

Chapter 2

Addendum M

Data Requirements - Default Values For Complete Claims Denials

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

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

FIGURE 2.M-1 COMMON ELEMENTS

| ELEMENT NAME | DEFAULT VALUE |
|--|---------------|
| Adjustment Sequence Number | 000 |
| Adjustment/Denial Reason Code | N/D |
| Administrative CLIN | N/D |
| AGR Legal Authority Code | Z |
| Amount Interest Payment | Zeroes |
| Amount Network Provider Discount | Zeroes |
| Amount Paid By Other Health Insurance | Zeroes |
| Amount Patient Cost-share | Zeroes |
| Begin Date Of Care | N/D |
| CA/NAS Exception Reason | N/D |
| CA/NAS Number | N/D |
| CA/NAS Reason For Issuance | N/D |
| Claim Form Type/EMC Indicator | N/D |
| Date Adjustment Identified | N/D |
| Date Ted Record Processed To Completion | N/D |
| DEERS Identifier (Patient) | Zeroes |
| * Prior to October 1, 2015. ** On or after October 1, 2015. | |

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FIGURE 2.M-1 COMMON ELEMENTS (CONTINUED)

| ELEMENT NAME | DEFAULT VALUE |
|---|----------------|
| End Date Of Care | N/D |
| Enrollment/Health Plan Code | N/D |
| Health Care Coverage Copayment Factor Code | Z |
| Health Care Coverage Member Category Code | Z |
| Health Care Coverage Member Relationship Code | Z |
| Health Care Delivery Program Plan Coverage Code | 000 |
| Health Care Delivery Program Special Entitlement Code | 00 |
| Occurrence/Line Item Number | N/D |
| Other Government Program Begin Reason Code | W |
| Other Government Program Type Code | N |
| Override Code | N/D |
| Patient Identifier (DoD) | Zeroes |
| Patient Zip Code | N/D |
| Pay Grade Code (Sponsor) | 00 |
| Pay Plan Code (Sponsor) | ZZ |
| PCM Location DMIS-ID (Enrollment) Code | N/D |
| Person Birth Calendar Date (Patient) | 19111111 |
| Person Cadency Name (Patient) | Blanks |
| Person First Name (Patient) | Blanks |
| Person Identifier (Patient) | Zeroes |
| Person Identifier (Sponsor) | N/D |
| Person Identifier Type Code (Patient) | Z |
| Person Identifier Type Code (Sponsor) | Z |
| Person Last Name (Patient) | N/D |
| Person Middle Name (Patient) | Blanks |
| Person Sex (Patient) | Z |
| Pricing Rate Code | Blanks |
| Principal Treatment Diagnosis | 7999* R69** |
| Provider Group NPI Number (Reserved) | Reserved |
| Provider Individual NPI Number (Reserved) | Reserved |
| Provider Network Status Indicator | N/D |
| Provider Participation Indicator | N/D |
| Provider State Or Country Code | N/D |
| Provider Sub-Identifier | N/D |
| Provider Taxpayer Number | N/D |
| Provider Zip Code | N/D |
| Reason For Interest Payment | Blanks |
| Record Type Indicator | N/D |
| * Prior to October 1, 2015. | |
| ** On or after October 1, 2015. | |

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FIGURE 2.M-1 COMMON ELEMENTS (CONTINUED)

| ELEMENT NAME | DEFAULT VALUE |
|--|---------------|
| Region Indicator | N/D |
| Secondary Treatment Diagnosis | N/D |
| Service Branch Classification Code (Sponsor) | Z |
| Special Processing Code | N/D |
| TED Record Indicator | N/D |
| Total Occurrence/Line Item Count | N/D |
| Type Of Submission | D |
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FIGURE 2.M-2 INSTITUTIONAL-SPECIFIC ELEMENTS

| ELEMENT NAME | DEFAULT VALUE |
|--|--|
| Admission Date | Report same date as Begin Date of Care |
| Admission Diagnosis | 7999* R69** |
| Amount Allowed (Total) | Zeroes |
| Amount Billed (Total) | N/D |
| Amount Paid By Government Contractor (Total) | Zeroes |
| Covered Days | Zeroes |
| DRG Number | Zeroes |
| Frequency Code | 1 (N/D on DRG interim billing) |
| Patient Status | 01 (N/D on DRG interim billing) |
| Principal Op/Nonsurgical Procedure Code | Blanks |
| Revenue Code | N/D |
| Secondary Op/Nonsurgical Procedure Code | Blanks |
| SNF HIPPS Code | N/D |
| Sole Community Hospital DRG Calculation | Zeroes |
| Sole Community Hospital DRG Number | Blanks |
| Point of Origin | 9 |
| Total Charge by Revenue Code | N/D |
| Type of Admission | 3 |
| Type of Institution | N/D |
| Units of Service by Revenue Code | 0000000001 |
| * Prior to October 1, 2015. ** On or after October 1, 2015. | |

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FIGURE 2.M-3 NON-INSTITUTIONAL-SPECIFIC ELEMENTS

| ELEMENT NAME | DEFAULT VALUE |
|--|---|
| Amount Allowed By Procedure Code | Zeroes |
| Amount Applied Toward Deductible | Zeroes |
| Amount Billed By Procedure Code | N/D |
| Amount Paid By Government Contractor By Procedure Code | Zeroes |
| DEERS Dependent Suffix | 75 |
| National Drug Code | Blanks |
| Number of Services | 001 |
| Physician Referral Number | Blanks |
| Place of Service | 99 |
| Procedure Code | See *NOTE |
| Procedure Code Modifier | N/D |
| Provider Specialty | N/D |
| Type of Service | Must agree with Place of Service and Procedure Code |

Note: Defaults for procedure code must be the “Miscellaneous” code in the range for services provided. For example, a service shown only as “laboratory” or with a non-acceptable lab code should be coded 89399. Any such defaults used by the contractor must still agree with Type of Service.

- END -

