjustment Reason Codes Release 11/05/2007.

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Data Requirements - Adjustment/Denial Reason Codes

FIGURE 2.G-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
214	Worker's Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.
220	The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required.
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.

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Data Requirements - Adjustment/Denial Reason Codes

FIGURE 2.G-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
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.
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.

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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	Payment adjusted because the payer deems the information submitted does not support this many/ frequency of 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.

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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. Upon review, it was determined that this claim was processed properly.
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.
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.
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.

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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.

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Data Requirements - Adjustment/Denial Reason Codes

FIGURE 2.G-3 ADJUSTMENT/REMARK CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
99	Medicare Secondary Payer Adjustment Amount.
100	Payment made to patient/insured/responsible party/ employer .
101	Predetermination: anticipated payment upon completion of services or claim adjudication.
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount).
104	Managed care withholding.
105	Tax withholding.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.
118	ESRD network support adjustment.
121	Indemnification adjustment - compensation for outstanding member responsibility.
122	Psychiatric reduction.
123	Payer refund due to overpayment.
124	Payer refund amount - not our patient.
126	Deductible -- Major Medical
127	Coinsurance -- Major Medical
130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
133	The disposition of this claim/service is pending further review.
139	Contracted funding agreement - Subscriber is employed by the provider of services.
142	Monthly Medicaid patient liability amount.
143	Portion of payment deferred.
144	Incentive adjustment, e.g., preferred product/service.
145	Premium payment withholding.
156	Flexible spending account payment.
161	Provider performance bonus.
162	State-mandated requirement for property and casualty.
187	Health Savings account payments.
192	Non-standard adjustment code from paper remittance.
205	Pharmacy discount card processing fee.
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837).
A0	Patient refund amount.
A2	Contractual adjustment.
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.

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 (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
A7	Presumptive Payment Adjustment
B2	Covered visits.
B3	Covered charges.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
W1	Workers Compensation State Fee Schedule Adjustment

HIPAA Adjustment Reason Codes Release 11/05/2007.

- END -

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Chapter 2, Addendum L

Data Requirements - Health Care Delivery Program (HCDP) Plan Coverage Code Values

VALID VALUE	DESCRIPTION
151	TRICARE Plus Coverage for Transitional Survivors of Guard/Reserve Deceased Sponsors
152	TRICARE Overseas Prime Individual Coverage for Active Duty Sponsors
153	TRICARE Overseas Prime Individual Coverage for Active Duty Family Members
154	TRICARE Overseas Prime Family Coverage for Active Duty Family Members
155	TRICARE Global Remote Overseas Prime Individual Coverage for Active Duty Sponsors
156	TRICARE Global Remote Overseas Prime Individual Coverage for Active Duty Family Members
157	TRICARE Global Remote Overseas Prime Family Coverage for Active Duty Family Members
158	TRICARE Remote Individual Coverage for Transitional Survivors of Active Duty Deceased Sponsors
159	TRICARE Remote Family Coverage for Transitional Survivors of Active Duty Deceased Sponsors
201	TRICARE Dental Plan Individual Coverage for Active Duty Family Members
202	TRICARE Dental Plan Family Coverage for Active Duty Family Members
203	TRICARE Dental Plan Individual Remote Coverage for Active Duty Family Members
204	TRICARE Dental Plan Family Remote Coverage for Active Duty Family Members
205	TRICARE Dental Plan Individual Coverage for Survivors of Active Duty Deceased Sponsors
206	TRICARE Dental Plan Family Coverage for Survivors of Active Duty Deceased Sponsors
207	TRICARE Dental Plan Individual Coverage for Selected Reserve (SelRes) Sponsors
208	TRICARE Dental Plan Individual Coverage for Selected Reserve (SelRes) Family Members
209	TRICARE Dental Plan family coverage for Selected Reserve (SelRes) family members
210	TRICARE Dental Plan Individual Remote Coverage for Selected Reserve (SelRes) Family Members
211	TRICARE Dental Plan Family Remote Coverage for Selected Reserve (SelRes) Family Members
212	TRICARE Dental Plan Individual Coverage for Survivors of Selected Reserve (SelRes) Deceased Sponsors
213	TRICARE Dental Plan Family Coverage for Survivors of Selected Reserve (SelRes) Deceased Sponsors
214	TRICARE Dental Plan Individual Coverage for Active Guard/Reserve (AGR) Family Members
215	TRICARE Dental Plan Family Coverage for Active Guard/Reserve (AGR) Family Members
216	TRICARE Dental Plan Individual Remote Coverage for Active Guard/Reserve (AGR) Family Members
217	TRICARE Dental Plan Family Remote Coverage for Active Guard/Reserve (AGR) Family Members
218	TRICARE Dental Plan Individual Coverage for Survivors of Active Guard/Reserve (AGR) Family Members
219	TRICARE Dental Plan Family Coverage for Survivors of Active Guard/Reserve (AGR) Family Members
220	TRICARE Dental Plan for Mobilization-Asset Individual Ready Reserve (IRR) Sponsors
221	TRICARE Dental Plan Individual Coverage for Mobilization-Asset Individual Ready Reserve (IRR) Family Member
222	TRICARE Dental Plan Family Coverage for Mobilization-Asset Individual Ready Reserve (IRR) Family Members
223	TRICARE Dental Plan Individual Remote Coverage for Mobilization-Asset Individual Ready Reserve (IRR) Family Members
224	TRICARE Dental Plan Family Remote Coverage for Mobilization-Asset Individual Ready Reserve (IRR) Family Members
225	TRICARE Dental Plan Individual Coverage for Survivors of Mobilization-Asset Individual Ready Reserve (IRR) Deceased Sponsors
226	TRICARE Dental Plan Family Coverage for Survivors of Mobilization-Asset Individual Ready Reserve (IRR) Deceased Sponsors

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Chapter 2, Addendum L

Data Requirements - Health Care Delivery Program (HCDP) Plan Coverage Code Values

VALID VALUE	DESCRIPTION
227	TRICARE Dental Plan for Non-Mobilization-Asset Individual Ready Reserve (IRR) Sponsors
228	TRICARE Dental Plan Individual Coverage for Non-Mobilization-Asset Individual Ready Reserve (IRR) Family Members
229	TRICARE Dental Plan Family Coverage for Non-Mobilization-Asset Individual Ready Reserve (IRR) Family Members
230	TRICARE Dental Plan Individual Remote Coverage for Non-Mobilization-Asset Individual Ready Reserve (IRR) Family Members
231	TRICARE Dental Plan Family Remote Coverage for Non-Mobilization-Asset Individual Ready Reserve (IRR) Family Members
301	BRAC Pharmacy
302	Pharmacy Redesign Pilot Project (PRPP)
400	TRICARE Extended Care Health Option (ECHO) Program
401	TRICARE Reserve Select Tier 1 Member-Only Coverage (Contingency Operations)
402	TRICARE Reserve Select Tier 1 Member and Family Coverage (Contingency Operations)
403	Tobacco Cessation Demonstration Program
404	Weight Management Demonstration Program
405	TRICARE Reserve Select Tier 2 Member-Only Coverage (Certified Qualifications)
406	TRICARE Reserve Select Tier 2 Member and Family Coverage (Certified Qualifications)
407	TRICARE Reserve Select Tier 3 Member-Only Coverage (Service Agreement)
408	TRICARE Reserve Select Tier 3 Member and Family Coverage (Service Agreement)
409	TRICARE Reserve Select Survivor Continuing with Individual Coverage
410	TRICARE Reserve Select Survivor Continuing with Family Coverage
411	TRICARE Reserve Select Survivor New Individual Coverage
412	TRICARE Reserve Select Survivor New Family Coverage
413	TRICARE Reserve Select Member-Only Coverage
414	TRICARE Reserve Select Member and Family Coverage
415	Wounded, Ill, and Injured (e.g., Warrior Transition/MEDHOLD Unit (WTU))
416	Wounded, Ill, and Injured - Community-Based (e.g., Community-Based Health Care Organization (CBHCO))
602	Direct Care and TRICARE Mail Order Pharmacy (TMOP) and Retail Pharmacies
603	Direct Care Only
999	Unverified Newborn

- END -

Acronyms And Abbreviations

3D	Three Dimensional
AA	Anesthesiologist Assistant
AA&E	Arms, Ammunition and Explosives
AAA	Abdominal Aortic Aneurysm
AAAHC	Accreditation Association for Ambulatory Health Care, Inc.
AAFES	Army/Air Force Exchange Service
AAMFT	American Association for Marriage and Family Therapy
AAP	American Academy of Pediatrics
AAPC	American Association of Pastoral Counselors
AARF	Account Authorization Request Form
AATD	Access and Authentication Technology Division
ABA	American Banking Association Applied Behavioral Analysis
ABMT	Autologous Bone Marrow Transplant
ABPM	Ambulatory Blood Pressure Monitoring
ABR	Auditory Brainstem Response
AC	Active Component
ACD	Augmentative Communication Devices
ACI	Autologous Chondrocyte Implantation
ACIP	Advisory Committee on Immunization Practices
ACO	Administrative Contracting Officer
ACOG	American College of Obstetricians and Gynecologists
ACOR	Administrative Contracting Officer's Representative
ACS	American Cancer Society
ACSP	Autism Demonstration Corporate Services Provider
ACTUR	Automated Central Tumor Registry
AD	Active Duty
ADA	American Dental Association American Diabetes Association Americans with Disabilities Act
ADAMHA	Alcohol, Drug Abuse, And Mental Health Administration
ADAMHRA	Alcohol, Drug Abuse, And Mental Health Reorganization Act
ADCP	Active Duty Claims Program
ADD	Active Duty Dependent
ADFM	Active Duty Family Member

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Appendix A

Acronyms And Abbreviations

ADL	Activities of Daily Living
ADP	Automated Data Processing
ADSM	Active Duty Service Member
AF	Atrial Fibrillation
AFOSI	Air Force Office of Special Investigations
AGR	Active Guard/Reserve
AHA	American Hospital Association
AHLTA	Armed Forces Health Longitudinal Technology Application
AHRQ	Agency for Healthcare Research and Quality
AI	Administrative Instruction
AIDS	Acquired Immune Deficiency Syndrome
AIIM	Association for Information and Image Management
AIS	Automated Information Systems
AIX	Advanced IBM Unix
AJ	Administrative Judge
ALA	Annual Letter of Assurance
ALB	All Lines Busy
ALL	Acute Lymphocytic Leukemia
ALOS	Average Length-of-Stay
ALS	Action Lead Sheet Advanced Life Support
ALT	Autolymphocyte Therapy
AM&S	Acquisition Management and Support (Directorate)
AMA	Against Medical Advice American Medical Association
AMH	Accreditation Manual for Hospitals
AMHCA	American Mental Health Counselor Association
AML	Acute Myelogenous Leukemia
ANSI	American National Standards Institute
AOA	American Osteopathic Association
APA	American Psychiatric Association American Podiatry Association
APC	Ambulatory Payment Classification
API	Application Program Interface
APN	Assigned Provider Number
APO	Army Post Office
ART	Assisted Reproductive Technology
ARU	Automated Response Unit
ASA	Adjusted Standardized Amount American Society of Anesthesiologists
ASAP	Automated Standard Application for Payment
ASC	Accredited Standards Committee Ambulatory Surgical Center

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Appendix A

Acronyms And Abbreviations

ASCA	Administrative Simplification Compliance Act
ASCUS	Atypical Squamous Cells of Undetermined Significance
ASD	Assistant Secretary of Defense Atrial Septal Defect Autism Spectrum Disorder
ASD(C3I)	Assistant Secretary of Defense for Command, Control, Communications, and Intelligence
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
ASD (MRA&L)	Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics
ASP	Average Sale Price
ATB	All Trunks Busy
ATO	Approval to Operate
AVM	Arteriovenous Malformation
AWOL	Absent Without Leave
AWP	Average Wholesale Price
B&PS	Benefits and Provider Services
B2B	Business to Business
BACB	Behavioral Analyst Certification Board
BBA	Balanced Budget Act
BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act
BCABA	Board Certified Associate Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBS	Blue Cross Blue Shield
BC	Birth Center
BCC	Biostatistics Center
BI	Background Investigation
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support
BMT	Bone Marrow Transplantation
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BPS	Beneficiary and Provider Services
BRAC	Base Realignment and Closure
BRCA	BReast CAncer
BS	Bachelor of Science
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&CS	Communications and Customer Service

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Appendix A

Acronyms And Abbreviations

C/S	Client/Server
CA	Care Authorization
CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Craft
CAC	Common Access Card
CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAH	Critical Access Hospital
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBHCO	Community-Based Health Care Organizations
CBSA	Core Based Statistical Area
CC	Common Criteria Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCDD	Catastrophic Cap and Deductible Data
CCEP	Comprehensive Clinical Evaluation Program
CCMHC	Certified Clinical Mental Health Counselor
CCN	Case Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-To-Charge Ratio
CCTP	Custodial Care Transitional Policy
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
CDCF	Central Deductible and Catastrophic Cap File
CDD	Childhood Disintegrative Disorder
CDH	Congenital Diaphragmatic Hernia
CD-I	Compact Disc - Interactive
CDR	Clinical Data Repository
CDRL	Contract Data Requirements List
CD-ROM	Compact Disc - Read Only Memory
CDT	Current Dental Terminology
CEIS	Corporate Executive Information System
CEO	Chief Executive Officer
CEOB	CHAMPUS Explanation of Benefits
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFS	Chronic Fatigue Syndrome

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Appendix A

Acronyms And Abbreviations

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs
CHBC	Criminal History Background Check
CHBR	Criminal History Background Review
CHC	Civilian Health Care
CHCBP	Continued Health Care Benefits Program
CHCS	Composite Health Care System
CHEA	Council on Higher Education Accreditation
CHKT	Combined Heart-Kidney Transplant
CHOP	Children's Hospital of Philadelphia
CI	Counterintelligence
CIA	Central Intelligence Agency
CIF	Central Issuing Facility
CIO	Chief Information Officer
CIPA	Classified Information Procedures Act
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CL	Confidentiality Level (Classified, Public, Sensitive)
CLIA	Clinical Laboratory Improvement Amendment
CLIN	Contract Line Item Number
CLKT	Combined Liver-Kidney Transplant
CLL	Chronic Lymphocytic Leukemia
CMAC	CHAMPUS Maximum Allowable Charge
CMHC	Community Mental Health Center
CML	Chronic Myelogenous Leukemia
CMN	Certificate(s) of Medical Necessity
CMO	Chief Medical Officer
CMP	Civil Money Penalty
CMS	Centers for Medicare and Medicaid Services
CMVP	Cryptographic Module Validation Program
CNM	Certified Nurse Midwife
CNS	Central Nervous System Clinical Nurse Specialist
CO	Contracting Officer
COB	Close of Business Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
CoCC	Certificate of Creditable Coverage
COCO	Contractor Owned-Contractor Operated
COE	Common Operating Environment
CONUS	Continental United States
COO	Chief Operating Officer

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Acronyms And Abbreviations

COOP	Continuity of Operations Plan
COPA	Council on Postsecondary Accreditation
COPD	Chronic Obstructive Pulmonary Disease
COR	Contracting Officer's Representative
CORF	Comprehensive Outpatient Rehabilitation Facility
CORPA	Commission on Recognition of Postsecondary Accreditation
COTS	Commercial-off-the-shelf
CPA	Certified Public Accountant
CPE	Contract Performance Evaluation
CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists
CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRT	Computer Remote Terminal
CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)
CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time
CSU	Channel Sending Unit
CSV	Comma-Separated Value
CSW	Clinical Social Worker
CT	Central Time Computerized Tomography
CTC	Computed Tomographic Colonography
CTCL	Cutaneous T-Cell Lymphoma
CTEP	Cancer Therapy Evaluation Program
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DC	Direct Care
DCAA	Defense Contract Audit Agency

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Acronyms And Abbreviations

DCAO	Debt Collection Assistance Officer
DCID	Director of Central Intelligence Directive
DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigating Service
DCN	Document Control Number
DCP	Data Collection Period
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
DDP	Dependent Dental Plan
DDS	DEERS Dependent Suffix
DE	Durable Equipment
DECC	Defense Enterprise Computing Center
DED	Dedicated Emergency Department
DEERS	Defense Enrollment Eligibility Reporting System
DELM	Digital Epiluminescence Microscopy
DENC	Detailed Explanation of Non-Concurrence
DepSecDef	Deputy Secretary of Defense
DES	Data Encryption Standard
DFAS	Defense Finance and Accounting Service
DG	Diagnostic Group
DGH	Denver General Hospital
DHHS	Department of Health and Human Services
DHP	Defense Health Program
DIA	Defense Intelligence Agency
DIACAP	DoD Information Assurance Certification And Accreditation Process
DII	Defense Information Infrastructure
DIS	Defense Investigative Service
DISA	Defense Information System Agency
DISCO	Defense Industrial Security Clearance Office
DISN	Defense Information Systems Network
DISP	Defense Industrial Security Program
DITSCAP	DoD Information Technology Security Certification and Accreditation Process
DLAR	Defense Logistics Agency Regulation
DLE	Dialyzable Leukocyte Extract
DM	Disease Management
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface

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DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)
DMLSS	Defense Medical Logistics Support System
DMZ	Demilitarized Zone
DNA	Deoxyribonucleic Acid
DNA-HLA	Deoxyribonucleic Acid - Human Leucocyte Antigen
DNACI	DoD National Agency Check Plus Written Inquiries
DO	Doctor of Osteopathy Operations Directorate
DOB	Date of Birth
DoD	Department of Defense
DoD AI	Department of Defense Administrative Instruction
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDIG	Department of Defense Inspector General
DoD P&T	Department of Defense Pharmacy and Therapeutics (Committee)
DOE	Department of Energy
DOEBA	Date of Earliest Billing Action
DOES	DEERS Online Enrollment System
DOHA	Defense Office of Hearings and Appeals
DOJ	Department of Justice
DOLBA	Date of Latest Billing Action
DOS	Date Of Service
DP	Designated Provider
DPA	Differential Power Analysis
DPI	Designated Providers Integrator
DPO	DEERS Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
DRG	Diagnosis Related Group
DRPO	DEERS RAPIDS Program Office
DSAA	Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSMC	Data and Safety Monitoring Committee
DSMO	Designated Standards Maintenance Organization
DSO	DMDC Support Office
DSU	Data Sending Unit
DTF	Dental Treatment Facility

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DTR	Derived Test Requirements
DTRO	Director, TRICARE Regional Office
DUA	Data Use Agreement
DVA	Department of Veterans Affairs
DVAHCF	Department of Veterans Affairs Health Care Finder
DVD	Digital Video Disc
DWR	DSO Web Request
Dx	Diagnosis
DXA	Dual Energy X-Ray Absorptiometry
ECAS	European Cardiac Arrhythmia Society
EHRA	European Heart Rhythm Association
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EAL	Common Criteria Evaluation Assurance Level
EAP	Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDC	Error Detection Code
EDI	Electronic Data Information Electronic Data Interchange
EDIPI	Electronic Data Interchange Person Identifier
EDIPN	Electronic Data Interchange Person Number
EDI_PN	Electronic Data Interchange Patient Number
EEG	Electroencephalogram
EEPROM	Erasable Programmable Read-Only Memory
EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program
EFP	Environmental Failure Protection
EFT	Electronic Funds Transfer Environmental Failure Testing
EGHP	Employer Group Health Plan
E/HPC	Enrollment/Health Plan Code
EHHC	ECHO Home Health Care Extended Care Health Option Home Health Care
EHP	Employee Health Program
EIA	Educational Interventions for Autism Spectrum Disorders
EIDS	Executive Information and Decision Support

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EIN	Employer Identification Number
EIP	External Infusion Pump
EKG	Electrocardiogram
ELN	Element Locator Number
ELISA	Enzyme-Linked Immunoabsorbent Assay
E/M	Evaluation and Management
EMC	Electronic Media Claim
	Enrollment Management Contractor
EMDR	Eye Movement Desensitization and Reprocessing
EMG	Electromyogram
EMTALA	Emergency Medical Treatment & Active Labor Act
ENTNAC	Entrance National Agency Check
EOE	Evoked Otoacoustic Emission
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits
ePHI	electronic Protected Health Information
EPO	Erythropoietin
	Exclusive Provider Organization
EPR	EIA Program Report
EPROM	Erasable Programmable Read-Only Memory
ER	Emergency Room
ERISA	Employee Retirement Income and Security Act of 1974
ESRD	End Stage Renal Disease
EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy
ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank

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FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV ₁	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FOBT	Fecal Occult Blood Testing
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 Hospital Acquired Condition
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program

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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
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 Nonpolposis Colorectal Cancer
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRG	Health Resource Group
HRS	Heart Rhythm Society
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy

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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
HUD	Humanitarian Use Device
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
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

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IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio 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
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

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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
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&RB	Medical Benefits and Reimbursement Branch
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

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MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
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
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
NACLCL	National Agency Check with Law Enforcement and Credit

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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
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

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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
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

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PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAT	Performance Assessment Tracking
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PC	Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
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
PPFWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information

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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
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission
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
PPP	Purchasing Power Parity
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

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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
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

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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
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)

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Acronyms And Abbreviations

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) Special Indicator (code) 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
SOR	Statement of Reasons
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

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STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
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
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

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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)
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

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Acronyms And Abbreviations

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
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	Veterans Affairs (hospital) Veterans Administration

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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)
WII	Wounded, Ill, and Injured
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
WTU	Warrior Transition Unit
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

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