

Non-Institutional Edit Requirements (ELN 300 - 399)

Revision:

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300)			
VALIDITY EDITS			
2-300-01V	MUST BE A VALID ENROLLMENT/HEALTH PLAN CODE (REFER TO SECTION 2.5)		
RELATIONAL EDITS			
2-300-02R	IF ENROLLMENT/HEALTH PLAN CODE =	Y	CHCBP - STANDARD OR
		AA	CHCBP - EXTRA
	THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE =	CL	CLINICAL TRIALS OR
		PF	ECHO
2-300-07R	IF ENROLLMENT/HEALTH PLAN CODE =	SN	SHCP - NON-MTF/eMSM-REFERRED CARE OR
		SO	SHCP - NON-TRICARE ELIGIBLE OR
		SR	SHCP - MTF/eMSM REFERRED CARE OR
		ST	SHCP - TRICARE ELIGIBLE
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AN	SHCP - NON-MTF/eMSM-REFERRED CARE OR
		AR	SHCP - MTF/eMSM REFERRED CARE OR
		CE	SHCP - CCEP OR
		SC	SHCP - NON-TRICARE ELIGIBLE OR
		SE	SHCP - TRICARE ELIGIBLE OR
		SM	SHCP - EMERGENCY
2-300-10R	IF ENROLLMENT/HEALTH PLAN CODE =	PS	TSRx
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS OR
		M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
2-300-11R	IF ENROLLMENT/HEALTH PLAN CODE =	PS	TSRx
	THEN BEGIN DATE OF CARE MUST BE ≥ 04/01/2001		
	AND NATIONAL DRUG CODE CANNOT BE BLANK.		
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	1	MEDICAID
	OR PROVIDER STATE OR COUNTRY CODE IS FOREIGN COUNTRY CODE (ADDENDUM A)		
¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.			

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ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (Continued)		
2-300-12R	<ul style="list-style-type: none"> TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001. FOR EACH LINE ITEM WHERE BEGIN DATE OF CARE IS < 10/01/2001, THE 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 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., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) OR
	FS	TFL (SECOND PAYOR)
ELSE IF BEGIN DATE OF CARE IS < 10/01/2001 (FOR THAT DETAILED LINE ITEM)		
THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE 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
	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
2-300-13R	<ul style="list-style-type: none"> TFL CLAIMS: THE PATIENT MUST BE 64 YEARS AND 11 MONTHS OR GREATER. IF THE PATIENT IS LESS THAN THIS AGE, THE 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 OR
	PS	TSRx
AND TYPE OF SERVICE (SECOND POSITION) ≠	M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.		

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ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (Continued)			
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 DETAIL OCCURRENCE 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	
	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	
2-300-15R IF ENROLLMENT/HEALTH PLAN CODE =	SU	SCHP - REFERRAL DESIGNATION UNKNOWN	
THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS OR	
	M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS	
2-300-16R IF ENROLLMENT/HEALTH PLAN CODE =	SU	SCHP - REFERRAL DESIGNATION UNKNOWN	
THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	SC	SHCP - NON-TRICARE ELIGIBLE OR	
	SE	SHCP - TRICARE ELIGIBLE	
2-300-17R		<ul style="list-style-type: none"> FOR MOP ONLY: FOR TSRx, THE PATIENT MUST BE 64 YEARS AND 8 MONTHS OR GREATER. IF THE PATIENT IS LESS THAN THIS AGE, THE LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT. 	
IF ENROLLMENT/HEALTH PLAN CODE =	PS	TSRx	
AND TYPE OF SERVICE (SECOND POSITION) =	M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS	
THEN PATIENT AGE ¹ MUST BE ≥ 64 YEARS AND 8 MONTHS			
ELSE IF PATIENT AGE ¹ < 64 YEARS AND 8 MONTHS			
¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.			

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ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (Continued)			
THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE 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	
	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	
2-300-18R	IF ENROLLMENT/HEALTH PLAN CODE =	X	FOREIGN SERVICE MEMBER
THEN HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR	
	T	FOREIGN MILITARY MEMBER	
AND HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR	
	G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR	
	J	ACADEMY STUDENT OR	
	N	NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR	
	S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR	
	V	RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS)	
¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.			

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ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (2-301)			
VALIDITY EDITS			
2-301-01V	MUST BE A VALID HCDP PLAN COVERAGE CODE LISTED IN ADDENDUM L .		
2-301-02V	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 OR ACTIVE DUTY DECEASED SPONSORS OR
		138	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
		139	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS
	THEN THE TOTAL OF ALL OCCURRENCES/LINEITEMS OF AMOUNT ALLOWED BY PROCEDURE CODES MUST = ZERO		
2-301-03R	IF HCDP PLAN COVERAGE CODE =	417	TCSRC
	THEN ENROLLMENT/HEALTH PLAN CODE MUST =	X	FOREIGN SERVICE MEMBER OR
		SR	SHCP - MTF/eMSM REFERRED CARE
RELATIONAL EDITS			
2-301-01R	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

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ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (2-301) (Continued)		
	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	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	HCP-REFERRED CARE
2-301-02R 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

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ELEMENT NAME: REGION INDICATOR (2-303)	
VALIDITY EDITS	
2-303-01V	MUST BE A VALID REGION INDICATOR (REFER TO SECTION 2.8)
2-303-02V	IF TYPE OF SUBMISSION \neq
	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 OR
	SC SOUTH CONTRACT OR
	WC WEST CONTRACT OR
	E7 EAST CONTRACT 2017 OR
	W7 WEST CONTRACT 2017
THEN ADJUSTMENT KEY MUST =	0 BATCH OR
	5 VOUCHER
RELATIONAL EDITS	
NONE	

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ELEMENT NAME: SPECIAL PROCESSING CODE (2-305)			
VALIDITY EDITS			
2-305-01V	OCCURRENCE NUMBER 1--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8)		
2-305-02V	OCCURRENCE NUMBER 2--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8)		
2-305-03V	OCCURRENCE NUMBER 3--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8)		
2-305-04V	OCCURRENCE NUMBER 4--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8)		
2-305-05V	A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).		
2-305-06V	ALL OCCURRENCES OF SPECIAL PROCESSING CODE MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED SPECIAL PROCESSING CODE.		
2-305-07V	<ul style="list-style-type: none"> SHCP - MTF/eMSM REFERRED/NON-REFERRED 		
	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AN	SHCP - NON-MTF/eMSM-REFERRED CARE OR
		AR	SHCP - MTF/eMSM REFERRED CARE
	THEN BEGIN DATE OF CARE MUST BE < 06/01/2004		
2-305-08V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	GF	TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE SERVICE MEMBER
	THEN BEGIN DATE OF CARE MUST BE < 09/01/2002		
2-305-10V	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		
2-305-11V	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		
2-305-14V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	ST	SPECIALIZED TREATMENT
	THEN BEGIN DATE OF CARE MUST BE < 10/01/2004		
RELATIONAL EDITS			
2-305-02R	IF CA/NAS EXCEPTION REASON =	6	RESOURCE SHARING
	THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST =	S	RESOURCE SHARING - EXTERNAL
2-305-08R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF	ECHO
	THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE =	6	HHC OR
		A	PARTNERSHIP PROGRAM OR
		E	HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP) OR
		S	RESOURCE SHARING - EXTERNAL OR
		CM	ICMP OR
		CT	CCTP OR
		RI	RESOURCE SHARING - INTERNAL
¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.			

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ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)		
2-305-12R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	U BRAC MEDICARE PHARMACY
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	AND BEGIN DATE OF CARE MUST BE < 04/01/2001	
2-305-13R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	16 AMBULATORY SURGERY FACILITY CHARGE
	THEN PRICING RATE CODE MUST =	0 PRICING NOT APPLICABLE (DENIED SERVICE/SUPPLIES AND ALLOWED DRUGS) OR
		1 PRICED MANUALLY OR
		C AMBULATORY SURGERY FACILITY PAYMENT RATE OR
		D DISCOUNTED AMBULATORY SURGERY - FACILITY PAYMENT RATE OR
		E AMBULATORY SURGERY-PAID AS BILLED OR
		P CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-FACILITY PAYMENT RATE OR
		Q CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, DISCOUNTED AMBULATORY SURGERY-FACILITY PAYMENT RATE OR
		R CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-PAID AS BILLED OR
		V MEDICARE REIMBURSEMENT RATE OR
		CA CAH REIMBURSEMENT OR
		P1 OPPTS OR
		P2 OPPTS WITH COST OUTLIER OR
		P3 OPPTS WITH DISCOUNT
2-305-14R	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/eMSM/PCM OR
		WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE SERVICE MEMBER OR
		XF FOREIGN ADFM
2-305-22R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	SHCP - NON-MTF/eMSM-REFERRED CARE OR
		AN
		AR SHCP - MTF/eMSM REFERRED CARE OR
		CE SHCP - CCEP OR
		SC SHCP - NON-TRICARE ELIGIBLE OR
		SE SHCP - TRICARE ELIGIBLE OR
		SM SHCP - EMERGENCY
	THEN ENROLLMENT/HEALTH PLAN CODE MUST =	SHCP - NON-MTF/eMSM-REFERRED CARE OR
		SN

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

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ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)		
	SO	SHCP - NON-TRICARE ELIGIBLE OR
	SR	SHCP - MTF/eMSM REFERRED CARE OR
	ST	SHCP - TRICARE ELIGIBLE OR
	SU	SHCP - REFERRAL DESIGNATION UNKNOWN
2-305-24R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	E HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP)
	THEN BEGIN DATE OF CARE MUST BE ≥ 03/15/1999	
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	CM ICMP
2-305-26R	• TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001.	
	IF AMOUNT ALLOWED BY PROCEDURE CODE IS ≤ ZERO	
	THEN BYPASS THIS EDIT	
	ELSE 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., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) OR
		FS TFL (SECOND PAYOR)
	THEN BEGIN DATE OF CARE MUST BE ≥ 10/01/2001	
	AND ENROLLMENT/HEALTH PLAN CODE MUST =	FE TFL EXTRA OR
		FS TFL STANDARD
2-305-30R	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
		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
¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.		

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ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)		
	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
2-305-31R	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	
2-305-32R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	RB RESPITE BENEFIT FOR ADsMs
	THEN BEGIN DATE OF CARE MUST BE ≥ 01/01/2008	
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	SE SHCP - TRICARE ELIGIBLE
2-305-33R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PS SPECIALTY PHARMACY SERVICES
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	M MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	AND PROCEDURE CODE MUST ≠	000MN PRESCRIPTION MEDICAL NECESSITY REVIEWS OR 000PA PRESCRIPTION PRIOR AUTHORIZATIONS
2-305-34R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PV RETAIL PHARMACY FOR DVA BENEFICIARIES
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	AND PROVIDER NETWORK STATUS INDICATOR MUST =	1 NETWORK PROVIDER
	AND PROCEDURE CODE MUST ≠	000MN PRESCRIPTION MEDICAL NECESSITY REVIEWS OR 000PA PRESCRIPTION PRIOR AUTHORIZATIONS
2-305-35R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	DE TDRL PHYSICAL EXAMS
	THEN BEGIN DATE OF CARE MUST BE ≥ 03/30/2009	
	AND ENROLLMENT/HEALTH PLAN CODE MUST =	SR SHCP - MTF/eMSM REFERRED CARE
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	SE SHCP - TRICARE ELIGIBLE

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

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ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)		
2-305-36R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	EF TRICARE RESERVE AND NATIONAL GUARD FAMILY MEMBER BENEFITS
	THEN BEGIN DATE OF CARE MUST BE ≥ 11/01/2009	
	AND ENROLLMENT/HEALTH PLAN CODE MUST =	T TRICARE STANDARD PROGRAM OR
		V TRICARE EXTRA
	AND HCDP SPECIAL ENTITLEMENT CODE MUST =	02 NOBLE EAGLE PARTICIPATION SPECIAL ENTITLEMENT OR
		03 ENDURING FREEDOM PARTICIPATION SPECIAL ENTITLEMENT
	AND AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO	
2-305-37R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	DC DCPE-DVA
	THEN BEGIN DATE OF CARE MUST BE ≥ 01/01/2011	
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	17 VA MEDICAL PROVIDER CLAIM OR
		AD FOREIGN ACTIVE DUTY CLAIMS
	AND ENROLLMENT/HEALTH PLAN CODE MUST =	W TPR SERVICE MEMBER - USA OR
		X FOREIGN SERVICE MEMBER OR
		SR SHCP - MTF/eMSM REFERRED CARE OR
		WA TPR FOREIGN SERVICE MEMBER
	AND AT LEAST ONE PROCEDURE CODE MUST = 99456	
	OR PRINCIPLE DIAGNOSIS CODE MUST = V68.01 OR Z02.71	
2-305-38R	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
¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.		

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ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (Continued)		
	018	TFL RETIRED SPONSORS AND FAMILY MEMBERS AND MOH OR
	020	TFL TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	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
2-305-39R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AS COMPREHENSIVE AUTISM CARE DEMONSTRATION
	THEN PROCEDURE CODE MUST BE 0359T, 0360T, 0361T, 0364T, 0365T, 0368T, 0369T, OR 0370T	
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 (2-306)	
VALIDITY EDITS	
2-306-01V	MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE (REFER TO SECTION 2.5)
RELATIONAL EDITS	
NONE	

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ELEMENT NAME: CA/NAS NUMBER (2-310)	
VALIDITY EDITS	
2-310-01V	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 BEGIN DATE OF CARE IS OLDER THAN SIX YEARS
	THEN DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA ¹
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/eMSM-REFERRED CARE OR
	AR SHCP - MTF/eMSM REFERRED CARE OR
	CE SHCP - CCEP OR
	PF ECHO
	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 SERVICE MEMBER - USA OR
	X FOREIGN SERVICE MEMBER OR
	Y CHCBP - STANDARD OR
	Z TRICARE PRIME, MTF/eMSM/PCM OR
	AA CHCBP - EXTRA OR
	BB TSP OR
	FE TFL - EXTRA OR
	FS TFL - STANDARD OR
	PS TSRx OR
	SN SHCP - NON-MTF/eMSM-REFERRED CARE OR
¹ CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.	

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ELEMENT NAME: CA/NAS NUMBER (2-310) (Continued)		
	SR	SHCP - MTF/eMSM REFERRED CARE OR
	WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE SERVICE MEMBER
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 FOR THAT DETAIL OCCURRENCE =	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.		
2-310-02R	IF CA/NAS EXCEPTION REASON ≠ BLANK	
THEN CA/NAS NUMBER MUST = BLANK		
2-310-03R	• MENTAL HEALTH CHECK	
	IF CA/NAS EXCEPTION REASON = BLANK	
	AND TYPE OF SERVICE (FIRST POSITION) =	I INPATIENT
	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/eMSM CATCHMENT AREA ¹		
AND BEGIN DATE OF CARE IS < 03/28/2013		
THEN CA/NAS NUMBER MUST BE CODED		

¹ CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.

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Non-Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: CA/NAS NUMBER (2-310) (Continued)	
	UNLESS ANY OCCURRENCE OF OVERRIDE CODE = C GOOD FAITH PAYMENT
	THEN CA/NAS NUMBER MUST = BLANK
2-310-04R	IF CA/NAS NUMBER IS CODED
	THEN CA/NAS EXCEPTION REASON MUST = BLANK
[†] CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.	

ELEMENT NAME: CA/NAS REASON FOR ISSUANCE (2-315)	
VALIDITY EDITS	
2-315-01V	IF BEGIN DATE OF CARE ≥ 03/28/2013
	THEN CA/NAS REASON FOR ISSUANCE MUST BE BLANK.
	ELSE VALUE MUST A VALID CA/NAS REASON FOR ISSUANCE.
RELATIONAL EDITS	
2-315-02R	IF CA/NAS NUMBER = BLANK
	THEN CA/NAS REASON FOR ISSUANCE MUST = BLANK.

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ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320)	
VALIDITY EDITS	
2-320-01V	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.
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 BEGIN DATE OF CARE 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-NOT A MEDICARE BENEFIT) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
	AN SHCP - NON-MTF/eMSM-REFERRED CARE OR
	AR SHCP - MTF/eMSM REFERRED CARE OR
	CE SHCP - CCEP OR
	PF ECHO
	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 SERVICE MEMBER - USA OR
	X FOREIGN SERVICE MEMBER OR
	Y CHCBP - STANDARD OR
	Z TRICARE PRIME, MTF/eMSM/PCM OR
	AA CHCBP - EXTRA OR
	BB TSP OR
	FE TFL - EXTRA OR
	FS TFL - STANDARD OR
	PS TSRx OR
	SN SHCP - NON-MTF/eMSM-REFERRED CARE OR
¹ CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.	

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Non-Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320) (Continued)		
	SR	SHCP - MTF/eMSM REFERRED CARE OR
	WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE SERVICE MEMBER
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 FOR THAT DETAIL OCCURRENCE =	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		
2-320-04R	IF PATIENT ZIP CODE IS IN AN MTF/eMSM CATCHMENT AREA ¹	
	AND TYPE OF SERVICE (FIRST POSITION) =	I INPATIENT
	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 NOT CODED	
	AND BEGIN DATE OF CARE IS < 03/28/2013	
THEN CA/NAS EXCEPTION REASON MUST BE CODED		
¹ CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.		

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Non-Institutional Edit Requirements (ELN 300 - 399)

ELEMENT NAME: PRICING RATE CODE (2-325)			
VALIDITY EDITS			
2-325-01V	VALUE MUST A VALID NON-INSTITUTIONAL PRICING RATE CODE.		
RELATIONAL EDITS			
2-325-01R	IF PRICING RATE CODE =	C	AMBULATORY SURGERY FACILITY PAYMENT RATE OR
		D	DISCOUNTED AMBULATORY SURGERY FACILITY PAYMENT RATE OR
		E	AMBULATORY SURGERY-PAID AS BILLED OR
		P	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-FACILITY PAYMENT RATE OR
		Q	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, DISCOUNTED AMBULATORY SURGERY-FACILITY PAYMENT RATE OR
		R	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-PAID AS BILLED
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	16	AMBULATORY SURGERY FACILITY CHARGE
2-325-02R	IF ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM IS A CODE LISTED IN ADDENDUM G, FIGURE 2.G-1 .		
	THEN PRICING RATE CODE MUST =	0	PRICING NOT APPLICABLE (DENIED SERVICE/SUPPLIES AND ALLOWED DRUGS)
2-325-03R	IF PRICING RATE CODE FOR THAT OCCURRENCE/LINE ITEM =	0	PRICING NOT APPLICABLE (DENIED SERVICE/SUPPLIES AND ALLOWED DRUGS)
	THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO		
	UNLESS TYPE OF SERVICE (SECOND POSITION) =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS OR
		M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR)
2-325-04R	IF PRICING RATE CODE =	V	MEDICARE REIMBURSEMENT RATE
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	16	AMBULATORY SURGERY FACILITY CHARGE OR
		T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
		FS	TFL (SECOND PAYOR) OR
		MN	TSP - NON-NETWORK OR
		MS	TSP - NETWORK
2-325-05R	IF PRICING RATE CODE =	U	SHCP CLAIM OR ACTIVE DUTY MEMBER TPR PAID OUTSIDE NORMAL LIMITS
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AR	SHCP - MTF/eMSM REFERRED CARE OR
		AN	SHCP - NON-MTF/eMSM-REFERRED CARE OR
		CE	SHCP - CCEP OR

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ELEMENT NAME: PRICING RATE CODE (2-325) (Continued)		
		GU SERVICE MEMBER 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/eMSM-REFERRED CARE OR
		SR SHCP - MTF/eMSM REFERRED CARE
2-325-06R	IF PRICING CODE =	W PRICED OVER CMAC
	AND ENROLLMENT/HEALTH PLAN CODE =	T TRICARE STANDARD PROGRAM
	AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE =	NE OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM DEMONSTRATION
	AND BEGIN DATE OF CARE ≥ 09/14/2001 AND < 11/01/2009	
	THEN PROVIDER PARTICIPATING INDICATOR MUST =	N NO
2-325-08R	IF PRICING RATE CODE =	P1 OPPS OR
		P2 OPPS WITH COST OUTLIER OR
		P3 OPPS WITH DISCOUNT OR
		P5 PARTIAL HOSPITALIZATION - PAID AS OPPS
	THEN APC CODE MUST ≠ BLANK OR ZEROES.	
2-325-09R	IF PRICING RATE CODE =	CA CAH REIMBURSEMENT
	THEN BEGIN DATE OF CARE MUST BE ≥ 12/01/2009	
	UNLESS PROVIDER STATE OR COUNTRY CODE =	AK ALASKA
	THEN BEGIN DATE OF CARE MUST BE ≥ 07/01/2007	
2-325-10R	IF PRICING CODE =	W PRICED OVER CMAC
	AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE =	EF TRICARE RESERVE AND NATIONAL GUARD FAMILY MEMBER BENEFITS
	AND ENROLLMENT/HEALTH PLAN CODE =	T TRICARE STANDARD PROGRAM
	THEN PROVIDER PARTICIPATING INDICATOR MUST =	N NO

ELEMENT NAME: AMBULATORY PAYMENT CLASSIFICATION (APC) CODE (2-330)		
VALIDITY EDITS		
2-330-01V	MUST BE A VALID APC CODE AS LISTED ON DHA'S OPPS WEB SITE AT HTTP://WWW.TRICARE.MIL/OPPS , BLANK, OR ALL ZEROES	
	UNLESS AMOUNT ALLOWED BY PROCEDURE CODE = ZERO	
RELATIONAL EDITS		
2-330-01R	IF APC CODE = BLANK OR ZEROES.	
	THEN PRICING RATE CODE ≠	P1 OPPS OR
		P2 OPPS WITH COST OUTLIER OR
		P3 OPPS WITH DISCOUNT OR
		P5 PARTIAL HOSPITALIZATION - PAID AS OPPS

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ELEMENT NAME: OPPTS PAYMENT STATUS INDICATOR CODE (2-331)	
VALIDITY EDITS	
2-331-01V	MUST BE A VALID OPPTS PAYMENT STATUS INDICATOR CODE (REFER TO SECTION 2.6) OR BLANK.
RELATIONAL EDITS	
2-331-01R	IF OPPTS PAYMENT STATUS INDICATOR CODE = BLANK
	THEN APC CODE MUST = ALL ZEROES OR BLANK.

ELEMENT NAME: AMOUNT NETWORK PROVIDER DISCOUNT (2-335)	
VALIDITY EDITS	
2-335-01V	MUST BE NUMERIC AND \geq ZERO
RELATIONAL EDITS	
2-335-01R	IF TYPE OF SUBMISSION =
	B ADJUSTMENT TO NON-TED (HCSR) DATA OR
	C COMPLETE CANCELLATION OR
	D COMPLETE DENIAL OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
	O ZERO GOVERNMENT TED RECORD DUE TO 100% OHI
	THEN AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO
2-335-02R	IF PROVIDER NETWORK STATUS INDICATOR = 2 NON-NETWORK PROVIDER
	THEN AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO
2-335-03R	IF REGION INDICATOR = h BLANK
	THEN AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO

- END -

