Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: PERSON SEX (PATIENT) (1-100)			
VALIDITY EDITS			
1-100-01V	PERSON SEX (PATIENT) MUST =	F	FEMALE **OR**
		M	MALE **OR**
		Z	UNKNOWN
RELATIONAL EDITS			
	NONE		

ELEMENT NAME: PATIENT ZIP CODE (1-105)	
VALIDITY EDITS	
1-105-01V	MUST BE NINE DIGITS **OR** FIVE DIGITS WITH FOUR BLANKS
	MUST BE A VALID ZIP CODE (BASED ON ADMISSION DATE) IN THE GOVERNMENT PROVIDED ELECTRONIC ZIP CODE FILE **OR**
	MUST BE A THREE CHARACTER FOREIGN COUNTRY CODE (BASED ON THE COUNTRY CODES TABLE[1]) FOLLOWED BY SIX BLANKS
RELATIONAL EDITS	
	NONE

[1] WHEN FOREIGN COUNTRY CODES ARE SUBMITTED, THE FIRST THREE CHARACTERS WILL BE EDITED AGAINST ADDENDUM A.

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**

[1] PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.

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 **OR**
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED **OR**
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED **OR**
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE **OR**
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORN **OR**
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION **OR**
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
1-110-10R	• TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001 **UNLESS** THE BENEFICIARY IS AN INPATIENT AND THE ADMISSION DATE WAS PRIOR TO 10/01/2001, TFL WILL PAY FOR THE ENTIRE HOSPITAL STAY.		
	IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD
	AND TYPE OF INSTITUTION =	10	GENERAL MEDICAL AND SURGICAL
	THEN END DATE OF CARE ≥ 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)
1-110-11R	• 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.		
	IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD
	THEN PATIENT AGE[1] MUST BE ≥ 64 YEARS AND 11 MONTHS		
	ELSE IF PATIENT AGE[1] IS < 64 YEARS AND 11 MONTHS		
	THEN 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 **OR**
		26	EXPENSES INCURRED PRIOR TO COVERAGE **OR**
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED **OR**

[1] PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.

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 **OR**
31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED **OR**
32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED **OR**
33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE **OR**
34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS **OR**
62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION **OR**
141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE

[1] PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.

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		
	AND HCDP PLAN COVERAGE CODE =	109	TRICARE USFHP DIRECT CARE COVERAGE FOR ADFMs **OR**
		114	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		115	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		118	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR RETIRED SPONSORS AND FAMILY MEMBERS **OR**
		119	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR RETIRED SPONSORS AND FAMILY MEMBERS **OR**
		133	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		138	TRICARE USFHP DIRECT CARE INDIVUDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS **OR**
		139	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS
	THEN AMOUNT ALLOWED (TOTAL) MUST = ZERO		
RELATIONAL EDITS			
1-111-01R	IF HCDP PLAN COVERAGE CODE =	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
		406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
		407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) **OR**
		408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) **OR**
		409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE **OR**
		410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE **OR**
		411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR**
		412	TRS SURVIVOR NEW FAMILY COVERAGE **OR**
		413	TRS MEMBER-ONLY COVERAGE **OR**
		414	TRS MEMBER AND FAMILY COVERAGE **OR**

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

ELEMENT NAME: REGION INDICATOR (1-112)			
	VALIDITY EDITS		
1-112-01V	MUST BE VALID REGION INDICATOR (REFER TO SECTION 2.8).		
1-112-02V	IF TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	AND REGION INDICATOR =	NC	NORTH CONTRACT **OR**
		OC	OVERSEAS CONTRACT
		SC	SOUTH CONTRACT **OR**
		WC	WEST CONTRACT
	THEN ADJUSTMENT KEY MUST =	0	BATCH **OR**
		5	VOUCHER
	RELATIONAL EDITS		
	NONE		

ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (1-115)			
	VALIDITY EDITS		
1-115-01V	MUST BE A VALID FOUR DIGIT PCM LOCATION DMIS-ID.		
1-115-03V	IF FILING DATE ≥ 09/01/2007		
	AND PCM LOCATION DMIS-ID =	0190	JOHNS HOPKINS MEDICAL SERVICES CORPORATION **OR**
		0191	BRIGHTON MARINE **OR**
		0192	CHRISTUS HEALTH/ST JOHN'S **OR**
		0193	ST VINCENTS CATHOLIC MEDICAL CENTERS OF NY **OR**
		0194	PACIFIC MEDICAL CLINICS **OR**
		0196	CHRISTUS HEALTH/ST JOSEPH'S **OR**
		0197	CHRISTUS HEALTH/ST MARY'S **OR**
		0198	MARTIN'S POINT HEALTH CARE **OR**
		0199	FAIRVIEW HEALTH SYSTEM
	THEN AMOUNT ALLOWED (TOTAL) MUST = ZERO		
	RELATIONAL EDITS		
	NONE		

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		

ELEMENT NAME: AMOUNT ALLOWED (TOTAL) (1-125)			
	VALIDITY EDITS		
1-125-01V	MUST BE NUMERIC.		
	RELATIONAL EDITS		
1-125-01R	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL
	THEN AMOUNT ALLOWED (TOTAL) MUST = ZERO		
	AND ALL OCCURRENCES/LINE ITEMS (EXCLUDING REVENUE CODE 0001) MUST CONTAIN A DENIAL CODE LISTED IN FIGURE 2.G-1 **OR** FIGURE 2.G-2		
1-125-02R	IF ALL DETAIL ADJUSTMENT/DENIAL REASON CODES CONTAIN A DENIAL CODE (REFER TO FIGURE 2.G-1 **OR** FIGURE 2.G-2)		
	AND TYPE OF SUBMISSION =	B	ADJUSTMENT NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN AMOUNT ALLOWED (TOTAL) MUST BE ≤ ZERO		
1-125-03R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
	THEN AMOUNT ALLOWED (TOTAL) MUST BE > ZERO		
	UNLESS ALL OCCURRENCES/LINE ITEMS (EXCLUDING REVENUE CODE 0001) CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN FIGURE 2.G-1 **OR** FIGURE 2.G-2		
	AND 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
1-125-04R	IF AMOUNT ALLOWED (TOTAL) = ZERO		
	THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST = ZERO		
	UNLESS TYPE OF SUBMISSION =	B	ADJUSTMENT NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

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

ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) TYPE CODE (1-131)			
	VALIDITY EDITS		
1-131-01V	MUST BE A VALID OGP TYPE CODE LISTING IN SECTION 2.6.		
	RELATIONAL EDITS		
1-131-01R	IF OGP TYPE CODE =	V	CHAMPVA
	THEN TYPE OF SUBMISSION MUST =	C	COMPLETE CANCELLATION **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) BEGIN REASON CODE (1-132)	
VALIDITY EDITS	
1-132-01V	MUST BE A VALID OGP BEGIN REASON CODE LISTING IN SECTION 2.6.
RELATIONAL EDITS	
	NONE

ELEMENT NAME: AMOUNT PATIENT COST-SHARE (1-135)			
	VALIDITY EDITS		
1-135-01V	MUST BE NUMERIC.		
	RELATIONAL EDITS		
1-135-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
	THEN AMOUNT PATIENT COST-SHARE MUST BE ≥ ZERO		
1-135-02R	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL
	THEN AMOUNT PATIENT COST-SHARE MUST BE = ZERO		

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) COPAYMENT FACTOR CODE (1-136)	
VALIDITY EDITS	
1-136-01V	MUST BE A VALID HCC COPAYMENT FACTOR CODE LISTING IN SECTION 2.5.
RELATIONAL EDITS	
	NONE

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

ELEMENT NAME: AMOUNT INTEREST PAYMENT (1-145)			
	VALIDITY EDITS		
1-145-01V	MUST BE NUMERIC.		
	RELATIONAL EDITS		
1-145-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		C	COMPLETE CANCELLATION **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		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 **OR**
		B	CLAIMS REQUIRING GOVERNMENT INTERVENTION **OR**
		C	CLAIMS REQUIRING DEVELOPMENT FOR POTENTIAL TPL **OR**
		D	CLAIMS REQUIRING AN ACTION/INTERFACE WITH ANOTHER PRIME CONTRACTOR **OR**
		E	CLAIMS RETAINED BY THE CONTRACTOR THAT DO NOT FALL INTO ONE OF THE ABOVE CATEGORIES
1-145-04R	IF TYPE OF SUBMISSION =	D	COMPLETE DENIAL
	THEN AMOUNT INTEREST PAYMENT MUST BE = 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		
1-150-01R	IF REASON FOR INTEREST PAYMENT =	A	CLAIMS PENDED AT GOVERNMENT DIRECTION **OR**
		B	CLAIMS REQUIRING GOVERNMENT INTERVENTION **OR**
		C	CLAIMS REQUIRING DEVELOPMENT FOR POTENTIAL TPL **OR**
		D	CLAIMS REQUIRING AN ACTION/INTERFACE WITH ANOTHER PRIME CONTRACTOR **OR**
		E	CLAIMS RETAINED BY THE CONTRACTOR THAT DO NOT FALL INTO ONE OF THE ABOVE CATEGORIES
	THEN AMOUNT INTEREST PAYMENT MUST ≠ ZERO		

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	ALL OCCURRENCES OF OVERRIDE CODE MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED OVERRIDE CODE.		
	RELATIONAL EDITS		
1-160-13R	IF ANY OCCURRENCE OF OVERRIDE CODE =	NC	NON-CERTIFIED PROVIDER (DOES NOT INCLUDE SANCTIONED/SUSPENDED PROVIDERS)
	THEN ANY OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AD	FOREIGN ACTIVE DUTY CLAIMS **OR**
		AN	SHCP - NON-MTF-REFERRED CARE **OR**
		AR	SHCP - REFERRED CARE **OR**
		CE	SHCP - CCEP **OR**
		EU	EMERGENCY SERVICES RENDERED BY AN UNAUTHORIZED PROVIDER **OR**
		GU	ADSM ENROLLED IN TPR **OR**
		MN	TSP - NETWORK **OR**
		MS	TSP - NON-NETWORK **OR**
		SC	SHCP - NON-TRICARE ELIGIBLE **OR**
		SE	SHCP - TRICARE ELIGIBLE **OR**
		SM	SHCP - EMERGENCY
	OR ENROLLMENT/HEALTH PLAN CODE MUST =	SN	SHCP - NON-MTF-REFERRED CARE **OR**
		SR	SHCP - REFERRED CARE

ELEMENT NAME: TYPE OF SUBMISSION (1-165)			
	VALIDITY EDITS		
1-165-01V	VALUE MUST BE A VALID TYPE OF SUBMISSION.		
1-165-02V	IF TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN ADJUSTMENT KEY CANNOT =	0	BATCH **OR**
		5	VOUCHER
1-165-03V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		C	COMPLETE CANCELLATION **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN MATCH MUST BE FOUND ON THE TMA DATABASE		
	AND TYPE OF SUBMISSION ON THE EXISTING TMA DATABASE RECORD ≠	C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	UNLESS THE RECORD HAS PROVISIONAL ERRORS		
1-165-04V	IF TYPE OF SUBMISSION =	D	COMPLETE DENIAL **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
	THEN A TED RECORD MUST NOT BE PRESENT ON THE DATABASE WITH THE SAME TRI.		
1-165-06V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		C	COMPLETE CANCELLATION TO TED RECORD DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	AND CONTRACT NUMBER =	MDA906-02-C-0013 (TMOP) **OR**	
		MDA906-03-C-0009 (WEST) **OR**	
		MDA906-03-C-0010 (SOUTH) **OR**	
		MDA906-03-C-0011 (NORTH) **OR**	
		MDA906-03-C-0015 (TDEFIC) **OR**	
		MDA906-03-C-0019 (TRRx)	
	THEN TED RECORD CORRECTION INDICATOR MUST =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) **SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR**
		2	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT CLAIM PROCESSING ERRORS OR TO UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION **OR**

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		

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**

[1] CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.
[2] MTF IS A 40 MILES CATCHMENT AREA.

ELEMENT NAME: CA/NAS NUMBER (1-170) (Continued)			
		SR	SHCP - REFERRED CARE **OR**
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	THEN BYPASS ALL CA/NAS NUMBER EDITING		
NO ERROR	IF HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER
	THEN BYPASS ALL CA/NAS NUMBER EDITING		
NO ERROR	IF ANY OCCURRENCE OF ADJUSTMENT/ DENIAL REASON CODE =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER **OR**
		26	EXPENSES INCURRED PRIOR TO COVERAGE **OR**
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED **OR**
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS **OR**
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED **OR**
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED **OR**
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE **OR**
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS **OR**
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION **OR**
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
	THEN BYPASS ALL CA/NAS NUMBER EDITING		
NO ERROR	IF AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO		
	THEN NO CA/NAS IS REQUIRED -- BYPASS ALL CA/NAS NUMBER EDITING.		
1-170-02R	IF CA/NAS EXCEPTION REASON IS **NOT** BLANK		
	THEN CA/NAS NUMBER MUST = BLANK		
1-170-03R	IF CA/NAS EXCEPTION REASON = BLANK		
	AND PRINCIPAL TREATMENT DIAGNOSIS/ POA INDICATOR (POSITIONS 1-7) =	290-316 (MENTAL HEALTH, ICD-9-CM) **OR**	
		F01.50-F69 OR F99 (MENTAL HEALTH, ICD-10-CM)	
	AND PATIENT ZIP CODE IS IN AN MTF[2] CATCHMENT AREA[1]		
	AND BEGIN DATE OF CARE IS < 03/28/2013		
	THEN CA/NAS NUMBER MUST BE CODED		
	UNLESS ANY OCCURRENCE OF OVERRIDE CODE =	C	GOOD FAITH PAYMENT
1-170-04R	IF CA/NAS NUMBER IS CODED		

[1] CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.
[2] MTF IS A 40 MILES CATCHMENT AREA.

ELEMENT NAME: CA/NAS NUMBER (1-170) (Continued)	
	THEN CA/NAS EXCEPTION REASON MUST = BLANK
[1] CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE. [2] MTF IS A 40 MILES CATCHMENT AREA.	

ELEMENT NAME: CA/NAS REASON FOR ISSUANCE (1-175)	
	VALIDITY EDITS
1-175-01V	**IF** BEGIN DATE OF CARE ≥ 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.

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**

[1] CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.
[2] MTF IS A 40 MILES CATCHMENT AREA.

ELEMENT NAME: CA/NAS EXCEPTION REASON (1-180) (Continued)			
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING		
NO ERROR	IF HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER
	THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING		
NO ERROR	IF ANY OCCURRENCE OF ADJUSTMENT/ DENIAL REASON CODE =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER **OR**
		26	EXPENSES INCURRED PRIOR TO COVERAGE **OR**
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED **OR**
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS **OR**
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED **OR**
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED **OR**
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE **OR**
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS **OR**
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION **OR**
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
	THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING		
NO ERROR	IF AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO		
	THEN NO CA/NAS IS REQUIRED -- BYPASS ALL CA/NAS EXCEPTION REASON EDITING.		
1-180-03R	IF PATIENT ZIP CODE IS IN AN MTF[2] CATCHMENT AREA[1]		
	AND PRINCIPAL TREATMENT DIAGNOSIS/ POA INDICATOR (POSITIONS 1-7) =	290-316 (MENTAL HEALTH, ICD-9-CM) **OR**	
		F01.50-F69 OR F99 (MENTAL HEALTH, ICD-10-CM)	
	AND CA/NAS NUMBER IS **NOT** CODED		
	AND BEGIN DATE OF CARE IS < 03/28/2013		
	THEN CA/NAS EXCEPTION REASON MUST BE CODED		
1-180-07R	IF CA/NAS EXCEPTION REASON =	5	RTC
	AND PATIENT ZIP CODE IS IN AN MTF[2] CATCHMENT AREA[1]		
	THEN TYPE OF INSTITUTION =	72	RTC
1-180-08R	IF CA/NAS EXCEPTION REASON =	S	HHA PPS
	THEN TYPE OF INSTITUTION MUST =	70	HHA

[1] CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.
[2] MTF IS A 40 MILES CATCHMENT AREA.

ELEMENT NAME:	**CA/NAS EXCEPTION REASON (1-180) (Continued)**		
	AND ONE OCCURRENCE OF REVENUE CODE MUST =	0023	HHA PPS

[1] CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.
[2] MTF IS A 40 MILES CATCHMENT AREA.

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	ALL OCCURRENCES OF SPECIAL PROCESSING CODE MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED SPECIAL PROCESSING CODE.		
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

[1] PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)			
	THEN ENROLLMENT/HEALTH PLAN CODE MUST =	SR	SHCP - REFERRED CARE **OR**
		SN	SHCP - NON-MTF REFERRED CARE **OR**
		SO	SHCP - NON-TRICARE ELIGIBLE **OR**
		ST	SHCP - TRICARE ELIGIBLE
1-185-32R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	E	HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP)
	THEN BEGIN DATE OF CARE IS ≥ 03/15/1999		
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	CM	ICMP
1-185-34R	• 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) **OR**
		FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) **OR**
		FS	TFL (SECOND PAYOR)
	AND TYPE OF INSTITUTION ≠	10	GENERAL MEDICAL AND SURGICAL
	THEN BEGIN DATE OF CARE MUST BE ≥ 10/01/2001		
	AND ENROLLMENT/HEALTH PLAN CODE MUST =	FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD
	ELSE IF BEGIN DATE OF CARE IS < 10/01/2001		
	THEN 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 **OR**
		26	EXPENSES INCURRED PRIOR TO COVERAGE **OR**
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED **OR**
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS **OR**
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED **OR**
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED **OR**
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE **OR**

[1] PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)			
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS **OR**
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION **OR**
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE.
1-185-35R	• TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001 **UNLESS** THE BENEFICIARY IS AN INPATIENT AND THE ADMISSION DATE WAS PRIOR TO 10/01/2001, TFL WILL PAY FOR THE ENTIRE HOSPITAL STAY.		
	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	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)
	AND TYPE OF INSTITUTION =	10	GENERAL MEDICAL AND SURGICAL
	THEN END DATE OF CARE MUST BE ≥ 10/01/2001		
	AND ENROLLMENT/HEALTH PLAN CODE MUST =	FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD
1-185-39R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF	ECHO
	THEN HCDP PLAN COVERAGE CODE MUST ≠	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) **OR**
		405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
		406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) **OR**
		407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) **OR**
		408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) **OR**
		409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE **OR**
		410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE **OR**
		411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR**
		412	TRS SURVIVOR NEW FAMILY COVERAGE **OR**
		413	TRS MEMBER-ONLY COVERAGE **OR**
		414	TRS MEMBER AND FAMILY COVERAGE **OR**

[1] PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)			
		418	TRR MEMBER-ONLY COVERAGE **OR**
		419	TRR MEMBER AND FAMILY COVERAGE **OR**
		420	TRR SURVIVOR INDIVIDUAL COVERAGE **OR**
		421	TRR SURVIVOR FAMILY COVERAGE
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[1] 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/.		
	AND IF END DATE OF CARE < 10/01/2014		
	THEN 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/.		
	ELSE END DATE OF CARE MUST BE ≥ THE DRG EFFECTIVE DATE AND ≤ THE DRG TERMINATION DATE		
1-185-51R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PH	PHILIPPINES DEMONSTRATION PROJECT
	THEN BEGIN DATE OF CARE MUST BE ≥ 01/01/2013		
	AND HCDP PLAN COVERAGE CODE MUST =	003	TRICARE STANDARD FOR ADFMS **OR**
		005	TRICARE STANDARD SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		007	TRICARE STANDARD TRANSITIONAL ASSISTANCE SPONSORS AND FAMILY MEMBERS **OR**
		009	TRICARE STANDARD RETIRED AND MOH SPONSORS AND FAMILY MEMBERS **OR**
		010	TRICARE STANDARD TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		015	TRICARE STANDARD TRANSITIONAL SURVIVORS OF NG/RESERVE DECEASED SPONSORS **OR**
		017	TRICARE STANDARD SURVIVORS OF NG/RESERVE DECEASED SPONSORS **OR**
		018	TFL RETIRED SPONSORS AND FAMILY MEMBERS AND MOH **OR**
		020	TFL TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**

[1] PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)		
	021	TFL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
	022	TFL TRANSITIONAL SURVIVORS OF NG/RESERVE DECEASED SPONSORS **OR**
	023	TFL SURVIVORS OF NG/RESERVE DECEASED SPONSORS **OR**
	028	TRICARE STANDARD FOR MEDICALLY RETIRED SPONSORS AND FAMILY MEMBERS **OR**
	029	TFL FOR MEDICALLY RETIRED SPONSORS AND FAMILY MEMBERS **OR**
	409	TRS SURVIVOR CONTINUING INDIVIDUAL COVERAGE **OR**
	410	TRS SURVIVOR CONTINUING FAMILY COVERAGE **OR**
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE **OR**
	412	TRS SURVIVOR NEW FAMILY COVERAGE **OR**
	413	TRS MEMBER-ONLY COVERAGE **OR**
	414	TRS MEMBER AND FAMILY COVERAGE **OR**
	418	TRR MEMBER-ONLY COVERAGE **OR**
	419	TRR MEMBER AND FAMILY COVERAGE **OR**
	420	TRR SURVIVOR INDIVIDUAL COVERAGE **OR**
	421	TRR SURVIVOR FAMILY COVERAGE **OR**
	422	TYA STANDARD FOR ADFMS **OR**
	423	TYA STANDARD FOR RETIRED AND MOH FAMILY MEMBERS **OR**
	424	TYA RESERVE SELECT **OR**
	425	TYA RETIRED RESERVE **OR**
	999	UNVERIFIED NEWBORN
AND PATIENT ZIP CODE MUST =	PHL	PHILIPPINES
AND PROVIDER STATE OR COUNTRY CODE MUST =	PHL	PHILIPPINES
[1] 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

ELEMENT NAME: PRICING RATE CODE (1-190)			
	VALIDITY EDITS		
1-190-01V	VALUE MUST BE A VALID INSTITUTIONAL PRICING RATE CODE.		
	RELATIONAL EDITS		
1-190-01R	IF FILING STATE/COUNTRY CODE =	MD	MARYLAND
	THEN PRICING RATE CODE MUST ≠	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER **OR**
		I	TRICARE DRG REIMBURSEMENT WITH COST OUTLIER **OR**
		J	TRICARE DRG REIMBURSEMENT WITH NO OUTLIER **OR**
		DD	DISCOUNTED DRG
1-190-02R	IF DRG NUMBER IS CODED (OTHER THAN ZERO)		
	THEN PRICING RATE CODE MUST =	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER **OR**
		I	TRICARE DRG REIMBURSEMENT WITH COST OUTLIER **OR**
		J	TRICARE DRG REIMBURSEMENT WITH NO OUTLIER **OR**
		U	SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS **OR**
		V	MEDICARE REIMBURSEMENT RATE **OR**
		DD	DISCOUNTED DRG
1-190-03R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	11	HOSPICE
	THEN PRICING RATE CODE MUST =	D	DISCOUNT RATE AGREEMENT **OR**
		P	PER DIEM RATE AGREEMENT **OR**
		U	SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS **OR**
		V	MEDICARE REIMBURSEMENT RATE
	UNLESS TYPE OF SUBMISSION =	D	COMPLETE DENIAL
	OR AMOUNT ALLOWED (TOTAL) = ZERO		
1-190-04R	IF PRICING RATE CODE =	V	MEDICARE REIMBURSEMENT RATE
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) **AND** EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 **OR**
		FS	TFL (SECOND PAYOR) **OR**
		MN	TSP - NON-NETWORK **OR**
		MS	TSP - NETWORK
	OR TYPE OF INSTITUTION =	70	HHA **OR**
		76	SNF
1-190-05R	IF PRICING RATE CODE =	U	SHCP CLAIM OR ACTIVE DUTY MEMBER TPR CLAIM PAID OUTSIDE NORMAL LIMITS
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AN	SHCP - NON-MTF-REFERRED CARE **OR**

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

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[1] 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		

[1] "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).

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