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TRICARE  
MANAGEMENT ACTIVITY

PCSIB

CHANGE 41  
7950.2-M  
AUGUST 24, 2012

## CORRECTED COPY

### PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE SYSTEMS MANUAL (TSM), FEBRUARY 2008

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

**CHANGE TITLE:** MODIFICATIONS FOR CONVERSION FROM INTERNATIONAL CLASSIFICATION OF DISEASES, 9TH REVISION (ICD-09) TO INTERNATIONAL CLASSIFICATION OF DISEASES, 10TH REVISION (ICD-10)

**CONREQ:** 15316

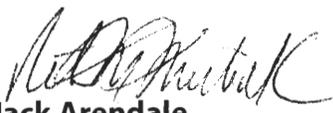
**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** These changes were made to reflect the new ICD-10 requirements as a result of the Health Insurance Portability and Accountability Act (HIPAA) Final Rule published in the Federal Register on January 16, 2009 mandating nationwide conversion from ICD-09 coding to ICD-10-Clinical Modification (CM) (diagnosis) and ICD-10-Procedure Coding System (PCS) (procedures).

**EFFECTIVE DATE:** Upon direction of the Contracting Officer.

**IMPLEMENTATION DATE:** October 1, 2014.

This change is made in conjunction with Feb 2008 TOM, Change No. 82, Feb 2008 TPM, Change No. 75, and Feb 2008 TRM, Change No. 71.

  
Jack Arendale  
Chief, Purchased Care Systems  
Integration Branch

**ATTACHMENT(S):** 99 PAGES  
**DISTRIBUTION:** 7950.2-M

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## Chapter 2

### TRICARE Encounter Data (TED)

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### Chapter 2, TRICARE Encounter Data (TED)

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**6.2.1 Criteria For Selecting TMA Foreign Non-Financially Underwritten ASAP Accounts (Foreign Contract Only)**

All claims submitted by the foreign contract shall be submitted to TMA, CRM using the non-financially underwritten ASAP Account Numbers with a '3', or '4', or '5', or '6' in position 8. The BATCH/VOUCHER CLIN/ASAP Account Number with a '3' in position 8 shall be used for all appropriated fund foreign benefit payments - excluding Navy/Marine deployed claims covered by TRICARE Overseas Program (TOP). The BATCH/VOUCHER CLIN/ASAP Account Number with a '4' in position 8 shall be used for all Accrual/Trust fund foreign benefit payments. The BATCH/VOUCHER CLIN/ASAP Account Number with a '5' in position 8 shall be used for all Navy deployed claims covered by TOP. The BATCH/VOUCHER CLIN/ASAP Account Number with a '6' in position 8 shall be used for all Marine deployed claims covered by TOP.

**6.2.2 Criteria For Selecting TMA Non-Financially Underwritten ASAP Account (excludes foreign contract and claims that meet criteria specified under paragraph 6.2.1)**

All non-financially underwritten claims shall be submitted to TMA, CRM using the non-financially underwritten ASAP Account Number with a '1' in position 8.

**6.2.3 Criteria For Selecting Financially Underwritten CLINs (excludes claims that meet criteria specified under paragraphs 6.2.1 and 6.2.2)**

All financially underwritten benefit payments and all Resource Sharing claims must use the BATCH/VOUCHER CLIN/ASAP Account Number containing the TMA Benefit CLIN (positions 1 through 6 of ASAP).

**6.2.4 Criteria For Selecting ASAP Type (Pass Through) BATCH/VOUCHER CLIN/ASAP Account Number based on 'Active' Dates (Fiscal Year)**

All ASAP Type BATCH/VOUCHER CLIN/ASAP Account Numbers assigned by TMA, CRM shall have an 'active' date range assigned. The BATCH/VOUCHER CLIN/ASAP Account Number's 'active' dates shall not overlap across fiscal years. The BATCH/VOUCHER Date (0-030) is the field TMA shall use when editing for proper selection of ASAP Type BATCH/VOUCHER CLIN/ASAP Account Number based on date. All disbursements shall be made using a currently 'active' ASAP Type BATCH/VOUCHER CLIN/ASAP Account Number. All credits where reported disbursements did not occur (stale dated checks, voids, etc.) shall be credited back to the BATCH/VOUCHER CLIN/ASAP Account Number originally used to report the disbursement. All collections (credits) of funds where the disbursement was originally reported to TMA using a ASAP Type BATCH/VOUCHER CLIN/ASAP Account Numbers (BATCH/VOUCHER CLIN/ASAP Account Number with a '1' or '3' or '4' or '5' or '6' in position 8) shall be credited to TMA using currently 'active' BATCH/VOUCHER CLIN/ASAP Account Number.

**6.2.5 Criteria For Selecting CLIN TYPE (UNDERWRITTEN) BATCH/VOUCHER CLIN/ASAP Account Number based on 'Active' Dates (Fiscal Year and Option Period)**

All CLIN Type BATCH/VOUCHER CLIN/ASAP Account Numbers assigned by TMA, CRM shall have an 'active' date range assigned. The BATCH/VOUCHER CLIN/ASAP Account Number's 'active' dates shall not overlap across Option Periods or fiscal year. The BEGIN DATE OF CARE (1-275 or 2-150) is the field TMA shall use when editing for proper selection of CLIN Type BATCH/VOUCHER

CLIN/ASAP Account Number based on date. All disbursements shall be made using the CLIN Type BATCH/VOUCHER CLIN/ASAP Account Number that was 'active' at the time care started. All credits shall cite the original CLIN Type BATCH/VOUCHER CLIN/ASAP Account Number originally used to report the disbursement.

## 7.0 INTERIM INSTITUTIONAL PAYMENTS

**7.1** In certain cases, providers can submit interim bills for institutional claims as a method to facilitate cash flow. Interim-interim and interim-final TED records with filing dates before January 1, 2011 must be submitted as an adjustment using the same TED Record Indicator (TRI) as the initial submission.

**7.2** Interim-interim and interim-final TED records (FREQUENCY CODES '3' and '4') with filing dates on or after 01/01/2011 **with the exception of interim billings reimbursed under the DRG or Home Health Agency (HHA) payment methodology** must be submitted with a unique TRI and must be submitted on batch/vouchers with HEADER TYPE INDICATOR '0' or '5'. DRG and HHA interim-interim and interim-final TED records will continue to be submitted as an adjustment using the same TRI as the initial submission.

**7.3** For claims that are reimbursed under the TRICARE Diagnosis Related Group (DRG) payment methodology please see the TRICARE Reimbursement Manual (TRM), [Chapter 6, Section 3](#) for requirements on submitting DRG interim bills.

**7.4** For claims that are reimbursed under the Home Health Agency Prospective Payment System (HHA PPS) methodology, please see the guidelines on submitting interim bills in the TRM, [Chapter 12, Section 6](#).

**7.5** International Classification of Diseases (ICD) version and Operation/Non-Surgical Procedure (OP/NSP) codes are determined by patient discharge date. ICD, 10th Revision, Clinical Modification, (ICD-10-CM) diagnosis and ICD-10-Procedure Coding System (ICD-10-PCS) OP/NSP codes are appropriate for claims with discharge dates on or after the date specified by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule as published in the **Federal Register** and ICD, 9th Revision, Clinical Modification (ICD-9-CM) and ICD-9-Procedure Coding System (ICD-9-PCS) codes are appropriate for discharge dates prior to ICD-10 implementation. Since the TED record does not report discharge date, end date of care will determine ICD version when patient status indicates discharged, transferred or expired (i.e., codes 01, 02, 03). Admission date will determine ICD version when the patient status indicates the patient remains hospitalized (i.e., 30).

## 8.0 PROCESS FOR REPORTING EXTERNAL RESOURCE SHARING ENCOUNTERS TO TMA

The following process is to be used by claims processors to submit data to TMA which relates to External Resource Sharing encounters.

### 8.1 Special Processing Code

For External Resource Sharing encounters, submit a TED record which includes SPECIAL PROCESSING CODE of 'S' Resource Sharing - External, for each patient encounter.

## **8.2 "Amount" Field Reporting**

The "amount" fields must contain the following:

### **8.2.1 Amount Billed By Procedure Code**

If a Resource Sharing provider is being reimbursed on a fee-for-service basis with negotiated/discounted rates, report these amounts in the Amount Billed By Procedure Code field.

### **8.2.2 Amount Allowed/Amount Allowed By Procedure Code**

The Amount Allowed By Procedure Code field must contain the CHAMPUS Maximum Allowable Charge (CMAC) or negotiated/discounted rates as appropriate.

### **8.2.3 Amount Paid By Government Contractor**

The AMOUNT PAID BY GOVERNMENT CONTRACTOR field must equal the "lesser" of the amount allowed minus (PATIENT COST-SHARE plus AMOUNT APPLIED TOWARD DEDUCTIBLE) or AMOUNT ALLOWED minus amount of OHI. If the "Lesser" computed amount is negative, AMOUNT PAID BY GOVERNMENT CONTRACTOR must = \$0.00.

## **9.0 PROCESS FOR REPORTING BLOOD CLOTTING FACTOR DATA TO TMA**

Blood clotting factor reimbursement will be calculated based on the reimbursement methodology described in the TRM. Blood clotting factor charges will not be submitted separately from the DRG reimbursable hospital charges but will be included on the institutional TED record.

### **9.1 Data Reporting**

The following are data reporting requirements specific for TED records containing blood clotting factor charges.

- Revenue Code 0636 (Drugs Requiring Detailed Coding) is to be reported for blood clotting factor.
- UNITS OF SERVICE will reflect the number of units billed on the claim, not the number of payment units.
- AMOUNT BILLED (TOTAL) is the sum of all billed charges on the claim including charges for the blood clotting factor.
- AMOUNT ALLOWED (TOTAL) is the sum of DRG allowed amount and the allowable reimbursement for the blood clotting factor.

- END -



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Chapter 2, Section 2.2

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
1-293	ICD VERSION	X	422	422
1-295	ADMISSION DIAGNOSIS	X(7)	423	429
1-300	PRINCIPAL TREATMENT DIAGNOSIS/PRESENT ON ADMISSION	X(8)	430	437

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Chapter 2, Section 2.2

Data Requirements - Data Element Layout

**2.0 INSTITUTIONAL DATA ELEMENT (CONTINUED)**

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
1-305	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-1	X(8)	438	445
1-306	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-2	X(8)	446	453
1-307	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-3	X(8)	454	461
1-308	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-4	X(8)	462	469
1-309	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-5	X(8)	470	477
1-310	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-6	X(8)	478	485
1-311	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-7	X(8)	486	493
1-312	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-8	X(8)	494	501
1-313	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-9	X(8)	502	509
1-314	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-10	X(8)	510	517
1-315	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-11	X(8)	518	525
1-316	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-12	X(8)	526	533
1-317	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-13	X(8)	534	541
1-318	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-14	X(8)	542	549
1-319	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-15	X(8)	550	557
1-320	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-16	X(8)	558	565
1-321	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-17	X(8)	566	573
1-322	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-18	X(8)	574	581
1-323	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-19	X(8)	582	589
1-324	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-20	X(8)	590	597
1-325	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-21	X(8)	598	605
1-326	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-22	X(8)	606	613
1-327	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-23	X(8)	614	621
1-328	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-24	X(8)	622	629
1-345	PRINCIPAL OPERATION/NON-SURGICAL PROCEDURE CODE	X(7)	630	636
1-350	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-1	X(7)	637	643
1-351	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-2	X(7)	644	650
1-352	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-3	X(7)	651	657
1-353	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-4	X(7)	658	664
1-354	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-5	X(7)	665	671
1-355	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-6	X(7)	672	678
1-356	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-7	X(7)	679	685
1-357	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-8	X(7)	686	692
1-358	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-9	X(7)	693	699
1-359	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-10	X(7)	700	706
1-360	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-11	X(7)	707	713
1-361	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-12	X(7)	714	720
1-362	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-13	X(7)	721	727
1-363	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-14	X(7)	728	734

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Data Requirements - Data Element Layout

**2.0 INSTITUTIONAL DATA ELEMENT (CONTINUED)**

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
1-364	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-15	X(7)	735	741
1-365	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-16	X(7)	742	748
1-366	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-17	X(7)	749	755
1-367	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-18	X(7)	756	762
1-368	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-19	X(7)	763	769
1-369	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-20	X(7)	770	776
1-370	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-21	X(7)	777	783
1-371	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-22	X(7)	784	790
1-372	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-23	X(7)	791	797
1-373	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE-24	X(7)	798	804
1-374	TED RECORD CORRECTION INDICATOR	X	805	805
1-375	TOTAL OCCURRENCE/LINE ITEM COUNT	9(3)	806	808
1-377	AMOUNT NETWORK PROVIDER DISCOUNT	S9(7)V99	809	817
1-378	ADJUSTMENT SEQUENCE NUMBER	X(3)	818	820
	FILLER	X(20)	821	840
1-380	OCCURRENCE/LINE ITEM NUMBER (OCCURS 1 TO 450 TIMES)	9(3)	841	843
1-385	REVENUE CODE	X(4)	844	847
1-390	UNITS OF SERVICE BY REVENUE CODE	S9(10)	848	857
1-395	TOTAL CHARGE BY REVENUE CODE	S9(7)V99	858	866
1-400	ADJUSTMENT/DENIAL REASON CODE	X(5)	867	871
	FILLER	X(30)	872	901

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Chapter 2, Section 2.2

Data Requirements - Data Element Layout

**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
2-114	ICD VERSION	X	241	241
2-115	PRINCIPAL TREATMENT DIAGNOSIS/PRESENT ON ADMISSION	X(8)	242	249
2-116	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-1	X(8)	250	257
2-117	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-2	X(8)	258	265
2-118	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-3	X(8)	266	273

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**3.0 NON-INSTITUTIONAL DATA ELEMENT (CONTINUED)**

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
2-119	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-4	X(8)	274	281
2-120	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-5	X(8)	282	289
2-121	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-6	X(8)	290	297
2-122	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-7	X(8)	298	305
2-123	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-8	X(8)	306	313
2-124	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-9	X(8)	314	321
2-125	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-10	X(8)	322	329
2-126	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-11	X(8)	330	337
2-127	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-12	X(8)	338	345
2-128	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-13	X(8)	346	353
2-129	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-14	X(8)	354	361
2-130	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-15	X(8)	362	369
2-131	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-16	X(8)	370	377
2-132	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-17	X(8)	378	385
2-133	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-18	X(8)	386	393
2-134	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-19	X(8)	394	401
2-135	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-20	X(8)	402	409
2-136	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-21	X(8)	410	417
2-137	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-22	X(8)	418	425
2-138	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-23	X(8)	426	433
2-340	SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION-24	X(8)	434	441
2-139	TED RECORD CORRECTION INDICATOR	X	442	442
2-140	TOTAL OCCURRENCE/LINE ITEM COUNT	9(3)	443	445
2-141	ADJUSTMENT SEQUENCE NUMBER	X(3)	446	448
	FILLER	X(20)	449	468
2-145	OCCURRENCE/LINE ITEM NUMBER (OCCURS 1 TO 99 TIMES)	9(3)	469	471
2-150	BEGIN DATE OF CARE	YYYYMMDD	472	479
2-155	END DATE OF CARE	YYYYMMDD	480	487
2-160	PROCEDURE CODE	X(5)	488	492
2-165	PROCEDURE CODE MODIFIER	X(8)	493	500
2-170	NATIONAL DRUG CODE	X(11)	501	511
2-175	NUMBER OF SERVICES	S9(3)	512	514
2-180	AMOUNT BILLED BY PROCEDURE CODE	S9(7)V99	515	523
2-185	AMOUNT ALLOWED BY PROCEDURE CODE	S9(7)V99	524	532
2-190	AMOUNT PAID BY OTHER HEALTH INSURANCE	S9(7)V99	533	541
2-191	OTHER GOVERNMENT PROGRAM TYPE CODE	X	542	542
2-192	OTHER GOVERNMENT PROGRAM BEGIN REASON CODE	X	543	543
2-195	AMOUNT APPLIED TOWARD DEDUCTIBLE	S9(3)V99	544	548
2-200	AMOUNT PATIENT COST-SHARE	S9(7)V99	549	557

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Data Requirements - Data Element Layout

**3.0 NON-INSTITUTIONAL DATA ELEMENT (CONTINUED)**

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
2-201	HEALTH CARE COVERAGE COPAYMENT FACTOR CODE	X	558	558
2-205	AMOUNT PAID BY GOV'T CONTRACTOR BY PROCEDURE CODE	S9(7)V99	559	567
2-220	ADJUSTMENT/DENIAL REASON CODE	X(5)	568	572
2-225	PROVIDER INDIVIDUAL NPI NUMBER (TYPE 1)	X(10)	573	582
2-230	PROVIDER ORGANIZATIONAL NPI NUMBER (TYPE 2)	X(10)	583	592
2-235	PROVIDER STATE OR COUNTRY CODE	X(3)	593	595
2-240	PROVIDER TAXPAYER NUMBER	X(9)	596	604
2-245	PROVIDER SUB-IDENTIFIER	X(4)	605	608
2-250	PROVIDER ZIP CODE	X(9)	609	617
2-255	PROVIDER TAXONOMY SPECIALTY	X(10)	618	627
2-260	PROVIDER PARTICIPATION INDICATOR	X	628	628
2-265	PROVIDER NETWORK STATUS INDICATOR	X	629	629
2-270	PHYSICIAN REFERRAL NUMBER	X(13)	630	642
2-275	PLACE OF SERVICE	X(2)	643	644
2-280	TYPE OF SERVICE	X(2)	645	646
2-285	HEALTH CARE COVERAGE MEMBER CATEGORY CODE	X	647	647
2-291	PAY GRADE CODE (SPONSOR)	X(2)	648	649
2-292	PAY PLAN CODE (SPONSOR)	X(5)	650	654
2-295	HEALTH CARE COVERAGE MEMBER RELATIONSHIP CODE	X	655	655
2-300	ENROLLMENT/HEALTH PLAN CODE	X(2)	656	657
2-301	HEALTH CARE DELIVERY PROGRAM PLAN COVERAGE CODE	X(3)	658	660
2-303	REGION INDICATOR	X(2)	661	662
2-305	SPECIAL PROCESSING CODE	X(8)	663	670
2-306	HEALTH CARE DELIVERY PROGRAM SPECIAL ENTITLEMENT CODE	X(2)	671	672
2-310	CA/NAS NUMBER	X(15)	673	687
2-315	CA/NAS REASON FOR ISSUANCE	X	688	688
2-320	CA/NAS EXCEPTION REASON	X(2)	689	690
2-325	PRICING RATE CODE	X(2)	691	692
2-330	AMBULATORY PAYMENT CLASSIFICATION CODE	X(5)	693	697
2-331	OPPS PAYMENT STATUS INDICATOR CODE	X(2)	698	699
2-335	AMOUNT NETWORK PROVIDER DISCOUNT	S9(7)V99	700	708
	FILLER	X(30)	709	738

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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

**5.0 TRANSMISSION RECORDS**

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

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

**TRANSMISSION HEADER RECORD FORMAT**

POSITION(S)	DESCRIPTION	CONTENT	COMMENT
1-8	Alpha	Data Type	Must be "TED Data".
9-10	**	Delimiter	Must be **.
11-22	Alphanumeric	File Name	Must be named in accordance with <a href="#">Chapter 1, Section 1.1, paragraph 11.7.3.1.5.</a>
23-24	**	Delimiter	Must be **
25-29	Alpha		Must be "FSIZE"
30-Variable	Numeric	File Size	Includes the total number of batch/voucher header records, provider, pricing and TED records (variable length). Includes transmission header, excludes transmission trailer.
Variable (2 positions)	**	Delimitier	Must be **.
Variable (6 positions)	Alpha	Record Type	Must be "RTYPEV".
Variable (2 positions)	**	Delimiter	Must be **.
Variable (7 positions)	Alpha		Must be "MAXRLEN".
Variable	Numeric	Maximum Record Length	Length of the longest variable length record within the transmission. Must be > 0.
Variable (2 positions)	**	Delimiter	Must be **.
Variable - 80	Blank	Reserved	Must be HEX 40.

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

**TRANSMISSION TRAILER RECORD FORMAT**

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

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Data Requirements - Data Element Layout

**TRANSMISSION TRAILER RECORD FORMAT (CONTINUED)**

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

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

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

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### Data Requirements - Data Element Layout

ERROR CODE	ERROR TYPE	VALIDATION RULE
1998	Invalid non-printable character	Transmission file must not contain invalid non-printable characters (ASCII Values 0-9, 11-31, 127-255)
1999	Invalid printable character	Transmission file must not contain invalid printable characters (e.g., binary values, >, <, :, ;, \, ",  , etc.). The only acceptable characters are A-Z (uppercase only), 0-9, ', @, *, #, and blank.

## 6.0 PRINT/REPORT TRANSMISSIONS

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

### ERRORS RECORDS RETURNED FORMAT

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

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

### ERROR CODE FORMAT

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

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

- END -

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Chapter 2, Section 2.4

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: ADMISSION DATE**

<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-265	1	Yes
<b>PRIMARY PICTURE (FORMAT)</b> Eight (8) alphanumeric characters, YYYYMMDD.			
<b>DEFINITION</b> Date the patient was first admitted to the institution for this episode of care.			
<b>CODE/VALUE SPECIFICATIONS</b>			
	YYYY	4 digit calendar year	
	MM	2 digit calendar month	
	DD	2 digit calendar day	
<b>ALGORITHM</b> N/A			
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
	<b>SUBORDINATE</b>		<b>GROUP</b>
	N/A		N/A
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
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
<b>PRIMARY PICTURE (FORMAT)</b> Seven (7) alphanumeric characters.			
<b>DEFINITION</b> Diagnosis code under which patient was admitted to institution.			
<b>CODE/VALUE SPECIFICATIONS</b> Use the most current diagnosis code edition (ICD-9-CM or ICD-10-CM), as directed by TMA. Must code the most detailed subcategory or subclassification. Do not code the decimal point.			
<b>ALGORITHM</b> 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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Chapter 2, Section 2.5

Data Requirements - Institutional/Non-Institutional Record Data Elements (E - L)

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: ICD VERSION**

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
Institutional	1-293	1	Yes
Non-Institutional	2-114	1	Yes

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

**DEFINITION** Code to indicate the International Classification of Diseases (ICD) version.

CODE/VALUE SPECIFICATIONS	0	ICD-10
	9	ICD-9

**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 (E - L)

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: INTERNAL CONTROL NUMBER (ICN)**

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
Institutional	1-010	1	Yes
Non-Institutional	2-010	Up to 99	Yes

**PRIMARY PICTURE (FORMAT)** Group

**DEFINITION** N/A

**CODE/VALUE SPECIFICATIONS** Refer to subordinate element definitions.

**ALGORITHM** N/A

**SUBORDINATE AND/OR GROUP ELEMENTS**

SUBORDINATE	GROUP
FILING DATE	TED RECORD INDICATOR
FILING STATE/COUNTRY CODE	
SEQUENCE NUMBER	

**NOTES AND SPECIAL INSTRUCTIONS:**

N/A

- END -

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

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PRINCIPAL OPERATION/NON-SURGICAL PROCEDURE CODE</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-345	1	Yes <sup>1</sup>
<b>PRIMARY PICTURE (FORMAT)</b> Seven (7) alphanumeric characters.			
<b>DEFINITION</b> The code that identifies the principal procedure performed during the period reported on the TED record as submitted on the UB-04/UB-92.			
<b>CODE/VALUE SPECIFICATIONS</b> Use the most current procedure code edition (ICD-9-CM or ICD-10-PCS) as directed by TMA. Must provide the most detailed code. Do not code the decimal point.			
<b>ALGORITHM</b> N/A			
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>	<b>GROUP</b>		
N/A	N/A		
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
<sup>1</sup> Required if one of the following Revenue Codes are present 036X or 072X.			

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS/PRESENT ON ADMISSION (POA) INDICATOR**

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
Institutional	1-300	1	Yes
Non-Institutional	2-115	1	Yes

**PRIMARY PICTURE (FORMAT)** Eight (8) alphanumeric characters.

**DEFINITION** **Principal Treatment Diagnosis:** The condition established, after study, to be the major cause for the patient to obtain medical care as submitted on the claim form or otherwise indicated by the provider.

**POA Indicator: Diagnosis present at the time the order for inpatient admission occurs.**

**CODE/VALUE SPECIFICATIONS** **Principal Treatment Diagnosis (Positions 1 through 7):** Use the most current diagnosis code edition (ICD-9-CM or ICD-10-CM), as directed by TMA. Must provide the most detailed code. Do not code the decimal point.

**POA Indicator (Position 8):**

Valid POA values are::

<del>B</del>	Not reported
1	Unreported/Not Used - Exempt from POA reporting
N	No - Not present at time of admission
U	Unknown - Documentation insufficient to determine if the condition was present at time of admission
W	Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission
Y	Yes - Present at time of admission

**ALGORITHM** N/A

**SUBORDINATE AND/OR GROUP ELEMENTS**

SUBORDINATE	GROUP
N/A	N/A

**NOTES AND SPECIAL INSTRUCTIONS:**

For MOP and Retail Pharmacy, if a more specific diagnosis code is not available, use ICD-9-CM 799.89 prior to ICD-10 implementation and ICD-10-CM R68.89 on or after the date specified by the CMS in the Final Rule as published in the **Federal Register**.

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PROCEDURE CODE**

<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Non-Institutional	2-160	Up to 99	Yes
<b>PRIMARY PICTURE (FORMAT)</b> Five (5) alphanumeric characters.			
<b>DEFINITION</b> The code that identifies the procedure performed or describes the care received as submitted on the claim form.			
<b>CODE/VALUE SPECIFICATIONS</b> Refer to Physician's Current Procedure Terminology, 4th Edition <sup>1</sup> (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) National Level II Medicare Codes or TMA approved codes ( <a href="#">Addendum E, Figure 2.E-2</a> ). For Dental Services, use HCPC or ADA Dental procedure codes.			
<b>ALGORITHM</b> N/A			
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>	<b>GROUP</b>		
N/A	N/A		

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

For MOP report procedure code <sup>1</sup>98800 for all drug prescriptions and procedure code <sup>1</sup>99070 for all supplies. The first line item must report the information on the prescription and the second line item to report corresponding supplies that are issued such as alcohol pads, lancets, etc. The procedure code on the second occurrence/line item on MOP records must be procedure code 99070.

For Mail Order and Retail Pharmacy Prior Authorizations and Medical Necessity Reviews report 000PA or 000MN.

For the list of the No Government Pay Procedure Codes that are excluded from TRICARE coverage and are not payable under TRICARE, refer to the No Government Pay Procedure Code list on TMA's web site at <http://tricare.mil/nogovernmentpay>.

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PROCEDURE CODE MODIFIER**

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-165	4/Up to 99	No
<b>PRIMARY PICTURE (FORMAT)</b> Four (4) occurrences of two (2) alphanumeric characters per occurrence/line item.			
<b>DEFINITION</b> Two digit code which provides the means by which the health care professional can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. (Refer to Physician's Current Procedure Terminology, 4th Edition <sup>1</sup> (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) National Level II Medicare Codes.)			
<b>CODE/VALUE SPECIFICATIONS</b> Must be 21-27, 32, 33, 47, 50-59, 62, 63, 66, 73-82, 90-92, 99, 0A-0P, 0Z, 1A-1J, 1P, 1Z, 2A-2T, 2Z, 3A-3I, 3K, 3P, 3Z, 4A-4U, 4Z, 5A-5O, 5Z, 6A-6F, 6Z, 7A-7F, 7Z, 8A-8C, 8P, 8Z, 9A-9D, 9L-9Q, 9Z, A1-A9, AA, AD-AK, AM, AP-AZ, BA, BL, BO-BR, BU, CA-CG, CR, CS, DA, DE, DG-DJ, DN, DP, DR, DS, DX, E1-E4, EA-EE, EG-EJ, EM, EN, EP, ER-ET, EX, EY, F1-F9, FA-FC, FP, G1-G9, GA-GZ, H9, HA-HZ, ID, IE, IG-IJ, IN, IR, IS, IX, J1-J4, JA-JE, JG-JJ, JN, JP, JR, JS, JW, JX, K0-K4, KA-KZ, LC, LD, LL, LR-LT, M2, MR, MS, NB, ND, NE, NG-NJ, NN, NP, NR-NU, NX, P1-P6, PA-PE, PG, PI, PJ, PL, PN, PP, PR-PT, PX, Q0-Q9, QA-QH, QJ-QZ, RA-RE, RG-RJ, RN, RP-RT, RX, SA-SN, SQ-SY, T1-T9, TA, TC-TK, TL-TN, TP-TW, U1-U9, UA-UH, UJ-UK, UN, UP-US, V5-V9, VP, XD, XE, XG-XJ, XN, XR, XS, or blank.			
<b>ALGORITHM</b> N/A			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE	GROUP		
N/A	N/A		
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.			
<b>Note:</b> Can report from zero to four codes. Each occurrence consists of two characters left justified and blank filled. Do not duplicate.			

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Chapter 2, Section 2.8

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

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODES</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-350 --1-373	24	Yes <sup>1</sup>
<b>PRIMARY PICTURE (FORMAT)</b> Seven (7) alphanumeric characters.			
<b>DEFINITION</b> Secondary OP/NSP Codes. Codes identifying the procedures, other than the principal procedure, performed during the period reported on the TED record. The secondary OP/NSP code(s) shall not duplicate the primary OP/NSP code. Do not duplicate secondary OP/NSP codes.			
<b>CODE/VALUE SPECIFICATIONS</b> Use the most current procedure code edition (ICD-9-CM or ICD-10-PCS) as directed by TMA. Must code the most detailed procedure. Do not code the decimal point.			
<b>ALGORITHM</b> N/A			
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>			<b>GROUP</b>
N/A			N/A
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
<sup>1</sup> Required if available.			

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS/PRESENT ON ADMISSION (POA) INDICATOR**

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-305 -- 1-328	24	Yes <sup>1</sup>
Non-Institutional	2-116 -- 2-138, 2-340	24	Yes <sup>1</sup>

**PRIMARY PICTURE (FORMAT)** Eight (8) alphanumeric characters.

**DEFINITION** **Secondary Treatment Diagnosis:** Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter. The secondary treatment diagnosis code(s) shall not duplicate the primary treatment diagnosis code. Do not duplicate secondary treatment diagnosis codes.

**POA Indicator:** Diagnosis present at the time the order for inpatient admission occurs.

**CODE/VALUE SPECIFICATIONS** **Secondary Treatment Diagnosis (Positions 1 through 7):** Use the most current diagnoses edition (ICD-9-CM or ICD-10-CM) as directed by TMA. Must code the most detailed procedure. Do not code decimal point.

**POA Indicator (Position 8):**

Valid POA values are:

-	Not reported
1	Unreported/Not Used - Exempt from POA reporting
N	No - Not present at time of admission
U	Unknown - Documentation insufficient to determine if the condition was present at time of admission
W	Clinically Undetermined - The provider is unable to clinically determine if the condition was present at time of admission
Y	Yes - Present at time of admission

**ALGORITHM** N/A

**SUBORDINATE AND/OR GROUP ELEMENTS**

SUBORDINATE	GROUP
N/A	N/A

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> Required if available.

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: SOURCE OF ADMISSION**

		RECORDS/LOCATOR NUMBERS	
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-260	1	Yes
<b>PRIMARY PICTURE (FORMAT)</b> One (1) alphanumeric character.			
<b>DEFINITION</b> Code indicating the source of the referral for this admission.			
CODE/VALUE SPECIFICATIONS	SOURCE OF ADMISSION CODE		
1	Physician Referral	The patient was admitted to this facility upon the recommendation of his or her personal physician.	
2	Clinic Referral	The patient was admitted to this facility upon recommendation of this facility's clinic physician.	
3	HMO Referral	The patient was admitted to this facility upon the recommendation of a HMO physician.	
4	Transfer from a Hospital (Different Facility)	The patient was admitted to this facility as a hospital transfer from a different acute care facility where he or she was an inpatient.	
5	Transfer from a SNF	The patient was admitted to this facility as a transfer from a SNF where he or she was a resident.	
6	Transfer from another Health Care Facility	The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a SNF.	
7	Emergency	The patient was admitted to this facility upon the recommendation of this facility's emergency room physician. <i>(Discontinued effective 07/01/2010).</i>	
8	Court/Law Enforcement	The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.	
9	Information Not Available	The means by which the patient was admitted to this hospital is not known.	
A	Transfer from a CAH	The patient was admitted to this facility as a transfer from a CAH where he or she was an inpatient.	
B	Transfer from Another HHA	The patient was admitted to this HHA as a transfer from another HHA. <i>(Discontinued effective 07/01/2010).</i>	
C	Readmission to the Same HHA	The patient was readmitted to this HHA within the existing 60 day payment. <i>(Discontinued effective 07/01/2010).</i>	
D	Transfer from Hospital Inpatient in the same facility resulting in a separate claim to the payer	The patient was admitted to this facility as a transfer from Hospital Inpatient within this facility resulting in a separate claim.	

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> Use this coding structure when the TYPE OF ADMISSION = '4' (newborn).

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: SOURCE OF ADMISSION (Continued)**

<b>CODE/VALUE SPECIFICATIONS (CONTINUED)</b>		<b>CODE STRUCTURE FOR NEWBORN<sup>1</sup></b>
1	Normal Delivery	A baby delivered without complications. (Discontinued effective 10/01/2007.)
2	Premature Delivery	A baby delivered with time and/or weight factors qualifying it for premature status. (Discontinued effective 10/01/2007.)
3	Sick Baby	A baby delivered with medical complications, other than those relating to premature status. (Discontinued effective 10/01/2007.)
4	Extramural Birth	A newborn born in a non-sterile environment. (Discontinued effective 10/01/2007.)
5	Born Inside This Hospital	A baby born inside this hospital. (Effective 10/01/2007.)
6	Born Outside This Hospital	A baby born outside this hospital. (Effective 10/01/2007.)

**ALGORITHM** N/A

**SUBORDINATE AND/OR GROUP ELEMENTS**

<b>SUBORDINATE</b>	<b>GROUP</b>
N/A	N/A

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> Use this coding structure when the TYPE OF ADMISSION = '4' (newborn).

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Chapter 2, Section 5.2

Institutional Edit Requirements (ELN 100 - 199)

<b>ELEMENT NAME: CA/NAS NUMBER (1-170) (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 =	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>1-170-02R</b>	IF CA/NAS EXCEPTION REASON IS <b>NOT</b> BLANK		
<b>THEN</b> CA/NAS NUMBER MUST = BLANK			
<b>1-170-03R</b>	IF CA/NAS EXCEPTION REASON = BLANK		
<b>AND</b> PRINCIPAL TREATMENT DIAGNOSIS/ POA INDICATOR (POSITIONS 1-7) =			
		290-316 (MENTAL HEALTH, ICD-9-CM) <b>OR</b>	
		F01.50-F69 OR F99 (MENTAL HEALTH, ICD-10-CM)	
<b>AND</b> PATIENT ZIP CODE IS IN AN MTF <sup>2</sup> CATCHMENT AREA <sup>1</sup>			
<b>THEN</b> CA/NAS NUMBER MUST BE CODED			
	UNLESS ANY OCCURRENCE OF OVERRIDE CODE =	C	GOOD FAITH PAYMENT
<b>1-170-04R</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 ADMISSION DATE.			
<sup>2</sup> MTF IS A 40 MILES CATCHMENT AREA.			

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Institutional Edit Requirements (ELN 100 - 199)

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**ELEMENT NAME: CA/NAS REASON FOR ISSUANCE (1-175)**

**VALIDITY EDITS**

**1-175-01V** VALUE MUST BE A VALID CA/NAS REASON OF ISSUANCE.

**RELATIONAL EDITS**

**1-175-02R** IF CA/NAS NUMBER IS BLANK

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

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Institutional Edit Requirements (ELN 100 - 199)

<b>ELEMENT NAME: CA/NAS EXCEPTION REASON (1-180)</b>	
<b>VALIDITY EDITS</b>	
<b>1-180-01V</b>	VALUE MUST BE A VALID CA/NAS EXCEPTION REASON CODE OR BLANK (REFER TO <a href="#">SECTION 2.4</a> ).
<b>RELATIONAL EDITS</b>	
<b>NO ERROR</b>	IF TYPE OF SUBMISSION =
	C COMPLETE CANCELLATION <b>OR</b>
	D COMPLETE DENIAL
<b>THEN</b> BYPASS ALL CA/NAS EXCEPTION REASON EDITING.	
<b>NO ERROR</b>	IF ADMISSION DATE IS OLDER THAN 6 YEARS
<b>THEN</b> DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA	
<b>NO ERROR</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	R MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NOT A MEDICARE BENEFIT) <b>AND</b> 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 - <b>CCEP</b> <b>OR</b>
	PF ECHO <b>OR</b>
	RS MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b>
	SC SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
	SE SHCP - TRICARE ELIGIBLE <b>OR</b>
	SM SHCP - EMERGENCY <b>OR</b>
	ST SPECIALIZED TREATMENT <b>OR</b>
	WR MENTAL HEALTH WRAP AROUND
<b>THEN</b> BYPASS ALL CA/NAS EXCEPTION REASON EDITING	
<b>NO ERROR</b>	IF ENROLLMENT/HEALTH PLAN CODE =
	U TRICARE PRIME, CIVILIAN PCM <b>OR</b>
	W TPR ADSM - USA <b>OR</b>
	X FOREIGN ADSM <b>OR</b>
	Y CHCBP - STANDARD <b>OR</b>
	Z TRICARE PRIME, MTF/PCM <b>OR</b>
	AA CHCBP - EXTRA <b>OR</b>
	BB TSP <b>OR</b>
	FE TFL - EXTRA <b>OR</b>
	FS TFL - STANDARD <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 ADMISSION DATE.

<sup>2</sup> MTF IS A 40 MILES CATCHMENT AREA.

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Chapter 2, Section 5.2

Institutional Edit Requirements (ELN 100 - 199)

**ELEMENT NAME: CA/NAS EXCEPTION REASON (1-180) (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 =

	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

**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.

**1-180-03R** IF PATIENT ZIP CODE IS IN AN MTF<sup>2</sup> CATCHMENT AREA<sup>1</sup>

**AND** PRINCIPAL TREATMENT DIAGNOSIS/  
POA INDICATOR (POSITIONS 1-7) = 290-316 (MENTAL HEALTH, ICD-9-CM) **OR**  
F01.50-F69 OR F99 (MENTAL HEALTH, ICD-10-CM)

**AND** CA/NAS NUMBER IS **NOT** CODED

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

**1-180-07R** IF CA/NAS EXCEPTION REASON = 5 RTC

**AND** PATIENT ZIP CODE IS IN AN MTF<sup>2</sup> CATCHMENT AREA<sup>1</sup>

**THEN** TYPE OF INSTITUTION = 72 RTC

**1-180-08R** IF CA/NAS EXCEPTION REASON = S HHA PPS

**THEN** TYPE OF INSTITUTION MUST = 70 HHA

**AND** ONE OCCURRENCE OF REVENUE  
CODE MUST = 0023 HHA PPS

<sup>1</sup> CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.

<sup>2</sup> MTF IS A 40 MILES CATCHMENT AREA.

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Institutional Edit Requirements (ELN 200 - 299)

**ELEMENT NAME: FREQUENCY CODE (1-250)**

**VALIDITY EDITS**

**1-250-01V** MUST BE A VALID FREQUENCY CODE

**1-250-02V** IF DRG NUMBER IS NOT BLANK

<b>AND</b> TYPE OF SUBMISSION =	A	ADJUSTMENT TO TED RECORD DATA <b>OR</b>
	C	COMPLETE CANCELLATION TO TED RECORD DATA <b>OR</b>
	I	INITIAL TED RECORD SUBMISSION <b>OR</b>
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI <b>OR</b>
	R	RESUBMISSION OF AN INITIAL TED RECORD
<b>AND</b> FREQUENCY CODE =	2	INTERIM-INITIAL <b>OR</b>
	3	INTERIM-INTERIM <b>OR</b>
	4	INTERIM-FINAL

**THEN** THE FREQUENCY CODE SUBMISSION MUST FOLLOW THE DIRECTIONS IN THE TABLE BELOW

FREQUENCY CODE	PREVIOUS TED RECORD FREQUENCY CODE
2	= 2 <b>OR</b> NO PREVIOUS TED RECORD
3	= 2 <b>OR</b> 3 (PREVIOUS TED RECORD MUST EXIST)
4	= 2, 3, <b>OR</b> 4 (PREVIOUS TED RECORD MUST EXIST)

**RELATIONAL EDITS**

**1-250-01R** IF PATIENT STATUS = 30 STILL A PATIENT

**AND** AMOUNT ALLOWED (TOTAL) ≠ ZERO

**OR** OCCURRENCE OF SPECIAL PROCESSING CODE = T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYER) **OR**

FS TFL (SECOND PAYER)

**THEN** FREQUENCY CODE MUST = 2 INTERIM-INITIAL **OR**

3 INTERIM-INTERIM

**UNLESS** TYPE OF INSTITUTION = 70 HHA

**THEN** FREQUENCY CODE MUST = 2 INTERIM-INITIAL **OR**

3 INTERIM-INTERIM **OR**

7 REPLACEMENT OF PRIOR CLAIM **OR**

8 VOID/CANCEL OF PRIOR CLAIM **OR**

9 FINAL CLAIM FOR HHA EPISODE

**1-250-02R** IF PATIENT STATUS = 01 DISCHARGED **OR**

02 TRANSFERRED **OR**

20 EXPIRED

**THEN** FREQUENCY CODE MUST = 0 NON-PAYMENT/ZERO CLAIM **OR**

1 ADMIT THROUGH DISCHARGE **OR**

4 INTERIM-FINAL **OR**

7 REPLACEMENT OF PRIOR CLAIM **OR**

8 VOID/CANCELLATION OF PRIOR CLAIM **OR**

9 FINAL CLAIM FOR HHA PPS EPISODE

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Institutional Edit Requirements (ELN 200 - 299)

**ELEMENT NAME: FREQUENCY CODE (1-250) (Continued)**

<b>1-250-03R</b>	IF PRICING RATE CODE =	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER
	<b>THEN</b> FREQUENCY CODE MUST =	1	ADMIT THROUGH DISCHARGE

**ELEMENT NAME: TYPE OF ADMISSION (1-255)**

**VALIDITY EDITS**

<b>1-255-01V</b>	VALUE MUST BE A VALID TYPE OF ADMISSION CODE.		
	<b>UNLESS</b> REVENUE CODE ON ANY OF THE OCCURRENCES/LINE ITEMS =	0023	HHA
	<b>OR</b> TYPE OF INSTITUTION =	70	HHA
	<b>OR</b> AMOUNT ALLOWED (TOTAL) = ZERO		
	<b>OR</b> ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	11	HOSPICE
	<b>THEN</b> VALUE MUST BE BLANK OR A VALID TYPE OF ADMISSIONS CODE		

**RELATIONAL EDITS**

<b>1-255-03R</b>	IF TYPE OF ADMISSION =	4	NEWBORN
	<b>AND</b> ICD VERSION =	9	ICD-9
	<b>AND</b> SOURCE OF ADMISSION =	1	NORMAL DELIVERY <b>OR</b>
		2	PREMATURE DELIVERY <b>OR</b>
		4	EXTRAMURAL BIRTH <b>OR</b>
		5	BORN INSIDE THIS HOSPITAL <b>OR</b>
		6	BORN OUTSIDE THIS HOSPITAL
	<b>THEN</b> PRINCIPAL DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) MUST BE BETWEEN V30.0 AND V39.2.		
<b>1-255-04R</b>	IF TYPE OF ADMISSION =	4	NEWBORN
	<b>AND</b> ICD VERSION =	0	ICD-10
	<b>THEN</b> SOURCE OF ADMISSION =	5	BORN INSIDE THIS HOSPITAL <b>OR</b>
		6	BORN OUTSIDE THIS HOSPITAL
	<b>AND</b> PRINCIPAL DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) MUST BE BETWEEN Z38.00 AND Z38.8.		

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Institutional Edit Requirements (ELN 200 - 299)

**ELEMENT NAME: SOURCE OF ADMISSION (1-260)**

**VALIDITY EDITS**

**1-260-01V** VALUE MUST BE A VALID SOURCE OF ADMISSION.

**RELATIONAL EDITS**

<b>1-260-01R</b>	IF TYPE OF ADMISSION =	4	NEWBORN
	<b>THEN</b> SOURCE OF ADMISSION MUST =	1	NORMAL DELIVERY <b>OR</b>
		2	PREMATURE DELIVERY <b>OR</b>
		3	SICK BABY <b>OR</b>
		4	EXTRAMURAL BIRTH
		4	EXTRAMURAL BIRTH <b>OR</b>
		5	BORN INSIDE THIS HOSPITAL <b>OR</b>
		6	BORN OUTSIDE THIS HOSPITAL

**ELEMENT NAME: ADMISSION DATE (1-265)**

**VALIDITY EDITS**

**1-265-01V** MUST BE A VALID GREGORIAN DATE AND CANNOT BE > TMA CURRENT SYSTEM DATE.

**RELATIONAL EDITS**

<b>1-265-01R</b>	ADMISSION DATE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION		
<b>1-265-02R</b>	ADMISSION DATE MUST BE ≤ END DATE OF CARE		
<b>1-265-03R</b>	IF FREQUENCY CODE =	1	ADMIN THROUGH DISCHARGE <b>OR</b>
		2	INTERIM-INITIAL
	<b>THEN</b> ADMISSION DATE MUST = BEGIN DATE OF CARE		
<b>1-265-04R</b>	IF TYPE OF SUBMISSION =	A	ADJUSTMENT <b>OR</b>
		B	ADJUSTMENT OF NON-TED RECORD (HCSR) DATA <b>OR</b>
		C	COMPLETE CANCELLATION <b>OR</b>
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	<b>THEN</b> ADMISSION DATE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED		
	<b>UNLESS</b> TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) <b>SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD</b>
	<b>AND</b> DATE ADJUSTMENT IDENTIFIED ON TMA DATABASE = ZEROES.		

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Chapter 2, Section 5.3

Institutional Edit Requirements (ELN 200 - 299)

**ELEMENT NAME: PATIENT STATUS (1-270)**

**VALIDITY EDITS**

**1-270-01V** VALUE MUST BE A VALID PATIENT STATUS CODE.

**RELATIONAL EDITS**

<b>1-270-01R</b>	IF FREQUENCY CODE =	2	INTERIM-INITIAL <b>OR</b>
		3	INTERIM-INTERIM
	<b>THEN</b> PATIENT STATUS MUST =	30	STILL A PATIENT
<b>1-270-02R</b>	IF FREQUENCY CODE =	1	ADMIT THROUGH DISCHARGE
	<b>THEN</b> PATIENT STATUS MUST =	01	DISCHARGED <b>OR</b>
		02	TRANSFERRED <b>OR</b>
		03	DISCHARGED/TRANSFERRED TO SNF <b>OR</b>
		04	DISCHARGED/TRANSFERRED TO INTERMEDIATE CARE FACILITY (ICF) <b>OR</b>
		05	DISCHARGED/TRANSFERRED TO A DESIGNATED CANCER CENTER OR CHILDREN'S HOSPITAL <b>OR</b>
		06	DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF ORGANIZED HOME HEALTH SERVICE ORGANIZATION <b>OR</b>
		07	LEFT AGAINST MEDICAL ADVICE OR DISCONTINUED CARE <b>OR</b>
		08	DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF A HOME IV PROVIDER <b>OR</b>
		20	EXPIRED <b>OR</b>
		40	DIED AT HOME <b>OR</b>
		41	DIED IN MEDICAL FACILITY, SUCH AS HOSPITAL, SNF OR FREESTANDING HOSPICE <b>OR</b>
		42	PLACE OF DEATH UNKNOWN <b>OR</b>
		43	DISCHARGED/TRANSFERRED TO A FEDERAL HOSPITAL <b>OR</b>
		50	HOSPICE-HOME <b>OR</b>
		51	HOSPICE-MEDICAL FACILITY <b>OR</b>
		61	DISCHARGED/TRANSFERRED WITHIN THIS INSTITUTION TO A HOSPITAL-BASED MEDICARE APPROVED SWING BED <b>OR</b>
		62	DISCHARGED/TRANSFERRED TO ANOTHER REHABILITATION FACILITY INCLUDING REHABILITATION DISTINCT PART UNITS OF A HOSPITAL <b>OR</b>
		63	DISCHARGED/TRANSFERRED TO A LONG-TERM CARE HOSPITAL <b>OR</b>
		64	DISCHARGED/TRANSFERRED TO A NURSING FACILITY CERTIFIED UNDER MEDICAID BUT NOT CERTIFIED UNDER MEDICARE <b>OR</b>
		65	DISCHARGED/TRANSFERRED TO A PSYCHIATRIC HOSPITAL OR PSYCHIATRIC DISTINCT PART OF A HOSPITAL <b>OR</b>

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Chapter 2, Section 5.3

Institutional Edit Requirements (ELN 200 - 299)

<b>ELEMENT NAME: ICD VERSION (1-293)</b>		
<b>VALIDITY EDITS</b>		
<b>1-293-01V</b>	VALUE MUST BE A VALID ICD VERSION.	
<b>RELATIONAL EDITS</b>		
<b>NO ERROR</b>	IF AMOUNT ALLOWED (TOTAL) = ZERO	
<b>1-293-01R</b>	IF ADMISSION DATE ON OR AFTER THE DATE SPECIFIED BY THE CMS IN THE FINAL RULE AS PUBLISHED IN THE <b>FEDERAL REGISTER</b>	
	<b>THEN</b> ICD VERSION MUST BE	0 ICD-10
<b>1-293-02R</b>	IF END DATE OF CARE ON OR AFTER THE DATE SPECIFIED BY THE CMS IN THE FINAL RULE AS PUBLISHED IN THE <b>FEDERAL REGISTER</b>	
	<b>AND</b> PATIENT STATUS ≠	30 STILL PATIENT
	<b>THEN</b> ICD VERSION MUST BE	0 ICD-10
<b>1-293-03R</b>	IF ADMISSION DATE PRIOR TO ICD-10 IMPLEMENTATION	
	<b>AND</b> PATIENT STATUS =	30 STILL PATIENT
	<b>THEN</b> ICD VERSION MUST BE	9 ICD-9
<b>1-293-04R</b>	IF END DATE OF CARE PRIOR TO ICD-10 IMPLEMENTATION	
	<b>THEN</b> ICD VERSION MUST BE	9 ICD-9

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 2, Section 5.3

Institutional Edit Requirements (ELN 200 - 299)

**ELEMENT NAME: ADMISSION DIAGNOSIS (1-295)**

**VALIDITY EDITS**

**1-295-01V** IF FILING DATE IS PRIOR TO 10/01/2004

**THEN** VALUE MUST BE VALID ICD DIAGNOSIS CODE, EXCLUDING E000.0-E999.1

**UNLESS** REVENUE CODE ON ANY OF THE OCCURRENCES/LINE ITEMS = 0023 HHA

**THEN** VALUE MUST BE BLANK OR A VALID ICD DIAGNOSIS CODE, EXCLUDING E000.0-E999.1

**1-295-02V** IF FILING DATE ON OR AFTER 10/01/2004

**THEN** VALUE MUST BE VALID ICD DIAGNOSIS CODE, EXCLUDING E000.0-E999.1 (ICD-9-CM) AND V00-Y99.9 (ICD-10-CM).

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

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

**UNLESS** REVENUE CODE ON ANY OF THE OCCURRENCES/LINE ITEMS = 0023 HHA

**OR** TYPE OF INSTITUTION = 70 HHA

**OR** AMOUNT ALLOWED (TOTAL) = ZERO

**OR** ANY OCCURRENCE OF SPECIAL PROCESSING CODE = 11 HOSPICE

**THEN** VALUE MUST BE BLANK **OR** VALUE MUST BE A VALID ICD DIAGNOSIS CODE, EXCLUDING E000.0-E999.1 (ICD-9-CM) AND V00-Y99.9 (ICD-10-CM)

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

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

**RELATIONAL EDITS**

NONE

- END -

## Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (1-300)	
VALIDITY EDITS	
<b>1-300-01V</b>	<b>IF</b> FILING DATE PRIOR TO 10/01/2004  <b>THEN</b> VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE, EXCLUDING E000.0-E999.1 (ICD-9-CM).
<b>1-300-02V</b>	<b>IF</b> FILING DATE ON OR AFTER 10/01/2004  <b>THEN</b> VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE, EXCLUDING E000.0-E999.1 (ICD-9-CM) AND V00-Y99.9 (ICD-10-CM).  <b>AND</b> BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD DIAGNOSIS REFERENCE TABLE  <b>OR</b> END DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD DIAGNOSIS REFERENCE TABLE
<b>1-300-03V</b>	POA INDICATOR (POSITION 8 OF THE PRINCIPAL DIAGNOSIS/POA INDICATOR) MUST BE A VALID VALUE.
RELATIONAL EDITS	
<b>1-300-01R</b>	IF PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) = 799.9 ICD-9-CM <b>OR</b> R69 ICD-10-CM <b>OR</b> R99 ICD-10-CM  <b>THEN</b> AMOUNT ALLOWED (TOTAL) MUST = ZERO  <b>OR</b> ANY OCCURRENCE OF SPECIAL PROCESSING CODE = 1 MEDICAID
<b>1-300-02R</b>	IF PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) IS FOR FEMALE  <b>AND</b> PERSON SEX (PATIENT) = MALE  <b>THEN</b> AT LEAST ONE OVERRIDE CODE MUST = G DIAGNOSIS/PROCEDURE CODE FOR FEMALE: SEX INDICATES MALE
<b>1-300-03R</b>	IF PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) IS FOR MALE  <b>AND</b> PERSON SEX (PATIENT) = FEMALE  <b>THEN</b> AT LEAST ONE OVERRIDE CODE MUST = H DIAGNOSIS/PROCEDURE CODE FOR MALE: SEX INDICATES FEMALE
<b>1-300-05R</b>	IF OP/NSP CODE IS CESAREAN SECTION OR REMOVAL OF FETUS (74.2, 74.0-74.99, 10D00Z0, 10D00Z1, 10D00Z2, 10A00AA, 10A02ZZ, 10A03ZZ, 10A04ZZ, 10T20ZZ, 10T23ZZ, OR 10T24ZZ)  <b>THEN</b> PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) MUST BE 640-676 <b>OR</b> O10.011-077.9, O82, <b>OR</b> O85-09A.99.
<b>1-300-06R</b>	IF OP/NSP CODE IS ECTOPIC PREGNANCY (74.3, 10D27ZZ, 10D28ZZ, 10T20ZZ, OR 10T24ZZ)  <b>THEN</b> PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) MUST BE 633.0-633.9 <b>OR</b> O00.0-O00.9
<b>1-300-07R</b>	IF TYPE OF INSTITUTION = 72 RTC

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Chapter 2, Section 5.4

Institutional Edit Requirements (ELN 300 - 399)

**ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (1-300) (Continued)**

**AND** AMOUNT ALLOWED (TOTAL) > 0

**THEN** PRINCIPAL TREATMENT  
DIAGNOSIS/POA INDICATOR  
(POSITIONS 1-7) MUST =

290-316 (MENTAL HEALTH, ICD-9-CM) **OR**

F01.50-F69 OR F99 (MENTAL HEALTH, ICD-10-CM)

**ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR OCCURRENCES 1-24 (1-305 THROUGH 1-328)**

**VALIDITY EDITS**

**1-XXX-01V<sup>1</sup>** **IF** FILING DATE PRIOR TO 10/01/2004

**THEN** VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE IF PRESENT **OR** BLANK FILLED

**1-XXX-02V<sup>1</sup>** **IF** FILING DATE ON OR AFTER 10/01/2004

**THEN** VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE **OR** BLANK FILLED

**AND** BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD DIAGNOSIS REFERENCE TABLE.

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

**1-XXX-03V<sup>1</sup>** ALL OCCURRENCES OF SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR .

**1-XXX-04V<sup>1</sup>** POA INDICATOR (POSITION 8 OF THE SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR) MUST BE A VALID VALUE.

**RELATIONAL EDITS**

**1-XXX-01R<sup>1</sup>** **IF** ANY SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) IS FOR FEMALE

**AND** PERSON SEX (PATIENT) = MALE

**THEN** AT LEAST ONE OVERRIDE CODE  
MUST =

G DIAGNOSIS/PROCEDURE CODE FOR FEMALE: SEX INDICATES MALE

**1-XXX-02R<sup>1</sup>** **IF** ANY SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) IS FOR MALE

**AND** PERSON SEX (PATIENT) = FEMALE

**THEN** AT LEAST ONE OVERRIDE CODE  
MUST =

H DIAGNOSIS/PROCEDURE CODE FOR MALE: SEX INDICATES FEMALE

<sup>1</sup> XXX EQUALS ELN (305 THROUGH 328) FOR EACH OCCURRENCE OF SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR.

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Chapter 2, Section 5.4

Institutional Edit Requirements (ELN 300 - 399)

**ELEMENT NAME: PRINCIPAL OPERATION/NON-SURGICAL PROCEDURE CODE (OP/NSP) (1-345)**

**VALIDITY EDITS**

**1-345-01V** IF FILING DATE IS PRIOR TO 10/01/2004

**THEN** VALUE MUST BE A VALID **ICD** OP/NSP CODE IF PRESENT **OR** BLANK FILLED

**1-345-02V** IF FILING DATE IS ON OR AFTER 10/01/2004

**THEN** VALUE MUST BE A VALID **ICD** OP/NSP CODE IF PRESENT **OR** BLANK FILLED

**AND** BEGIN DATE OF CARE MUST BE ON OR AFTER THE OP/NSP EFFECTIVE DATE AND NOT LATER THAN THE OP/NSP TERMINATION DATE ON THE **ICD** OP/NSP REFERENCE TABLE

**OR** END DATE OF CARE MUST BE ON OR AFTER THE OP/NSP EFFECTIVE DATE AND NOT LATER THAN THE OP/NSP TERMINATION DATE ON THE **ICD** OP/NSP REFERENCE TABLE

**RELATIONAL EDITS**

**1-345-01R** IF ANY OCCURRENCE OF REVENUE CODE = 036X **OR** 0722

**THEN** PRINCIPAL OP/NSP PROCEDURE CODE IS REQUIRED.

**UNLESS** DRG NUMBER = BLANK

**1-345-02R** IF ANY OCCURRENCE OF REVENUE CODE = 036X **OR** 0722

**AND** DIAGNOSIS CODE FOR DELIVERY (640-669, V27)

**THEN** PRINCIPAL OP/NSP PROCEDURE CODE MUST = 54.21, 64.0 (CIRCUMCISION), 65.0-75.99, 87.81, 88.03, 88.46, 88.78, **OR** 92.17.

**ELSE** IF ANY OCCURRENCE OF REVENUE CODE = 036X **OR** 0722

**AND** THE DIAGNOSIS CODE IS FOR MATERNITY/OBSTETRICS (630-676, V27)

**EXCLUDING** PRENATAL **AND** POSTPARTUM

**THEN** PRINCIPAL OP/NSP PROCEDURE CODE MUST = 54.21, 65.0-75.99, 87.81, 88.03, 88.46, 88.78, **OR** 92.17

**ELEMENT NAME: SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE OCCURRENCES 1-11 (1-350 THROUGH 1-373)**

**VALIDITY EDITS**

**1-XXX-01V<sup>1</sup>** IF FILING DATE IS PRIOR TO 10/01/2004

**THEN** VALUE MUST BE A VALID **ICD** OP/NSP CODE IF PRESENT **OR** BLANK FILLED

**1-XXX-02V<sup>1</sup>** IF FILING DATE IS ON OR AFTER 10/01/2004

**THEN** VALUE MUST BE VALID **ICD** OP/NSP CODE IF PRESENT **OR** BLANK FILLED

**AND** BEGIN DATE OF CARE MUST BE ON OR AFTER THE OP/NSP EFFECTIVE DATE AND NOT LATER THAN THE OP/NSP TERMINATION DATE ON THE **ICD** OP/NSP REFERENCE TABLE

**OR** END DATE OF CARE MUST BE ON OR AFTER THE OP/NSP EFFECTIVE DATE AND NOT LATER THAN THE OP/NSP TERMINATION DATE ON THE **ICD** OP/NSP REFERENCE TABLE

**1-XXX-03V<sup>1</sup>** ALL OCCURRENCES OF SECONDARY OP/NSP CODE FIELD MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED SECONDARY OP/NSP CODE.

**RELATIONAL EDITS**

NONE

<sup>1</sup> XXX EQUALS ELN (350 THROUGH 373) FOR EACH OCCURRENCE OF SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE.

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Chapter 2, Section 5.4

Institutional Edit Requirements (ELN 300 - 399)

**ELEMENT NAME: TED RECORD CORRECTION INDICATOR (1-374)**

**VALIDITY EDITS**

<b>1-374-01V</b>	VALUE MUST BE A VALID TED RECORD CORRECTION INDICATOR									
<b>1-374-02V</b>	IF TED RECORD CORRECTION INDICATOR =	<table border="1"> <tr> <td>1</td> <td>ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) <b>SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR</b></td> </tr> <tr> <td>2</td> <td>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. <b>(NOT TO BE USED TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD) OR</b></td> </tr> <tr> <td>3</td> <td>ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT <b>BOTH</b> CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD</td> </tr> </table>	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) <b>SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR</b>	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. <b>(NOT TO BE USED TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD) OR</b>	3	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT <b>BOTH</b> CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD		
1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) <b>SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR</b>									
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	<b>THEN</b> TYPE OF SUBMISSION MUST =	<table border="1"> <tr> <td>A</td> <td>ADJUSTMENT <b>OR</b></td> </tr> <tr> <td>B</td> <td>ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b></td> </tr> <tr> <td>C</td> <td>COMPLETE CANCELLATION OF TED RECORD DATA <b>OR</b></td> </tr> <tr> <td>E</td> <td>COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA</td> </tr> </table>	A	ADJUSTMENT <b>OR</b>	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>	C	COMPLETE CANCELLATION OF TED RECORD DATA <b>OR</b>	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
A	ADJUSTMENT <b>OR</b>									
B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>									
C	COMPLETE CANCELLATION OF TED RECORD DATA <b>OR</b>									
E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA									
	<b>AND</b> CONTRACT NUMBER MUST =	<table border="1"> <tr> <td>MDA906-02-C-0013 <b>OR</b></td> </tr> <tr> <td>MDA906-03-C-0009 <b>OR</b></td> </tr> <tr> <td>MDA906-03-C-0010 <b>OR</b></td> </tr> <tr> <td>MDA906-03-C-0011 <b>OR</b></td> </tr> <tr> <td>MDA906-03-C-0015 <b>OR</b></td> </tr> <tr> <td>MDA906-03-C-0019</td> </tr> </table>	MDA906-02-C-0013 <b>OR</b>	MDA906-03-C-0009 <b>OR</b>	MDA906-03-C-0010 <b>OR</b>	MDA906-03-C-0011 <b>OR</b>	MDA906-03-C-0015 <b>OR</b>	MDA906-03-C-0019		
MDA906-02-C-0013 <b>OR</b>										
MDA906-03-C-0009 <b>OR</b>										
MDA906-03-C-0010 <b>OR</b>										
MDA906-03-C-0011 <b>OR</b>										
MDA906-03-C-0015 <b>OR</b>										
MDA906-03-C-0019										
<b>1-374-03V</b>	IF TED RECORD CORRECTION INDICATOR =	<table border="1"> <tr> <td>1</td> <td>ADJUSTMENT/CANCELLATION (TYPE OR SUBMISSION A, B, C, OR E) <b>SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR</b></td> </tr> <tr> <td>3</td> <td>ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT <b>BOTH</b> CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD</td> </tr> </table>	1	ADJUSTMENT/CANCELLATION (TYPE OR SUBMISSION A, B, C, OR E) <b>SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR</b>	3	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT <b>BOTH</b> CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD				
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3	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT <b>BOTH</b> CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD									
	<b>THEN</b> A MATCH TO A PROVISIONALLY ACCEPTED TED RECORD <b>MUST</b> BE PRESENT ON THE TMA DATABASE.									
<b>1-374-04V</b>	IF TED RECORD CORRECTION INDICATOR =	<table border="1"> <tr> <td>2</td> <td>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</td> </tr> </table>	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						
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									
	<b>THEN</b> A CORRESPONDING PROVISIONALLY ACCEPTED TED RECORD <b>MUST NOT</b> BE PRESENT ON THE TMA DATABASE.									

**RELATIONAL EDITS**

NONE

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Chapter 2, Section 6.2

Non-Institutional Edit Requirements (ELN 100 - 199)

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**ELEMENT NAME: ICD VERSION (2-114)**

**VALIDITY EDITS**

**2-114-01V** VALUE MUST BE A VALID ICD VERSION

**RELATIONAL EDITS**

**NO ERROR** IF THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO

**2-114-01R** IF ICD VERSION = 9 ICD-9

**THEN** END DATE OF CARE OF EACH LINE ITEM MUST BE PRIOR TO ICD-10 IMPLEMENTATION

**2-114-02R** IF ICD VERSION = 0 ICD-10

**THEN** BEGIN DATE OF CARE OF EACH LINE ITEM MUST BE ON OR AFTER THE DATE SPECIFIED BY THE CMS IN THE FINAL RULE AS PUBLISHED IN THE **FEDERAL REGISTER**

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**TRICARE Systems Manual 7950.2-M, February 1, 2008**

Chapter 2, Section 6.2

Non-Institutional Edit Requirements (ELN 100 - 199)

**ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (2-115)**

**VALIDITY EDITS**

**2-115-01V** IF FILING DATE IS PRIOR TO 10/01/2004

**THEN** VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE, EXCLUDING E000.0-E999.1

**2-115-02V** IF FILING DATE IS ON OR AFTER 10/01/2004

**THEN** VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE, EXCLUDING E000.0-E999.1 (ICD-9-CM) AND V00-Y99.9 (ICD-10-CM)

**AND** FOR AT LEAST ONE LINE ITEM

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

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

**2-115-03V** POA INDICATOR (POSITION 8 OF THE PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR) MUST BE A VALID VALUE.

**RELATIONAL EDITS**

**2-115-01R** IF PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) IS FOR FEMALE

**AND** PERSON SEX (PATIENT) IS MALE

**THEN** AT LEAST ONE OVERRIDE CODE  
MUST =

G DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE

**2-115-02R** IF PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) IS FOR MALE

**AND** PERSON SEX (PATIENT) IS FEMALE

**THEN** AT LEAST ONE OVERRIDE CODE  
MUST =

H DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE

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

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

**AND** TYPE OF SERVICE (FIRST  
POSITION) MUST =

A AMBULATORY SURGERY COST-SHARED AS INPATIENT (ADFM<sub>s</sub> ONLY) **OR**

I INPATIENT **OR**

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

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

**AND** TYPE OF SERVICE (SECOND  
POSITION) MUST =

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

5 DIAGNOSTIC LABORATORY **OR**

7 ANESTHESIA

**UNLESS** TYPE OF SUBMISSION =

D COMPLETE DENIAL

**OR** ANY OCCURRENCE OF SPECIAL  
PROCESSING CODE =

1 MEDICAID

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

PF ECHO

**THEN** PRINCIPAL TREATMENT  
DIAGNOSIS/POA INDICATOR (POSITIONS  
1-7) **CANNOT** =

799.9 ICD-9-CM **OR**

R69 ICD-10-CM **OR**

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Non-Institutional Edit Requirements (ELN 100 - 199)

**ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (2-115) (Continued)**

R99 ICD-10-CM

**UNLESS TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO**

**OR ANY OCCURRENCE OF SPECIAL  
PROCESSING CODE =**

1 MEDICAID

**ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR OCCURRENCES 1 - 24 (2-116 THROUGH 2-138, 2-340)**

**VALIDITY EDITS**

**2-XXX-01V<sup>1</sup>** IF FILING DATE IS PRIOR TO 10/01/2004

**THEN** VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE **OR** BLANK FILLED.

**2-XXX-02V<sup>1</sup>** IF FILING DATE IS ON OR AFTER 10/01/2004

**THEN** VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE **OR** BLANK FILLED

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

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

**2-XXX-03V<sup>1</sup>** ALL OCCURRENCES OF SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR

**2-XXX-04V** POA INDICATOR (POSITION 8 OF THE PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR) MUST BE A VALID VALUE.

**RELATIONAL EDITS**

**2-XXX-01R<sup>1</sup>** IF ANY SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) IS FOR FEMALE

**AND** PERSON SEX (PATIENT) IS MALE

**THEN** AT LEAST ONE OVERRIDE CODE  
MUST =

G DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE

**2-XXX-02R<sup>1</sup>** IF ANY SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) IS FOR MALE

**AND** PERSON SEX (PATIENT) IS FEMALE

**THEN** AT LEAST ONE OVERRIDE CODE  
MUST =

H DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE

<sup>1</sup> XXX EQUALS ELN (116 THROUGH 138, 2-340) FOR EACH OCCURRENCE OF SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR.

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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.

- |                  |                         |   |   |
|------------------|-------------------------|---|---|
| <b>2-140-02V</b> | IF TYPE OF SUBMISSION = | A | ADJUSTMENT <b>OR</b>                                |
|                  |                         | B | ADJUSTMENT OF NON-TED RECORD (HCSR) DATA <b>OR</b>  |
|                  |                         | C | COMPLETE CANCELLATION <b>OR</b>                     |
|                  |                         | 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)<sup>1</sup>**

**VALIDITY EDITS**

**2-141-01V** MUST BE NUMERIC.

**RELATIONAL EDITS**

- |                  |                         |   |  |
|------------------|-------------------------|---|--|
| <b>2-141-01R</b> | IF TYPE OF SUBMISSION = | D | COMPLETE DENIAL <b>OR</b>                |
|                  |                         | I | INITIAL SUBMISSION <b>OR</b>             |
|                  |                         | O | ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b> |
|                  |                         | R | RESUBMISSION                             |

**THEN** ADJUSTMENT SEQUENCE NUMBER MUST = 000 (ZEROES)

- |                  |                         |   |                       |
|------------------|-------------------------|---|-----------------------|
| <b>2-141-02R</b> | IF TYPE OF SUBMISSION = | A | ADJUSTMENT <b>OR</b>  |
|                  |                         | C | COMPLETE CANCELLATION |

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

- |                  |                         |   |   |
|------------------|-------------------------|---|---|
| <b>2-141-03R</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 |

**THEN** ADJUSTMENT SEQUENCE NUMBER MUST = 000 (ZEROES)

<sup>1</sup> 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)

<b>ELEMENT NAME: BEGIN DATE OF CARE (2-150)</b>	
<b>VALIDITY EDITS</b>	
<b>2-150-01V</b>	MUST BE A VALID GREGORIAN DATE <b>AND</b> CANNOT BE > TMA CURRENT SYSTEM DATE.
<b>2-150-02V</b>	CANNOT BE MORE THAN 10 YEARS PRIOR TO TMA CURRENT SYSTEM DATE.
<b>2-150-03V</b>	BEGIN DATE OF CARE MUST BE ≤ END DATE OF CARE.
<b>RELATIONAL EDITS</b>	
<b>2-150-01R</b>	BEGIN DATE OF CARE MUST BE ≤ END DATE OF CARE.
<b>2-150-02R</b>	BEGIN DATE OF CARE MUST BE ≤ FILING DATE.
<b>2-150-03R</b>	BEGIN DATE OF CARE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION.
<b>2-150-04R</b>	BEGIN DATE OF CARE MUST BE ≥ PERSON BIRTH CALENDAR DATE (PATIENT).
<b>2-150-05R</b>	IF TYPE OF SUBMISSION =
	A ADJUSTMENT <b>OR</b>
	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>
	C COMPLETE CANCELLATION <b>OR</b>
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	<b>THEN</b> BEGIN DATE OF CARE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED.
	<b>UNLESS</b> TED RECORD CORRECTION INDICATOR =
	1 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD
	<b>AND</b> DATE ADJUSTMENT IDENTIFIED = ZEROES.
<b>2-150-06R</b>	PROVIDER MUST BE "AUTHORIZED" <sup>1</sup> ON PROVIDER FILE FOR EACH BEGIN DATE OF CARE
	<b>UNLESS</b> AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO
	<b>OR</b> ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM =
	38 SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS <b>OR</b>
	52 THE REFERRING/PRESCRIBING/RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE BILLED <b>OR</b>
	B7 THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE
	<b>OR</b> PROVIDER SPECIALTY =
	172A00000X (OTHER SERVICE PROVIDER/DRIVERS) <b>OR</b>
	344600000X (TRANSPORTATION SERVICES/TAXI)
	<b>OR</b> ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 <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>OR</b>
<sup>1</sup> "AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER MAJOR SPECIALTY, PROVIDER ZIP CODE, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (2-240-04R).	

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Non-Institutional Edit Requirements (ELN 100 - 199)

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

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

**THEN** DO NOT CHECK PROVIDER FILE

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

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

**VALIDITY EDITS**

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

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

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

**RELATIONAL EDITS**

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

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

**2-155-04R** IF TYPE OF SUBMISSION =

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

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

**UNLESS** TED RECORD CORRECTION INDICATOR =

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

**AND** DATE ADJUSTMENT IDENTIFIED = ZEROES.

**2-155-05R** PROVIDER MUST BE "AUTHORIZED"<sup>1</sup> ON PROVIDER FILE FOR EACH END DATE OF CARE

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

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

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

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

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

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Non-Institutional Edit Requirements (ELN 100 - 199)

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

**OR** ANY OCCURRENCE OF SPECIAL  
PROCESSING CODE =

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

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

FS TFL (SECOND PAYOR) **OR**

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

**THEN** DO NOT CHECK PROVIDER FILE

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

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

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Non-Institutional Edit Requirements (ELN 100 - 199)

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

**VALIDITY EDITS**

**2-160-01V<sup>2</sup>** 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 <b>OR</b>
	I	INITIAL TED RECORD SUBMISSION <b>OR</b>
	O	ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>
	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 <b>OR</b>
	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>
	C	COMPLETE CANCELLATION <b>OR</b>
	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

**2-160-02V<sup>2</sup>** 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**

**2-160-01R<sup>3</sup>** 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 <b>OR</b>
AD	FOREIGN ACTIVE DUTY CLAIMS (EFFECTIVE 06/30/1996) <b>OR</b>
AN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
AR	SHCP - REFERRED CARE <b>OR</b>
CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM <b>OR</b>
CL	CLINICAL TRIALS <b>OR</b>

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

<sup>3</sup> 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)**

	FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b>
	FS	TFL (SECOND PAYOR) <b>OR</b>
	GU	ADSM ENROLLED IN TPR <b>OR</b>
	MN	TSP - NETWORK <b>OR</b>
	MS	TSP - NON-NETWORK <b>OR</b>
	SC	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
	SE	SHCP - TRICARE ELIGIBLE <b>OR</b>
	SM	SHCP - EMERGENCY
<b>OR ENROLLMENT/HEALTH PLAN CODE MUST =</b>	X	FOREIGN ADSM <b>OR</b>
	SN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
	SR	SHCP - REFERRED CARE <b>OR</b>
	WA	TPR - FOREIGN ADSM
<b>2-160-05R</b>	IF PROCEDURE CODE <sup>1</sup> = 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, S9122 - S9124, <b>OR</b> 99082	
		<b>THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =</b>
	PF	ECHO
	<b>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</b>	
<b>OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =</b>	AN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
	AR	SHCP - REFERRED CARE <b>OR</b>
	CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM <b>OR</b>
	GU	ADSM ENROLLED IN TPR <b>OR</b>
	MN	TSP - NETWORK <b>OR</b>
	MS	TSP - NON-NETWORK <b>OR</b>
	SC	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
	SE	SHCP - TRICARE ELIGIBLE <b>OR</b>
	SM	SHCP - EMERGENCY
<b>OR ENROLLMENT/HEALTH PLAN CODE =</b>	X	FOREIGN ADSM <b>OR</b>
	SN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
	SR	SHCP - REFERRED CARE <b>OR</b>
	WA	TPR - FOREIGN ADSM
<b>2-160-06R</b>	I	INPATIENT

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

<sup>3</sup> 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)**

**THEN** PROCEDURE CODE MUST NOT BE FOR OUTPATIENT ONLY CARE (REFER TO [ADDENDUM E, FIGURE 2.E-1](#)).

<b>2-160-08R</b>	IF PROCEDURE CODE <sup>1</sup> =	98800 FOR DRUGS <b>OR</b>
		00MN PRESCRIPTION MEDICAL NECESSITY REVIEWS <b>OR</b>
		00PA PRESCRIPTION PRIOR AUTHORIZATIONS

**THEN** 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

**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<sup>1</sup> = 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 <b>OR</b>
AR	SHCP - REFERRED CARE <b>OR</b>
CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM <b>OR</b>
GU	ADSM ENROLLED IN TPR <b>OR</b>
MN	TSP - NETWORK <b>OR</b>
MS	TSP - NON-NETWORK <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 =	X FOREIGN ADSM <b>OR</b>
	SN SHCP - NON-MTF-REFERRED CARE <b>OR</b>
	SR SHCP - REFERRED CARE <b>OR</b>
	WA TPR - FOREIGN ADSM

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

<sup>3</sup> BYPASS EDIT 2-160-01R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.

**ELEMENT NAME: PROCEDURE CODE MODIFIER (2-165)**

**VALIDITY EDITS**

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

**RELATIONAL EDITS**

NONE

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Non-Institutional Edit Requirements (ELN 100 - 199)

<b>ELEMENT NAME: NATIONAL DRUG CODE (2-170)</b>	
<b>VALIDITY EDITS</b>	
<b>2-170-01V</b>	MUST BE A VALID NATIONAL DRUG CODE OR BLANK
<b>RELATIONAL EDITS</b>	
<b>2-170-01R</b>	IF NATIONAL DRUG CODE = BLANK
<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>AND</b> PROCEDURE CODE <sup>1</sup> MUST ≠	98800 FOR DRUGS
<b>UNLESS</b> PROVIDER STATE OR COUNTRY CODE IS A FOREIGN COUNTRY CODE ( <a href="#">ADDENDUM A</a> )	
<b>2-170-02R</b>	IF NATIONAL DRUG CODE ≠ BLANK
<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>AND</b> PROCEDURE CODE <sup>1</sup> MUST =	98800 FOR DRUGS <b>OR</b>
	99070 FOR SUPPLIES <b>OR</b>
	000MN PRESCRIPTION MEDICAL NECESSITY REVIEWS <b>OR</b>
	000PA PRESCRIPTION PRIOR AUTHORIZATIONS
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Non-Institutional Edit Requirements (ELN 100 - 199)

<b>ELEMENT NAME: NUMBER OF SERVICES (2-175)</b>	
<b>VALIDITY EDITS</b>	
<b>2-175-01V</b>	MUST BE NUMERIC.
<b>RELATIONAL EDITS</b>	
<b>2-175-01R</b>	IF TYPE OF SUBMISSION =
	A ADJUSTMENT <b>OR</b>
	C COMPLETE CANCELLATION <b>OR</b>
	D COMPLETE DENIAL <b>OR</b>
	I INITIAL SUBMISSION <b>OR</b>
	O ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>
	R RESUBMISSION
	<b>THEN</b> NUMBER OF SERVICES FOR EACH OCCURRENCE MUST BE > ZERO
	<b>UNLESS</b> TYPE OF SERVICE (SECOND POSITION) =
	M MOP DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS
	<b>AND</b> OCCURRENCE/LINE ITEM NUMBER = 002
	<b>THEN</b> NUMBER OF SERVICES ON THIS LINE ITEM MUST = ZERO
<b>2-175-02R<sup>2</sup></b>	• SURGERY PROCEDURE CODES
	IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO
	<b>AND</b> PROCEDURE CODE <sup>1</sup> = 10000-36399 <b>OR</b> 36800-69999 (SURGERY)
	<b>THEN</b> NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM CANNOT EXCEED 10 PER DAY
	<b>UNLESS</b> PROCEDURE CODE = 11201, 11721, 13102, 13122, 13133, 13153, 15001, 15003, 15101, 15201, 15221, 15241, 15261, 15301, 15321, 15331, 15341, 15343, 15361, 15366, 15401, 15421, 15431, 17003, 17004, 17110, 17111, OR 17310
	<b>OR</b> ANY OCCURRENCE OF OVERRIDE CODE =
	NS CONTRACTOR HAS DETERMINED THA NUMBER OF SERVICES IS MEDICALLY NECESSARY
<b>2-175-03R<sup>2</sup></b>	• E/M PROCEDURE CODES
	IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO
	<b>AND</b> PROCEDURE CODE <sup>1</sup> =
	99201-99205 (OFFICE VISITS - NEW PATIENTS) <b>OR</b>
	99211-99215 (OFFICE VISITS - ESTABLISHED PATIENTS) <b>OR</b>
	99217 (DISCHARGE SERVICES) <b>OR</b>
	99221-99233 (HOSPITAL CARE PER DAY) <b>OR</b>
	99234-99236 (OBSERVATION OR IMPATIENT CARE SERVICES) <b>OR</b>
	99238-99239 (HOSPITAL DISCHARGE SERVICES) <b>OR</b>
	99241-99245 (OFFICE CONSULTATIONS) <b>OR</b>
<sup>1</sup> CPT ONLY © 2006 AMERICAN MEDICAL ASSOCIATION (OR SUCH OTHER DATE OF PUBLICATION OF CPT). ALL RIGHTS RESERVED.	
<sup>2</sup> EDITS 2-175-02R, 2-175-03R, 2-175-04R, AND 2-175-06R ARE ONLY EXECUTED FOR FILING DATES < 02/01/2010.	
<sup>3</sup> EDIT 2-175-07R IS ONLY EXECUTED FOR FILING DATES ≥ 02/01/2010. PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-175-07R. BYPASS EDIT 2-175-07R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.	
<sup>4</sup> TO DETERMINE MAXIMUM NUMBER OF SERVICES REFER TO THE MAXIMUM NUMBER OF SERVICES CODE LIST AT <a href="http://www.tricare.mil/TMA/RATES.ASPX">HTTP://WWW.TRICARE.MIL/TMA/RATES.ASPX</a> .	

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Non-Institutional Edit Requirements (ELN 100 - 199)

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

	99251-99255 (INITIAL INPATIENT CONSULTATIONS) <b>OR</b>
	99261-99263 (FOLLOW-UP INPATIENT CONSULTATIONS) <b>OR</b>
	99271-99275 (CONFIRMATORY CONSULTATIONS) <b>OR</b>
	99281-99285 (EMERGENCY DEPARTMENT VISIT) <b>OR</b>
	99291 (CRITICAL CARE) (NOTE: CODE 99292 EXCLUDED BECAUSE UTILIZED TO REPORT FOR EACH ADDITIONAL 15 MINUTES OF CARE) <b>OR</b>
	99295-99298 (NEONATAL INTENSIVE CARE) <b>OR</b>
	99301-99315 (NURSING FACILITY CHARGES) <b>OR</b>
	99321-99333 (DOMICILIARY, REST HOME, OR CUSTODIAL CARE SERVICES) <b>OR</b>
	99341-99350 (HOME SERVICES) <b>OR</b>
	99354 (PROLONGED SERVICES) (NOTE: CODE 99355 EXCLUDED BECAUSE UTILIZED TO REPORT FOR EACH ADDITIONAL 30 MINUTES OF CARE) <b>OR</b>
	99356 (PROLONGED SERVICES) (NOTE: CODE 99357 EXCLUDED BECAUSE UTILIZED TO REPORT FOR EACH ADDITIONAL 30 MINUTES OF CARE) <b>OR</b>
	99361-99373 (CASE MANAGEMENT SERVICES) <b>OR</b>
	99374-99380 (CARE PLAN OVERSIGHT) <b>OR</b>
	99381-99429 (PREVENTIVE MEDICINE SERVICES) <b>OR</b>
	99431-99440 (NEWBORN CARE) <b>OR</b>
	99450-99456 (SPECIAL EVALUATION AND MANAGEMENT SERVICES)

**THEN** NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM **CANNOT** EXCEED 3 PER DAY

**UNLESS** ANY OCCURRENCE OF OVERRIDE

CODE =	NS	CONTRACTOR HAS DETERMINED THAT NUMBER OF SERVICES IS MEDICALLY NECESSARY
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**2-175-04R<sup>2</sup>** • MEDICAL PROCEDURE CODES

IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO

<b>AND</b> PROCEDURE CODE <sup>1</sup> =	99500-99512 (HOME HEALTH VISIT) <b>OR</b>
	99551-99568 (HOME INFUSION PER DIEM CODES)

**THEN** NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM **CANNOT** EXCEED 3 PER DAY

**UNLESS** ANY OCCURRENCE OF OVERRIDE

CODE =	NS	CONTRACTOR HAS DETERMINED THAT NUMBER OF SERVICES IS MEDICALLY NECESSARY
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**2-175-06R<sup>2</sup>** • VACCINES (VACCINE PRODUCT ONLY) PROCEDURE CODES

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<sup>2</sup> EDITS 2-175-02R, 2-175-03R, 2-175-04R, AND 2-175-06R ARE ONLY EXECUTED FOR FILING DATES < 02/01/2010.  
<sup>3</sup> EDIT 2-175-07R IS ONLY EXECUTED FOR FILING DATES ≥ 02/01/2010. PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-175-07R. BYPASS EDIT 2-175-07R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.  
<sup>4</sup> TO DETERMINE MAXIMUM NUMBER OF SERVICES REFER TO THE MAXIMUM NUMBER OF SERVICES CODE LIST AT [HTTP://WWW.TRICARE.MIL/TMA/RATES.ASPX](http://www.tricare.mil/TMA/RATES.ASPX).

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Non-Institutional Edit Requirements (ELN 100 - 199)

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

IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO

**AND** PROCEDURE CODE<sup>1</sup> = 90476-90479 (VACCINES, TOXOIDS)

**THEN** NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM **CANNOT** EXCEED 3 PER DAY

**UNLESS** ANY OCCURRENCE OF OVERRIDE

CODE = NS CONTRACTOR HAS DETERMINED THAT NUMBER OF SERVICES IS MEDICALLY NECESSARY

**2-175-07R<sup>3</sup>** IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO

**THEN** NUMBER OF SERVICES **CANNOT** EXCEED THE MAXIMUM ALLOWED NUMBER OF SERVICES PER DAY FOR THE PROCEDURE CODE ON THIS LINE ITEM<sup>4</sup>

**UNLESS** ANY OCCURRENCE OF OVERRIDE

CODE = NS CONTRACTOR HAS DETERMINED THAT NUMBER OF SERVICES IS MEDICALLY NECESSARY

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<sup>2</sup> EDITS 2-175-02R, 2-175-03R, 2-175-04R, AND 2-175-06R ARE ONLY EXECUTED FOR FILING DATES < 02/01/2010.

<sup>3</sup> EDIT 2-175-07R IS ONLY EXECUTED FOR FILING DATES ≥ 02/01/2010. PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-175-07R. BYPASS EDIT 2-175-07R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.

<sup>4</sup> TO DETERMINE MAXIMUM NUMBER OF SERVICES REFER TO THE MAXIMUM NUMBER OF SERVICES CODE LIST AT [HTTP://WWW.TRICARE.MIL/TMA/RATES.ASPX](http://www.tricare.mil/tma/rates.aspx).

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Non-Institutional Edit Requirements (ELN 100 - 199)

**ELEMENT NAME: AMOUNT BILLED BY PROCEDURE CODE (2-180)**

**VALIDITY EDITS**

**2-180-01V** MUST BE NUMERIC.

**2-180-02V** IF CONTRACT NUMBER = MDA906-02-C-0013  
**THEN** IF PROCEDURE CODE = 000MN PRESCRIPTION MEDICAL NECESSITY REVIEWS **OR**  
 000PA PRESCRIPTION PRIOR AUTHORIZATIONS

**THEN** AMOUNT BILLED BY PROCEDURE CODE MUST > ZERO

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

**THEN** AMOUNT BILLED BY PROCEDURE CODE MUST = ZERO

**AND** AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO

**AND** AMOUNT PAID BY OHI MUST = ZERO

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

**AND** AMOUNT PAITENT COST SHARE MUST = ZERO

**ELSE** IF OCCURRENCE/LINE ITEM NUMBER = 002

**THEN** AMOUNT BILLED BY PROCEDURE CODE MUST = ZERO

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

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

**AND** AMOUNT BILLED BY PROCEDURE CODE = ZERO

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

**OR** OCCURRENCE/LINE ITEM NUMBER MUST = 002

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

**RELATIONAL EDITS**

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

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

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Non-Institutional Edit Requirements (ELN 100 - 199)

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

**VALIDITY EDITS**

**2-185-01V** MUST BE NUMERIC.

**RELATIONAL EDITS**

**2-185-00R** TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE FOR THIS TED RECORD EXCEEDS TMA LIMIT OF \$1,000,000.00.

**2-185-01R** IF TYPE OF SUBMISSION = C COMPLETE CANCELLATION **OR**  
D COMPLETE DENIAL

**THEN** AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO FOR ALL OCCURRENCES/LINE ITEMS

**2-185-02R** IF PRICING RATE CODE = ~~h~~ NO SPECIAL RATE **OR**  
D DISCOUNT RATE **OR**  
V MEDICARE REIMBURSEMENT RATE

**AND** NO OCCURRENCE OF SPECIAL PROCESSING CODE =

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

FS TFL (SECOND PAYOR) **OR**

16 AMBULATORY SURGERY FACILITY CHARGE

**AND** TYPE OF SUBMISSION =

A ADJUSTMENT **OR**

I INITIAL SUBMISSION **OR**

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

R RESUBMISSION

**THEN** AMOUNT ALLOWED BY PROCEDURE CODE MUST BE ≤ AMOUNT BILLED BY PROCEDURE CODE FOR EACH OCCURRENCE/LINE ITEM

**2-185-03R** IF PRICING RATE CODE = 4 PAID AS BILLED **OR**

I CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, PAID AS BILLED

**AND** TYPE OF SUBMISSION =

A ADJUSTMENT **OR**

I INITIAL SUBMISSION **OR**

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

R RESUBMISSION

**THEN** AMOUNT ALLOWED BY PROCEDURE CODE MUST BE = AMOUNT BILLED BY PROCEDURE CODE

**2-185-04R** IF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO

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

**UNLESS** TYPE OF SUBMISSION =

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

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

**2-185-05R** IF TYPE OF SUBMISSION = E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

**THEN** AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO

**2-185-06R** IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO

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

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

I INITIAL SUBMISSION **OR**

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Non-Institutional Edit Requirements (ELN 100 - 199)

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

	O	ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>
	R	RESUBMISSION
<b>2-185-07R</b>	IF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO	
	<b>THEN</b> AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO	
	<b>UNLESS</b> TYPE OF SUBMISSION =	
	B	ADJUSTMENT NON-TED DATA (HCSR) DATA <b>OR</b>
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

**ELEMENT NAME: AMOUNT PAID BY OTHER HEALTH INSURANCE (2-190)**

**VALIDITY EDITS**

**2-190-01V** MUST BE NUMERIC.

**RELATIONAL EDITS**

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

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

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

**ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) TYPE CODE (2-191)**

**VALIDITY EDITS**

**2-191-01V** MUST BE A VALID OGP TYPE CODE LISTING IN [SECTION 2.6](#).

**RELATIONAL EDITS**

<b>2-191-01R</b>	IF OGP TYPE CODE =	
	V	CHAMPVA
	<b>THEN</b> TYPE OF SUBMISSION MUST =	
	C	COMPLETE CANCELLATION <b>OR</b>
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

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Non-Institutional Edit Requirements (ELN 100 - 199)

**ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) BEGIN REASON CODE (2-192)**

**VALIDITY EDITS**

**2-192-01V** MUST BE A VALID OGP BEGIN REASON CODE LISTING IN [SECTION 2.6](#).

**RELATIONAL EDITS**

NONE

**ELEMENT NAME: AMOUNT APPLIED TOWARD DEDUCTIBLE (2-195)**

**VALIDITY EDITS**

**2-195-01V** MUST BE NUMERIC.

**RELATIONAL EDITS**

**2-195-00R** TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT APPLIED TOWARD DEDUCTIBLE FOR THIS TED RECORD EXCEEDS TMA LIMIT OF \$1,000,000.00.

**2-195-01R** IF TYPE OF SUBMISSION =

A	ADJUSTMENT <b>OR</b>
I	INITIAL SUBMISSION <b>OR</b>
O	ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>
R	RESUBMISSION

**THEN** AMOUNT APPLIED TOWARD DEDUCTIBLE MUST BE ≥ ZERO

**2-195-02R** IF TYPE OF SUBMISSION =

C	COMPLETE CANCELLATION <b>OR</b>
D	COMPLETE DENIAL

**THEN** AMOUNT APPLIED TOWARD DEDUCTIBLE MUST BE = ZERO

**2-195-03R** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

NE	OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM DEMONSTRATION
----	--

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

**AND** ENROLLMENT/HEALTH PLAN CODE =

T	TRICARE STANDARD PROGRAM <b>OR</b>
V	TRICARE EXTRA

**THEN** AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO

**2-195-04R** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

DE	TDRL PHYSICAL EXAMS <b>OR</b>
PF	ECHO

**THEN** AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO

- END -



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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 **SIX** YEARS

**THEN** DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA<sup>1</sup>

**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)

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

**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 <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

**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.

**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/  
POA INDICATOR (POSITIONS 1-7) = 290-316 (MENTAL HEALTH, ICD-9-CM) **OR**

F01.50-F69 OR F99 (MENTAL HEALTH, ICD-10-CM)

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

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

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

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

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

<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 NUMBER (2-310) (Continued)**

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

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

---

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

**VALIDITY EDITS**

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

**RELATIONAL EDITS**

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

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

---

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Non-Institutional Edit Requirements (ELN 300 - 399)

<b>ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320)</b>		
<b>VALIDITY EDITS</b>		
<b>2-320-01V</b>	VALUE MUST BE A VALID CA/NAS EXCEPTION REASON.	
<b>RELATIONAL EDITS</b>		
<b>NO ERROR</b>	IF TYPE OF SUBMISSION =	C COMPLETE CANCELLATION <b>OR</b> D COMPLETE DENIAL
<b>THEN</b> BYPASS ALL CA/NAS EXCEPTION REASON EDITING.		
<b>NO ERROR</b>	IF BEGIN DATE OF CARE IS OLDER THAN <b>SIX</b> YEARS	
<b>THEN</b> DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA		
<b>NO ERROR</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	R MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NOT A MEDICARE BENEFIT) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b> T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR-NOT A MEDICARE BENEFIT) <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
<b>THEN</b> BYPASS ALL CA/NAS EXCEPTION REASON EDITING.		
<b>NO ERROR</b>	IF ENROLLMENT/HEALTH PLAN CODE =	U TRICARE PRIME, CIVILIAN PCM <b>OR</b> W TPR ADSM - USA <b>OR</b> X FOREIGN ADSM <b>OR</b> Y CHCBP - STANDARD <b>OR</b> Z TRICARE PRIME, MTF/PCM <b>OR</b> AA CHCBP - EXTRA <b>OR</b> BB TSP <b>OR</b> 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>

**† 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 EXCEPTION REASON (2-320) (Continued)**

WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE AD5M

**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<sup>1</sup>

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

**AND** PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) = 290-316 (MENTAL HEALTH, ICD-9-CM) **OR**

F01.50-F69 OR F99 (MENTAL HEALTH, ICD-10-CM)

**AND** CA/NAS NUMBER NOT CODED

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

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

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<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>

## Data Requirements - Other Special Procedure Codes

**FIGURE 2.E-1 OUTPATIENT PROCEDURE CODES**

DESCRIPTION OF PROCEDURES	CODES <sup>1</sup>
NONINVASIVE CARDIAC DIAGNOSTIC TEST	93025
OFFICE/Outpatient Visit, New Patient	99201-99205
OFFICE/Outpatient Visit, Established Patient	99211-99215
OFFICE Consultation	99241-99245
HOME VISIT, New Patient	99341-99345
HOME VISIT, Established Patient	99347-99350
NEWBORN CARE, Not In Hospital	99461
HOME INFUSION THERAPY	S5036-S5523

<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

**FIGURE 2.E-2 TMA-APPROVED PROCEDURE CODES FOR RETAIL AND MAIL ORDER PHARMACY (MOP) ONLY**

DESCRIPTION OF PROCEDURES	CODES
The following are special codes that are valid and payable.	
Drugs; the procedure code to be used for all Drug TED records	98800
Prescription Medical Necessity Reviews	000MN
Prescription Prior Authorizations	000PA

- END -



## Data Requirements - Default Values For Complete Claims Denials

The values used as defaults can be used only on complete claim denials and only when the appropriate value is not available from the claim and/or supporting documents, history, provider file, or other available resources. Thus, the defaults are element-specific and are not to be used as a “blanket” approach for complete claim denials, edits are in place to ensure appropriate reporting of defaults.

The following is arranged in alphabetical order, with those elements that are common to both Institutional and Non-Institutional addressed first, then the Institutional-specific elements followed by the Non-Institutional-specific elements. Where “N/D” (No Default) appears, the TRICARE Encounter Data (TED) must be reported in accordance with current requirements. Wherever a group level element is listed, the value shown applies to all subordinate elements unless shown separately.

**FIGURE 2.M-1 COMMON ELEMENTS**

ELEMENT NAME	DEFAULT VALUE
Adjustment/Denial Reason Code	N/D
Administrative CLIN	N/D
AGR Legal Authority Code	Z
Amount Interest Payment	Zeroes
Amount Paid By Other Health Insurance	Zeroes
Amount Patient Cost-share	Zeroes
Begin Date Of Care	N/D
CA/NAS Exception Reason	N/D
CA/NAS Number	N/D
CA/NAS Reason For Issuance	N/D
Claim Form Type/EMC Indicator	N/D
Date Adjustment Identified	N/D
Date Ted Record Processed To Completion	N/D
DEERS Identifier (Patient)	Zeroes
End Date Of Care	N/D
Enrollment/Health Plan Code	N/D
Health Care Coverage Copayment Factor Code	Z
Health Care Coverage Member Category Code	Z

\* Prior to International Classification of Diseases, 10th Revision (ICD-10) implementation.

\*\* On or after the date specified by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule as published in the **Federal Register**.

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**FIGURE 2.M-1 COMMON ELEMENTS (CONTINUED)**

ELEMENT NAME	DEFAULT VALUE
Health Care Coverage Member Relationship Code	Z
Health Care Delivery Program Plan Coverage Code	000
Health Care Delivery Program Special Entitlement Code	00
Occurrence/Line Item Number	N/D
Other Government Program Begin Reason Code	W
Other Government Program Type Code	N
Override Code	N/D
Patient Identifier (DoD)	Zeroes
Patient Zip Code	N/D
Pay Grade Code (Sponsor)	00
Pay Plan Code (Sponsor)	ZZ
PCM Location DMIS-ID (Enrollment) Code	N/D
Person Birth Calendar Date (Patient)	19111111
Person Cadency Name (Patient)	Blanks
Person First Name (Patient)	Blanks
Person Identifier (Patient)	Zeroes
Person Identifier (Sponsor)	N/D
Person Identifier Type Code (Patient)	Z
Person Identifier Type Code (Sponsor)	Z
Person Last Name (Patient)	N/D
Person Middle Name (Patient)	Blanks
Person Sex (Patient)	Z
Pricing Rate Code	Blanks
Principal Treatment Diagnosis	7999* R69**
Provider Group NPI Number (Reserved)	Reserved
Provider Individual NPI Number (Reserved)	Reserved
Provider Network Status Indicator	N/D
Provider Participation Indicator	N/D
Provider State Or Country Code	N/D
Provider Sub-Identifier	N/D
Provider Taxpayer Number	N/D
Provider Zip Code	N/D
Reason For Interest Payment	Blanks
Record Type Indicator	N/D
Region Indicator	N/D
Secondary Treatment Diagnosis	N/D
Service Branch Classification Code (Sponsor)	Z

\* Prior to International Classification of Diseases, 10th Revision (ICD-10) implementation.

\*\* On or after the date specified by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule as published in the **Federal Register**.

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**FIGURE 2.M-1 COMMON ELEMENTS (CONTINUED)**

ELEMENT NAME	DEFAULT VALUE
Special Processing Code	N/D
TED Record Indicator	N/D
Total Occurrence/Line Item Count	N/D
Type Of Submission	D

\* Prior to International Classification of Diseases, 10th Revision (ICD-10) implementation.

\*\* On or after the date specified by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule as published in the **Federal Register**.

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**FIGURE 2.M-2 INSTITUTIONAL-SPECIFIC ELEMENTS**

ELEMENT NAME	DEFAULT VALUE
Admission Date	Report same date as Begin Date of Care
Admission Diagnosis	7999* R69**
Amount Allowed (Total)	Zeroes
Amount Billed (Total)	N/D
Amount Paid By Gov't Contractor (Total)	Zeroes
Covered Days	Zeroes
DRG Number	Zeroes
Frequency Code	1 (N/D on DRG interim billing)
Patient Status	01 (N/D on DRG interim billing)
Principal Op/Nonsurgical Procedure Code	Blanks
Revenue Code	N/D
Secondary Op/Nonsurgical Procedure Code	Blanks
SNF HIPPS Code	N/D
Source of Admission	9
Total Charge by Revenue Code	N/D
Type of Admission	3
Type of Institution	N/D
Units of Service by Revenue Code	0000000001

\* Prior to International Classification of Diseases, 10th Revision (ICD-10) implementation.

\*\* On or after the date specified by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule as published in the **Federal Register**.

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### Appendix A

#### Acronyms And Abbreviations

---

ARVC	Arrhythmogenic Right Ventricular Cardiomyopathy
ASA	Adjusted Standardized Amount American Society of Anesthesiologists
ASAP	Automated Standard Application for Payment
ASC	Accredited Standards Committee Ambulatory Surgical Center
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
ATA	American Telemedicine Association
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
BC	Birth Center
BCaBA	Board Certified Assistant Behavior Analyst
BCABA	Board Certified Associate Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBS	Blue Cross [and] Blue Shield
BCBSA	Blue Cross [and] Blue Shield Association
BCC	Biostatistics Center
<b>BE&amp;SD</b>	<b>Beneficiary Education and Support Division</b>
BH	Behavioral Health
BI	Background Investigation
<b>BIA</b>	<b>Bureau of Indian Affairs</b>
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support

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#### Acronyms And Abbreviations

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BMI	Body Mass Index
BMT	Bone Marrow Transplantation
BNAF	Budget Neutrality Adjustment Factor
BOS	Bronchiolitis Obliterans Syndrome
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BRAC	Base Realignment and Closure
BRCA	BReast CAncer (genetic testing)
BRCA1/2	BReast CAncer Gene 1/2
BS	Bachelor of Science
BSGI	Breast-Specific Gamma Imaging
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&P	Compensation and Pension
C/S	Client/Server
CA	Care Authorization
CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Graft
CAC	Common Access Card
CACREP	Council for Accreditation of Counseling and Related Educational Programs
CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAH	Critical Access Hospital
CAMBHC	Comprehensive Accreditation Manual for Behavioral Health Care
CAP	Competitive Acquisition Program
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAQH	Council for Affordable Quality Health
CAS	Carotid Artery Stenosis
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBE	Clinical Breast Examination
CBHCO	Community-Based Health Care Organizations
CBP	Competitive Bidding Program
CBSA	Core Based Statistical Area
CC	Common Criteria Convenience Clinic Criminal Control (Act)

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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
CQM	Clinical Quality Management
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
CRS	Cytoreductive Surgery
CRSC	Combat-Related Special Compensation
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
CTA	<b>Composite Tissue Allotransplantation</b> Computerized Tomography Angiography
CTC	Computed Tomographic Colonography
CTCL	Cutaneous T-Cell Lymphoma
CTEP	Cancer Therapy Evaluation Program
CTX	Corporate Trade Exchange
CUC	Chronic Ulcerative Colitis
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DBN	DoD Benefits Number
DC	Direct Care
DCAA	Defense Contract Audit Agency
DCAO	Debt Collection Assistance Officer

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Appendix A

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DCID	Director of Central Intelligence Directive
DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigating Service Ductal Carcinoma In Situ
DCN	Document Control Number
DCP	Data Collection Period
DCPE	Disability Compensation and Pension Examination
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DCWS	DEERS Claims Web Service
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
<b>DDD</b>	<b>Degenerative Disc Disease</b>
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 Disability Evaluation System
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
DLI	Donor Lymphocyte Infusion

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DM	Disease Management
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface
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
DOC	Dynamic Orthotic Cranioplasty (Band)
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
DPPO	Designated Provider Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
DRG	Diagnosis Related Group
DRPO	DEERS RAPIDS Program Office
DRS	Decompression Reduction Stabilization
DSAA	Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center

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DS Logon	DoD Self-Service Logon
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
DSMT	Diabetes Self-Management Training
DSO	DMDC Support Office
DSPOC	Dental Service Point of Contact
DSU	Data Sending Unit
DTF	Dental Treatment Facility
DTM	Directive-Type Memorandum
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
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
e-QIP	Electronic Questionnaires for Investigations Processing
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EAL	Common Criteria Evaluation Assurance Level
EAP	Employee-Assistance Program Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECAS	European Cardiac Arrhythmia Society
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

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Appendix A

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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
EHRA	European Heart Rhythm Association
EIA	Educational Interventions for Autism Spectrum Disorders
EID	Early Identification Enrollment Information for Dental
EIDS	Executive Information and Decision Support
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
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOE	Evoked Otoacoustic Emission
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

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Acronyms And Abbreviations

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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)
FAI	Femoroacetabular Impingement
FAP	Familial Adenomatous Polyposis
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
FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV <sub>1</sub>	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
FMRI	Functional Magnetic Resonance Imaging
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
FSO	Facility Security Officer
FTE	Full Time Equivalent
FTP	File Transfer Protocol

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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
GHP	Group Health Plan
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
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCM	Hypertrophic Cardiomyopathy
HCO	Healthcare Operations Division
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly HCFA 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
HDGC	Hereditary Diffuse Gastric Cancer
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

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HHC	Home Health Care
HHC/CM	Home Health Care/Case Management
HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIAA	Health Insurance Association of America
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HINT	Hearing in Noise Test
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPEC	Hyperthermic Intraperitoneal Chemotherapy
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 Non-Polyposis Colorectal Cancer
HOPD	Hospital Outpatient Department
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRA	Health Reimbursement Arrangement
HRG	Health Resource Group
HRS	Heart Rhythm Society
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy
HSCRC	Health Services Cost Review Commission
HSWL	Health, Safety and Work-Life
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

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IAVM	Information Assurance Vulnerability Management
IAW	In accordance with
IBD	Inflammatory Bowel Disease
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD	Implantable Cardioverter Defibrillator
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System
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
IDB	Intradiscal Biacuplasty
IDD	Internal or Intervertebral Disc Decompression
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDES	Integrated Disability Evaluation System
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IDTA	Intradiscal Thermal Annuloplasty
IE	Interface Engine Internet Explorer
IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program
IFR	Interim Final Rule
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IgA	Immunoglobulin A
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 Instant Message/Messaging 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
IOP	Intraocular Pressure
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy
IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing
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
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCIH	Joint Committee on Infant Hearing
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

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JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
<b>LGS</b>	<b>Lennox-Gastaut Syndrome</b>
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent
LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]
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
MBI	Molecular Breast Imaging
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services

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MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index Multiple Daily Injection
MDQC	Mail Delivery Quality Code
MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
MHO	Medical Holdover
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
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
<b>mild®</b>	<b>Minimally Invasive Lumbar Decompression</b>
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act
MMEA	Medicare and Medicaid Extenders Act (of 2010)
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOH	Medal Of Honor
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index

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MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
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
MUE	Medically Unlikely Edits
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
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Naval Air Station Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCE	National Counselor Examination
NCF	National Conversion Factor
NCI	National Cancer Institute
NCMHCE	National Clinical Mental Health Counselor Examination
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

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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
NG	National Guard
NGPL	No Government Pay List
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
NMA	Non-Medical Attendant
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
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NRS	Non-Routine [Medical] Supply
NSDSMEP	National Standards for Diabetes Self-Management Education Programs
NSF	Non-Sufficient Funds
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center

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OA	Office of Administration
OAE	Otoacoustic Emissions
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
OCMO	Office of the Chief Medical Officer
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel
OGC-AC	Office of General Counsel-Appeals, Hearings & Claims Collection Division
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
OR	Operating Room
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

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PACAB	Port Access Coronary Artery Bypass
PACO <sub>2</sub>	Partial Pressure of Carbon Dioxide
PAO <sub>2</sub>	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	Peritoneal Carcinomatosis 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
PCSIB	Purchased Care Systems Integration Branch
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDD	Percutaneous (or Plasma) Disc Decompression
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDI	Potentially Disqualifying Information
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System

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PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIRFT	Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMPM	Per Member Per Month
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
PPACA	Patient Protection and Affordable Care Act
PPD	Per Patient Day
PPN	Preferred Provider Network

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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
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRFA	Percutaneous Radiofrequency Ablation
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
PSD	Personnel Security Division
PSG	Polysomnography
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
PTNS	Posterior Tibial Nerve Stimulation
PTSD	Post-Traumatic Stress Disorder
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization

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QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Radiofrequency Annuloplasty Remittance Advice
RADDP	Remote Active Duty Dental Program
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCC	Recurring Credit/Debit Charge Renal Cell Carcinoma
RCCPDS	Reserve Component Common Personnel Data System
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RF	Radiofrequency
RFA	Radiofrequency Ablation
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 OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation

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RUG	Resource Utilization Group
RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
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	Stem Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SFTP	Secure File Transfer Protocol
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
SIF	Source Input Format
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

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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
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
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
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis

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TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCMHC	TRICARE Certified Mental Health Counselor
TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program/Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
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
TIP	Thermal Intradiscal Procedure
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment
TMH	Telemental Health
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TNEX	TRICARE Next Generation (MHS Systems)

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### Appendix A

#### Acronyms And Abbreviations

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TNP	Topical Negative Pressure
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
TOPO	TRICARE Overseas Program Office
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
TRIAP	TRICARE Assistance Program
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
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

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#### Acronyms And Abbreviations

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TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTOP	TRICARE Transitional Outpatient Payment
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
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
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouse
URL	Universal Resource Locator
US	Ultrasound 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

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#### Acronyms And Abbreviations

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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
VAC	Vacuum-Assisted Closure
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thorascopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
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
WebDOES	DEERS Online Enrollment System Web (application)
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
WWW	World Wide Web
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

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Appendix A

Acronyms And Abbreviations

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2D	Two Dimensional
3D	Three Dimensional

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