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TRICARE  
MANAGEMENT ACTIVITY

PCSIB

CHANGE 8  
7950.2-M  
AUGUST 6, 2009

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE SYSTEMS MANUAL (TSM)**

The TRICARE Management Activity has authorized the following addition(s)/revision(s) to 7950.2-M, issued February 2008.

**CHANGE TITLE:** ADOPTING MEDICARE'S ADJUSTMENTS FOR REPLACEMENT OF IMPLANTED DEVICES

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

**SUMMARY OF CHANGE(S):** This change follows Medicare's adjustments by reducing TRICARE payments when an implanted device is replaced. This change brings this manual up-to-date with published Change 96 to the Aug 2002 TRICARE Reimbursement Manual and Change 72 to the Aug 2002 TRICARE Systems Manual 7950.1-M (June 22, 2009).

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

This change is made in conjunction with Feb 2008 TRM, Change No. 10.



Jack Arendale  
Chief, Purchased Care Systems  
Integration Branch

**ATTACHMENT(S):** 26 PAGES  
**DISTRIBUTION:** 7950.2-M

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

**CHANGE 8**  
**7950.2-M**  
**AUGUST 6, 2009**

**REMOVE PAGE(S)**

**CHAPTER 2**

Section 2.7, pages 21 through 37

Section 2.8, pages 11 through 14

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Chapter 2, Section 2.7

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

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PLACE OF SERVICE (Continued)</b>		
<b>CODE/VALUE SPECIFICATIONS (CONTINUED)</b>	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
<b>ALGORITHM</b>	N/A	
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>		
<b>SUBORDINATE</b>	<b>GROUP</b>	
N/A	N/A	
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>		
This data element must be '19' for Mail Order Pharmacy (MOP).		

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Chapter 2, Section 2.7

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PRICING RATE CODE**

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
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
	<del>h</del> 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
	<b>NON-INSTITUTIONAL CODE</b>
	0 Pricing not applicable (denied service/supplies and allowed drugs) <sup>1</sup>
	1 Priced Manually <sup>2</sup>
	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
	F Claim Auditing Software-added procedure, priced manually

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> Code '0' for all allowed drug charges.

<sup>2</sup> 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.

**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**

<b>ELEMENT NAME: PRICING RATE CODE (Continued)</b>	
<b>CODE/VALUE SPECIFICATIONS (CONTINUED)</b>	<b>NON-INSTITUTIONAL CODE (CONTINUED)</b>
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)
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

**ALGORITHM** N/A

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> Code '0' for all allowed drug charges.

<sup>2</sup> 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](#).

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Chapter 2, Section 2.7

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PRICING RATE CODE (Continued)**

**SUBORDINATE AND/OR GROUP ELEMENTS**

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

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> Code '0' for all allowed drug charges.

<sup>2</sup> 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](#).

**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 OPERATION/NON-SURGICAL PROCEDURE CODE**

<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-345	1	Yes <sup>1</sup>
<b>PRIMARY PICTURE (FORMAT)</b> Five (5) alphanumeric characters.			
<b>DEFINITION</b> The code that identifies the principal procedure performed during the period reported on the TED record as submitted on the UB-04/UB-92.			
<b>CODE/VALUE SPECIFICATIONS</b> Use the most current procedure code edition (ICD-9-CM) as directed by TMA. Must provide the most detailed code. Must be left justified and blank filled. Do not code the decimal point.			
<b>ALGORITHM</b> N/A			
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>			<b>GROUP</b>
N/A			N/A
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
<sup>1</sup> Required if one of the following Revenue Codes are present 036X or 072X.			

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Chapter 2, Section 2.7

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS**

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

**PRIMARY PICTURE (FORMAT)** Six (6) alphanumeric characters.

**DEFINITION** 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.

**CODE/VALUE SPECIFICATIONS** Use the most current diagnosis code edition (ICD-9-CM), as directed by TMA. Must provide the most detailed code. Left justify and blank fill. Do not code the decimal point.

**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 799.89.

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

**NOTES AND SPECIAL INSTRUCTIONS:**

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

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

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

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

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Chapter 2, Section 2.7

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PROCEDURE CODE MODIFIER**

<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Non-Institutional	2-165	4/Up to 99	No
<b>PRIMARY PICTURE (FORMAT)</b> Four (4) occurrences of two (2) alphanumeric characters per occurrence/line item.			
<b>DEFINITION</b> Two digit code which provides the means by which the health care professional can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. (Refer to Physician's Current Procedure Terminology, 4th Edition <sup>1</sup> (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) National Level II Medicare Codes.)			
<b>CODE/VALUE SPECIFICATIONS</b> Must be 21-27, 32, 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-4O, 4Z, 5A-5O, 5Z, 6A-6F, 6Z, 7A-7F, 7Z, 8A-8C, 8P, 8Z, 9A-9D, 9L-9Q, 9Z, A1-A9, AA, AD-AH, AJ, AK, AM, AP-AX, BA, BL, BO-BR, BU, CA-CG, CR, 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-GT, GV-GZ, H9, HA-HZ, ID, IE, IG-IJ, IN, IR, IS, IX, J1-J3, JA-JE, JG-JJ, JN, JP, JR, JS, JW, JX, K0-K4, KA-KZ, LC, LD, LL, LR-LT, M2, MR, MS, ND, NE, NG-NJ, NN, NP, NR-NU, NX, P1-P6, PA-PE, PG, PI, PJ, PL, PN, PP, PR, PS, 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, VP, XD, XE, XG-XJ, XN, XR, XS, or blank.			
<b>ALGORITHM</b> N/A			
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>		<b>GROUP</b>	
N/A		N/A	

**NOTES AND SPECIAL INSTRUCTIONS:**

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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.

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PROCESSING INFORMATION**

		RECORDS/LOCATOR NUMBERS		
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED	
Institutional	1-155	1	Yes	
<b>PRIMARY PICTURE (FORMAT)</b> Group				
<b>DEFINITION</b>		Field containing multiple elements that describe processing related to the TED record.		
<b>CODE/VALUE SPECIFICATIONS</b>		N/A		
<b>ALGORITHM</b>		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

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PROVIDER INDIVIDUAL NPI NUMBER (TYPE 1)**

<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Non-Institutional	2-225	Up to 99	Yes <sup>1</sup>
<b>PRIMARY PICTURE (FORMAT)</b> Ten (10) alphanumeric characters.			
<b>DEFINITION</b> 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.			
<b>CODE/VALUE SPECIFICATIONS</b> N/A			
<b>ALGORITHM</b> N/A			
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>		<b>GROUP</b>	
N/A		N/A	

**NOTES AND SPECIAL INSTRUCTIONS:**

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

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Chapter 2, Section 2.7

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PROVIDER NETWORK STATUS INDICATOR**

<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-230	1	Yes
Non-Institutional	2-265	Up to 99	Yes
<b>PRIMARY PICTURE (FORMAT)</b> One (1) alphanumeric character.			
<b>DEFINITION</b> Code indicating whether the provider is a network or non-network provider.			
<b>CODE/VALUE SPECIFICATIONS</b>			
	1	Network Provider	
	2	Non-Network Provider	
<b>ALGORITHM</b> N/A			
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>			<b>GROUP</b>
N/A			N/A

**NOTES AND SPECIAL INSTRUCTIONS:**

This data element must be '1' for MOP.

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PROVIDER ORGANIZATIONAL NPI NUMBER (TYPE 2)**

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
Institutional	1-215	'0	Yes <sup>1</sup>
Non-Institutional	2-230	Up to 99	Yes <sup>1</sup>

**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:**

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

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Chapter 2, Section 2.7

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PROVIDER PARTICIPATION INDICATOR**

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
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.

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Chapter 2, Section 2.7

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PROVIDER TAXONOMY (SPECIALTY)**

		RECORDS/LOCATOR NUMBERS	
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-255	Up to 99	Yes
<b>PRIMARY PICTURE (FORMAT)</b> Ten (10) alphanumeric characters.			
<b>DEFINITION</b> Code describing the provider's specialty.			
<b>CODE/VALUE SPECIFICATIONS</b> Refer to <a href="http://www.wpc-edi.com/codes">http://www.wpc-edi.com/codes</a> for Provider Specialty Codes. Refer to <a href="#">Addendum C, Figure 2.C-1</a> as a reference when assigning Provider Major Specialty Codes to Outpatient Hospital Non-Institutional TED records.			
<b>ALGORITHM</b> N/A			
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		GROUP	
N/A		N/A	
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
This data element must be '183500000X' for MOP and '333600000X' for Retail Pharmacy.			

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Chapter 2, Section 2.7

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PROVIDER STATE OR COUNTRY CODE**

<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-195	1	Yes
Non-Institutional	2-235	Up to 99	Yes
<b>PRIMARY PICTURE (FORMAT)</b> Three (3) alphanumeric characters.			
<b>DEFINITION</b> 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.			
<b>CODE/VALUE SPECIFICATIONS</b> <a href="#">Addendum A</a> and <a href="#">Addendum B</a> .			
<b>ALGORITHM</b> N/A			
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>	<b>GROUP</b>		
N/A	N/A		
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
N/A			

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

**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	
<b>PRIMARY PICTURE (FORMAT)</b> Four (4) alphanumeric characters.				
<b>DEFINITION</b> Identification number that uniquely identifies multiple providers using the same TIN.				
<b>CODE/VALUE SPECIFICATIONS</b> Refer to <a href="#">Section 2.10</a> , ELN 3-010.				
<b>ALGORITHM</b> N/A				
SUBORDINATE AND/OR GROUP ELEMENTS				
SUBORDINATE		GROUP		
N/A		N/A		
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>				
N/A				

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PROVIDER TAXPAYER NUMBER**

RECORD NAME	RECORDS/LOCATOR NUMBERS		REQUIRED
	LOCATOR#	OCCURRENCES	
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.

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Chapter 2, Section 2.7

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

**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	
<b>PRIMARY PICTURE (FORMAT)</b>		Nine (9) alphanumeric characters.		
<b>DEFINITION</b>		Location of provider's business office where care is usually provided.		
<b>CODE/VALUE SPECIFICATIONS</b>		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 <a href="#">Addendum A</a> .		
<b>ALGORITHM</b>		N/A		
SUBORDINATE AND/OR GROUP ELEMENTS				
SUBORDINATE		GROUP		
N/A		N/A		
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>				
N/A				

- END -

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Chapter 2, Section 2.8

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: SPECIAL PROCESSING CODE**

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-185	4	Yes <sup>1</sup>
Non-Institutional	2-305	4/Up to 99	Yes <sup>1</sup>
<b>PRIMARY PICTURE (FORMAT)</b> Four occurrences of two (2) alphanumeric characters per occurrence/line item for non-institutional.			
<b>DEFINITION</b> Code indicating care that requires special processing.			
<b>CODE/VALUE SPECIFICATIONS</b>			
	0	Hospice non-affiliated provider	
	1	Medicaid	
	3	Allogeneic bone marrow recipient (Wilford Hall referred only prior to 10/01/1997 and PCM/HCF referred after 12/31/2002)	
	4	Allogeneic bone marrow donor (Wilford Hall referred only prior to 10/01/1997 and PCM/HCF referred after 12/31/2002)	
	5	Liver transplant (effective for care before 03/01/1997, or between 02/20/1998 and 08/31/1999 and after 05/31/2003)	
	6	Home Health Care (HHC) (non-institutional only)	
	7	Heart Transplant	
	10	Active duty cost-share ambulatory surgery taken from professional claim	
	11	Hospice	
	12	Capitated Arrangements	
	14	Bone marrow transplants (BMTs) - TMA approved	
	16	Ambulatory Surgery Facility charge	
	17	VA medical provider claim (care rendered by a VA provider)	
	49	Hospital reimbursement reduced by manufacturer credit/replacement of device during warranty period	
	50	Hospital reimbursement reduced by manufacturer credit/recalled device	
	A	Partnership Program (internal providers with signed agreements)	
	E	HHC/CM Demonstration (After 03/15/1999, grandfathered into the Individual Case Management Program (ICMP)) <sup>2</sup>	

**NOTES AND SPECIAL INSTRUCTIONS:**

- <sup>1</sup> Required if TED record processing is applicable to special processing conditions. Can report from 0 to 4 codes, left justify and blank fill. Do not duplicate. Each occurrence consists of two characters.
- <sup>2</sup> Whenever SPECIAL PROCESSING CODE = 'E' (grandfathered HHC claims) is coded, SPECIAL PROCESSING CODE 'CM' must be present.
- <sup>3</sup> Whenever SPECIAL PROCESSING CODE = 'AU' (AUTISM DEMONSTRATION) is coded, SPECIAL PROCESSING CODE 'PF' (ECHO) must be present.
- <sup>4</sup> Whenever SPECIAL PROCESSING CODE = 'RB' (Respite Benefit for Seriously Injured or Ill ADSM) is coded, SPECIAL PROCESSING CODE 'SE' (SHCP- TRICARE Eligible) must be present.

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

Chapter 2, Section 2.8

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: SPECIAL PROCESSING CODE (Continued)**

CODE/VALUE SPECIFICATIONS (CONTINUED)		
	Q	Active Duty Delayed Deductible
	R	Medicare/TRICARE Dual Entitlement First Payor - not a Medicare Benefit (Effective 10/01/2001)
	S	Resource Sharing - External
	T	Medicare/TRICARE Dual Entitlement (formally normal COB processing (Effective 10/01/2001 process as Second Payor))
	U	BRAC Medicare Pharmacy (Section 702) claim (Terminated 04/01/2001)
	V	Financially underwritten payment by contractor
	W	Non-financially underwritten payment by financially underwritten contractor
	X	Partial hospitalization - provider not contracted with or employed by the partial hospitalization program billing for psychotherapy services in a partial hospitalization program
	Y	Heart-lung transplant
	Z	Kidney transplant
	AB	Abused dependent of discharged or dismissed member (Effective 07/28/1999)
	AD	Foreign active duty claims (Effective 06/30/1996)
	AN	SHCP - Non-MTF-Referral Care (Effective 10/01/1999 through 05/31/2004)
	AR	SHCP - Referred Care (Effective 10/01/1999 through 05/31/2004)
	AU	Autism Demonstration (Effective 03/15/2008) <sup>3</sup>
	BD	Bosnia Deductible (Effective 12/08/1995)
	CA	Civil Action Payment (Effective 07/01/1999)
	CE	SHCP - CCEP (Effective 10/01/1999)
	CL	Clinical Trials Demonstration (Enrollment Effective 03/17/2003 through 03/31/2008)
	CM	ICMP claims (Effective 03/15/1999)
	CP	Cancer Clinical Trials (Enrollment Effective on or after 04/01/2008)
	CT	CCTP (Effective 12/28/2001)

**NOTES AND SPECIAL INSTRUCTIONS:**

- <sup>1</sup> Required if TED record processing is applicable to special processing conditions. Can report from 0 to 4 codes, left justify and blank fill. Do not duplicate. Each occurrence consists of two characters.
- <sup>2</sup> Whenever SPECIAL PROCESSING CODE = 'E' (grandfathered HHC claims) is coded, SPECIAL PROCESSING CODE 'CM' must be present.
- <sup>3</sup> Whenever SPECIAL PROCESSING CODE = 'AU' (AUTISM DEMONSTRATION) is coded, SPECIAL PROCESSING CODE 'PF' (ECHO) must be present.
- <sup>4</sup> Whenever SPECIAL PROCESSING CODE = 'RB' (Respite Benefit for Seriously Injured or Ill ADSM) is coded, SPECIAL PROCESSING CODE 'SE' (SHCP- TRICARE Eligible) must be present.

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

Chapter 2, Section 2.8

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: SPECIAL PROCESSING CODE (Continued)**

CODE/VALUE SPECIFICATIONS (CONTINUED)		
	EU	Emergency services rendered by an unauthorized provider (Effective 06/01/1999)
	FF	TFL (First Payor - Not A Medicare Benefit) (Effective 10/01/2001)
	FG	TFL (First Payor - No TRICARE Provider Certification, i.e., Medicare benefits have been exhausted) (Effective 10/01/2001)
	FS	TFL (Second Payor) (Effective 10/01/2001)
	GF	TPR for eligible ADFM residing with a TPR Eligible ADSM (Effective 10/30/2000 through 08/31/2002)
	GU	ADSM enrolled in TPR (Effective 10/01/1999)
	KO	Allied Forces - Kosovo (Effective 06/01/1999)
	MH	Mental Health Active Duty Cost- Share
	MN	TSP (Non-Network) (Effective 01/01/1998 through 12/31/2001)
	MS	TSP (Network) (Effective 01/01/1998 through 12/31/2001)
	NE	Operation Noble Eagle/Operation Enduring Freedom (Reservist called to Active Duty under Executive Order 13223) (Effective 09/14/2001 through 10/31/2009)
	PD	Pharmacy Redesign Pilot Program (Effective 07/01/2000 through 04/01/2001)
	PF	ECHO (formerly PFPWD)
	PO	TRICARE Prime - Point of Service
	PS	Specialty Pharmacy Service (MOP Only)
	PV	Retail Network Pharmacy Services for DVA Beneficiaries (TPharm Retail Pharmacies Only)
	RB	Respite Benefit for Seriously Injured or Ill ADSMs <sup>4</sup>
	RI	Resource Sharing - Internal
	RS	Medicare/TRICARE Dual Entitlement (First Payor - No TRICARE Provider Certification, i.e., Medicare benefits have been exhausted) (Effective 10/01/2001)
	SC	SHCP - Non-TRICARE Eligible (Effective 10/01/1999)
	SE	SHCP - TRICARE Eligible (Effective 10/01/1999)
	SM	SHCP - Emergency (Effective 10/01/1999)
	SN	TSS (Non-Network) (Effective 04/01/2000 through 12/31/2002)

**NOTES AND SPECIAL INSTRUCTIONS:**

- <sup>1</sup> Required if TED record processing is applicable to special processing conditions. Can report from 0 to 4 codes, left justify and blank fill. Do not duplicate. Each occurrence consists of two characters.
- <sup>2</sup> Whenever SPECIAL PROCESSING CODE = 'E' (grandfathered HHC claims) is coded, SPECIAL PROCESSING CODE 'CM' must be present.
- <sup>3</sup> Whenever SPECIAL PROCESSING CODE = 'AU' (AUTISM DEMONSTRATION) is coded, SPECIAL PROCESSING CODE 'PF' (ECHO) must be present.
- <sup>4</sup> Whenever SPECIAL PROCESSING CODE = 'RB' (Respite Benefit for Seriously Injured or Ill ADSM) is coded, SPECIAL PROCESSING CODE 'SE' (SHCP- TRICARE Eligible) must be present.

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

Chapter 2, Section 2.8

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

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: SPECIAL PROCESSING CODE (Continued)**

CODE/VALUE SPECIFICATIONS (CONTINUED)		
	SP	Special/Emergent Care (Effective 06/01/1999)
	SS	TSS (Network) (Effective 04/01/2000 through 12/31/2002)
	ST	Specialized Treatment (Effective 03/01/1997 through 05/31/2003)
	WR	Mental Health Wraparound Demonstration (Effective 01/01/1998 through 06/30/2001)

**ALGORITHM** N/A

**SUBORDINATE AND/OR GROUP ELEMENTS**

SUBORDINATE	GROUP
N/A	PROCESSING INFORMATION

**NOTES AND SPECIAL INSTRUCTIONS:**

- <sup>1</sup> Required if TED record processing is applicable to special processing conditions. Can report from 0 to 4 codes, left justify and blank fill. Do not duplicate. Each occurrence consists of two characters.
- <sup>2</sup> Whenever SPECIAL PROCESSING CODE = 'E' (grandfathered HHC claims) is coded, SPECIAL PROCESSING CODE 'CM' must be present.
- <sup>3</sup> Whenever SPECIAL PROCESSING CODE = 'AU' (AUTISM DEMONSTRATION) is coded, SPECIAL PROCESSING CODE 'PF' (ECHO) must be present.
- <sup>4</sup> Whenever SPECIAL PROCESSING CODE = 'RB' (Respite Benefit for Seriously Injured or Ill ADSM) is coded, SPECIAL PROCESSING CODE 'SE' (SHCP- TRICARE Eligible) must be present.

- END -

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

Chapter 2, Section 5.2

Institutional Edit Requirements (ELN 100 - 199)

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

**VALIDITY EDITS**

<b>1-185-01V</b>	OCCURRENCE NUMBER 1--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO <a href="#">SECTION 2.8</a> ).
<b>1-185-02V</b>	OCCURRENCE NUMBER 2--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO <a href="#">SECTION 2.8</a> ).
<b>1-185-03V</b>	OCCURRENCE NUMBER 3--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO <a href="#">SECTION 2.8</a> ).
<b>1-185-04V</b>	OCCURRENCE NUMBER 4--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO <a href="#">SECTION 2.8</a> ).
<b>1-185-05V</b>	A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).
<b>1-185-06V</b>	SPECIAL PROCESSING CODE OCCURRENCES MUST BE LEFT JUSTIFIED.
<b>1-185-07V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	AN SHCP - NON-MTF-REFERRED CARE <b>OR</b>
	AR SHCP - REFERRED CARE
	<b>THEN</b> BEGIN DATE OF CARE MUST BE < 06/01/2004
<b>1-185-08V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	GF TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	<b>THEN</b> BEGIN DATE OF CARE MUST BE < 09/01/2002
<b>1-185-10V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	MN TSP - NON-NETWORK <b>OR</b>
	MS TSP - NETWORK
	<b>THEN</b> BEGIN DATE OF CARE MUST BE < 12/31/2001
<b>1-185-11V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	SN TSS - NON-NETWORK <b>OR</b>
	SS TSS - NETWORK
	<b>THEN</b> BEGIN DATE OF CARE MUST BE < 12/31/2002
<b>1-185-14V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	ST SPECIALIZED TREATMENT
	<b>THEN</b> BEGIN DATE OF CARE MUST BE < 10/01/2004

**RELATIONAL EDITS**

<b>1-185-08R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PO TRICARE PRIME - <b>POS</b>
	<b>THEN</b> ENROLLMENT/HEALTH PLAN CODE MUST =	U TRICARE PRIME (CIVILIAN PCM) <b>OR</b>
		Z TRICARE PRIME, MTF/PCM <b>OR</b>
		WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM <b>OR</b>
		XF FOREIGN ADFM
<b>1-185-14R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AN SHCP - NON-MTF-REFERRED CARE <b>OR</b>
		AR SHCP - REFERRED CARE <b>OR</b>
		CE SHCP - <b>CCEP</b> <b>OR</b>
		SC SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
		SE SHCP - TRICARE ELIGIBLE <b>OR</b>
		SM SHCP - EMERGENCY

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

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Chapter 2, Section 5.2

Institutional Edit Requirements (ELN 100 - 199)

**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>	<ul style="list-style-type: none"> <li>TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001.</li> <li>IF BEGIN DATE OF CARE IS &lt; 10/01/2001, THE LINE ITEMS MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.</li> </ul>		
IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =		FF	TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) <b>OR</b>
		FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., 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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Institutional Edit Requirements (ELN 100 - 199)

**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</li> <li><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

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

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Chapter 2, Section 5.2

Institutional Edit Requirements (ELN 100 - 199)

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

**1-185-49R** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = AU AUTISM DEMONSTRATION

**THEN** BEGIN DATE OF CARE MUST BE ≥ 03/15/2008

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

**AND** PATIENT AGE<sup>1</sup> MUST BE ≥ 18 MONTHS

**1-185-50R** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = 49 HOSPITAL REIMBURSEMENT REDUCED BY MANUFACTURER CREDIT/REPLACEMENT OF DEVICE DURING WARRANTY PERIOD **OR**

50 HOSPITAL REIMBURSEMENT REDUCED BY MANUFACTURER CREDIT/RECALLED DEVICE

**THEN** DRG NUMBER MUST EQUAL A DRG SUBJECT TO THE REPLACEMENT DEVICE POLICY POSTED ON TRICARE'S DRG WEB PAGE AT [HTTP://WWW.TRICARE.MIL/DRGRATES/](http://www.tricare.mil/drgrates/).

**AND** 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 [HTTP://WWW.TRICARE.MIL/DRGRATES/](http://www.tricare.mil/drgrates/).

<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