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HEALTH AGENCY

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
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PAT&IO

CHANGE 55
7950.2-M
DECEMBER 12, 2013

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: **FY14 REIMBURSEMENT AND CODING UPDATES 13-003**

CONREQ: 16707

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: See the Summary of Changes.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TPM, Change No. 103 and Feb 2008 TRM, Change No. 92.

JACOBS.KENNETH.C.1067162311

Digitally signed by JACOBS.KENNETH.C.1067162311
DN: c=US, o=U.S. Government, ou=DoD, ou=PKI, ou=TMA, cn=JACOBS.KENNETH.C.1067162311
Date: 2013.12.11 07:13:26 -07'00'

Kenneth C. Jacobs
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ATTACHMENT(S): **50 PAGES**
DISTRIBUTION: **7950.2-M**

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

REMOVE PAGE(S)	**INSERT PAGE(S)**
CHAPTER 2	
Section 2.7, pages 1 through 38	Section 2.7, pages 1 through 39
Section 5.3, pages 5 through 16	Section 5.3, pages 5 through 15

SUMMARY OF CHANGES

CHAPTER 2

1. Section 2.7. This change updates Daily Hospital Charges for Active Duty Family Member (ADFM), Diagnosis Related Group (DRG) inpatient cost-share, Cost-to-Charge Ratio (CCR) for Adjusted Standardized Amount (ASA), labor and non-labor related portions of ASA, CCR for admissions, the National Operating Standard Cost Share of Total Costs (NOSCASTC), TRICARE fixed loss cost-outlier, Children's CCR, Children's Marginal Cost Factor, and Table of Contents updates.
   EFFECTIVE DATE: 10/01/13

2. Section 5.3. This change updates Daily Hospital Charges for Active Duty Family Member (ADFM), Diagnosis Related Group (DRG) inpatient cost-share, Cost-to-Charge Ratio (CCR) for Adjusted Standardized Amount (ASA), labor and non-labor related portions of ASA, CCR for admissions, the National Operating Standard Cost Share of Total Costs (NOSCASTC), TRICARE fixed loss cost-outlier, Children's CCR, Children's Marginal Cost Factor, and Table of Contents updates.
   EFFECTIVE DATE: 10/01/13

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

DATA ELEMENT DEFINITION

ELEMENT NAME: PATIENT IDENTIFIER (DoD)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-095	1	Yes
Non-Institutional	2-080	1	Yes

PRIMARY PICTURE (FORMAT)	Ten (10) alphanumeric characters.
DEFINITION	The identifier associated with a particular patient. Download field from DEERS.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

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

DATA ELEMENT DEFINITION

ELEMENT NAME: PATIENT STATUS

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-270	1	Yes

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.	
DEFINITION	Code indicating patient status as of the end date of care on the TED record.	
CODE/VALUE SPECIFICATIONS	01	Discharged (Terminated 10/01/2013)
	02	Transferred (Terminated 10/01/2013)
	03	Discharged/transferred to SNF (Terminated 10/01/2013)
	04	Discharged/transferred to ICF (Terminated 10/01/2013)
	05	Discharged/transferred to another type of institution (including distinct parts of institutions) (definition not valid for discharges on or after 04/01/2008)
	05	Discharged/transferred to a designated cancer center or children's hospital (definition effective for discharges on or after 04/01/2008) (Terminated 10/01/2013)
	06	Discharged/transferred to home under care of organized home health service organization (Terminated 10/01/2013)
	07	Left against medical advice or discontinued care
	08	Discharged/transferred to home under care of a home IV provider (not valid for discharges on or after 10/01/2005)
	20	Expired (or did not recover - Christian Science Patient)
	21	Discharged/transferred to court/law enforcement (Terminated 10/01/2013)
	30	Still patient (remaining)
	40	Expired at home
	41	Expired in a medical facility, such as a hospital, SNF, ICF, or freestanding hospice
	42	Expired place unknown
	43	Discharged/transferred to a federal health care facility (Terminated 10/01/2013)
	50	Discharged to Hospice - Home
	51	Discharged to Hospice - Medical Facility
	61	Discharged/transferred to a hospital-based Medicare approved swing bed (Terminated 10/01/2013)
	62	Discharged/transferred to an inpatient Rehabilitation Facility including Rehabilitation Distinct Part Units of a hospital (Terminated 10/01/2013)
	63	Discharged/transferred to a LTC hospital (Terminated 10/01/2013)

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PATIENT STATUS (Continued)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare (Terminated 10/01/2013)
	65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital (Terminated 10/01/2013)
	66	Discharged/transferred to a CAH (Terminated 10/01/2013)
	69	Discharged/transferred to a designated disaster alternative care site (Effective 10/01/2013)
	70	Discharged/transferred to another type of health care institution not defined elsewhere in this code list (definition effective for discharges on or after 04/01/2008) (Terminated 10/01/2013)
	81	Discharged (Effective 10/01/2013)
	82	Transferred (Effective 10/01/2013)
	83	Discharged/transferred to SNF (Effective 10/01/2013)
	84	Discharged/transferred to ICF (Effective 10/01/2013)
	85	Discharged/transferred to a designated cancer center of children's hospital (definition effective for discharges on or after 04/01/2008) (Effective 10/01/2013)
	86	Discharged/transferred to home under care of organized home health service organization (Effective 10/01/2013)
	87	Discharged/transferred to court/law enforcement (Effective 10/01/2013)
	88	Discharged/transferred to a federal health care facility (Effective 10/01/2013)
	89	Discharged/transferred to a hospital-based Medicare approved swing bed (Effective 10/01/2013)
	90	Discharged/transferred to an inpatient Rehabilitation Facility including rehabilitation distinct part units of a hospital (Effective 10/01/2013)
	91	Discharged/transferred to an LTC hospital (Effective 10/01/2013)
	92	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare (Effective 10/01/2013)
	93	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital (Effective 10/01/2013)
	94	Discharged/transferred to a CAH (Effective 10/01/2013)
NOTES AND SPECIAL INSTRUCTIONS: N/A		

DATA ELEMENT DEFINITION

ELEMENT NAME: PATIENT STATUS (Continued)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	95	Discharged/transferred to another type of health care institution not defined elsewhere in this code list (definition effective for discharges on or after 04/01/2008) (Effective 10/01/2013)
ALGORITHM N/A		

SUBORDINATE AND/OR GROUP ELEMENTS	
SUBORDINATE	**GROUP**
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PATIENT ZIP CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-105	1	Yes
Non-Institutional	2-090	1	Yes

PRIMARY PICTURE (FORMAT)	Nine (9) alphanumeric characters.
DEFINITION	U.S. Postal Zip Code or foreign country code for patient's legal residence at the time service was rendered and must not be the zip code of a P.O. Box.
CODE/VALUE SPECIFICATIONS	Must be a valid five or nine digit zip code. If only 5 digits, left justify and blank fill. If foreign country, must be three character foreign country code, left justify and blank fill. Refer to Addendum A.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PAY GRADE CODE (SPONSOR)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-056	1	Yes[1]
Non-Institutional	2-291	Up to 99	Yes[1]

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.	
DEFINITION	The code that represents the level of pay. (The combination of pay plan code and pay grade code represents the sponsor's pay category.) Download field from DEERS.	
CODE/VALUE SPECIFICATIONS	00	Unknown
	00 - ZZ (not WW)	Used when pay plan is civil service
	01	Used when pay plan is cadet
	01 - 05	Used when pay plan is warrant office
	01 - 09	Used when pay plan is enlisted
	01 - 11	Used when pay plan is officer
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] If the DEERS response does not return a PAY GRADE CODE (SPONSOR), report '00' in this field.
If person not on DEERS but claim is payable (i.e., government liability), report '00' in this field.

DATA ELEMENT DEFINITION

ELEMENT NAME: PAY PLAN CODE (SPONSOR)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-057	1	Yes[1]
Non-Institutional	2-292	Up to 99	Yes[1]

PRIMARY PICTURE (FORMAT)	Five (5) alphanumeric characters.
DEFINITION	The code that represents the type of pay category. (The combination of pay plan code and pay grade code represents the sponsor's pay category.) Download field from DEERS.
CODE/VALUE SPECIFICATIONS	For valid values refer to Addendum J.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] If the DEERS response does not return a PAY PLAN CODE (SPONSOR), report 'ZZ' in this field, left justify. If person not on DEERS but claim is payable (i.e., government liability), report 'ZZ' in this field.

DATA ELEMENT DEFINITION

ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-115	1	No
Non-Institutional	2-110	1	No

PRIMARY PICTURE (FORMAT)	Four (4) alphanumeric characters.
DEFINITION	This code identifies and distinguishes MTF/Clinic enrollments from network enrollments. The code designations vary based on type of Prime enrollment and begin work dates of new programs. The codes also vary based on the individual requirements of enrolling platforms used by the MCS regions. Download field from DEERS using PCM Enrolling Division DMIS ID.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
If not applicable blank fill.

DATA ELEMENT DEFINITION

ELEMENT NAME: PERSON BIRTH CALENDAR DATE (PATIENT)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-085	1	Yes[1]
Non-Institutional	2-070	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Eight (8) alphanumeric characters, YYYYMMDD.	
DEFINITION	The date when a human being was born. Download field from DEERS.	
CODE/VALUE SPECIFICATIONS	YYYY	4 digit calendar year
	MM	2 digit calendar month
	DD	2 digit calendar day
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] Required if available on DEERS, if not available from DEERS report from the claim or report 19111111.

DATA ELEMENT DEFINITION

ELEMENT NAME: PERSON CADENCY NAME (PATIENT)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-079	1	Yes[1]
Non-Institutional	2-064	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Ten (10) alphanumeric characters.
DEFINITION	The cadency name (i.e., Sr., Jr., III, etc.) of the patient. Download field from DEERS.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	PERSON NAME (PATIENT)

NOTES AND SPECIAL INSTRUCTIONS:
[1] Required if available on DEERS, if not available from DEERS report from the claim or blank fill.

DATA ELEMENT DEFINITION

ELEMENT NAME: PERSON FIRST NAME (PATIENT)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-077	1	Yes[1]
Non-Institutional	2-062	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Twenty-five (25) alphanumeric characters.
DEFINITION	First name of patient. Download field from DEERS.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	PERSON NAME (PATIENT)

NOTES AND SPECIAL INSTRUCTIONS:
[1] Required if available on DEERS; if not available from DEERS report from the claim or blank fill.

DATA ELEMENT DEFINITION

ELEMENT NAME: PERSON IDENTIFIER (PATIENT)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-080	1	Yes
Non-Institutional	2-065	1	Yes

PRIMARY PICTURE (FORMAT)	Nine (9) alphanumeric characters.
DEFINITION	The identifier that represents a human being. This attribute will usually contain the person's SSN. Download field from DEERS.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
If person not on DEERS but claim is payable (i.e., government liability), report from the claim or report all nines in this field.

DATA ELEMENT DEFINITION

ELEMENT NAME: PERSON IDENTIFIER (SPONSOR)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-050	1	Yes
Non-Institutional	2-050	1	Yes

PRIMARY PICTURE (FORMAT)	Nine (9) alphanumeric characters.
DEFINITION	The identifier that represents a person who is a sponsor. This attribute will usually contain the sponsor's SSN. Download field from DEERS.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PERSON IDENTIFIER TYPE CODE (PATIENT)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-081	1	Yes
Non-Institutional	2-066	1	Yes

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.	
DEFINITION	The code that represents a specific kind of person identifier. Download field from DEERS.	
CODE/VALUE SPECIFICATIONS	D	Special nine digit code created for individuals (i.e., babies) who do not have or have not provided an SSN when the record is added to DEERS (dependents only).
	F	Special nine digit code created for foreign military and nationals.
	I	TIN
	P	Special nine digit code created for U.S. military personnel from Service Numbers before the switch to SSNs.
	R	Special nine digit code created for a DoD contractor who refused to give his or her SSN to RAPIDS. The associated PN_ID will begin with 99.
	S	SSN
	Z	Not applicable
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
If person not on DEERS but claim is payable (i.e., government liability), report from the claim or report 'Z' in this field.

DATA ELEMENT DEFINITION

ELEMENT NAME: PERSON IDENTIFIER TYPE CODE (SPONSOR)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-051	1	Yes
Non-Institutional	2-051	1	Yes

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

DEFINITION The code that represents a specific kind of person identifier. Download field from DEERS.

CODE/VALUE SPECIFICATIONS		
	D	Special nine digit code created for individuals (i.e., babies) who do not have or have not provided an SSN when the record is added to DEERS (dependents only).
	F	Special nine digit code created for foreign military and nationals.
	I	TIN
	P	Special nine digit code created for U.S. military personnel from Service Numbers before the switch to SSNs.
	R	Special nine digit code created for a DoD contractor who refused to give his or her SSN to RAPIDS. The associated PN_ID will begin with 99.
	S	SSN
	Z	Not applicable

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
If person not on DEERS but claim is payable (i.e., government liability), report from the claim or report 'Z' in this field.

DATA ELEMENT DEFINITION

ELEMENT NAME: PERSON LAST NAME (PATIENT)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-076	1	Yes
Non-Institutional	2-061	1	Yes

PRIMARY PICTURE (FORMAT)	Thirty-five (35) alphanumeric characters.
DEFINITION	Last name of patient. Download field from DEERS.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	PERSON NAME (PATIENT)

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PERSON MIDDLE NAME (PATIENT)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-078	1	Yes[1]
Non-Institutional	2-063	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Twenty-five (25) alphanumeric characters.
DEFINITION	Middle name of patient. Download field from DEERS.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	PERSON NAME (PATIENT)

NOTES AND SPECIAL INSTRUCTIONS:
[1] Required if available on DEERS, if not available from DEERS report from the claim or blank fill.

DATA ELEMENT DEFINITION

ELEMENT NAME: PERSON NAME (PATIENT)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-075	1	Yes
Non-Institutional	2-060	1	Yes

PRIMARY PICTURE (FORMAT)	Group
DEFINITION	Name of patient. Download field from DEERS.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
PERSON LAST NAME PERSON FIRST NAME PERSON MIDDLE NAME PERSON CADENCY NAME	N/A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PERSON SEX (PATIENT)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-100	1	Yes
Non-Institutional	2-085	1	Yes

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.	
DEFINITION	Code defining sex of patient. Download field from DEERS.	
CODE/VALUE SPECIFICATIONS	F	Female
	M	Male
	Z	Unknown
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
Use DEERS response if DEERS returns a value of 'F' or 'M'. If DEERS response is not 'F' or 'M', the person sex should be reported based on claim information or patient history.

DATA ELEMENT DEFINITION

ELEMENT NAME: PHYSICIAN REFERRAL NUMBER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-270	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Thirteen (13) alphanumeric characters.
DEFINITION	The identifying number of the referring physician. This field will report the NPI or PROVIDER TAXPAYER NUMBER and PROVIDER SUB-IDENTIFIER as applicable.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
[1] Required for all referred care (MTF and Civilian PCM). If not applicable blank fill.

DATA ELEMENT DEFINITION

ELEMENT NAME: PLACE OF SERVICE

RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Non-Institutional	2-275	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.	
DEFINITION	Code to indicate where the health care was provided.	
CODE/VALUE SPECIFICATIONS	03	School
	04	Homeless Shelter
	05	Indian Health Service (IHS) Freestanding Facility
	06	Indian Health Service (IHS) Provider-based Facility
	07	Tribal 638 Freestanding Facility
	08	Tribal 638 Provider-based Facility
	11	Office
	12	Home
	13	Assisted Living Facility
	14	Group Home
	15	Mobile Unit
	19	Pharmacy
	20	Urgent Care Facility
	21	Inpatient Hospital
	22	Outpatient Hospital
	23	Emergency Room - Hospital
	24	Ambulatory Surgical Center (ASC)
	25	Birthing Center
	26	Military Treatment Facility (MTF)
	31	Skilled Nursing Facility (SNF)
	32	Nursing Facility
	33	Custodial Care Facility
	34	Hospice
	41	Ambulance - Land
	42	Ambulance - Air or Water
	49	Independent Clinic
	50	Federally Qualified Health Center
	51	Inpatient Psychiatric Facility
	52	Psychiatric Facility Partial Hospitalization
	53	Community Mental Health Center (CMHC)
	54	Intermediate Care Facility/Mentally Retarded
	55	Residential Substance Abuse Treatment Facility
	56	Psychiatric Residential Treatment Center (RTC)

NOTES AND SPECIAL INSTRUCTIONS:
This data element must be '19' for Mail Order Pharmacy (MOP).

DATA ELEMENT DEFINITION

ELEMENT NAME: PLACE OF SERVICE (Continued)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	57	Non-Residential Substance Abuse Treatment Facility
	60	Mass Immunization Center
	61	Comprehensive Inpatient Rehabilitation Facility
	62	Comprehensive Outpatient Rehabilitation Facility (CORF)
	65	End Stage Renal Disease (ESRD) Treatment Facility
	71	Public Health Clinic
	72	Rural Health Clinic (RHC)
	81	Independent Laboratory
	99	Other Unlisted Facility
ALGORITHM N/A		

SUBORDINATE AND/OR GROUP ELEMENTS	
SUBORDINATE	**GROUP**
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
This data element must be '19' for Mail Order Pharmacy (MOP).

DATA ELEMENT DEFINITION

ELEMENT NAME: PRICING RATE CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-190	1	Yes
Non-Institutional	2-325	Up to 99	Yes

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

DEFINITION Code indicating the pricing methodology used in determining the amount allowed for the service(s)/supplies. Left justify and blank fill.

CODE/VALUE SPECIFICATIONS	INSTITUTIONAL CODE	
	~~b~~	No special rate
	D	Discount rate agreement
	H	TRICARE DRG reimbursement with Short Stay Outlier
	I	TRICARE DRG reimbursement with Cost Outlier
	J	TRICARE DRG reimbursement with No Outlier
	K	Hospital-specific Psychiatric per diem rate
	L	Region-specific Psychiatric per diem rate
	P	Per diem rate
	U	Supplemental Health Care Program (SHCP) claim or active duty member TPR claim paid outside normal limits
	V	Medicare Reimbursement Rate
	CA	Critical Access Hospital (CAH) Reimbursement
	CR	Cost-To-Charge Ratio (CCR) (Effective 01/01/2014)
	DD	Discounted DRG
	NON-INSTITUTIONAL CODE	
	0	Pricing not applicable (denied service/supplies and allowed drugs)[1]
	1	Priced Manually[2]
	2	Prevailing charge (state)
	3	Conversion amount (state)
	4	Paid as billed
	5	Paid on negotiated rate
	A	National prevailing charge
	B	National conversion factor
	C	Ambulatory surgery-facility payment rate
	D	Discounted ambulatory surgery-facility payment rate
	E	Ambulatory surgery-paid as billed

NOTES AND SPECIAL INSTRUCTIONS:

[1] Code '0' for all allowed drug charges.

[2] Use Pricing Rate Code '1' (Priced Manually) for consultation procedures for which the allowable charge is limited to that for a Limited Initial Visit, New Patient.

To indicate that the hospital reimbursement was reduced by a full or partial credit a provider received for a replaced device, Special Processing Codes 49 or 50 should be used. See Section 2.8.

DATA ELEMENT DEFINITION

ELEMENT NAME: PRICING RATE CODE (Continued)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	**NON-INSTITUTIONAL CODE (CONTINUED)**	
	F	Claim Auditing Software-added procedure, priced manually
	G	Claim Auditing Software-added procedure, prevailing charge (State)
	H	Claim Auditing Software-added procedure, conversion factor (Contractor)
	I	Claim Auditing Software-added procedure, paid as billed
	J	Claim Auditing Software-added procedure, paid on negotiated rate
	N	Claim Auditing Software-added procedure, national prevailing charge
	O	Claim Auditing Software-added procedure, national conversion factor
	P	Claim Auditing Software-added procedure, ambulatory surgery-facility payment rate
	Q	Claim Auditing Software-added procedure, discounted ambulatory surgery-facility payment rate
	R	Claim Auditing Software-added procedure, ambulatory surgery-paid as billed
	T	Claim Auditing Software-added procedure, allowed as billed but paid less than billed
	U	SHCP or active duty member TPR claim paid outside normal limits
	V	Medicare Reimbursement Rate
	W	Priced over CMAC (Effective 09/27/2001)
	BR	Blended Rate
	CA	Critical Access Hospital (CAH) Reimbursement
	GG	Global Rate Agreement (used with corporate service providers only) (Effective 08/01/2003)
	GP	Per Diem Rate Agreement (used with corporate service providers only) (Effective 08/01/2003)
	LC	TRICARE Claim-added procedure, CMAC priced laboratory code
	P1	OPPS
	P2	OPPS with Cost Outlier
	P3	OPPS with Discount
	P5	Hospital-based Partial Hospitalization - paid as OPPS

NOTES AND SPECIAL INSTRUCTIONS:

[1] Code '0' for all allowed drug charges.

[2] Use Pricing Rate Code '1' (Priced Manually) for consultation procedures for which the allowable charge is limited to that for a Limited Initial Visit, New Patient.

To indicate that the hospital reimbursement was reduced by a full or partial credit a provider received for a replaced device, Special Processing Codes 49 or 50 should be used. See Section 2.8.

DATA ELEMENT DEFINITION

ELEMENT NAME: PRICING RATE CODE (Continued)	
ALGORITHM N/A	
SUBORDINATE AND/OR GROUP ELEMENTS	
SUBORDINATE	**GROUP**
N/A	PROCESSING INFORMATION

NOTES AND SPECIAL INSTRUCTIONS:

[1] Code '0' for all allowed drug charges.

[2] Use Pricing Rate Code '1' (Priced Manually) for consultation procedures for which the allowable charge is limited to that for a Limited Initial Visit, New Patient.

To indicate that the hospital reimbursement was reduced by a full or partial credit a provider received for a replaced device, Special Processing Codes 49 or 50 should be used. See Section 2.8.

DATA ELEMENT DEFINITION

ELEMENT NAME: PRINCIPAL OPERATION/NON-SURGICAL PROCEDURE CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-345	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Seven (7) alphanumeric characters.
DEFINITION	The code that identifies the principal procedure performed during the period reported on the TED record as submitted on the UB-04/UB-92.
CODE/VALUE SPECIFICATIONS	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.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
[1] Required if one of the following Revenue Codes are present 036X or 072X.

DATA ELEMENT DEFINITION

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

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
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:
	~~b~~ 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 on or before September 30, 2014, and ICD-10-CM R68.89 on or after October 1, 2014.

DATA ELEMENT DEFINITION

ELEMENT NAME: PROCEDURE CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-160	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Five (5) alphanumeric characters.
DEFINITION	The code that identifies the procedure performed or describes the care received as submitted on the claim form.
CODE/VALUE SPECIFICATIONS	Refer to Physician's Current Procedure Terminology, 4th Edition[1] (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) National Level II Medicare Codes or TMA approved codes (Addendum E, Figure 2.E-2). For Dental Services, use HCPC or ADA Dental procedure codes.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

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For MOP report procedure code [1]98800 for all drug prescriptions and procedure code[1] 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.

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

PRIMARY PICTURE (FORMAT)	Four (4) occurrences of two (2) alphanumeric characters per occurrence/line item.
DEFINITION	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'[1] (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) National Level II Medicare Codes.)
CODE/VALUE SPECIFICATIONS	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-CN, 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, LM, 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.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

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Note: Can report from zero to four codes. Each occurrence consists of two characters left justified and blank filled. Do not duplicate.

DATA ELEMENT DEFINITION

ELEMENT NAME: PROCESSING INFORMATION

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-155	1	Yes

PRIMARY PICTURE (FORMAT)	Group
DEFINITION	Field containing multiple elements that describe processing related to the TED record.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
OVERRIDE CODE	N/A
TYPE OF SUBMISSION	
CA/NAS NUMBER	
CA/NAS REASON FOR ISSUANCE	
CA/NAS EXCEPTION REASON	
SPECIAL PROCESSING CODE	
PRICING RATE CODE	
HEALTHCARE DELIVERY PROGRAM SPECIAL ENTITLEMENT CODE	

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER INDIVIDUAL NPI NUMBER (TYPE 1)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-225	Up to 99	Yes[1]

PRIMARY PICTURE (FORMAT)	Ten (10) alphanumeric characters.
DEFINITION	Standard unique health identifier for individual providers, including but not limited to those (human beings) who provide care such as physicians, nurse practitioners, dentists, chiropractors, pharmacists, and physical therapists.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] Required for all "covered entities" that submit HIPAA-compliant standard electronic transactions in accordance with the TRICARE Operations Manual (TOM), Chapter 20, Section 4.

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER NETWORK STATUS INDICATOR

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-230	1	Yes
Non-Institutional	2-265	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.	
DEFINITION	Code indicating whether the provider is a network or non-network provider.	
CODE/VALUE SPECIFICATIONS	1	Network Provider
	2	Non-Network Provider
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
This data element must be '1' for MOP.

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER ORGANIZATIONAL NPI NUMBER (TYPE 2)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-215	'0	Yes[1]
Non-Institutional	2-230	Up to 99	Yes[1]

PRIMARY PICTURE (FORMAT)	Ten (10) alphanumeric characters.
DEFINITION	Standard unique health identifier for organizational providers, including but not limited to non-person providers such as hospitals, HHAs, clinics, laboratories, suppliers of DME, pharmacies, and groups.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] Required for all "covered entities" that submit HIPAA-compliant standard electronic transactions in accordance with the TOM, Chapter 20, Section 4.

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER PARTICIPATION INDICATOR

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-225	1	Yes
Non-Institutional	2-260	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.
DEFINITION	Code indicating whether or not the provider accepted assignment of benefits for services rendered.
CODE/VALUE SPECIFICATIONS	N No
	Y Yes
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
This data element must be 'Y' for MOP.

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER TAXONOMY (SPECIALTY)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-255	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Ten (10) alphanumeric characters.
DEFINITION	Code describing the provider's specialty.
CODE/VALUE SPECIFICATIONS	Refer to http://www.wpc-edi.com/codes for Provider Specialty Codes. Refer to Addendum C, Figure 2.C-1 as a reference when assigning Provider Major Specialty Codes to Outpatient Hospital Non-Institutional TED records.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
This data element must be '183500000X' for MOP and '333600000X' for Retail Pharmacy.

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER STATE OR COUNTRY CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-195	1	Yes
Non-Institutional	2-235	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Three (3) alphanumeric characters.
DEFINITION	Code assigned to identify the state or foreign country in which the care was received. State Code must be left justified and blank fill to right.
CODE/VALUE SPECIFICATIONS	Addendum A and Addendum B.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER SUB-IDENTIFIER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-205	1	Yes
Non-Institutional	2-245	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Four (4) alphanumeric characters.
DEFINITION	Identification number that uniquely identifies multiple providers using the same TIN.
CODE/VALUE SPECIFICATIONS	Refer to Section 2.10, ELN 3-010.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER TAXPAYER NUMBER

RECORDS/LOCATOR NUMBERS

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

PRIMARY PICTURE (FORMAT)	Nine (9) alphanumeric characters.
DEFINITION	The IRS TIN assigned to the institution/provider supplying the care.
CODE/VALUE SPECIFICATIONS	For institutions must be nine digit EIN. For individual providers, should be the nine digit EIN or SSN, if available. If not available, report the contractor-assigned number. (Refer to Section 2.10 ELN 3-005). Report all nines for transportation services.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
Claims for care rendered by an EIA Tutor must be identified on the TED record using the billing ACSP Provider Taxpayer Number.

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER ZIP CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-220	1	Yes
Non-Institutional	2-250	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Nine (9) alphanumeric characters.
DEFINITION	Location of provider's business office where care is usually provided.
CODE/VALUE SPECIFICATIONS	Must be a valid five or nine digit zip code. If only five digits, left justify and blank fill. If a foreign country, must be three character foreign country code, left justify and blank fill. Refer to Addendum A.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

- END -

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		
	AND TYPE OF SUBMISSION =	A	ADJUSTMENT TO TED RECORD DATA **OR**
		C	COMPLETE CANCELLATION TO TED RECORD DATA **OR**
		I	INITIAL TED RECORD SUBMISSION **OR**
		O	ZERO PAYMENT TED RECORD DUE TO 100% OHI **OR**
		R	RESUBMISSION OF AN INITIAL TED RECORD
	AND FREQUENCY CODE =	2	INTERIM-INITIAL **OR**
		3	INTERIM-INTERIM **OR**
		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 **OR** NO PREVIOUS TED RECORD
3	= 2 **OR** 3 (PREVIOUS TED RECORD MUST EXIST)
4	= 2, 3, **OR** 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 (TERMINATED 10/01/2013) **OR**
		02	TRANSFERRED (TERMINATED 10/01/2013) **OR**
		20	EXPIRED **OR**
		81	DISCHARGED (EFFECTIVE 10/01/2013) **OR**
		82	TRANSFERRED (EFFECTIVE 10/01/2013)
	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**

ELEMENT NAME: FREQUENCY CODE (1-250) (Continued)			
		9	FINAL CLAIM FOR HHA PPS EPISODE
1-250-03R	IF PRICING RATE CODE =	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER
	THEN FREQUENCY CODE MUST =	1	ADMIT THROUGH DISCHARGE

ELEMENT NAME: TYPE OF ADMISSION (1-255)			
	VALIDITY EDITS		
1-255-01V	VALUE MUST BE A VALID TYPE OF ADMISSION CODE.		
	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 A VALID TYPE OF ADMISSIONS CODE		
	RELATIONAL EDITS		
1-255-03R	IF TYPE OF ADMISSION =	4	NEWBORN
	AND ICD VERSION =	9	ICD-9
	AND SOURCE OF ADMISSION =	1	NORMAL DELIVERY **OR**
		2	PREMATURE DELIVERY **OR**
		4	EXTRAMURAL BIRTH **OR**
		5	BORN INSIDE THIS HOSPITAL **OR**
		6	BORN OUTSIDE THIS HOSPITAL
	THEN PRINCIPAL DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) MUST BE BETWEEN V30.0 AND V39.2.		
1-255-04R	IF TYPE OF ADMISSION =	4	NEWBORN
	AND ICD VERSION =	0	ICD-10
	THEN SOURCE OF ADMISSION =	5	BORN INSIDE THIS HOSPITAL **OR**
		6	BORN OUTSIDE THIS HOSPITAL
	AND PRINCIPAL DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) MUST BE BETWEEN Z38.00 AND Z38.8.		

ELEMENT NAME: SOURCE OF ADMISSION (1-260)			
	VALIDITY EDITS		
1-260-01V	VALUE MUST BE A VALID SOURCE OF ADMISSION.		
	RELATIONAL EDITS		
1-260-01R	IF TYPE OF ADMISSION =	4	NEWBORN
	THEN SOURCE OF ADMISSION MUST =	1	NORMAL DELIVERY **OR**
		2	PREMATURE DELIVERY **OR**
		3	SICK BABY **OR**
		4	EXTRAMURAL BIRTH
		4	EXTRAMURAL BIRTH **OR**
		5	BORN INSIDE THIS HOSPITAL **OR**
		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		
1-265-01R	ADMISSION DATE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION		
1-265-02R	ADMISSION DATE MUST BE ≤ END DATE OF CARE		
1-265-03R	IF FREQUENCY CODE =	1	ADMIN THROUGH DISCHARGE **OR**
		2	INTERIM-INITIAL
	THEN ADMISSION DATE MUST = BEGIN DATE OF CARE		
1-265-04R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		B	ADJUSTMENT OF NON-TED RECORD (HCSR) DATA **OR**
		C	COMPLETE CANCELLATION **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN ADMISSION DATE 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 ON TMA DATABASE = ZEROES.		

ELEMENT NAME: PATIENT STATUS (1-270)			
	VALIDITY EDITS		
1-270-01V	VALUE MUST BE A VALID PATIENT STATUS CODE.		
	RELATIONAL EDITS		
1-270-01R	IF FREQUENCY CODE =	2	INTERIM-INITIAL **OR**
		3	INTERIM-INTERIM
	THEN PATIENT STATUS MUST =	30	STILL A PATIENT
1-270-03R	IF PRICING RATE CODE =	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER **OR**
		J	TRICARE DRG REIMBURSEMENT WITH NO OUTLIER
	THEN PATIENT STATUS MUST ≠	30	STILL A PATIENT

ELEMENT NAME: BEGIN DATE OF CARE (1-275)			
	VALIDITY EDITS		
1-275-01V	MUST BE A VALID GREGORIAN DATE AND CANNOT BE > TMA CURRENT SYSTEM DATE.		
1-275-02V	CANNOT BE MORE THAN 10 YEARS PRIOR TO TMA CURRENT SYSTEM DATE.		
1-275-03V	BEGIN DATE OF CARE MUST BE ≤ END DATE OF CARE.		
	RELATIONAL EDITS		
1-275-02R	BEGIN DATE OF CARE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION		
1-275-03R	BEGIN DATE OF CARE MUST BE ≥ PERSON BIRTH CALENDAR DATE (PATIENT)		
1-275-04R	BEGIN DATE OF CARE MUST BE ≥ ADMISSION DATE		
1-275-05R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		C	COMPLETE CANCELLATION **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN BEGIN 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 ON TMA DATABASE = ZEROES.		
1-275-06R	PROVIDER MUST BE "AUTHORIZED"[1] ON PROVIDER FILE FOR THIS BEGIN DATE OF CARE		
	UNLESS AMOUNT ALLOWED (TOTAL) ≤ ZERO		
	OR ADJUSTMENT/DENIAL REASON CODE =	38	SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS **OR**
		52	THE REFERRING/PRESCRIBING/RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/ PERFORM THE SERVICE BILLED **OR**
		B7	THIS PROVIDER WAS NOT CERTIFIED ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **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		

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

ELEMENT NAME: END DATE OF CARE (1-280)			
	VALIDITY EDITS		
1-280-01V	MUST BE A VALID GREGORIAN DATE AND CANNOT BE > TMA CURRENT SYSTEM DATE.		
1-280-02V	CANNOT BE MORE THAN 10 YEARS PRIOR TO TMA CURRENT SYSTEM DATE.		
1-280-03V	END DATE OF CARE MUST BE ≥ BEGIN DATE OF CARE.		
	RELATIONAL EDITS		
1-280-01R	END DATE OF CARE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION		
1-280-02R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		C	COMPLETE CANCELLATION **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN 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 ON TMA DATABASE = ZEROES.		
1-280-03R	PROVIDER MUST BE "AUTHORIZED"[1] ON PROVIDER FILE FOR THIS END DATE OF CARE		
	UNLESS AMOUNT ALLOWED (TOTAL) ≤ ZERO		
	OR ADJUSTMENT/DENIAL REASON CODE =	38	SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS **OR**
		52	THE REFERRING/PRESCRIBING/RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/ PERFORM THE SERVICE BILLED **OR**
		B7	THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **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		

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

ELEMENT NAME: ADMINISTRATIVE CLIN (1-283)			
	VALIDITY EDITS		
1-283-01V	MUST BE BLANKS OR A VALID CLIN FOR THE CONTRACT NUMBER ON THE TMA DATABASE.		
1-283-02V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		B	HCSR ADJUSTMENT **OR**
		C	COMPLETE CANCELLATION **OR**
		E	HCSR CANCELLATION
	AND CONTRACT NUMBER =	MDA906-02-C-0013 (TMOP) **OR**	
		MDA906-03-C-0009 (WEST) **OR**	
		MDA906-03-C-0010 (SOUTH) **OR**	
		MDA906-03-C-0011 (NORTH) **OR**	
		MDA906-03-C-0015 (TDEFIC) **OR**	
		MDA906-03-C-0019 (TRRx)	
	AND ADMINISTRATIVE CLAIM COUNT CODE (TMA DERIVED FIELD) ON TMA FILE =	1	CLAIM RATE HAS BEEN PAID
	THEN ADMINISTRATIVE CLIN ON THE ADJUSTMENT MUST = ADMINISTRATIVE CLIN ON TMA DATABASE[1]		
1-283-03V	**IF** CONTRACT NUMBER ≠	MDA906-02-C-0013 (TMOP) **OR**	
		MDA906-03-C-0009 (WEST) **OR**	
		MDA906-03-C-0010 (SOUTH) **OR**	
		MDA906-03-C-0011 (NORTH) **OR**	
		MDA906-03-C-0015 (TDEFIC) **OR**	
		MDA906-03-C-0019 (TRRx)	
	THEN ADMINISTRATIVE CLIN MUST BE BLANK.		
	RELATIONAL EDITS		
	REFER TO SECTION 8.1.		

[1] THIS EDIT IS CHECKED DURING THE ADJUSTMENT/CANCELLATION MATCH AND MARRY PROCESS.

ELEMENT NAME: COVERED DAYS (1-285)			
	VALIDITY EDITS		
1-285-01V	MUST BE NUMERIC.		
1-285-02V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	11	HOSPICE
	OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	OR TYPE OF INSTITUTION =	78	NON-HOSPITAL BASED HOSPICE **OR**
		79	HOSPITAL BASED HOSPICE
	THEN BYPASS THIS EDIT		
	ELSE IF AMOUNT ALLOWED (TOTAL) ≤ ZERO		
	OR TYPE OF INSTITUTION =	70	HHA
	OR THE SUM OF UNITS OF SERVICE BY REVENUE CODE FOR REVENUE CODES THAT INDICATE THAT A ROOM WAS USED (010X-021X, **OR** 0724) = ZERO		
	THEN COVERED DAYS MUST = ZERO		
	ELSE IF TYPE OF SUBMISSION =	A	ADJUSTMENT TO TED RECORD DATA **OR**
		I	INITIAL TED RECORD SUBMISSION **OR**
		O	ZERO PAYMENT TED RECORD DUE TO 100% OHI **OR**
		R	RESUBMISSION OF AN INITIAL TED RECORD
	AND FREQUENCY CODE =	2	INTERIM - INITIAL TED RECORD **OR**
		3	INTERIM - INTERIM TED RECORD
	OR BEGIN DATE OF CARE = END DATE OF CARE		
	THEN COVERDAYS MUST BE ≤ END DATE OF CARE - BEGIN DATE OF CARE +1		
	ELSE COVERED DAYS MUST BE ≤ END DATE OF CARE - BEGIN DATE OF CARE		
	RELATIONAL EDITS		
	NONE		

ELEMENT NAME: DRG NUMBER (1-290)			
	VALIDITY EDITS		
1-290-01V	MUST BE A VALID DRG NUMBER **OR** BLANK FILLED.		
	RELATIONAL EDITS		
1-290-01R	IF PRICING RATE CODE =	~~b~~	NO SPECIAL RATE CODE **OR**
		K	HOSPITAL-SPECIFIC PSYCHIATRIC PER DIEM RATE **OR**
		L	REGIONAL-SPECIFIC PSYCHIATRIC PER DIEM RATE **OR**
		P	PER DIEM RATE AGREEMENT **OR**
		CA	CAH REIMBURSEMENT
	THEN DRG NUMBER MUST = BLANK		
1-290-02R	IF ANY OCCURRENCE OF OVERRIDE CODE =	Y	NEWBORN IN MOTHER'S ROOM WITHOUT NURSERY CHARGES
	THEN DRG NUMBER MUST = BLANK		
1-290-31R	IF PRICING RATE CODE =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER **OR**
		I	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER **OR**
		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER **OR**
		DD	DISCOUNTED DRG
	THEN DRG MUST NOT BE BLANK		
	AND DATE OF ADMISSION MUST BE ≥ THE DRG EFFECTIVE DATE AND ≤ THE DRG TERMINATION DATE		

ELEMENT NAME: HIPPS CODE (1-292)			
	VALIDITY EDITS		
1-292-01V	MUST BE VALID HIPPS CODES REFER TO SECTION 2.8.		
	RELATIONAL EDITS		
1-292-01R	IF HIPPS CODE = BLANK		
	THEN NO OCCURRENCE OF REVENUE CODE CAN =	0022	SNF **OR**
		0023	HHA PPS

ELEMENT NAME: ICD VERSION (1-293)			
	VALIDITY EDITS		
1-293-01V	VALUE MUST BE A VALID ICD VERSION.		
	RELATIONAL EDITS		
NO ERROR	IF AMOUNT ALLOWED (TOTAL) = ZERO		
1-293-01R	IF ADMISSION DATE ≥ 10/01/2014		
	THEN ICD VERSION MUST BE	0	ICD-10
1-293-02R	IF END DATE OF CARE ≥ 10/01/2014		
	AND PATIENT STATUS ≠	30	STILL PATIENT
	THEN ICD VERSION MUST BE	0	ICD-10
1-293-03R	IF ADMISSION DATE < 10/01/2014		
	AND PATIENT STATUS =	30	STILL PATIENT
	THEN ICD VERSION MUST BE	9	ICD-9
1-293-04R	IF END DATE OF CARE < 10/01/2014		
	THEN ICD VERSION MUST BE	9	ICD-9

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 -