

## Non-Institutional Edit Requirements (ELN 300 - 399)

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

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

**THEN** BEGIN DATE OF CARE MUST BE ≥ 10/01/2001

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

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 (FOR THAT DETAILED LINE ITEM)

**THEN** ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE MUST =

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

**2-300-13R** • TFL CLAIMS: THE PATIENT MUST BE 64 YEARS AND 11 MONTHS OR GREATER. IF THE PATIENT IS LESS THAN THIS AGE, THE LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.

IF ENROLLMENT/HEALTH PLAN CODE =

FE TFL - EXTRA **OR**

FS TFL - STANDARD **OR**

PS TSRx

**AND** TYPE OF SERVICE (SECOND POSITION) ≠

M MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS

**THEN** PATIENT AGE<sup>1</sup> MUST BE ≥ 64 YEARS AND 11 MONTHS

**ELSE** IF PATIENT AGE<sup>1</sup> IS < 64 YEARS AND 11 MONTHS

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

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

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

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

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

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

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

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Non-Institutional Edit Requirements (ELN 300 - 399)

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

**VALIDITY EDITS**

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

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

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

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

**2-301-03R** IF HCDP PLAN COVERAGE CODE = 417 TCSRC

**THEN** ENROLLMENT/HEALTH PLAN CODE MUST = X FOREIGN AD SM **OR**

SR SHCP - REFERRED CARE

**RELATIONAL EDITS**

<b>2-301-01R</b> IF HCDP PLAN COVERAGE CODE =	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
	402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
	405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
	406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
	407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
	408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE <b>OR</b>

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

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

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

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<b>ELEMENT NAME: SPECIAL PROCESSING CODE (2-305)</b>			
<b>VALIDITY EDITS</b>			
<b>2-305-01V</b>	OCCURRENCE NUMBER 1--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8)		
<b>2-305-02V</b>	OCCURRENCE NUMBER 2--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8)		
<b>2-305-03V</b>	OCCURRENCE NUMBER 3--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8)		
<b>2-305-04V</b>	OCCURRENCE NUMBER 4--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8)		
<b>2-305-05V</b>	A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).		
<b>2-305-06V</b>	SPECIAL PROCESSING CODE OCCURRENCES MUST BE LEFT JUSTIFIED.		
<b>2-305-07V</b>	• SHCP REFERRED/NON-REFERRED		
	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
		AR	SHCP - REFERRED CARE
	<b>THEN</b> BEGIN DATE OF CARE MUST BE < 06/01/2004		
<b>2-305-08V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	GF	TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	<b>THEN</b> BEGIN DATE OF CARE MUST BE < 09/01/2002		
<b>2-305-10V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	MN	TSP - NON-NETWORK <b>OR</b>
		MS	TSP - NETWORK
	<b>THEN</b> BEGIN DATE OF CARE MUST BE < 12/31/2001		
<b>2-305-11V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	SN	TSS - NON-NETWORK <b>OR</b>
		SS	TSS - NETWORK
	<b>THEN</b> BEGIN DATE OF CARE MUST BE < 12/31/2002		
<b>2-305-14V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	ST	SPECIALIZED TREATMENT
	<b>THEN</b> BEGIN DATE OF CARE MUST BE < 10/01/2004		
<b>RELATIONAL EDITS</b>			
<b>2-305-02R</b>	IF CA/NAS EXCEPTION REASON =	6	RESOURCE SHARING
	<b>THEN</b> AT LEAST ONE SPECIAL PROCESSING CODE MUST =	S	RESOURCE SHARING - EXTERNAL
<b>2-305-08R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF	ECHO
	<b>THEN NO</b> OCCURRENCE OF SPECIAL PROCESSING CODE =	6	HHC <b>OR</b>
		A	PARTNERSHIP PROGRAM <b>OR</b>
		E	HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP) <b>OR</b>
		S	RESOURCE SHARING - EXTERNAL <b>OR</b>
		CM	ICMP <b>OR</b>
		CT	CCTP <b>OR</b>
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<sup>2</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.			

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

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

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

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

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

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<sup>2</sup> 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)**

		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
<b>2-305-30R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF	ECHO
	<b>THEN</b> HCDP PLAN COVERAGE CODE MUST ≠	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
		405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
		406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
		407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
		408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
		409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE <b>OR</b>
		410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE <b>OR</b>
		411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE <b>OR</b>
		412	TRS SURVIVOR NEW FAMILY COVERAGE <b>OR</b>
		413	TRS MEMBER-ONLY COVERAGE <b>OR</b>
		414	TRS MEMBER AND FAMILY COVERAGE <b>OR</b>
		418	TRR MEMBER-ONLY COVERAGE <b>OR</b>
		419	TRR MEMBER AND FAMILY COVERAGE <b>OR</b>
		420	TRR SURVIVOR INDIVIDUAL COVERAGE <b>OR</b>
		421	TRR SURVIVOR FAMILY COVERAGE
<b>2-305-31R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AU	AUTISM DEMONSTRATION
	<b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 03/15/2008		
	<b>AND</b> AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	PF	ECHO
	<b>AND</b> PATIENT AGE <sup>2</sup> MUST BE ≥ 18 MONTHS		
<b>2-305-32R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	RB	RESPIRE BENEFIT FOR AD <sup>SM</sup> s
	<b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 01/01/2008		
	<b>AND</b> AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	SE	SHCP - TRICARE ELIGIBLE

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Non-Institutional Edit Requirements (ELN 300 - 399)

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

<b>2-305-33R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PS	SPECIALTY PHARMACY SERVICES
	<b>THEN</b> TYPE OF SERVICE (SECOND POSITION) MUST =	M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	<b>AND</b> PROCEDURE CODE MUST ≠	000MN	PRESCRIPTION MEDICAL NECESSITY REVIEWS <b>OR</b>
		000PA	PRESCRIPTION PRIOR AUTHORIZATIONS
<b>2-305-34R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PV	RETAIL PHARMACY FOR DVA BENEFICIARIES
	<b>THEN</b> TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	<b>AND</b> PROVIDER NETWORK STATUS INDICATOR MUST =	1	NETWORK PROVIDER
	<b>AND</b> PROCEDURE CODE MUST ≠	000MN	PRESCRIPTION MEDICAL NECESSITY REVIEWS <b>OR</b>
		000PA	PRESCRIPTION PRIOR AUTHORIZATIONS
<b>2-305-35R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	EF	TRICARE RESERVE AND NATIONAL GUARD FAMILY MEMBER BENEFITS
	<b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 11/01/2009		
	<b>AND</b> ENROLLMENT/HEALTH PLAN CODE MUST =	T	TRICARE STANDARD PROGRAM <b>OR</b>
		V	TRICARE EXTRA
	<b>AND</b> HCDP SPECIAL ENTITLEMENT CODE MUST =	02	NOBLE EAGLE PARTICIPATION SPECIAL ENTITLEMENT <b>OR</b>
		03	ENDURING FREEDOM PARTICIPATION SPECIAL ENTITLEMENT
	<b>AND</b> AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO		
<b>2-305-36R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	DE	TDRL PHYSICAL EXAMS
	<b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 03/30/2009		
	<b>AND</b> ENROLLMENT/HEALTH PLAN CODE MUST =	SR	SHCP - REFERRED CARE
	<b>AND</b> AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	SE	SHCP - TRICARE ELIGIBLE
<b>2-305-37R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	DC	DCPE-DVA
	<b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 01/01/2011		
	<b>AND</b> AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	17	VA MEDICAL PROVIDER CLAIM

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Non-Institutional Edit Requirements (ELN 300 - 399)

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

<b>AND</b> ENROLLMENT/HEALTH PLAN CODE MUST =			SR	SHCP - REFERRED CARE
<b>AND</b> AT LEAST ONE PROCEDURE CODE <sup>1</sup> MUST = 99456				
<b>2-305-38R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PH	PHILIPPINES DEMONSTRATION PROJECT	
<b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 01/01/2013				
<b>AND</b> HCDP PLAN COVERAGE CODE MUST =			003	TRICARE STANDARD FOR ADFMS <b>OR</b>
			005	TRICARE STANDARD SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b>
			007	TRICARE STANDARD TRANSITIONAL ASSISTANCE SPONSORS AND FAMILY MEMBERS <b>OR</b>
			009	TRICARE STANDARD RETIRED AND MOH SPONSORS AND FAMILY MEMBERS <b>OR</b>
			010	TRICARE STANDARD TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b>
			015	TRICARE STANDARD TRANSITIONAL SURVIVORS OF NG/RESERVE DECEASED SPONSORS <b>OR</b>
			017	TRICARE STANDARD SURVIVORS OF NG/RESERVE DECEASED SPONSORS <b>OR</b>
			018	TFL RETIRED SPONSORS AND FAMILY MEMBERS AND MOH <b>OR</b>
			020	TFL TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b>
			021	TFL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b>
			022	TFL TRANSITIONAL SURVIVORS OF NG/RESERVE DECEASED SPONSORS <b>OR</b>
			023	TFL SURVIVORS OF NG/RESERVE DECEASED SPONSORS <b>OR</b>
			028	TRICARE STANDARD FOR MEDICALLY RETIRED SPONSORS AND FAMILY MEMBERS <b>OR</b>
			029	TFL FOR MEDICALLY RETIRED SPONSORS AND FAMILY MEMBERS <b>OR</b>
			409	TRS SURVIVOR CONTINUING INDIVIDUAL COVERAGE <b>OR</b>
			410	TRS SURVIVOR CONTINUING FAMILY COVERAGE <b>OR</b>
			411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE <b>OR</b>
			412	TRS SURVIVOR NEW FAMILY COVERAGE <b>OR</b>
			413	TRS MEMBER-ONLY COVERAGE <b>OR</b>
			414	TRS MEMBER AND FAMILY COVERAGE <b>OR</b>
			418	TRR MEMBER-ONLY COVERAGE <b>OR</b>
			419	TRR MEMBER AND FAMILY COVERAGE <b>OR</b>

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Non-Institutional Edit Requirements (ELN 300 - 399)

<b>ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)</b>	
	420 TRR SURVIVOR INDIVIDUAL COVERAGE <b>OR</b>
	421 TRR SURVIVOR FAMILY COVERAGE <b>OR</b>
	422 TYA STANDARD FOR ADFMS <b>OR</b>
	423 TYA STANDARD FOR RETIRED AND MOH FAMILY MEMBERS <b>OR</b>
	424 TYA RESERVE SELECT <b>OR</b>
	425 TYA RETIRED RESERVE <b>OR</b>
	999 UNVERIFIED NEWBORN
<b>AND PATIENT ZIP CODE MUST =</b>	PHL PHILIPPINES
<b>AND PROVIDER STATE OR COUNTRY CODE MUST =</b>	PHL PHILIPPINES
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<b>ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) SPECIAL ENTITLEMENT CODE (2-306)</b>	
<b>VALIDITY EDITS</b>	
<b>2-306-01V</b>	MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE (REFER TO <a href="#">SECTION 2.5</a> )
<b>RELATIONAL EDITS</b>	
NONE	

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**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 <b>OR</b>
T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b>
AN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
AR	SHCP - REFERRED CARE <b>OR</b>
CE	SHCP - CCEP <b>OR</b>
PF	ECHO
RS	MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b>
SC	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
SE	SHCP - TRICARE ELIGIBLE <b>OR</b>
SM	SHCP - EMERGENCY <b>OR</b>
ST	SPECIALIZED TREATMENT <b>OR</b>
WR	MENTAL HEALTH WRAP AROUND

**THEN** BYPASS ALL CA/NAS NUMBER EDITING.

**NO ERROR** IF ENROLLMENT/HEALTH PLAN CODE =

U	TRICARE PRIME, CIVILIAN PCM <b>OR</b>
W	TPR ADSM - USA <b>OR</b>
X	FOREIGN ADSM <b>OR</b>
Y	CHCBP - STANDARD <b>OR</b>
Z	TRICARE PRIME, MTF/PCM <b>OR</b>
AA	CHCBP - EXTRA <b>OR</b>
BB	TSP <b>OR</b>
FE	TFL - EXTRA <b>OR</b>
FS	TFL - STANDARD <b>OR</b>
PS	TSRx <b>OR</b>
SN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
SR	SHCP - REFERRED CARE <b>OR</b>
WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM

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

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Non-Institutional Edit Requirements (ELN 300 - 399)

<b>ELEMENT NAME: CA/NAS NUMBER (2-310) (Continued)</b>	
<b>THEN</b> BYPASS ALL CA/NAS NUMBER EDITING.	
<b>NO ERROR</b>	IF HCC MEMBER CATEGORY CODE = T FOREIGN MILITARY MEMBER
<b>THEN</b> BYPASS ALL CA/NAS NUMBER EDITING.	
<b>NO ERROR</b>	IF ANY OCCURRENCE OF ADJUSTMENT/ DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE =
	15 PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER <b>OR</b>
	26 EXPENSES INCURRED PRIOR TO COVERAGE <b>OR</b>
	27 EXPENSES INCURRED AFTER COVERAGE TERMINATED <b>OR</b>
	30 PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS <b>OR</b>
	31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED <b>OR</b>
	32 OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED <b>OR</b>
	33 CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE <b>OR</b>
	34 CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS <b>OR</b>
	62 PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION <b>OR</b>
	141 CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
<b>THEN</b> BYPASS ALL CA/NAS NUMBER EDITING	
<b>NO ERROR</b>	IF AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO
<b>THEN</b> NO CA/NAS IS REQUIRED -- BYPASS ALL CA/NAS NUMBER EDITING.	
<b>2-310-02R</b>	IF CA/NAS EXCEPTION REASON ≠ BLANK
<b>THEN</b> CA/NAS NUMBER MUST = BLANK	
<b>2-310-03R</b>	• MENTAL HEALTH CHECK
IF CA/NAS EXCEPTION REASON = BLANK	
<b>AND</b> TYPE OF SERVICE (FIRST POSITION) = I INPATIENT	
<b>AND</b> PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316	
<b>AND</b> PATIENT ZIP CODE IS IN AN MTF CATCHMENT AREA <sup>1</sup>	
<b>THEN</b> CA/NAS NUMBER MUST BE CODED	
<b>UNLESS</b> ANY OCCURRENCE OF OVERRIDE CODE = C GOOD FAITH PAYMENT	
<b>THEN</b> CA/NAS NUMBER MUST = BLANK	
<b>2-310-04R</b>	IF CA/NAS NUMBER IS CODED
<b>THEN</b> CA/NAS EXCEPTION REASON MUST = BLANK	
<sup>1</sup> CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.	

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Non-Institutional Edit Requirements (ELN 300 - 399)

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**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 - CCEP **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

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

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

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

**AND** CA/NAS NUMBER NOT CODED

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

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Non-Institutional Edit Requirements (ELN 300 - 399)

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

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Non-Institutional Edit Requirements (ELN 300 - 399)

<b>ELEMENT NAME: PRICING RATE CODE (2-325) (Continued)</b>		
	GU	ADSM ENROLLED IN TPR <b>OR</b>
	SC	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
	SE	SHCP - TRICARE ELIGIBLE <b>OR</b>
	SM	SHCP - EMERGENCY
<b>OR</b> ENROLLMENT/HEALTH PLAN CODE MUST =	SN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
	SR	SHCP - REFERRED CARE
<b>2-325-06R</b> IF PRICING CODE =	W	PRICED OVER CMAC
<b>AND</b> ENROLLMENT/HEALTH PLAN CODE =	T	TRICARE STANDARD PROGRAM
<b>AND</b> AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE =	NE	OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM DEMONSTRATION
<b>AND</b> BEGIN DATE OF CARE ≥ 09/14/2001 <b>AND</b> < 11/01/2009		
<b>THEN</b> PROVIDER PARTICIPATING INDICATOR MUST =	N	NO
<b>2-325-08R</b> IF PRICING RATE CODE =	P1	OPPS <b>OR</b>
	P2	OPPS WITH COST OUTLIER <b>OR</b>
	P3	OPPS WITH DISCOUNT <b>OR</b>
	P5	PARTIAL HOSPITALIZATION - PAID AS OPPS
<b>THEN</b> APC CODE MUST ≠ BLANK <b>OR</b> ZEROES.		
<b>2-325-09R</b> IF PRICING RATE CODE =	CA	CAH REIMBURSEMENT
<b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 12/01/2009		
<b>UNLESS</b> PROVIDER STATE OR COUNTRY CODE =	AK	ALASKA
<b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 07/01/2007		
<b>2-325-10R</b> IF PRICING CODE =	W	PRICED OVER CMAC
<b>AND</b> AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE =	EF	TRICARE RESERVE AND NATIONAL GUARD FAMILY MEMBER BENEFITS
<b>AND</b> ENROLLMENT/HEALTH PLAN CODE =	T	TRICARE STANDARD PROGRAM
<b>THEN</b> PROVIDER PARTICIPATING INDICATOR MUST =	N	NO

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

**VALIDITY EDITS**

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

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

**RELATIONAL EDITS**

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

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

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

**VALIDITY EDITS**

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

**RELATIONAL EDITS**

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

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

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

**VALIDITY EDITS**

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

**RELATIONAL EDITS**

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

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

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

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

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

- END -