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**CHANGE 67
7950.2-M
SEPTEMBER 22, 2014**

**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: UPDATE INTERNATIONAL CLASSIFICATION OF DISEASES-10 COMPLIANCE DATE

CONREQ: 16287

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change updates current ICD-10 language to comply with the Protecting Access to Medicare Act of 2014 (H.R. 4302), which precludes International Classification of Diseases, 10th Revision (ICD-10) code sets from being adopted by the Department of Health and Human Services (HHS) prior to 1 October 2015.

EFFECTIVE DATE: September 3, 2014.

IMPLEMENTATION DATE: October 1, 2015.

This change is made in conjunction with Feb 2008 TOM, Change No. 129, Feb 2008 TPM, Change No. 117, and Feb 2008 TRM, Change No. 103.

**JACOBS.KENNE
TH.C.1067162311**

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Date: 2014.09.18 11:16:45 -06'00'

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**ATTACHMENT(S): 12 PAGES
DISTRIBUTION: 7950.2-M**

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

CHANGE 67
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REMOVE PAGE(S)

CHAPTER 2

Section 1.1, pages 9 and 10

Section 2.7, pages 27 and 28

Section 5.3, pages 13 and 14

Section 6.2, pages 7 and 8

Addendum M, pages 1 through 4

INSERT PAGE(S)

Section 1.1, pages 9 and 10

Section 2.7, pages 27 and 28

Section 5.3, pages 13 and 14

Section 6.2, pages 7 and 8

Addendum M, pages 1 through 4

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

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

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

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

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

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

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

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

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

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

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

7.0 INTERIM INSTITUTIONAL PAYMENTS

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

7.2 Interim-interim and interim-final TED records (FREQUENCY CODES '3' and '4') with filing dates on or after January 1, 2011 **with the exception of interim billings reimbursed under the DRG or Home Health Agency (HHA) payment methodology** must be submitted with a unique TRI and must be submitted on batch/vouchers with HEADER TYPE INDICATOR '0' or '5'. DRG and HHA interim-interim and interim-final TED records will continue to be submitted as an adjustment using the same TRI as the initial submission.

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

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

7.5 International Classification of Diseases (ICD) version and Operation/Non-Surgical Procedure (OP/NSP) codes are determined by patient discharge date. ICD, 10th Revision, Clinical Modification, (ICD-10-CM) diagnosis and ICD-10-Procedure Coding System (ICD-10-PCS) OP/NSP codes are appropriate for claims with discharge dates on or after October 1, 2015, and ICD, 9th Revision, Clinical Modification (ICD-9-CM) and ICD-9-Procedure Coding System (ICD-9-PCS) codes are appropriate for discharge dates on or before September 30, 2015. Since the TED record does not report discharge date, end date of care will determine ICD version when patient status indicates discharged, transferred or expired (i.e., codes 01, 02, 03). Admission date will determine ICD version when the patient status indicates the patient remains hospitalized (i.e., 30).

8.0 PROCESS FOR REPORTING EXTERNAL RESOURCE SHARING ENCOUNTERS TO TMA

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

8.1 Special Processing Code

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

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 2, Section 2.7

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

DATA ELEMENT DEFINITION

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

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

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

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

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

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

POA Indicator (Position 8):

Valid POA values are:

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, 2015, and ICD-10-CM R68.89 on or after October 1, 2015.

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 2, Section 2.7

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

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 ¹98800 for all drug prescriptions and procedure code ¹99070 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>.

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 2, Section 5.3

Institutional Edit Requirements (ELN 200 - 299)

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 IF END DATE OF CARE < 10/01/2014
	THEN DATE OF ADMISSION MUST BE ≥ THE DRG EFFECTIVE DATE AND ≤ THE DRG TERMINATION DATE
	ELSE END DATE OF CARE 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

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 2, Section 5.3

Institutional Edit Requirements (ELN 200 - 299)

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 ≥ 10/01/2015		
	THEN ICD VERSION MUST BE	0	ICD-10
1-293-02R	IF END DATE OF CARE ≥ 10/01/2015		
	AND PATIENT STATUS ≠	30	STILL PATIENT
	THEN ICD VERSION MUST BE	0	ICD-10
1-293-03R	IF ADMISSION DATE < 10/01/2015		
	AND PATIENT STATUS =	30	STILL PATIENT
	THEN ICD VERSION MUST BE	9	ICD-9
1-293-04R	IF END DATE OF CARE < 10/01/2015		
	THEN ICD VERSION MUST BE	9	ICD-9

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 2, Section 6.2

Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: ICD VERSION (2-114)

VALIDITY EDITS

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

RELATIONAL EDITS

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

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

THEN END DATE OF CARE OF EACH LINE ITEM MUST BE < 10/01/2015.

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

THEN BEGIN DATE OF CARE OF EACH LINE ITEM MUST BE ON OR AFTER ≥ 10/01/2015.

TRICARE Systems Manual 7950.2-M, February 1, 2008

Chapter 2, Section 6.2

Non-Institutional Edit Requirements (ELN 100 - 199)

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

VALIDITY EDITS

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

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

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

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

AND FOR AT LEAST ONE LINE ITEM

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

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

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

RELATIONAL EDITS

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

AND PERSON SEX (PATIENT) IS MALE

THEN AT LEAST ONE OVERRIDE CODE
MUST =

G DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE

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

AND PERSON SEX (PATIENT) IS FEMALE

THEN AT LEAST ONE OVERRIDE CODE
MUST =

H DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE

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

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

AND TYPE OF SERVICE (FIRST POSITION) MUST =

A AMBULATORY SURGERY COST-SHARED AS INPATIENT (ADFM_s ONLY) **OR**

I INPATIENT **OR**

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

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

AND TYPE OF SERVICE (SECOND POSITION) MUST =

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

5 DIAGNOSTIC LABORATORY **OR**

7 ANESTHESIA

UNLESS TYPE OF SUBMISSION =

D COMPLETE DENIAL

OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

1 MEDICAID

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

PF ECHO

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

799.9 ICD-9-CM **OR**

R69 ICD-10-CM **OR**

Data Requirements - Default Values For Complete Claims Denials

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

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

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 Chapter 2, Addendum M
 Data Requirements - Default Values For Complete Claims Denials

FIGURE 2.M-1 COMMON ELEMENTS

ELEMENT NAME	DEFAULT VALUE
Adjustment Sequence Number	000
Adjustment/Denial Reason Code	N/D
Administrative CLIN	N/D
AGR Legal Authority Code	Z
Amount Interest Payment	Zeroes
Amount Network Provider Discount	Zeroes
Amount Paid By Other Health Insurance	Zeroes
Amount Patient Cost-share	Zeroes
Begin Date Of Care	N/D
CA/NAS Exception Reason	N/D
CA/NAS Number	N/D
CA/NAS Reason For Issuance	N/D
Claim Form Type/EMC Indicator	N/D
Date Adjustment Identified	N/D
Date Ted Record Processed To Completion	N/D
DEERS Identifier (Patient)	Zeroes
End Date Of Care	N/D
Enrollment/Health Plan Code	N/D
Health Care Coverage Copayment Factor Code	Z
Health Care Coverage Member Category Code	Z
Health Care Coverage Member Relationship Code	Z
Health Care Delivery Program Plan Coverage Code	000
Health Care Delivery Program Special Entitlement Code	00
Occurrence/Line Item Number	N/D
Other Government Program Begin Reason Code	W
Other Government Program Type Code	N
Override Code	N/D
Patient Identifier (DoD)	Zeroes
Patient Zip Code	N/D
Pay Grade Code (Sponsor)	00
Pay Plan Code (Sponsor)	ZZ
PCM Location DMIS-ID (Enrollment) Code	N/D
Person Birth Calendar Date (Patient)	19111111
Person Cadency Name (Patient)	Blanks
Person First Name (Patient)	Blanks
Person Identifier (Patient)	Zeroes
Person Identifier (Sponsor)	N/D
Person Identifier Type Code (Patient)	Z

* Prior to **October 1, 2015**.

** On or after **October 1, 2015**.

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 Data Requirements - Default Values For Complete Claims Denials

FIGURE 2.M-1 COMMON ELEMENTS (CONTINUED)

ELEMENT NAME	DEFAULT VALUE
Person Identifier Type Code (Sponsor)	Z
Person Last Name (Patient)	N/D
Person Middle Name (Patient)	Blanks
Person Sex (Patient)	Z
Pricing Rate Code	Blanks
Principal Treatment Diagnosis	7999* R69**
Provider Group NPI Number (Reserved)	Reserved
Provider Individual NPI Number (Reserved)	Reserved
Provider Network Status Indicator	N/D
Provider Participation Indicator	N/D
Provider State Or Country Code	N/D
Provider Sub-Identifier	N/D
Provider Taxpayer Number	N/D
Provider Zip Code	N/D
Reason For Interest Payment	Blanks
Record Type Indicator	N/D
Region Indicator	N/D
Secondary Treatment Diagnosis	N/D
Service Branch Classification Code (Sponsor)	Z
Special Processing Code	N/D
TED Record Indicator	N/D
Total Occurrence/Line Item Count	N/D
Type Of Submission	D

* Prior to **October 1, 2015**.

** On or after **October 1, 2015**.

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 Data Requirements - Default Values For Complete Claims Denials

FIGURE 2.M-2 INSTITUTIONAL-SPECIFIC ELEMENTS

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

* Prior to **October 1, 2015**.

** On or after **October 1, 2015**.