

## Institutional Edit Requirements (ELN 100 - 199)

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ELEMENT NAME: PERSON SEX (PATIENT) (1-100)	
<b>VALIDITY EDITS</b>	
<b>1-100-01V</b>	PERSON SEX (PATIENT) MUST =
	F FEMALE <b>OR</b>
	M MALE <b>OR</b>
	Z UNKNOWN
<b>RELATIONAL EDITS</b>	
NONE	
ELEMENT NAME: PATIENT ZIP CODE (1-105)	
<b>VALIDITY EDITS</b>	
<b>1-105-01V</b>	MUST BE NINE DIGITS <b>OR</b> FIVE DIGITS WITH FOUR BLANKS
	MUST BE A VALID ZIP CODE (BASED ON ADMISSION DATE) IN THE GOVERNMENT PROVIDED ELECTRONIC ZIP CODE FILE <b>OR</b>
	MUST BE A THREE CHARACTER FOREIGN COUNTRY CODE (BASED ON THE COUNTRY CODES TABLE <sup>1</sup> ) FOLLOWED BY SIX BLANKS
<b>RELATIONAL EDITS</b>	
NONE	
<sup>1</sup> WHEN FOREIGN COUNTRY CODES ARE SUBMITTED, THE FIRST THREE CHARACTERS WILL BE EDITED AGAINST <a href="#">ADDENDUM A</a> .	

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**ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (1-110)**

**VALIDITY EDITS**

**1-110-01V** MUST BE A VALID ENROLLMENT/HEALTH PLAN CODE (REFER TO [SECTION 2.5](#)).

**RELATIONAL EDITS**

**1-110-02R** IF ENROLLMENT/HEALTH PLAN CODE = Y CHCBP - STANDARD **OR**  
AA CHCBP - EXTRA

**THEN NO** OCCURRENCE OF SPECIAL PROCESSING CODE CAN = CL CLINICAL TRIALS **OR**  
PF ECHO

**1-110-06R** IF ENROLLMENT/HEALTH PLAN CODE = SN SHCP - NON-MTF-REFERRED CARE **OR**  
SO SHCP - NON-TRICARE ELIGIBLE **OR**  
SR SHCP - REFERRED CARE **OR**  
ST SHCP - TRICARE ELIGIBLE

**THEN** AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = AN SHCP - NON-MTF-REFERRED CARE **OR**  
AR SHCP - REFERRED CARE **OR**  
CE SHCP - **CCEP** **OR**  
SC SHCP - NON-TRICARE ELIGIBLE **OR**  
SE SHCP - TRICARE ELIGIBLE **OR**  
SM SHCP - EMERGENCY

**1-110-09R** • TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001.  
WHEN BEGIN DATE OF CARE IS < 10/01/2001, THE OCCURRENCE/LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.

IF ENROLLMENT/HEALTH PLAN CODE = FE TFL - EXTRA **OR**  
FS TFL - STANDARD

**AND** TYPE OF INSTITUTION ≠ 10 GENERAL MEDICAL AND SURGICAL

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

**AND** AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = FF TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) **OR**

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

FS TFL (SECOND PAYOR)

**ELSE** IF BEGIN DATE OF CARE IS < 10/01/2001

**THEN** ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAILED OCCURRENCE/LINE ITEM (EXCEPT FOR LINE CONTAINING REVENUE CODE 0001) MUST = 15 PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER **OR**

26 EXPENSES INCURRED PRIOR TO COVERAGE **OR**

27 EXPENSES INCURRED AFTER COVERAGE TERMINATED **OR**

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

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**ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (1-110) (Continued)**

	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 NEWBORN <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>1-110-10R</b>		<ul style="list-style-type: none"> <li>TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE <math>\geq</math> 10/01/2001  <b>UNLESS</b> THE BENEFICIARY IS AN INPATIENT AND THE ADMISSION DATE WAS PRIOR TO 10/01/2001, TFL WILL PAY FOR THE ENTIRE HOSPITAL STAY.</li> </ul>
	IF ENROLLMENT/HEALTH PLAN CODE =	FE TFL - EXTRA <b>OR</b>
		FS TFL - STANDARD
	<b>AND</b> TYPE OF INSTITUTION =	10 GENERAL MEDICAL AND SURGICAL
	<b>THEN</b> END DATE OF CARE $\geq$ 10/01/2001	
	<b>AND</b> AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	FF TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) <b>OR</b>
		FG TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, I.E., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b>
		FS TFL (SECOND PAYOR)
<b>1-110-11R</b>		<ul style="list-style-type: none"> <li>TFL CLAIMS: THE PATIENT MUST BE 64 YEARS AND 11 MONTHS OR GREATER.  IF THE PATIENT IS LESS THAN THIS AGE THE OCCURRENCE/LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.</li> </ul>
	IF ENROLLMENT/HEALTH PLAN CODE =	FE TFL - EXTRA <b>OR</b>
		FS TFL - STANDARD
	<b>THEN</b> PATIENT AGE <sup>1</sup> MUST BE $\geq$ 64 YEARS AND 11 MONTHS	
	<b>ELSE</b> IF PATIENT AGE <sup>1</sup> IS $<$ 64 YEARS AND 11 MONTHS	
	<b>THEN</b> ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAILED OCCURRENCE/LINE ITEM (EXCEPT LINE CONTAINING REVENUE CODE 0001) MUST =	15 PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER <b>OR</b>
		26 EXPENSES INCURRED PRIOR TO COVERAGE <b>OR</b>
		27 EXPENSES INCURRED AFTER COVERAGE TERMINATED <b>OR</b>

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

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**ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (1-110) (Continued)**

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

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

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**ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111)**

**VALIDITY EDITS**

**1-111-01V** MUST BE A VALID HCDP PLAN COVERAGE CODE LISTED IN [ADDENDUM L](#).

**1-111-02V** IF FILING DATE ≥ 09/01/2007

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

**THEN** AMOUNT ALLOWED (TOTAL) MUST = ZERO

**RELATIONAL EDITS**

<b>1-111-01R</b> IF HCDP PLAN COVERAGE CODE =	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
	402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
	405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
	406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
	407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
	408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE <b>OR</b>
	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE <b>OR</b>
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE <b>OR</b>
	412	TRS SURVIVOR NEW FAMILY COVERAGE <b>OR</b>
	413	TRS MEMBER-ONLY COVERAGE <b>OR</b>
	414	TRS MEMBER AND FAMILY COVERAGE <b>OR</b>

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**ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111) (Continued)**

		418	TRICARE RETIRED RESERVE (TRR) MEMBER-ONLY COVERAGE <b>OR</b>
		419	TRR MEMBER AND FAMILY COVERAGE <b>OR</b>
		420	TRR SURVIVOR INDIVIDUAL COVERAGE <b>OR</b>
		421	TRR SURVIVOR FAMILY COVERAGE
	<b>THEN</b> ENROLLMENT/HEALTH PLAN CODE MUST =	T	TRICARE STANDARD <b>OR</b>
		V	TRICARE EXTRA <b>OR</b>
		FE	TFL - EXTRA <b>OR</b>
		FS	TFL - STANDARD <b>OR</b>
		PS	TSRX <b>OR</b>
		SR	SHCP-REFERRED CARE
<b>1-111-02R</b>	IF HCDP PLAN COVERAGE CODE =	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
		405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
		406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
		407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
		408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
		409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE <b>OR</b>
		410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE <b>OR</b>
		411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE <b>OR</b>
		412	TRS SURVIVOR NEW FAMILY COVERAGE <b>OR</b>
		413	TRS MEMBER-ONLY COVERAGE <b>OR</b>
		414	TRS MEMBER AND FAMILY COVERAGE <b>OR</b>
		418	TRR MEMBER-ONLY COVERAGE <b>OR</b>
		419	TRR MEMBER AND FAMILY COVERAGE <b>OR</b>
		420	TRR SURVIVOR INDIVIDUAL COVERAGE <b>OR</b>
		421	TRR SURVIVOR FAMILY COVERAGE
	<b>THEN NO</b> OCCURRENCE OF SPECIAL PROCESSING CODE CAN =	PF	ECHO
<b>1-111-03R</b>	IF HCDP PLAN COVERAGE CODE =	417	TCSRC
	<b>THEN</b> ENROLLMENT/HEALTH PLAN CODE MUST =	X	FOREIGN ADSM <b>OR</b>
		SR	SHCP - REFERRED CARE

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**ELEMENT NAME: REGION INDICATOR (1-112)**

**VALIDITY EDITS**

<b>1-112-01V</b>	MUST BE VALID REGION INDICATOR (REFER TO <a href="#">SECTION 2.8</a> ).		
<b>1-112-02V</b>	IF TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	<b>AND</b> REGION INDICATOR =	NC	NORTH CONTRACT <b>OR</b>
		OC	OVERSEAS CONTRACT
		SC	SOUTH CONTRACT <b>OR</b>
		WC	WEST CONTRACT
	<b>THEN</b> ADJUSTMENT KEY MUST =	0	BATCH <b>OR</b>
		5	VOUCHER

**RELATIONAL EDITS**

NONE

**ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (1-115)**

**VALIDITY EDITS**

<b>1-115-01V</b>	MUST BE A VALID FOUR DIGIT PCM LOCATION DMIS-ID.		
<b>1-115-03V</b>	IF FILING DATE ≥ 09/01/2007		
	<b>AND</b> PCM LOCATION DMIS-ID =	0190	JOHNS HOPKINS MEDICAL SERVICES CORPORATION <b>OR</b>
		0191	BRIGHTON MARINE <b>OR</b>
		0192	CHRISTUS HEALTH/ST JOHN'S <b>OR</b>
		0193	ST VINCENTS CATHOLIC MEDICAL CENTERS OF NY <b>OR</b>
		0194	PACIFIC MEDICAL CLINICS <b>OR</b>
		0196	CHRISTUS HEALTH/ST JOSEPH'S <b>OR</b>
		0197	CHRISTUS HEALTH/ST MARY'S <b>OR</b>
		0198	MARTIN'S POINT HEALTH CARE <b>OR</b>
		0199	FAIRVIEW HEALTH SYSTEM
	<b>THEN</b> AMOUNT ALLOWED (TOTAL) MUST = ZERO		

**RELATIONAL EDITS**

NONE

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**ELEMENT NAME: AMOUNT BILLED (TOTAL) (1-120)**

**VALIDITY EDITS**

**1-120-01V** MUST BE NUMERIC.

**RELATIONAL EDITS**

**1-120-01R** IF TYPE OF SUBMISSION =

A ADJUSTMENT **OR**

C COMPLETE CANCELLATION **OR**

D COMPLETE DENIAL **OR**

I INITIAL SUBMISSION **OR**

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

R RESUBMISSION

**THEN** AMOUNT BILLED (TOTAL) MUST BE > ZERO

**UNLESS** ANY OCCURRENCE/LINE ITEM REVENUE CODE = 0022 **OR** 0023

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

**1-120-02R** AMOUNT BILLED (TOTAL) MUST = TOTAL CHARGE BY REVENUE CODE FOR REVENUE CODE 0001

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<b>ELEMENT NAME: AMOUNT ALLOWED (TOTAL) (1-125)</b>		
<b>VALIDITY EDITS</b>		
<b>1-125-01V</b>	MUST BE NUMERIC.	
<b>RELATIONAL EDITS</b>		
<b>1-125-01R</b>	IF TYPE OF SUBMISSION =	C COMPLETE CANCELLATION <b>OR</b> D COMPLETE DENIAL
	<b>THEN</b> AMOUNT ALLOWED (TOTAL) MUST = ZERO	
	<b>AND</b> ALL OCCURRENCES/LINE ITEMS (EXCLUDING REVENUE CODE 0001) MUST CONTAIN A DENIAL CODE LISTED IN <a href="#">FIGURE 2.G-1</a> <b>OR</b> <a href="#">FIGURE 2.G-2</a>	
<b>1-125-02R</b>	IF ALL DETAIL ADJUSTMENT/DENIAL REASON CODES CONTAIN A DENIAL CODE (REFER TO <a href="#">FIGURE 2.G-1</a> <b>OR</b> <a href="#">FIGURE 2.G-2</a> )	
	<b>AND</b> TYPE OF SUBMISSION =	B ADJUSTMENT NON-TED RECORD (HCSR) DATA <b>OR</b> E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	<b>THEN</b> AMOUNT ALLOWED (TOTAL) MUST BE ≤ ZERO	
<b>1-125-03R</b>	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
	<b>THEN</b> AMOUNT ALLOWED (TOTAL) MUST BE > ZERO	
	UNLESS ALL OCCURRENCES/LINE ITEMS (EXCLUDING REVENUE CODE 0001) CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN <a href="#">FIGURE 2.G-1</a> <b>OR</b> <a href="#">FIGURE 2.G-2</a>	
	<b>AND</b> THE TED RECORD CORRECTION INDICATOR =	1 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD <b>OR</b> 3 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT BOTH EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD AND TO CORRECT CLAIM PROCESSING ERRORS OR UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION
<b>1-125-04R</b>	IF AMOUNT ALLOWED (TOTAL) = ZERO	
	<b>THEN</b> AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST = ZERO	
	<b>UNLESS</b> TYPE OF SUBMISSION =	B ADJUSTMENT NON-TED RECORD (HCSR) DATA <b>OR</b> E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

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<b>ELEMENT NAME: AMOUNT PAID BY OTHER HEALTH INSURANCE (1-130)</b>	
<b>VALIDITY EDITS</b>	
<b>1-130-01V</b>	MUST BE NUMERIC.
<b>RELATIONAL EDITS</b>	
<b>1-130-01R</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> AMOUNT OF OTHER HEALTH INSURANCE MUST BE $\geq$ ZERO
<b>1-130-03R</b>	IF AMOUNT PAID BY OTHER HEALTH INSURANCE > ZERO
	<b>AND</b> AMOUNT ALLOWED (TOTAL) > ZERO
	<b>AND</b> AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) = ZERO
	<b>AND</b> DATE ADJUSTMENT IDENTIFIER = ZEROES
	<b>THEN</b> TYPE OF SUBMISSION MUST = O ZERO PAYMENT TED RECORD DUE TO 100% OHI
	<b>UNLESS</b> THE AMOUNT PATIENT COST-SHARE = THE AMOUNT ALLOWED (TOTAL) <b>OR</b> THE TED RECORD CORRECTION INDICATOR $\neq$ BLANK

<b>ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) TYPE CODE (1-131)</b>	
<b>VALIDITY EDITS</b>	
<b>1-131-01V</b>	MUST BE A VALID OGP TYPE CODE LISTING IN <a href="#">SECTION 2.6</a> .
<b>RELATIONAL EDITS</b>	
<b>1-131-01R</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

<b>ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) BEGIN REASON CODE (1-132)</b>	
<b>VALIDITY EDITS</b>	
<b>1-132-01V</b>	MUST BE A VALID OGP BEGIN REASON CODE LISTING IN <a href="#">SECTION 2.6</a> .
<b>RELATIONAL EDITS</b>	
	NONE

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<b>ELEMENT NAME: AMOUNT PATIENT COST-SHARE (1-135)</b>	
<b>VALIDITY EDITS</b>	
<b>1-135-01V</b>	MUST BE NUMERIC.
<b>RELATIONAL EDITS</b>	
<b>1-135-01R</b>	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
	<b>THEN</b> AMOUNT PATIENT COST-SHARE MUST BE $\geq$ ZERO
<b>1-135-02R</b>	IF TYPE OF SUBMISSION =
	C COMPLETE CANCELLATION <b>OR</b>
	D COMPLETE DENIAL
	<b>THEN</b> AMOUNT PATIENT COST-SHARE MUST BE = ZERO

<b>ELEMENT NAME: HEALTH CARE COVERAGE (HCC) COPAYMENT FACTOR CODE (1-136)</b>	
<b>VALIDITY EDITS</b>	
<b>1-136-01V</b>	MUST BE A VALID HCC COPAYMENT FACTOR CODE LISTING IN <a href="#">SECTION 2.5</a> .
<b>RELATIONAL EDITS</b>	
	NONE

<b>ELEMENT NAME: AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) (1-140)</b>	
<b>VALIDITY EDITS</b>	
<b>1-140-01V</b>	MUST BE NUMERIC.
<b>RELATIONAL EDITS</b>	
<b>1-140-01R</b>	IF TYPE OF SUBMISSION =
	A ADJUSTMENT <b>OR</b>
	I INITIAL SUBMISSION <b>OR</b>
	R RESUBMISSION
	<b>THEN</b> AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST BE $\geq$ ZERO
<b>1-140-02R</b>	IF TYPE OF SUBMISSION =
	C COMPLETE CANCELLATION <b>OR</b>
	D COMPLETE DENIAL <b>OR</b>
	O ZERO PAYMENT WITH 100% OHI/TPL
	<b>THEN</b> AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST = ZERO

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**ELEMENT NAME: AMOUNT INTEREST PAYMENT (1-145)**

**VALIDITY EDITS**

**1-145-01V** MUST BE NUMERIC.

**RELATIONAL EDITS**

<b>1-145-01R</b>	IF TYPE OF SUBMISSION =	A	ADJUSTMENT <b>OR</b>
		C	COMPLETE CANCELLATION <b>OR</b>
		I	INITIAL SUBMISSION <b>OR</b>
		O	ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>
		R	RESUBMISSION

**THEN** AMOUNT INTEREST PAYMENT MUST BE ≥ ZERO

**1-145-02R** IF AMOUNT INTEREST PAYMENT ≠ ZERO

**THEN** REASON FOR INTEREST PAYMENT MUST =

A	CLAIMS PENDED AT GOVERNMENT DIRECTION <b>OR</b>
B	CLAIMS REQUIRING GOVERNMENT INTERVENTION <b>OR</b>
C	CLAIMS REQUIRING DEVELOPMENT FOR POTENTIAL TPL <b>OR</b>
D	CLAIMS REQUIRING AN ACTION/INTERFACE WITH ANOTHER PRIME CONTRACTOR <b>OR</b>
E	CLAIMS RETAINED BY THE CONTRACTOR THAT DO NOT FALL INTO ONE OF THE ABOVE CATEGORIES

**1-145-03R** IF FILING STATE/ COUNTRY CODE = A FOREIGN COUNTRY INCLUDING PUERTO RICO (PRI)

**THEN** AMOUNT INTEREST PAYMENT MUST = ZERO

**ELEMENT NAME: REASON FOR INTEREST PAYMENT (1-150)**

**VALIDITY EDITS**

**1-150-01V** MUST BE A VALID REASON FOR INTEREST PAYMENT CODE (REFER TO [SECTION 2.8](#)).

**RELATIONAL EDITS**

<b>1-150-01R</b>	IF REASON FOR INTEREST PAYMENT =	A	CLAIMS PENDED AT GOVERNMENT DIRECTION <b>OR</b>
		B	CLAIMS REQUIRING GOVERNMENT INTERVENTION <b>OR</b>
		C	CLAIMS REQUIRING DEVELOPMENT FOR POTENTIAL TPL <b>OR</b>
		D	CLAIMS REQUIRING AN ACTION/INTERFACE WITH ANOTHER PRIME CONTRACTOR <b>OR</b>
		E	CLAIMS RETAINED BY THE CONTRACTOR THAT DO NOT FALL INTO ONE OF THE ABOVE CATEGORIES

**THEN** AMOUNT INTEREST PAYMENT MUST ≠ ZERO

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Institutional Edit Requirements (ELN 100 - 199)

**ELEMENT NAME: OVERRIDE CODE (1-160)**

**VALIDITY EDITS**

- 1-160-01V** OCCURRENCE NUMBER 1--MUST BE A VALID OVERRIDE CODE (REFER TO [SECTION 2.6](#)).
- 1-160-02V** OCCURRENCE NUMBER 2--MUST BE A VALID OVERRIDE CODE (REFER TO [SECTION 2.6](#)).
- 1-160-03V** OCCURRENCE NUMBER 3--MUST BE A VALID OVERRIDE CODE (REFER TO [SECTION 2.6](#)).
- 1-160-04V** A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).
- 1-160-05V** OVERRIDE CODE OCCURRENCES MUST BE LEFT JUSTIFIED.

**RELATIONAL EDITS**

<b>1-160-13R</b>	IF ANY OCCURRENCE OF OVERRIDE CODE =	NC	NON-CERTIFIED PROVIDER (DOES NOT INCLUDE SANCTIONED/SUSPENDED PROVIDERS)
	<b>THEN</b> ANY OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AD	FOREIGN ACTIVE DUTY CLAIMS <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>
		EU	EMERGENCY SERVICES RENDERED BY AN UNAUTHORIZED PROVIDER <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 MUST =	SN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
		SR	SHCP - REFERRED CARE

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Institutional Edit Requirements (ELN 100 - 199)

<b>ELEMENT NAME: TYPE OF SUBMISSION (1-165)</b>	
<b>VALIDITY EDITS</b>	
<b>1-165-01V</b>	VALUE MUST BE A VALID TYPE OF SUBMISSION.
<b>1-165-02V</b>	IF TYPE OF SUBMISSION =
	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	<b>THEN</b> ADJUSTMENT KEY CANNOT =
	0 BATCH <b>OR</b>
	5 VOUCHER
<b>1-165-03V</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> MATCH MUST BE FOUND ON THE TMA DATABASE
	<b>AND</b> TYPE OF SUBMISSION ON THE EXISTING TMA DATABASE RECORD ≠
	C COMPLETE CANCELLATION <b>OR</b>
	D COMPLETE DENIAL <b>OR</b>
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	UNLESS THE RECORD HAS PROVISIONAL ERRORS
<b>1-165-04V</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
	<b>THEN</b> A TED RECORD MUST NOT BE PRESENT ON THE DATABASE WITH THE SAME TRI.
<b>1-165-06V</b>	IF TYPE OF SUBMISSION =
	A ADJUSTMENT <b>OR</b>
	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>
	C COMPLETE CANCELLATION TO TED RECORD DATA <b>OR</b>
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	<b>AND</b> CONTRACT NUMBER =
	MDA906-02-C-0013 (TMOP) <b>OR</b>
	MDA906-03-C-0009 (WEST) <b>OR</b>
	MDA906-03-C-0010 (SOUTH) <b>OR</b>
	MDA906-03-C-0011 (NORTH) <b>OR</b>
	MDA906-03-C-0015 (TDEFIC) <b>OR</b>
	MDA906-03-C-0019 (TRRx)
	<b>THEN</b> TED RECORD CORRECTION INDICATOR MUST =
	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) <b>SOLELY TO CORRECT CLAIM PROCESSING ERRORS OR TO UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION OR</b>

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**ELEMENT NAME: TYPE OF SUBMISSION (1-165) (Continued)**

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

**RELATIONAL EDITS**

**1-165-01R** IF TYPE OF SUBMISSION = O ZERO PAYMENT WITH 100% OHI/TPL

**THEN** THE AMOUNT OF OHI MUST BE > ZERO

**AND** AMOUNT ALLOWED (TOTAL) MUST BE > ZERO

**AND** AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST BE = ZERO

**1-165-02R** IF ALL OCCURRENCES/LINE ITEMS (EXCLUDING REVENUE CODE 0001) CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN [ADDENDUM G, FIGURE 2.G-1](#))

**THEN** TYPE OF SUBMISSION MUST = C COMPLETE CANCELLATION **OR**

D COMPLETE DENIAL **OR**

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

**UNLESS** THE 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 EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD AND TO CORRECT CLAIM PROCESSING ERRORS OR UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION

**1-165-04R** IF BATCH/VOUCHER RESUBMISSION NUMBER = ZERO FOR THIS BATCH OR VOUCHER

**THEN** TYPE OF SUBMISSION MUST ≠ R RESUBMISSION

**1-165-05R** IF BATCH/VOUCHER RESUBMISSION NUMBER > ZERO FOR THIS BATCH OR VOUCHER

**THEN** TYPE OF SUBMISSION MUST BE ≠ I INITIAL TED RECORD SUBMISSION

**1-165-06R** IF TYPE OF SUBMISSION = I INITIAL SUBMISSION **OR**

R RESUBMISSION

**AND** TYPE OF INSTITUTION ≠ 70 HHA **OR**

71 SNF

**AND** SPECIAL PROCESSING CODE ≠ 11 HOSPICE

**THEN** AMOUNT BILLED (TOTAL), AMOUNT ALLOWED (TOTAL), COVERED DAYS, AND TOTAL CHARGE BY REVENUE CODE MUST BE > 0.

**1-165-07R** IF TYPE OF SUBMISSION = B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**

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

**THEN** BEGIN DATE OF CARE MUST BE < 10/01/2010

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**ELEMENT NAME: CA/NAS NUMBER (1-170)**

**VALIDITY EDITS**

**1-170-01V** IF BEGIN DATE OF CARE ≥ 03/28/2013

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

**ELSE** 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 ADMISSION DATE IS OLDER THAN **SIX** YEARS

**THEN** DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA

**NO ERROR** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

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

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

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

AR SHCP - REFERRED CARE **OR**

CE SHCP - CCEP **OR**

PF ECHO **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 **OR**

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

SE SHCP - TRICARE ELIGIBLE **OR**

SM SHCP - EMERGENCY **OR**

ST SPECIALIZED TREATMENT **OR**

WR MENTAL HEALTH WRAP AROUND

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

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

W TPR ADSM - USA **OR**

X FOREIGN ADSM **OR**

Y CHCBP - STANDARD **OR**

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

AA CHCBP - EXTRA **OR**

BB TSP **OR**

FE TFL - EXTRA **OR**

FS TFL - STANDARD **OR**

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

<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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<b>ELEMENT NAME: CA/NAS NUMBER (1-170) (Continued)</b>			
		SR	SHCP - REFERRED CARE <b>OR</b>
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	<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>AND</b> BEGIN DATE OF CARE IS < 03/28/2013		
	<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		

<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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**ELEMENT NAME: CA/NAS NUMBER (1-170) (Continued)**

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

**VALIDITY EDITS**

**1-175-01V** **IF** BEGIN DATE OF CARE  $\geq$  03/28/2013

**THEN** CA/NAS REASON FOR ISSUANCE MUST BE BLANK

**ELSE** VALUE MUST BE A VALID CA/NAS REASON OF ISSUANCE **OR** BLANK.

**RELATIONAL EDITS**

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

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

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

**VALIDITY EDITS**

**1-180-01V** IF BEGIN DATE OF CARE ≥ 03/28/2013

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

**ELSE** VALUE MUST BE A VALID CA/NAS EXCEPTION REASON CODE OR BLANK (REFER TO SECTION 2.4).

**RELATIONAL EDITS**

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

**THEN** BYPASS ALL CA/NAS EXCEPTION REASON EDITING.

**NO ERROR** IF ADMISSION DATE IS OLDER THAN SIX YEARS

**THEN** DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA

**NO ERROR** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

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

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

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

AR SHCP - REFERRED CARE **OR**

CE SHCP - CCEP **OR**

PF ECHO **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 **OR**

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

SE SHCP - TRICARE ELIGIBLE **OR**

SM SHCP - EMERGENCY **OR**

ST SPECIALIZED TREATMENT **OR**

WR MENTAL HEALTH WRAP AROUND

**THEN** BYPASS ALL CA/NAS EXCEPTION REASON EDITING

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

W TPR ADSM - USA **OR**

X FOREIGN ADSM **OR**

Y CHCBP - STANDARD **OR**

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

AA CHCBP - EXTRA **OR**

BB TSP **OR**

FE TFL - EXTRA **OR**

FS TFL - STANDARD **OR**

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

SR SHCP - REFERRED CARE **OR**

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

	WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
<b>THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING</b>		
<b>NO ERROR</b>	IF HCC MEMBER CATEGORY CODE =	T FOREIGN MILITARY MEMBER
<b>THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING</b>		
<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 BYPASS ALL CA/NAS EXCEPTION REASON EDITING</b>		
<b>NO ERROR</b>	IF AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO	
<b>THEN NO CA/NAS IS REQUIRED -- BYPASS ALL CA/NAS EXCEPTION REASON EDITING.</b>		
<b>1-180-03R</b>	IF PATIENT ZIP CODE IS IN AN MTF <sup>2</sup> CATCHMENT AREA <sup>1</sup>	
	<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> CA/NAS NUMBER IS <b>NOT</b> CODED	
	<b>AND</b> BEGIN DATE OF CARE IS < 03/28/2013	
<b>THEN CA/NAS EXCEPTION REASON MUST BE CODED</b>		
<b>1-180-07R</b>	IF CA/NAS EXCEPTION REASON =	5 RTC
	<b>AND</b> PATIENT ZIP CODE IS IN AN MTF <sup>2</sup> CATCHMENT AREA <sup>1</sup>	
	<b>THEN</b> TYPE OF INSTITUTION =	72 RTC
<b>1-180-08R</b>	IF CA/NAS EXCEPTION REASON =	S HHA PPS
	<b>THEN</b> TYPE OF INSTITUTION MUST =	70 HHA

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

**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 100 - 199)

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

**VALIDITY EDITS**

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

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

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

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

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

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

**1-185-07V** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = AN SHCP - NON-MTF-REFERRED CARE **OR**

AR SHCP - REFERRED CARE

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

**1-185-08V** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = GF TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADSM

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

**1-185-10V** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = MN TSP - NON-NETWORK **OR**

MS TSP - NETWORK

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

**1-185-11V** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = SN TSS - NON-NETWORK **OR**

SS TSS - NETWORK

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

**1-185-14V** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = ST SPECIALIZED TREATMENT

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

**RELATIONAL EDITS**

**1-185-08R** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = PO TRICARE PRIME - POS

**THEN** ENROLLMENT/HEALTH PLAN CODE MUST = U TRICARE PRIME (CIVILIAN PCM) **OR**

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

WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM **OR**

XF FOREIGN ADFM

**1-185-14R** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = AN SHCP - NON-MTF-REFERRED CARE **OR**

AR SHCP - REFERRED CARE **OR**

CE SHCP - CCEP **OR**

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

SE SHCP - TRICARE ELIGIBLE **OR**

SM SHCP - EMERGENCY

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

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

<b>THEN</b> ENROLLMENT/HEALTH PLAN CODE MUST =	SR	SHCP - REFERRED CARE <b>OR</b>
	SN	SHCP - NON-MTF REFERRED CARE <b>OR</b>
	SO	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
	ST	SHCP - TRICARE ELIGIBLE
<b>1-185-32R</b> IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	E	HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP)
<b>THEN</b> BEGIN DATE OF CARE IS ≥ 03/15/1999		
<b>AND</b> AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	CM	ICMP
<b>1-185-34R</b> • TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001. IF BEGIN DATE OF CARE IS < 10/01/2001, THE LINE ITEMS MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.		
IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	FF	TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) <b>OR</b>
	FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b>
	FS	TFL (SECOND PAYOR)
<b>AND</b> TYPE OF INSTITUTION ≠	10	GENERAL MEDICAL AND SURGICAL
<b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 10/01/2001		
<b>AND</b> ENROLLMENT/HEALTH PLAN CODE MUST =	FE	TFL - EXTRA <b>OR</b>
	FS	TFL - STANDARD
<b>ELSE</b> IF BEGIN DATE OF CARE IS < 10/01/2001		
<b>THEN</b> ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAILED LINE ITEM (EXCEPT LINE CONTAINING REVENUE CODE 0001) MUST =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER <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>

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

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

	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>1-185-35R</b>		<ul style="list-style-type: none"> <li>TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001 <b>UNLESS</b> THE BENEFICIARY IS AN INPATIENT AND THE ADMISSION DATE WAS PRIOR TO 10/01/2001, TFL WILL PAY FOR THE ENTIRE HOSPITAL STAY.</li> </ul>
IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	FF	TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) <b>OR</b>
	FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, I.E., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b>
	FS	TFL (SECOND PAYOR)
<b>AND</b> TYPE OF INSTITUTION =	10	GENERAL MEDICAL AND SURGICAL
<b>THEN</b> END DATE OF CARE MUST BE ≥ 10/01/2001		
<b>AND</b> ENROLLMENT/HEALTH PLAN CODE MUST =	FE	TFL - EXTRA <b>OR</b>
	FS	TFL - STANDARD
<b>1-185-39R</b>		IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	PF	ECHO
<b>THEN</b> HCDP PLAN COVERAGE CODE MUST ≠	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
	402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
	402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
	405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
	406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
	407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
	408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE <b>OR</b>
	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE <b>OR</b>
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE <b>OR</b>
	412	TRS SURVIVOR NEW FAMILY COVERAGE <b>OR</b>
	413	TRS MEMBER-ONLY COVERAGE <b>OR</b>
	414	TRS MEMBER AND FAMILY COVERAGE <b>OR</b>

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

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

	418	TRR MEMBER-ONLY COVERAGE <b>OR</b>
	419	TRR MEMBER AND FAMILY COVERAGE <b>OR</b>
	420	TRR SURVIVOR INDIVIDUAL COVERAGE <b>OR</b>
	421	TRR SURVIVOR FAMILY COVERAGE
<b>1-185-49R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	
	AU	AUTISM DEMONSTRATION
	<b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 03/15/2008	
	<b>AND</b> AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	
	PF	ECHO
	<b>AND</b> PATIENT AGE <sup>1</sup> MUST BE ≥ 18 MONTHS	
<b>1-185-50R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	
	49	HOSPITAL REIMBURSEMENT REDUCED BY MANUFACTURER CREDIT/REPLACEMENT OF DEVICE DURING WARRANTY PERIOD <b>OR</b>
	50	HOSPITAL REIMBURSEMENT REDUCED BY MANUFACTURER CREDIT/RECALLED DEVICE
	<b>THEN</b> DRG NUMBER MUST EQUAL A DRG SUBJECT TO THE REPLACEMENT DEVICE POLICY POSTED ON TRICARE'S DRG WEB PAGE AT <a href="http://www.tricare.mil/drgrates/">HTTP://WWW.TRICARE.MIL/DRGRATES/</a> .	
	<b>AND IF</b> END DATE OF CARE < 10/01/2014	
	<b>THEN</b> DATE OF ADMISSION MUST BE ≥ THE DRG EFFECTIVE DATE AND ≤ THE DRG TERMINATION DATE AS PER THE REPLACEMENT DEVICE POLICY POSTED ON TRICARE'S DRG WEB PAGE AT <a href="http://www.tricare.mil/drgrates/">HTTP://WWW.TRICARE.MIL/DRGRATES/</a> .	
	<b>ELSE</b> END DATE OF CARE MUST BE ≥ THE DRG EFFECTIVE DATE AND ≤ THE DRG TERMINATION DATE	
<b>1-185-51R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	
	PH	PHILIPPINES DEMONSTRATION PROJECT
	<b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 01/01/2013	
	<b>AND</b> HCDP PLAN COVERAGE CODE MUST =	
	003	TRICARE STANDARD FOR ADFMS <b>OR</b>
	005	TRICARE STANDARD SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b>
	007	TRICARE STANDARD TRANSITIONAL ASSISTANCE SPONSORS AND FAMILY MEMBERS <b>OR</b>
	009	TRICARE STANDARD RETIRED AND MOH SPONSORS AND FAMILY MEMBERS <b>OR</b>
	010	TRICARE STANDARD TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b>
	015	TRICARE STANDARD TRANSITIONAL SURVIVORS OF NG/RESERVE DECEASED SPONSORS <b>OR</b>
	017	TRICARE STANDARD SURVIVORS OF NG/RESERVE DECEASED SPONSORS <b>OR</b>
	018	TFL RETIRED SPONSORS AND FAMILY MEMBERS AND MOH <b>OR</b>
	020	TFL TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b>

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

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

021	TFL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b>
022	TFL TRANSITIONAL SURVIVORS OF NG/RESERVE DECEASED SPONSORS <b>OR</b>
023	TFL SURVIVORS OF NG/RESERVE DECEASED SPONSORS <b>OR</b>
028	TRICARE STANDARD FOR MEDICALLY RETIRED SPONSORS AND FAMILY MEMBERS <b>OR</b>
029	TFL FOR MEDICALLY RETIRED SPONSORS AND FAMILY MEMBERS <b>OR</b>
409	TRS SURVIVOR CONTINUING INDIVIDUAL COVERAGE <b>OR</b>
410	TRS SURVIVOR CONTINUING FAMILY COVERAGE <b>OR</b>
411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE <b>OR</b>
412	TRS SURVIVOR NEW FAMILY COVERAGE <b>OR</b>
413	TRS MEMBER-ONLY COVERAGE <b>OR</b>
414	TRS MEMBER AND FAMILY COVERAGE <b>OR</b>
418	TRR MEMBER-ONLY COVERAGE <b>OR</b>
419	TRR MEMBER AND FAMILY COVERAGE <b>OR</b>
420	TRR SURVIVOR INDIVIDUAL COVERAGE <b>OR</b>
421	TRR SURVIVOR FAMILY COVERAGE <b>OR</b>
422	TYA STANDARD FOR ADFMS <b>OR</b>
423	TYA STANDARD FOR RETIRED AND MOH FAMILY MEMBERS <b>OR</b>
424	TYA RESERVE SELECT <b>OR</b>
425	TYA RETIRED RESERVE <b>OR</b>
999	UNVERIFIED NEWBORN
<b>AND PATIENT ZIP CODE MUST =</b>	PHL PHILIPPINES
<b>AND PROVIDER STATE OR COUNTRY CODE MUST =</b>	PHL PHILIPPINES

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

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

**VALIDITY EDITS**

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

**RELATIONAL EDITS**

NONE

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Institutional Edit Requirements (ELN 100 - 199)

**ELEMENT NAME: PRICING RATE CODE (1-190)**

**VALIDITY EDITS**

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

**RELATIONAL EDITS**

<b>1-190-01R</b>	IF FILING STATE/COUNTRY CODE =	MD	MARYLAND
	<b>THEN</b> PRICING RATE CODE MUST ≠	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER <b>OR</b>
		I	TRICARE DRG REIMBURSEMENT WITH COST OUTLIER <b>OR</b>
		J	TRICARE DRG REIMBURSEMENT WITH NO OUTLIER <b>OR</b>
		DD	DISCOUNTED DRG
<b>1-190-02R</b>	IF DRG NUMBER IS CODED (OTHER THAN ZERO)		
	<b>THEN</b> PRICING RATE CODE MUST =	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER <b>OR</b>
		I	TRICARE DRG REIMBURSEMENT WITH COST OUTLIER <b>OR</b>
		J	TRICARE DRG REIMBURSEMENT WITH NO OUTLIER <b>OR</b>
		U	SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS <b>OR</b>
		V	MEDICARE REIMBURSEMENT RATE <b>OR</b>
		DD	DISCOUNTED DRG
<b>1-190-03R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	11	HOSPICE
	<b>THEN</b> PRICING RATE CODE MUST =	D	DISCOUNT RATE AGREEMENT <b>OR</b>
		P	PER DIEM RATE AGREEMENT <b>OR</b>
		U	SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS <b>OR</b>
		V	MEDICARE REIMBURSEMENT RATE
	<b>UNLESS</b> TYPE OF SUBMISSION =	D	COMPLETE DENIAL
	<b>OR</b> AMOUNT ALLOWED (TOTAL) = ZERO		
<b>1-190-04R</b>	IF PRICING RATE CODE =	V	MEDICARE REIMBURSEMENT RATE
	<b>THEN</b> AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) <b>AND</b> EARLIEST 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>OR</b> TYPE OF INSTITUTION =	70	HHA <b>OR</b>
		76	SNF
<b>1-190-05R</b>	IF PRICING RATE CODE =	U	SHCP CLAIM OR ACTIVE DUTY MEMBER TPR CLAIM PAID OUTSIDE NORMAL LIMITS
	<b>THEN</b> AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>

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<b>ELEMENT NAME: PRICING RATE CODE (1-190) (Continued)</b>			
		AR	SHCP - REFERRED CARE <b>OR</b>
		CE	SHCP - CCEP <b>OR</b>
		GU	ADSM ENROLLED IN TPR <b>OR</b>
		SC	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
		SE	SHCP - TRICARE ELIGIBLE <b>OR</b>
		SM	SHCP - EMERGENCY
	<b>OR</b> ENROLLMENT/HEALTH PLAN CODE MUST =	SN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
		SR	SHCP - REFERRED CARE
<b>1-190-06R</b>	IF ANY OCCURRENCE OF REVENUE CODE =	0022	SNF - PPS
	<b>THEN</b> PRICING RATE CODE MUST =	D	DISCOUNT RATE AGREEMENT <b>OR</b>
		V	MEDICARE REIMBURSEMENT RATE
	<b>UNLESS</b> AMOUNT ALLOWED (TOTAL) = ZERO		
<b>1-190-07R</b>	IF ANY OCCURRENCE OF REVENUE CODE =	0023	HHA PPS
	<b>THEN</b> PRICING RATE CODE MUST =	D	DISCOUNT RATE AGREEMENT <b>OR</b>
		V	MEDICARE REIMBURSEMENT RATE
	<b>UNLESS</b> AMOUNT ALLOWED (TOTAL) = ZERO		
<b>1-190-08R</b>	IF PRICING RATE CODE =	CA	CAH REIMBURSEMENT
	<b>THEN</b> ADMISSION DATE MUST BE ≥ 12/01/2009		
	<b>UNLESS</b> PROVIDER STATE OR COUNTRY CODE =	AK	ALASKA
	<b>THEN</b> ADMISSION DATE MUST BE ≥ 07/01/2007		
<b>1-190-09R</b>	IF PRICING RATE CODE =	CR	CCR
	<b>THEN</b> ADMISSION DATE MUST BE ≥ 01/01/2014.		
<b>1-190-10R</b>	IF PRICING RATE CODE =	CA	CAH REIMBURSEMENT
	<b>AND</b> ADMISSION DATE ≥ 01/01/2014.		
	<b>THEN</b> TYPE OF INSTITUTION MUST =	93	CAH

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

**VALIDITY EDITS**

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

**RELATIONAL EDITS**

**1-195-01R** PROVIDER STATE/COUNTRY CODE MUST MATCH THE CORRESPONDING RECORD<sup>1</sup> IN THE PROVIDER FILE.

**UNLESS** AMOUNT ALLOWED (TOTAL) ≤ ZERO

**OR** ADJUSTMENT/DENIAL REASON  
CODE =

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

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

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

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

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

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

FS TFL (SECOND PAYOR) **OR**

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

**THEN** DO NOT CHECK FOR MATCH ON PROVIDER FILE

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

- END -

