

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 144)

ELEMENT NAME: PATIENT ZIP CODE (1-100)

VALIDITY EDITS

1-100-01 MUST BE 9 CHARACTERS, EITHER 9 DIGITS, **OR** 5 DIGITS (NOT 5 ZEROES **OR** 5 NINES) FOLLOWED BY 4 BLANKS, **OR** 2 CHARACTERS FOLLOWED BY 7 BLANKS. MUST NOT BE ALL ZEROES **OR** ALL NINES.

1-100-02 MUST BE **VALID ZIP CODE IN THE ELECTRONIC ZIP CODE FILE, BASED ON THE ADMISSION DATE**
OR THE FIRST 2 CHARACTERS AGAINST COUNTRY CODES TABLE
(SEE CHAPTER 2, ADDENDUM A)

RELATIONAL EDITS

| RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
|-------------------------|-----------------------------|----------------------------|
| NAS EXCEPTION REASON | SEE BELOW | |
| NAS NUMBER | SEE BELOW | |
| SPECIAL PROCESSING CODE | SEE BELOW | |
| ENROLLMENT STATUS | SEE BELOW | |

EDITED ELEMENT RELATIONSHIP

1-100-03R IF NAS EXCEPTION REASON IS CODED
THEN PATIENT ZIP CODE MUST BE WITHIN A CATCHMENT AREA
UNLESS NAS EXCEPTION CODE = 'O' (LIVING-RELATED DONOR LIVER TRANSPLANT)
OR IF EARLIEST BEGIN DATE OF CARE < 03/01/97 OR (> 02/19/98 AND < 09/01/99)
THEN AT LEAST ONE SPECIAL PROCESSING CODE = '5' (LIVER TRANSPLANT)
ELSE
EARLIEST BEGIN DATE OF CARE IS (≥ 03/01/97 AND ≤ 02/19/98)
OR ≥ 09/01/99
THEN SPECIAL PROCESS CODE = 'ST'¹ (SPECIALIZED TREATMENT FACILITY)

1-100-04R IF NAS NUMBER IS PRESENT
THEN PATIENT ZIP CODE MUST BE WITHIN A CATCHMENT AREA.
UNLESS EARLIEST BEGIN DATE OF CARE < 03/01/97 OR (> 02/19/98 AND < 09/01/99)
THEN AT LEAST ONE SPECIAL PROCESSING CODE = '5' (LIVER TRANSPLANT)
ELSE
EARLIEST BEGIN DATE OF CARE IS (≥ 03/01/97 AND ≤ 02/19/98)
OR ≥ 09/01/99
THEN SPECIAL PROCESS CODE = 'ST'¹ (SPECIALIZED TREATMENT FACILITY).

1-100-05R IF SPECIAL PROCESSING CODE = '9' (FORT DRUM COOPERATIVE MEDICAL CARE)
 PATIENT ZIP CODE MUST BE IN THE FORT DRUM DEMONSTRATION PROJECT AREA.

ELEMENT NAME: PATIENT ZIP CODE (1-100) (CONTINUED)

1-100-06R IF ENROLLMENT STATUS = 'A', 'B', 'C', 'K', 'L', 'M', 'N', OR 'S'
 AND NO OCCURRENCE OF OVERRIDE CODE = 'S'
 PATIENT ZIP CODE MUST BE IN CALIFORNIA OR HAWAII

1-100-07R IF ENROLLMENT STATUS = 'H', 'I', 'J', 'O', 'P', OR 'Q'
 AND NO OCCURRENCE OF OVERRIDE CODE = 'S'
 PATIENT ZIP CODE MUST BE A VALID ZIP CODE FOR THE NEW ORLEANS
 COORDINATED CARE PROGRAM, OR A BASE REALIGNMENT AND CLOSURE (BRAC)
 SITE (SEE [CHAPTER 2, ADDENDUM K](#)).

ELEMENT NAME: ENROLLMENT STATUS (1-105)

VALIDITY EDITS

1-105-01 MUST BE A VALID VALUE LISTED IN [CHAPTER 2](#).

RELATIONAL EDITS

| RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
|---|--------------------------------|----------------------------|
| OVERRIDE CODE | SEE BELOW | |
| SOURCE OF HEALTH CARE DATA (DERIVED) | SEE BELOW | |
| PROVIDER CONTRACT AFFILIATION CODE | SEE BELOW | |
| SPECIAL PROCESSING CODE | SEE BELOW | |

EDITED ELEMENT RELATIONSHIP

1-105-02R IF ANY OCCURRENCE OF OVERRIDE CODE = 'Z' (ENHANCED BENEFIT)

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| ENROLLMENT STATUS MUST = | A | FOUNDATION HEALTH PLAN |
| | B | PARTNERS HEALTH PLAN |
| | C | QUEEN'S HEALTH CARE PLAN |
| | N | NON-PRIME; E.G., EXTRA |
| | O | NEW ORLEANS PRIME |
| | P | NEW ORLEANS NOT ENROLLED, NOT STANDARD PROGRAM |
| | E | MANAGED CARE SUPPORT-TRICARE-TIDEWATER PRIME |
| | H | MANAGED CARE SUPPORT - HOMESTEAD, ENROLLED PATIENT |
| | K | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII, ENROLLED PATIENT |
| | U | MANAGED CARE SUPPORT-PRIME, CIVILIAN PCM |
| | Z | MANAGED CARE SUPPORT-PRIME, MTF/PCM |

1-105-03R IF SOURCE OF HEALTH CARE DATA (THIS IS A **DERIVED** ELEMENT) IS A CRI CONTRACTOR

ELEMENT NAME: ENROLLMENT STATUS (1-105) (CONTINUED)

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| THEN ENROLLMENT STATUS MUST = | A FOUNDATION HEALTH PLAN OR |
| | B PARTNERS HEALTH PLAN OR |
| | C QUEEN'S HEALTH CARE PLAN OR |
| | D MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM OR |
| | E MANAGED CARE SUPPORT - TRICARE-TIDEWATER PRIME OR |
| | G MANAGED CARE SUPPORT - TRICARE-TIDEWATER EXTRA OR |
| | N NON-PRIME OR |
| | R TRICARE EXTRA - NORTH CAROLINA OR |
| | S CRI STANDARD PROGRAM OR |
| | U MANAGED CARE SUPPORT - PRIME, CIVILLIAN PCM OR |
| | V MANAGED CARE SUPPORT - EXTRA OR |
| | Y CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD OR |
| | Z MANAGED CARE SUPPORT - PRIME, MTF/PCM OR |
| | AA CONTINUED HEALTH CARE BENEFIT PROGRAM EXTRA |

IF SOURCE OF HEALTH CARE DATA IS A FI

| | |
|--|--|
| THEN ENROLLMENT STATUS MUST = | F FI STANDARD PROGRAM OR |
| | D MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM OR |
| | E MANAGED CARE SUPPORT - TRICARE-TIDEWATER PRIME OR |
| | G MANAGED CARE SUPPORT - TRICARE-TIDEWATER EXTRA OR |
| | Y CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD OR |
| | AA CONTINUED HEALTH CARE BENEFIT PROGRAM EXTRA OR |
| | H MANAGED CARE SUPPORT - HOMESTEAD, ENROLLED PATIENT OR |
| | J MANAGED CARE SUPPORT - HOMESTEAD STANDARD PROGRAM OR |
| | R TRICARE EXTRA - NORTH CAROLINA |

IF SOURCE OF HEALTH CARE DATA IS ORLEANS DEMONSTRATION

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| THEN ENROLLMENT STATUS MUST = | O NEW ORLEANS PRIME OR |
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ELEMENT NAME: ENROLLMENT STATUS (1-105) (CONTINUED)

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| P | NEW ORLEANS NOT ENROLLED, NOT STANDARD OR |
| Q | NEW ORLEANS COORDINATE CARE STANDARD PROGRAM OR |
| Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD OR |
| AA | CONTINUED HEALTH CARE BENEFIT PROGRAM EXTRA |
| IF SOURCE OF HEALTH CARE DATA IS MANAGED CARE SUPPORT | |
| THEN ENROLLMENT STATUS MUST = | |
| K | MANAGED CARE SUPPORT - CALIFORNIA/ HAWAII, ENROLLED PATIENT OR |
| L | MANAGED CARE SUPPORT - CALIFORNIA/ HAWAII, NON-ENROLLED PATIENT, NETWORK PROVIDER OR |
| M | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM OR |
| O | NEW ORLEANS PRIME OR |
| P | NEW ORLEANS NOT ENROLLED, NOT STANDARD OR |
| Q | NEW ORLEANS COORDINATED CARE STANDARD PROGRAM OR |
| R | TRICARE EXTRA - NORTH CAROLINA OR |
| T | MANAGED CARE SUPPORT - STANDARD PROGRAM OR |
| U | MANAGED CARE SUPPORT - PRIME, CIVILIAN PCM OR |
| V | MANAGED CARE SUPPORT - EXTRA OR |
| W | ACTIVE DUTY USA OR |
| X | ACTIVE DUTY EUROPE OR |
| Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD OR |
| Z | MANAGED CARE SUPPORT PRIME, MTF/PCM OR |
| AA | CONTINUED HEALTH CARE BENEFIT PROGRAM EXTRA OR |
| BB | TRICARE-SENIOR PRIME OR |
| SN | SUPPLEMENTAL HEALTH CARE PROGRAM - NON- MTF-REFERRED CARE OR |
| SO | SUPPLEMENTAL HEALTH CARE PROGRAM - NON- TRICARE ELIGIBLE OR |
| SR | SUPPLEMENTAL HEALTH CARE PROGRAM - REFERRED CARE OR |

ELEMENT NAME: ENROLLMENT STATUS (1-105) (CONTINUED)

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| | | ST | SUPPLEMENTAL HEALTH CARE PROGRAM - TRICARE ELIGIBLE OR |
| | | TS | TRICARE SENIOR SUPPLEMENT |
| 1-105-04R | IF PROVIDER CONTRACT AFFILIATION CODE = 1 (CONTRACTED) | | |
| | THEN ENROLLMENT STATUS MUST NOT = | S | STANDARD PROGRAMS |
| | IF PROVIDER CONTRACT AFFILIATION CODE = 2 (NOT CONTRACTED) | | |
| | THEN ENROLLMENT STATUS MUST NOT = | N | NON-PRIME |
| 1-105-05R | IF ENROLLMENT STATUS = | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP) STANDARD OR |
| | | AA | CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP) EXTRA |
| | THEN PROGRAM INDICATOR MUST NOT = | H | PROGRAM FOR PERSONS WITH DISABILITIES |
| 1-105-06R | IF ENROLLMENT STATUS = | W | TPR ACTIVE DUTY - USA OR |
| | | X | ACTIVE DUTY - EUROPE |
| | THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | AD | ACTIVE DUTY OR |
| | | GU | ACTIVE DUTY SERVICE MEMBER ENROLLED IN TRICARE PRIME REMOTE: NOT-AT-RISK PAYMENT BY CONTRACTOR |
| 1-105-07R | IF ENROLLMENT STATUS = | BB | TRICARE-SENIOR PRIME |
| | THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | MS | TRICARE-SENIOR PRIME (NETWORK) OR |
| | | MN | TRICARE-SENIOR PRIME (NON-NETWORK) |
| 1-105-08R | IF ENROLLMENT STATUS = | SN | SUPPLEMENTAL HEALTH CARE PROGRAM - NON-MTF-REFERRED CARE OR |
| | | SO | SUPPLEMENTAL HEALTH CARE PROGRAM - NON-TRICARE ELIGIBLE OR |
| | | SR | SUPPLEMENTAL HEALTH CARE PROGRAM - MTF-REFERRED CARE OR |
| | | ST | SUPPLEMENTAL HEALTH CARE PROGRAM - TRICARE ELIGIBLE |
| | THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | AN | SUPPLEMENTAL HEALTH CARE PROGRAM - NON-MTF-REFERRED CARE OR |
| | | AR | SUPPLEMENTAL HEALTH CARE PROGRAM - MTF-REFERRED CARE OR |

ELEMENT NAME: ENROLLMENT STATUS (1-105) (CONTINUED)

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| | CE | SUPPLEMENTAL HEALTH CARE PROGRAM - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR |
| | SC | SUPPLEMENTAL HEALTH CARE PROGRAM - NON-TRICARE ELIGIBLE OR |
| | SE | SUPPLEMENTAL HEALTH CARE PROGRAM - TRICARE ELIGIBLE OR |
| 1-105-09R | IF ENROLLMENT STATUS = | Z MANAGED CARE SUPPORT PRIME, MTF/PCM |
| | THEN BEGIN DATE OF CARE MUST BE > OCTOBER 1, 1997 | |
| 1-105-10R | IF ENROLLMENT STATUS = | TS TRICARE SENIOR SUPPLEMENT |
| | THEN | |
| | AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | |
| | SN | TRICARE SENIOR SUPPLEMENT (NON-NETWORK) OR |
| | SS | TRICARE SENIOR SUPPLEMENT (NETWORK) |

ELEMENT NAME: NAS NUMBER (1-110)

VALIDITY EDITS

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|-----------------|--|
| 1-110-01 | IF NAS NUMBER IS CODED |
| | POSITIONS 2 - 4 (MTF FACILITY #), MUST BE VALID (USER SUPPLIED: USE MTF NUMBERS). POSITION 1 MUST BE ZERO. |
| | POSITIONS 5 - 8 (JULIAN DATE; FORMAT; YDDD), Y MUST BE 0 - 9, DDD MUST BE 001 - 366. |
| | POSITIONS 9 - 11 (SEQUENCE #), MUST BE NUMERIC AND NOT ZERO. |
| | UNLESS |
| | FIRST 4 DIGITS = '6501' |
| | AND PATIENT ZIP CODE IS BETWEEN 23000 - 23899 INCLUSIVE |
| | THEN BYPASS THIS EDIT |
| | OR |
| | POSITIONS 1 - 2 MUST BE '46' OR '47' AND POSITIONS 3 - 11 MUST BE ZEROS. |
| | IF NAS NUMBER IS NOT CODED, MUST BE BLANK-FILLED. |

RELATIONAL EDITS

| RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
|-------------------------|-----------------------------|--|
| PATIENT ZIP CODE | SEE BELOW | ADMISSION DATE |
| NAS EXCEPTION REASON | SEE BELOW | PATIENT ZIP CODE, SPONSOR BRANCH OF SERVICE, DENIAL REASON CODE, ADMISSION DATE, PROGRAM INDICATOR |
| SPECIAL PROCESSING FLAG | SEE BELOW | |

ELEMENT NAME: NAS NUMBER (1-110) (CONTINUED)**EDITED ELEMENT RELATIONSHIP**

| | | |
|--|----|--|
| NO ERROR IF SPECIAL PROCESSING CODE = | AN | SUPPLEMENTAL HEALTH CARE PROGRAM - NON-MTF-REFERRED CARE OR |
| | AR | SUPPLEMENTAL HEALTH CARE PROGRAM - REFERRED CARE OR |
| | CE | SUPPLEMENTAL HEALTH CARE PROGRAM - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR |
| | GU | ACTIVE DUTY SERVICE MEMBER ENROLLED IN TRICARE PRIME REMOTE: NOT AT RISK PAYMENT BY CONTRACTOR OR |
| | MS | TRICARE-SENIOR PRIME (NETWORK) OR |
| | MN | TRICARE-SENIOR PRIME (NON-NETWORK) OR |
| | SC | SUPPLEMENTAL HEALTH CARE PROGRAM - NON-TRICARE ELIGIBLE OR |
| | SE | SUPPLEMENTAL HEALTH CARE PROGRAM - TRICARE ELIGIBLE OR |
| | SM | SUPPLEMENTAL HEALTH CARE PROGRAM - EMERGENCY OR |

NO NAS IS REQUIRED -- BYPASS ALL NAS NUMBER EDITING.

NO ERROR IF BEGINNING DATE OF CARE \geq 9/23/96

AND

| | | |
|---------------------|---|--|
| ENROLLMENT STATUS = | E | MANAGED CARE SUPPORT TRICARE TIDEWATER PRIME |
| | H | MANAGED CARE SUPPORT HOMESTEAD ENROLLED PATIENT |
| | K | MANAGED CARE SUPPORT CALIFORNIA/HAWAII, TRICARE PRIME ENROLLED PATIENT |
| | O | NEW ORLEANS PRIME |
| | U | MANAGED CARE SUPPORT PRIME, CIVILIAN PCM |
| | Z | MANAGED CARE SUPPORT PRIME, MTF/PCM |

THEN NO NAS IS REQUIRED - BYPASS ALL NAS NUMBER EDITING.

1-110-02R IF PATIENT ZIP CODE IS NOT IN A CATCHMENT AREA (CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE)
NAS NUMBER MUST = BLANK
UNLESS SPECIAL PROCESSING CODE = 'ST'

1-110-04R IF NAS EXCEPTION REASON = BLANK AND PATIENT ZIP CODE IS IN A CATCHMENT AREA (CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE)

THEN

NAS NUMBER MUST BE CODED, **UNLESS**

OR

HEALTH CARE PLAN CODE = 11 MCS - FORT BRAGG DEMO

ELEMENT NAME: NAS NUMBER (1-110) (CONTINUED)

| | | | |
|------------------|---|---|---|
| | OR ANY OCCURRENCE OF DENIAL REASON CODE = | 9 | NAS NOT PROVIDED OR |
| | | 2 | INELIGIBLE CLAIMANT OR |
| | | A | DEERS OR |
| | | N | MULTIPLE DENIAL REASONS |
| | OR ANY OCCURRENCE OF OVERRIDE CODE = | C | GOOD FAITH PAYMENT |
| | OR PROGRAM INDICATOR = | H | PROGRAM FOR PERSONS WITH DISABILITIES OR |
| | OR SPONSOR STATUS = | T | NATO |
| | IN WHICH CASE NAS NUMBER MUST BE BLANK. | | |
| 1-110-05R | IF SPECIAL PROCESSING CODE = | I | BERGSTROM AFB CATCHMENT AREA |
| | | J | LUKE/WILLIAMS AFB CATCHMENT AREA |
| | NAS NUMBER MUST NOT = 4600000000. | | |
| 1-110-06R | (REGIONAL STS FACILITIES FOR CARDIAC SURGERY AND INTERVENTIONAL CARDIOLOGY FOR REGION 3) | | |
| | IF NAS EXCEPTION REASON = BLANK | | |
| | AND DRG = 104, 105, 106, 107, 108, 109, OR 112 | | |
| | AND PATIENT ZIP CODE IS IN EISENHOWER ARMY MEDICAL CENTER STSF CATCHMENT AREA | | |
| | AND REGION CODE = '03' (REGION 3) | | |
| | AND BEGIN DATE OF CARE ≥ 03/01/97 | | |
| | THEN NAS NUMBER MUST BE CODED, | | |
| 1-110-07R | (NATIONAL STSF) | | |
| | IF NAS EXCEPTION REASON = BLANK | | |
| | AND PATIENT ZIP CODE IS IN 48 CONTIGUOUS UNITED STATES AND DISTRICT OF COLUMBIA | | |
| | AND (DRG = 480 [LIVIER TRANSPLANT] AND BEGIN DATE OF CARE (≥ 03/01/97 AND ≤ 02/19/98) | | |
| | OR (DRG = 481 [ALLOGENEIC BONE MARROW TRANSPLANTATION] AND BEGIN DATE OF CARE ≥ 10/01/97) | | |
| | OR (DRG = 302 [KIDNEY TRANSPLANTATION] AND BEGIN DATE OF CARE ≥ 09/01/99) | | |
| | THEN NAS NUMBER MUST BE CODED, | | |
| 1-110-08R | (MULTI-REGIONAL STS FACILITIES FOR CARDIAC SURGERY FOR REGION 1 & 2) | | |
| | IF NAS EXCEPTION REASON = BLANK | | |
| | AND REGION CODE = '01' (REGION 1) | | |
| | OR REGION CODE = '02' (REGION 2) | | |

ELEMENT NAME: NAS NUMBER (1-110) (CONTINUED)**AND DRG = 104, 105, 106, 107, 108, 109, 110, OR 111****AND PATIENT ZIP CODE IS IN WALTER REED ARMY MEDICAL CENTER (WRAMC)****OR NATIONAL NAVAL MEDICAL CENTER (NNMC) STSF CATCHMENT AREA****AND BEGIN DATE OF CARE ≥ 10/01/97****THEN NAS NUMBER MUST BE CODED****1-110-09R** NAS NUMBER MUST BE BLANK**WHEN**

SPONSOR STATUS = T (FOREIGN MILITARY)

OR ANY OCCURRENCE OFDENIAL REASON CODE = 9 NONAVAILABILITY STATEMENT NOT PROVIDED
OR2 INELIGIBLE CLAIMANT **OR**A DEERS **OR**

N MULTIPLE DENIAL REASONS

OR AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO**1-110-10R** (REGIONAL STS FACILITIES FOR GENERAL SURGERY & ORTHOPEDIC SURGERY FOR REGION 1)

IF NAS EXCEPTION REASON = BLANK

AND REGION CODE = '01' (REGION 1)**AND PATIENT ZIP CODE IS IN NATIONAL NAVAL MEDICAL CENTER (NNMC)****OR WALTER REED ARMY MEDICAL CENTER (WRAMC)****OR MALCOLM CROW MEDICAL CENTER (MGMC) STSF CATCHMENT AREA****AND BEGIN DATE OF CARE ≥ 09/01/99****AND DRG - 191, 209, 286, 491****THEN NAS NUMBER MUST BE CODED****1-110-11R** (REGIONAL STS FACILITIES FOR NEUROSURGERY, OTORHINOLARYNGOLOGY SURGERY, AND GYNECOLOGIC ONCOLOGY SURGERY FOR REGION 1)

IF NAS EXCEPTION REASON = BLANK

AND REGION CODE = '01' (REGION 1)**AND PATIENT ZIP CODE IS IN NATIONAL NAVAL MEDICAL CENTER (NNMC)****OR WALTER REED ARMY MEDICAL CENTER (WRAMC) STSF CATCHMENT AREA****AND BEGIN DATE OF CARE ≥ 09/01/99****AND DRG = 001, 003, 004, 049, 286, 357****THEN NAS NUMBER MUST BE CODED****1-110-12R** (REGIONAL STS FACILITIES FOR NEUROSURGERY, ORTHOPEDIC SURGERY, GENERAL SURGERY, PERIPHERAL VASCULAR SURGERY, AND HEAD AND NECK SURGERY FOR REGION 3)

IF NAS EXCEPTION REASON = BLANK

AND REGION CODE = '03' (REGION 3)

ELEMENT NAME: NAS NUMBER (1-110) (CONTINUED)

AND PATIENT ZIP CODE IS IN EISENHOWER ARMY MEDICAL CENTER (EAMC) STSF CATCHMENT AREA

AND BEGIN DATE OF CARE ≥ 09/01/99

AND DRG = 001, 004, 049, 110, 111, 191, 209, 286, OR 491

THEN NAS NUMBER MUST BE CODED

1-110-14R (REGIONAL STS FACILITIES FOR NEONATAL INTENSIVE CARE FOR REGION 4)

IF NAS EXCEPTION REASON = BLANK

AND REGION CODE = '04' (REGION 4)

AND PATIENT ZIP CODE IS IN KEESLER MEDICAL CENTER STSF CATCHMENT AREA

AND BEGIN DATE OF CARE ≥ 05/01/98

AND DRG = 370, 372, 383, 604, 607, 611, 612, 613, 617, 618, 622, 626, 636

THEN NAS NUMBER MUST BE CODED

1-110-15R (REGIONAL STS FACILITIES FOR CARDIAC SURGERY FOR REGION 4)

IF NAS EXCEPTION REASON = BLANK

AND REGION CODE = '04' (REGION 4)

AND PATIENT ZIP CODE IS IN KEESLER MEDICAL CENTER STSF CATCHMENT AREA

AND BEGIN DATE OF CARE ≥ 05/01/98

AND DRG = 104, 105, 106, 107, 108, 109, 110, 111, 112, 124, OR 125

THEN NAS NUMBER MUST BE CODED

1-110-16R (REGIONAL STS FACILITIES FOR GENERAL SURGERY, ORTHOPEDIC SURGERY, NEUROSURGERY, OTORHINOLARYNGOLOGY SURGERY AND GYNECOLOGIC ONCOLOGY SURGERY FOR REGION 4)

IF NAS EXCEPTION REASON = BLANK

AND REGION CODE = '04' (REGION 4)

AND PATIENT ZIP CODE IS IN KEESLER MEDICAL CENTER STSF CATCHMENT AREA

AND BEGIN DATE OF CARE ≥ 05/01/00

AND DRG = 001, 003, 004, 049, 191, 209, 286, 357, OR 491

THEN NAS NUMBER MUST BE CODED

1-110-17R (REGIONAL STS FACILITIES FOR GENERAL SURGERY, NEUROSURGERY, OTORHINOLARYNGOLOGY SURGERY, CARDIOTHORACIC SURGERY, ORTHOPEDIC SURGERY, AND GYNECOLOGIC ONCOLOGY SURGERY FOR REGION 6)

IF NAS EXCEPTION REASON = BLANK

AND REGION CODE = '06' (REGION 6)

AND PATIENT ZIP CODE IS IN BROOKE ARMY MEDICAL CENTER (BAMC)

OR WILFORD HALL MEDICAL CENTER (WHMC) STSF CATCHMENT AREA

AND BEGIN DATE OF CARE ≥ 09/01/99

AND DRG = 001, 003, 004, 049, 104, 105, 106, 107, 109, 110, 111, 191, 209, 286, 357, OR 491

THEN NAS NUMBER MUST BE CODED

ELEMENT NAME: NAS NUMBER (1-110) (CONTINUED)

1-110-18R (REGIONAL STS FACILITIES FOR GENERAL SURGERY, NEUROSURGERY, OTORHINOLARYNGOLOGY SURGERY, CARDIOTHORACIC SURGERY, ORTHOPEDIC SURGERY, AND GYNECOLOGIC ONCOLOGY SURGERY FOR REGION 9)

IF NAS EXCEPTION REASON = BLANK

AND REGION CODE = '09' (REGION 9)

AND PATIENT ZIP CODE IS IN NAVAL MEDICAL CENTER SAN DIEGO (NMCS D) STSF CATCHMENT AREA

AND BEGIN DATE OF CARE ≥ 09/01/99

AND DRG = 001, 003, 004, 049, 104, 105, 106, 107, 109, 110, 111, 191, 209, 286, 357, OR 491

THEN NAS NUMBER MUST BE CODED

1-110-19R (REGIONAL STS FACILITIES FOR GENERAL SURGERY, NEUROSURGERY, OTORHINOLARYNGOLOGY SURGERY, CARDIOTHORACIC SURGERY, ORTHOPEDIC SURGERY, AND GYNECOLOGIC ONCOLOGY SURGERY FOR REGION 10)

IF NAS EXCEPTION REASON = BLANK

AND REGION CODE = '10' (REGION 10)

AND PATIENT ZIP CODE IS IN DAVID GRANT MEDICAL CENTER (DGMC) STSF CATCHMENT AREA

AND BEGIN DATE OF CARE ≥ 09/01/99

AND DRG = 001, 003, 004, 049, 110, 111, 191, 209, 286, 357, OR 491

THEN NAS NUMBER MUST BE CODED

1-110-20R (MULTI-REGIONAL STS FACILITIES FOR LIVER TRANSPLANTS FOR REGIONS 1, 2, AND 5)

IF NAS EXCEPTION REASON = BLANK

AND REGION CODE = '01' (REGION 01)

OR REGION CODE = '02' (REGION 02)

OR REGION CODE = '05' (REGION 05)

AND INCLUDES ALL PATIENT ZIP CODES WITHIN REGIONS 1, 2, OR 5

AND BEGIN DATE OF CARE ≥ 09/01/99

AND DRG = 480

THEN NAS NUMBER MUST BE CODED

1-110-21R (VA REGIONAL STS FACILITIES FOR CARDIOTHORACIC SURGERY FOR REGION 10)

IF NAS EXCEPTION REASON = BLANK

AND REGION CODE = '10' (REGION 10)

AND PATIENT ZIP CODE IS IN VA PALO ALTO HEALTH CARE SYSTEM (VAPAHCS)

OR SAN FRANCISCO VA MEDICAL CENTER (SFVAMC) STSF CATCHMENT AREA

AND BEGIN DATE OF CARE ≥ 11/01/99

AND DRG = 104 - 109

THEN NAS NUMBER MUST BE CODED

ELEMENT NAME: REASON FOR PAYMENT REDUCTION (1-113)

VALIDITY EDITS

1-113-01 MUST BE 'A', 'B', 'C' OR BLANK

RELATIONAL EDITS

| RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
|--|--------------------------------|----------------------------|
| AMOUNT OF PAYMENT REDUCTION | SEE BELOW | |
| NUMBER OF PAYMENT REDUCTION | SEE BELOW | |
| NUMBER OF PAYMENT REDUCTION DAYS/SERVICES | SEE BELOW | |

EDITED ELEMENT RELATIONSHIP

1-113-02R IF AMOUNT OF PAYMENT REDUCTION IS NOT EQUAL TO ZERO AND NUMBER OF PAYMENT REDUCTION DAYS/SERVICES IS NOT EQUAL TO ZEROS.
 REASON FOR PAYMENT REDUCTION MUST NOT BE BLANK.

1-113-03R IF ENROLLMENT STATUS EQUALS 'T', 'U', 'V', 'Z', 'Y', OR 'AA'
 REASON FOR PAYMENT REDUCTION MUST BE 'A', 'B', 'C', OR BLANK
 ELSE
 REASON FOR PAYMENT REDUCTION MUST BE 'A', 'B', OR BLANK.

ELEMENT NAME: AMOUNT BILLED (1-115)

VALIDITY EDITS

1-115-01 MUST BE NUMERIC

RELATIONAL EDITS

| RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
|-------------------------------|--------------------------------|---|
| TYPE OF SUBMISSION | SEE BELOW | FILING DATE |
| REVENUE CODE | SEE BELOW | TOTAL CHARGE BY REVENUE CODE |
| PRINCIPAL TREATMENT DIAGNOSIS | SEE BELOW | TYPE OF SUBMISSION, SPECIAL PROCESSING CODE |
| AMOUNT ALLOWED | SEE BELOW | SPECIAL RATE CODE, TYPE OF SUBMISSION, FILING DATE, ENROLLMENT STATUS |
| SPECIAL PROCESSING CODE | SEE BELOW | FREQUENCY CODE, TYPE OF SUBMISSION, FILING DATE |

EDITED ELEMENT RELATIONSHIP

1-115-02R AMOUNT BILLED MUST BE > ZERO **WHEN:**

| | | |
|----------------------|---|------------------------------|
| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | R | RESUBMISSION OF ERROR REJECT |

ELEMENT NAME: AMOUNT BILLED (1-115) (CONTINUED)

| | | |
|---|--|---|
| | O | ZERO PAYMENT |
| | F | ADJUSTMENT NEW SUFFIX |
| | D | COMPLETE DENIAL |
| | G | ADDITIONAL DRG INTERIM BILLING |
| OR | | |
| TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | C | COMPLETE CANCELLATION |
| WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 1-115-03R | AMOUNT BILLED MUST = TOTAL CHARGE BY REVENUE CODE FOR REVENUE CODE 001. | |
| 1-115-04R | AMOUNT BILLED MUST BE ≤ \$200.00 WHEN PRINCIPAL TREATMENT DIAGNOSIS EQUALS 799.9. | |
| | UNLESS TYPE OF SUBMISSION = | D COMPLETE DENIAL |
| | OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | 1 MEDICAID |
| 1-115-05R | AMOUNT BILLED MUST BE ≥ AMOUNT ALLOWED WHEN : | |
| ENROLLMENT STATUS = | F | FI STANDARD PROGRAM |
| | D | MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM |
| | J | MANAGED CARE SUPPORT - HOMESTEAD STANDARD PROGRAM |
| | M | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM |
| | T | MANAGED CARE SUPPORT - STANDARD PROGRAM |
| | S | CRI STANDARD PROGRAM |
| | Q | NEW ORLEANS STANDARD PROGRAM |
| SPECIAL RATE CODE = | b | NO SPECIAL RATE (BLANK) |
| | D | DISCOUNT RATE |
| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | R | RESUBMISSION OF ERROR REJECT |
| | O | ZERO PAYMENT |
| | F | ADJUSTMENT NEW SUFFIX |
| | D | COMPLETE DENIAL |
| | G | ADDITIONAL DRG INTERIM BILLING |
| OR | | |
| TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | C | COMPLETE CANCELLATION |

ELEMENT NAME: AMOUNT BILLED (1-115) (CONTINUED)

WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR_s STORED ON THE DATABASE.

1-115-06R AMOUNT BILLED MUST BE > \$90,000 **WHEN:**

DATES OF ADMISSION PRIOR TO DECEMBER 1, 1996

| | | |
|---------------------------|---|------------------------------------|
| SPECIAL PROCESSING CODE = | D | DRG QUALIFYING FOR INTERIM PAYMENT |
| FREQUENCY CODE = | 2 | INTERIM - INITIAL |
| | 3 | INTERIM - INTERIM |
| TYPE OF SUBMISSION = | F | ADJUSTMENT NEW SUFFIX |
| | I | INITIAL SUBMISSION (I) |
| | R | RESUBMISSION OF ERROR REJECT |
| | O | ZERO PAYMENT |
| | D | COMPLETE DENIAL |
| | G | ADDITIONAL DRG INTERIM BILLING |

OR

| | | |
|----------------------|---|-----------------------|
| TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | C | COMPLETE CANCELLATION |

WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR_s STORED ON THE DATABASE.

ELEMENT NAME: AMOUNT ALLOWED (1-120)

VALIDITY EDITS

1-120-01 MUST BE NUMERIC.

RELATIONAL EDITS

| RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
|--------------------------------|-----------------------------|---|
| 1-115-05R AMOUNT BILLED | | SPECIAL RATE CODE, TYPE OF SUBMISSION, FILING DATE, ENROLLMENT STATUS |
| TYPE OF SUBMISSION | SEE BELOW | AMOUNT PAID BY OHI/TPL, PATIENT COINSURANCE, PATIENT COPAYMENT, FILING DATE |
| DENIAL REASON CODE | SEE BELOW | TYPE OF SUBMISSION, FILING DATE |

EDITED ELEMENT RELATIONSHIP

1-120-02R AMOUNT ALLOWED MUST BE ZERO **WHEN:**

TYPE OF SUBMISSION = D COMPLETE CONTRACTOR DENIAL

1-120-03R AMOUNT ALLOWED MUST BE ZERO **WHEN:**

ELEMENT NAME: AMOUNT ALLOWED (1-120) (CONTINUED)

| | | |
|----------------------|---|-----------------------|
| TYPE OF SUBMISSION = | C | COMPLETE CANCELLATION |
|----------------------|---|-----------------------|

WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE, **UNLESS** THE CANCELLED HCSR REPORTS AMOUNT PAID BY OTHER HEALTH INSURANCE **OR** THIRD PARTY LIABILITY > ZERO, IN WHICH CASE AMOUNT ALLOWED MUST BE \geq ZERO, AND OHI PLUS TPL PLUS COPAYMENT PLUS COINSURANCE MUST BE \geq AMOUNT ALLOWED.

1-120-04R AMOUNT ALLOWED MUST BE ZERO **WHEN** ALL DETAIL DENIAL REASON CODES CONTAIN DENIAL CODE VALUES **WHEN**:

| | | |
|----------------------|---|--------------------------------|
| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | R | RESUBMISSION OF ERROR REJECT |
| | O | ZERO PAYMENT |
| | F | ADJUSTMENT NEW SUFFIX |
| | D | COMPLETE DENIAL |
| | G | ADDITIONAL DRG INTERIM BILLING |

OR

| | | |
|----------------------|---|-----------------------|
| TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | C | COMPLETE CANCELLATION |

WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE

ELSE

| | | |
|----------------------|---|----------------------------|
| TYPE OF SUBMISSION = | B | ADJUSTMENT NON-HCSR DATA |
| | E | CANCELLATION NON-HCSR DATA |

OR

| | | |
|----------------------|---|-----------------------|
| TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | C | COMPLETE CANCELLATION |

WITH FILING DATE OLDER THAN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATA BASE

THEN AMOUNT ALLOWED MUST BE \leq ZERO

ELEMENT NAME: AMOUNT PAID BY OTHER HEALTH INSURANCE (1-125)**VALIDITY EDITS**

1-125-01 MUST BE NUMERIC.

RELATIONAL EDITS

| RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
|--------------------|--------------------------------|----------------------------|
| TYPE OF SUBMISSION | SEE BELOW | |
| OVERRIDE CODE | SEE BELOW | |

EDITED ELEMENT RELATIONSHIP

1-125-02R AMOUNT OF OTHER HEALTH INSURANCE MUST BE \geq ZERO **WHEN**

ELEMENT NAME: AMOUNT PAID BY OTHER HEALTH INSURANCE (1-125) (CONTINUED)

| | | |
|---|---|--------------------------------|
| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | R | RESUBMISSION OF ERROR REJECT |
| | O | ZERO PAYMENT |
| | F | ADJUSTMENT NEW SUFFIX |
| | D | COMPLETE DENIAL |
| | G | ADDITIONAL DRG INTERIM BILLING |
| OR | | |
| TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | C | COMPLETE CANCELLATION |
| WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR _s STORED ON THE DATABASE. | | |

1-125-03R AMOUNT OF OTHER HEALTH INSURANCE MUST EQUAL ZERO WHEN:

| | | |
|--------------------------------------|---|--------------------------------------|
| ANY OCCURRENCE OF OVERRIDE CODE = | U | BENEFICIARY INDEMINIFICATION PAYMENT |
|--------------------------------------|---|--------------------------------------|

ELEMENT NAME: AMOUNT ALLOWED BY OTHER HEALTH INSURANCE (1-127)

VALIDITY EDITS

1-127-01 MUST BE NUMERIC.

RELATIONAL EDITS

| RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
|--------------------|--------------------------------|----------------------------|
| NONE | | |

ELEMENT NAME: AMOUNT OF THIRD PARTY LIABILITY (1-130)

VALIDITY EDITS

1-130-01 MUST BE NUMERIC.

RELATIONAL EDITS

| RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
|--------------------|--------------------------------|----------------------------|
| TYPE OF SUBMISSION | SEE BELOW | |
| OVERRIDE CODE | SEE BELOW | |

EDITED ELEMENT RELATIONSHIP

1-130-02R AMOUNT OF THIRD PARTY LIABILITY MUST BE ≥ ZERO WHEN:

| | | |
|----------------------|---|------------------------------|
| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | R | RESUBMISSION OF ERROR REJECT |
| | O | ZERO PAYMENT |

ELEMENT NAME: AMOUNT OF THIRD PARTY LIABILITY (1-130) (CONTINUED)

F ADJUSTMENT NEW SUFFIX

D COMPLETE DENIAL

G ADDITIONAL DRG INTERIM BILLING

OR

TYPE OF SUBMISSION = A ADJUSTMENT

C COMPLETE CANCELLATION

WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE
DATABASE.**1-130-03R AMOUNT OF THIRD PARTY LIABILITY MUST EQUAL ZERO WHEN:**ANY OCCURRENCE OF
OVERRIDE CODE = U BENEFICIARY INDEMNIFICATION PAYMENT**ELEMENT NAME: AMOUNT OF PAYMENT REDUCTION (1-133)****VALIDITY EDITS****1-133-01** MUST BE NUMERIC.**RELATIONAL EDITS**

| RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
|-----------------------------|--------------------------------|----------------------------|
| REASON FOR PAYMENT | SEE BELOW | |
| AMOUNT OF PAYMENT REDUCTION | SEE BELOW | |
| TYPE OF SUBMISSION | SEE BELOW | |

EDITED ELEMENT RELATIONSHIP**1-133-02R AMOUNT OF PAYMENT REDUCTION MUST BE GREATER THAN ZERO WHEN:**

| | | |
|-----------------------------------|---|--|
| REASON FOR PAYMENT REDUCTION = | A | MENTAL HEALTH PRE-AUTHORIZATION NOT OBTAINED TIMELY |
| | B | ADJUNCTIVE DENTAL CARE PRE-AUTHORIZATION NOT OBTAINED |
| | C | PROCEDURE/SERVICES IN TRICARE REGIONS CARE NOT PRE-AUTHORIZED |
| TYPE OF SUBMISSION = | A | ADJUSTMENT TO PRIOR HCSR DATA |
| | C | COMPLETE CANCELLATION OF PRIOR HCSR DATA |
| | I | INITIAL SUBMISSION |
| | R | RESUBMISSION OF REJECT |
| | O | ZERO PAYMENT |
| | F | ADJUSTMENT NEW SUFFIX |
| | G | ADDITIONAL DRUG INTERIM BILLING |

ELEMENT NAME: PATIENT COINSURANCE (1-140)

VALIDITY EDITS

1-140-01 MUST BE NUMERIC.

RELATIONAL EDITS

| RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
|--------------------|-----------------------------|--|
| SPONSOR STATUS | SEE BELOW | ENROLLMENT STATUS, PROGRAM INDICATOR, PATIENT RELATIONSHIP TO SPONSOR, SPECIAL RATE CODE, TYPE OF SUBMISSION, FILING DATE, OVERRIDE CODE |
| SPECIAL RATE CODE | SEE BELOW | ENROLLMENT STATUS, PROGRAM INDICATOR, PATIENT RELATIONSHIP, SPONSOR STATUS, TYPE OF SUBMISSION, FILING DATE, PATIENT DOB, BEGIN DATE OF CARE, PATIENT COPAYMENT, OVERRIDE CODE |
| TYPE OF SUBMISSION | SEE BELOW | FILING DATE, AMOUNT ALLOWED |
| SPECIAL RATE CODE | SEE BELOW | ENROLLMENT STATUS, PROGRAM INDICATOR, TYPE OF SUBMISSION, FILING DATE, AMOUNT ALLOWED, OVERRIDE CODE |
| OVERRIDE CODE | SEE BELOW | ENROLLMENT STATUS, PROGRAM INDICATOR, PATIENT RELATIONSHIP, SPONSOR STATUS, TYPE OF SUBMISSION, FILING DATE, PATIENT DOB, BEGIN DATE OF CARE, PATIENT COPAYMENT |
| OVERRIDE CODE | SEE BELOW | |

EDITED ELEMENT RELATIONSHIP

NO ERROR IF SPECIAL PROCESSING CODE = MS TRICARE-SENIOR PRIME (NETWORK) **OR**
 MN TRICARE-SENIOR PRIME (NON-NETWORK)

THEN BYPASS ALL COINSURANCE EDITING.

- ¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).
- ² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.
- ³ SEE 1-140-16R AND 1-145-16R.
- ⁴ SEE 1-145-15R.
- ⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.
- ⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.
- ⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)**NO ERROR IF BEGINNING DATE OF CARE ≥ 04/01/2001**

| | | |
|--|-----------|--|
| AND ENROLLMENT STATUS = | U | MANAGED CARE SUPPORT PRIME, CIVILIAN PCM OR |
| | W | TPR ACTIVE DUTY CLAIMS, USA OR |
| | X | ACTIVE DUTY CLAIMS, EUROPE OR |
| | Z | MANAGED CARE SUPPORT PRIME, MTF/PCM OR |
| | SN | SUPPLEMENTAL HEALTH CARE PROGRAM - NON-MTF-REFERRED CARE OR |
| | SR | SUPPLEMENTAL HEALTH CARE PROGRAM - REFERRED CARE |
| AND SPONSOR STATUS = | A | ACTIVE DUTY |
| AND PATIENT RELATIONSHIP TO SPONSOR = | B | SPONSOR OR |
| | C | CHILD OR |
| | S | SPOUSE OR |
| | V | STEP CHILD OR |
| | W | WARD |

THEN BYPASS ALL RELATIONAL PATIENT COINSURANCE EDITING.**1-140-02R PATIENT COINSURANCE MUST BE ZERO WHEN:**TYPE OF SUBMISSION = **D** COMPLETE CONTRACTOR DENIAL**1-140-03R PATIENT COINSURANCE MUST BE ZERO WHEN:**TYPE OF SUBMISSION = **C** COMPLETE CANCELLATION WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE**UNLESS**

THE CANCELLED HCSR REPORTS AMOUNT ALLOWED > ZERO, IN WHICH CASE PATIENT COINSURANCE MUST BE ≥ ZERO.

1-140-05R PATIENT COINSURANCE MUST BE ≤ AMOUNT ALLOWED WHEN:PROGRAM INDICATOR = **I** INSTITUTIONALENROLLMENT STATUS = **D** MANAGED CARE SUPPORT - TRICARE - TIDEWATER STANDARD PROGRAM**F** FI STANDARD PROGRAM**J** MANAGED CARE SUPPORT - HOMESTEAD STANDARD PROGRAM**¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).****² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.****³ SEE 1-140-16R AND 1-145-16R.****⁴ SEE 1-145-15R.****⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.****⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.****⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.**

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)

| | | |
|---|---|---|
| | M | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM |
| | Q | NEW ORLEANS STANDARD PROGRAM |
| | S | CRI STANDARD PROGRAM |
| | T | MANAGED CARE SUPPORT STANDARD PROGRAM |
| | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | F | ADJUSTMENT NEW SUFFIX |
| | O | ZERO PAYMENT |
| | R | RESUBMISSION OF ERROR REJECT |
| OR | | |
| TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE; | | |
| SPECIAL RATE CODE = | D | DISCOUNT RATE AGREEMENT |
| | P | PER DIEM RATE AGREEMENT |
| NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | L | NON-DRG REIMBURSEMENT USING DRG-RELATED COST-SHARE CALCULATION |
| NO OCCURRENCE OF SPECIAL PROCESSING CODES = | F | ARMY CAM DEMONSTRATIONS |
| | G | |
| | K | GEORGIA/FLORIDA PPO |
| | R | MEDICARE/CHAMPUS DUAL ENTITLEMENT |
| | # | HOSPICE |
| | | • EDITS FOR RETIRED SPONSORS AND THEIR FAMILY MEMBERS, AND FAMILY MEMBERS OF DECEASED SPONSORS, (OR FORMER SPOUSE), TRICARE/CHAMPUS-DRG RECORDS, (PATIENT NOT NEWBORN). SEE BELOW |

1-145-09R PATIENT COINSURANCE MUST EQUAL ZERO²

1-140-07R

¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).

² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.

³ SEE 1-140-16R AND 1-145-16R.

⁴ SEE 1-145-15R.

⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.

⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.

⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)**UNLESS**

25% OF AMOUNT BILLED MINUS TOTAL CHARGES BY REVENUE CODE FOR (DRG NON-REIMBURSABLE REVENUE CODES¹ AND DUPLICATE BILLING (1) DENIAL REASON CODE) IS LESS THAN [AUTHORIZED BED DAYS TIMES THE DRG/APPLICABLE DAILY RATE] **WHEN:**

| | | |
|---|---|---|
| PROGRAM INDICATOR = | I | INSTITUTIONAL |
| PATIENT DATE OF BIRTH ≠ BEGIN DATE OF CARE (NOT NEWBORN); | | |
| ENROLLMENT STATUS = | D | MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM |
| | F | FI STANDARD PROGRAM |
| | J | MANAGED CARE SUPPORT - HOMESTEAD STANDARD PROGRAM |
| | M | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM |
| | Q | NEW ORLEANS STANDARD PROGRAM |
| | S | CRI STANDARD PROGRAM |
| | T | MANAGED CARE SUPPORT - STANDARD PROGRAM |
| | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| SPECIAL RATE CODE = | G | DRG LONG STAY |
| | H | DRG SHORT STAY |
| | I | DRG COST OUTLIER |
| | J | DRG NO OUTLIER |
| | M | DISCOUNTED DRG LONG STAY |
| | N | DISCOUNTED DRG SHORT STAY |
| | O | DISCOUNTED DRG COST OUTLIER |
| | Q | DISCOUNTED DRG NO OUTLIER |
| TYPE OF SUBMISSION = | F | ADJUSTMENT NEW SUFFIX |
| | G | ADDITIONAL DRG INTERIM BILLING |
| | I | INITIAL SUBMISSION |
| | O | ZERO PAYMENT |
| | R | RESUBMISSION OF ERROR REJECT |

OR

TYPE OF SUBMISSION = A ADJUSTMENT

¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).

² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.

³ SEE 1-140-16R AND 1-145-16R.

⁴ SEE 1-145-15R.

⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.

⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.

⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)

| | |
|---|--|
| | C CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRS STORED ON THE DATABASE; | |
| SPONSOR STATUS = | F FORMER MEMBER |
| | I PERMANENTLY DISABLED |
| | O TEMPORARILY DISABLED |
| | R RETIRED |
| | H MEDAL OF HONOR |
| | K DECEASED |
| | D 100% DISABLED |
| | W TITLE III RETIREE |
| PATIENT RELATIONSHIP TO SPONSOR = | T FORMER SPOUSE |
| | H |
| | R |
| | Y |
| NO OCCURRENCE OF OVERRIDE CODE = | K CATASTROPHIC LOSS |
| | L NON-DRG REIMBURSEMENT USING DRG-RELATED COST-SHARE CALCULATION |
| | U BENEFICIARY INDEMNIFICATION PAYMENT |
| NO OCCURRENCE OF SPECIAL PROCESSING CODES = | F ARMY CAM DEMONSTRATIONS |
| | G |
| | K GEORGIA/FLORIDA PPO |
| | N CHAMPUS SELECT |
| | R MEDICARE/TRICARE DUAL ENTITLEMENT |
| | * VA MEDICAL CENTER CLAIM |
| | # HOSPICE |
| | • EDITS FOR RETIRED SPONSORS AND THEIR FAMILY MEMBERS, AND FAMILY MEMBERS OF DECEASED SPONSORS, TRICARE/CHAMPUS-DRG, PATIENT IS NEWBORN. |

1-145-09R PATIENT COINSURANCE MUST EQUAL ZERO²

1-140-08

- ¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).
- ² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.
- ³ SEE 1-140-16R AND 1-145-16R.
- ⁴ SEE 1-145-15R.
- ⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.
- ⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.
- ⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)**UNLESS**

25% OF AMOUNT BILLED MINUS TOTAL CHARGES BY REVENUE CODE FOR (DRG NON-REIMBURSABLE REVENUE CODES¹ AND DUPLICATE BILLING (1) DENIAL REASON CODE IS LESS THAN [(AUTHORIZED BED DAYS MINUS 3) TIMES THE DRG/APPLICABLE DAILY RATE] **WHEN:**

| | | |
|--|---|---|
| PROGRAM INDICATOR = | I | INSTITUTIONAL |
| PATIENT DATE OF BIRTH = BEGIN DATE OF CARE (NEWBORN) | | |
| ENROLLMENT STATUS = | S | CRI STANDARD PROGRAM |
| | J | MANAGED CARE SUPPORT - HOMESTEAD STANDARD PROGRAM |
| | M | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM |
| | T | MANAGED CARE SUPPORT - STANDARD PROGRAM |
| | Q | NEW ORLEANS STANDARD PROGRAM |
| | F | FI STANDARD PROGRAM |
| | D | MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM |
| | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| SPECIAL RATE CODE = | G | DRG LONG STAY |
| | H | DRG SHORT STAY |
| | I | DRG COST OUTLIER |
| | J | DRG NO OUTLIER |
| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | R | RESUBMISSION OF ERROR REJECT |
| | O | ZERO PAYMENT |
| | F | ADJUSTMENT NEW SUFFIX |
| | G | ADDITIONAL DRG INTERIM BILLING |
| OR | | |
| TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |

WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR_s STORED ON THE DATABASE;

¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).

² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.

³ SEE 1-140-16R AND 1-145-16R.

⁴ SEE 1-145-15R.

⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.

⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.

⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)

| | |
|--|---|
| SPONSOR STATUS = | F FORMER MEMBER |
| | I PERMANENTLY DISABLED |
| | O TEMPORARILY DISABLED |
| | R RETIRED |
| | H MEDAL OF HONOR |
| | K DECEASED |
| | D 100% DISABLED |
| | W TITLE III RETIREE |
| NO OCCURRENCE OF OVERRIDE CODE = | K CATASTROPHIC LOSS |
| | L NON-DRG REIMBURSEMENT USING DRG-RELATED COST-SHARE CALCULATION |
| | U BENEFICIARY INDEMNIFICATION PAYMENT |
| NO OCCURRENCE OF SPECIAL PROCESSING CODE = | F ARMY CAM DEMONSTRATIONS |
| | G |
| | K GEORGIA/FLORIDA PPO |
| | N CHAMPUS SELECT |
| | R MEDICARE/TRICARE DUAL ENTITLEMENT |
| | * VA MEDICAL CENTER CLAIM |
| | # HOSPICE |

IN WHICH CASE PATIENT COINSURANCE MUST EQUAL 25% (ALLOW 1^c ROUNDING ERROR) OF AMOUNT BILLED MINUS TOTAL CHARGES BY REVENUE CODE FOR (DRG NON-REIMBURSABLE REVENUE CODES AND DUPLICATE BILLING (1) DENIAL REASON CODE).

1-145-09R WHEN THE ABOVE CALCULATIONS RESULT IN EQUAL VALUES, PATIENT COINSURANCE MUST BE ZERO IF PATIENT COPAYMENT IS NOT ZERO. (USE 1-140-07R OR 1-140-08R IF CALCULATION RESULTS IN EQUAL VALUES, BUT VALUE SUBMITTED DOES NOT MATCH CALCULATION.)

NOTE: PATIENT COINSURANCE = ZERO FOR FAMILY MEMBERS OF ACTIVE DUTY SPONSORS OR TAMP DESIGNEES, INSTITUTIONAL HCSRs. SEE PATIENT COPAYMENT, EDIT 1-145-13R.

- EDITS FOR RETIRED SPONSORS AND THEIR FAMILY MEMBERS, AND FAMILY MEMBERS OF DECEASED SPONSORS, (OR FORMER SPOUSE), STATE-DRG AND NON-DRG RECORDS

1-140-10R PATIENT COINSURANCE MUST BE 25% (ALLOW 1^c ROUNDING ERROR) OF AMOUNT ALLOWED

- ¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).
- ² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.
- ³ SEE 1-140-16R AND 1-145-16R.
- ⁴ SEE 1-145-15R.
- ⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.
- ⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.
- ⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)**1-140-11R PATIENT COPAYMENT MUST BE ZERO WHEN:**

| | | |
|---------------------|---|--|
| PROGRAM INDICATOR = | I | INSTITUTIONAL |
| SPONSOR STATUS = | F | FORMER MEMBER |
| | I | PERMANENTLY DISABLED |
| | O | TEMPORARILY DISABLED |
| | R | RETIRED |
| | H | MEDAL OF HONOR |
| | K | DECEASED |
| | D | 100% DISABLED |
| | W | TITLE III RETIREE |
| ENROLLMENT STATUS = | S | CRI STANDARD PROGRAM |
| | J | MANAGED CARE SUPPORT - HOMESTEAD STANDARD PROGRAM |
| | M | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM |
| | T | MANAGED CARE SUPPORT - STANDARD PROGRAM |
| | Q | NEW ORLEANS STANDARD PROGRAM |
| | F | FI STANDARD PROGRAM |
| | D | MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM |
| | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| SPECIAL RATE CODE = | b | NO SPECIAL RATE |
| | A | DRG 4% DISCOUNT |
| | B | DRG 3% DISCOUNT |
| | C | DRG 2% DISCOUNT |
| | E | DRG 1% DISCOUNT (E) |
| | F | DRG NO DISCOUNT |
| | P | PER DIEM RATE |

¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).

² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.

³ SEE 1-140-16R AND 1-145-16R.

⁴ SEE 1-145-15R.

⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.

⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.

⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)

| | |
|---|--|
| PATIENT RELATIONSHIP TO SPONSOR = | T FORMER SPOUSE H R Y |
| TYPE OF SUBMISSION = | I INITIAL SUBMISSION |
| | R RESUBMISSION OF ERROR REJECT |
| | O ZERO PAYMENT |
| | F ADJUSTMENT NEW SUFFIX |
| | G ADDITIONAL DRG INTERIM BILLING |
| OR | |
| TYPE OF SUBMISSION = | A ADJUSTMENT |
| | C CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR _s STORED ON THE DATABASE; | |
| NO OCCURRENCE OF OVERRIDE CODE = | K CATASTROPHIC LOSS |
| | L NON-DRG REIMBURSEMENT USING DRG-RELATED COST-SHARE CALCULATION |
| | U BENEFICIARY INDEMNIFICATION PAYMENT |
| NO OCCURRENCE OF SPECIAL PROCESSING CODE = | F ARMY CAM DEMONSTRATIONS G |
| | K GEORGIA/FLORIDA PPO |
| | N CHAMPUS SELECT |
| | R MEDICARE/TRICARE DUAL ENTITLEMENT |
| | * VA MEDICAL CENTER CLAIM |
| | # HOSPICE |

1-140-14R PATIENT COST SHARE³ MUST BE THE LESSOR OF:
 A.) 25% (ALLOW 1^c ROUNDING ERROR) OF AMOUNT ALLOWED, **OR** THE LESSOR OF:
 B.) 25% (ALLOW 1^c ROUNDING ERROR) OF AMOUNT BILLED MINUS TOTAL CHARGES BY REVENUE CODE FOR (DRG NON-REIMBURSABLE CODES¹ AND DUPLICATE BILLING (1) DENIAL REASON CODE)

OR

¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).
² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.
³ SEE 1-140-16R AND 1-145-16R.
⁴ SEE 1-145-15R.
⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.
⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.
⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)C.) AUTHORIZED BED DAYS⁴ TIMES THE DRG/APPLICABLE DAILY RATE**1-145-14R WHEN:**

| | | |
|--|---|---|
| ANY OCCURRENCE OF OVERRIDE CODE = | L | NON-DRG REIMBURSEMENT USING DRG-RELATED COST-SHARE CALCULATION |
| PROGRAM INDICATOR = | I | INSTITUTIONAL |
| ENROLLMENT STATUS = | S | CRI STANDARD PROGRAM |
| | J | MANAGED CARE SUPPORT - HOMESTEAD STANDARD PROGRAM |
| | M | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM |
| | T | MANAGED CARE SUPPORT - STANDARD PROGRAM |
| | Q | NEW ORLEANS STANDARD PROGRAM |
| | F | FI STANDARD PROGRAM |
| | D | MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM |
| | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| NO OCCURRENCE OF SPECIAL PROCESSING CODE = | # | HOSPICE |
| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | R | RESUBMISSION OF ERROR REJECT |
| | O | ZERO PAYMENT |
| | F | ADJUSTMENT NEW SUFFIX |
| | G | ADDITIONAL DRG INTERIM BILLING |
| OR | | |
| TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR _s STORED ON THE DATABASE; | | |
| SPONSOR STATUS = | F | FORMER MEMBER |
| | I | PERMANENTLY DISABLED |
| | O | TEMPORARILY DISABLED |

¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES
AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.³ SEE 1-140-16R AND 1-145-16R.⁴ SEE 1-145-15R.⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)

| | | |
|-----------------------------------|---|-------------------|
| | R | RETIRED |
| | H | MEDAL OF HONOR |
| | K | DECEASED |
| | D | 100% DISABLED |
| | W | TITLE III RETIREE |
| PATIENT RELATIONSHIP TO SPONSOR = | T | FORMER SPOUSE |
| | H | |
| | R | |
| | Y | |

1-140-16R COST-SHARE MUST BE IN COINSURANCE BUCKET IF CALCULATION RESULTS IN A.) **OR** B.) ABOVE, IN WHICH CASE COPAYMENT MUST BE ZERO

1-145-16R COST-SHARE MUST BE IN COPAYMENT BUCKET IF CALCULATION RESULTS IN C.) ABOVE, IN WHICH CASE COINSURANCE MUST BE ZERO.

1-145-15R IF PATIENT DATE OF BIRTH = BEGIN DATE OF CARE (NEWBORN), USE (AUTHORIZED BED DAYS MINUS THREE) TIMES THE DRG DAILY RATE TO CALCULATE. DON'T DO IF BASED ON PATIENT RELATIONSHIP = FORMER SPOUSE. IF (AUTHORIZED BED DAYS MINUS THREE) IS NEGATIVE, CALCULATE USING 0 DAYS.

- EDIT FOR RETIRED SPONSORS AND THEIR FAMILY MEMBERS, AND FAMILY MEMBERS OF DECEASED SPONSORS, (**OR** FORMER SPOUSE), REGION-SPECIFIC PSYCHIATRIC PER DIEM RECORDS

1-140-18R PATIENT COINSURANCE MUST EQUAL ZERO⁵ **UNLESS**

1-140-17R 25% OF AMOUNT BILLED MINUS TOTAL CHARGES BY REVENUE CODE FOR (DRG NON REIMBURSABLE REVENUE CODES¹ AND DUPLICATE BILLING (1) (DENIAL REASON CODE) IS LESS THAN [AUTHORIZED BED DAYS TIMES THE PSYCH PER DIEM COST-SHARE DAILY RATE] **WHEN**

| | | |
|---------------------|---|---|
| PROGRAM INDICATOR = | I | INSTITUTIONAL |
| ENROLLMENT STATUS = | S | CRI STANDARD PROGRAM |
| | D | MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM |
| | J | MANAGED CARE SUPPORT - HOMESTEAD STANDARD PROGRAM |
| | M | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM |
| | T | MANAGED CARE SUPPORT STANDARD PROGRAM |
| | Q | NEW ORLEANS STANDARD PROGRAM |
| | F | FI STANDARD PROGRAM |

¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).

² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.

³ SEE 1-140-16R AND 1-145-16R.

⁴ SEE 1-145-15R.

⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.

⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.

⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)

| | | |
|---|---|--|
| | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| SPECIAL RATE CODE = | L | REGION SPECIFIC PSYCH PER DIEM |
| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | R | RESUBMISSION OF ERROR REJECT |
| | O | ZERO PAYMENT |
| | F | ADJUSTMENT NEW SUFFIX |
| OR | | |
| TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | C | CANCELLATION WITH AMOUNT ALLOWED |
| WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR _s STORED ON THE DATABASE; | | |
| SPONSOR STATUS = | F | FORMER MEMBER |
| | I | PERMANENTLY DISABLED |
| | O | TEMPORARILY DISABLED |
| | R | RETIRED |
| | H | MEDAL OF HONOR |
| | K | DECEASED |
| | D | 100% DISABLED |
| | W | TITLE III RETIREE |
| PATIENT RELATIONSHIP TO SPONSOR = | T | UNREMARIED FORMER SPOUSE |
| | H | |
| | R | |
| | Y | |
| NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | L | NON-DRG REIMBURSEMENT USING DRG-RELATED COST-SHARE CALCULATION |
| | N | RETROSPECTIVE PAYMENT-INPATIENT MENTAL HEALTH |
| | T | MHPD RECALCULATION OF RATES, NO COST-SHARE APPLIED |
| | U | BENEFICIARY INDEMNIFICATION PAYMENT |

¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).

² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.

³ SEE 1-140-16R AND 1-145-16R.

⁴ SEE 1-145-15R.

⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.

⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.

⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)

IN WHICH CASE PATIENT COINSURANCE MUST EQUAL 25% (ALLOW \$.01 ROUNDING ERROR) OF AMOUNT BILLED MINUS TOTAL CHARGES BY REVENUE CODE FOR DUPLICATE BILLING (1) DENIAL REASON CODE.

1-140-18R WHEN THE ABOVE CALCULATIONS RESULT IN EQUAL VALUES, PATIENT COINSURANCE MUST EQUAL ZERO IF PATIENT COPAYMENT IS NOT ZERO.

- EDIT FOR RETIRED SPONSORS AND THEIR FAMILY MEMBERS, AND FAMILY MEMBERS OF DECEASED SPONSORS, (OR FORMER SPOUSE), HOSPITAL-SPECIFIC PSYCHIATRIC PER DIEM RECORDS.

1-140-19R PATIENT COINSURANCE MUST BE 25% (ALLOW \$.01 ROUNDING ERROR) OF AMOUNT ALLOWED AND

1-145-19R PATIENT COPAYMENT MUST BE ZERO WHEN:

| | | |
|-----------------------------------|---|---|
| PROGRAM INDICATOR = | I | INSTITUTIONAL |
| SPONSOR STATUS = | F | FORMER MEMBER |
| | I | PERMANENTLY DISABLED |
| | O | TEMPORARILY DISABLED |
| | R | RETIRED |
| | H | MEDAL OF HONOR |
| | K | DECEASED |
| | D | 100% DISABLED |
| | W | TITLE III RETIREE |
| PATIENT RELATIONSHIP TO SPONSOR = | T | FORMER SPOUSE |
| | H | |
| | R | |
| | Y | |
| ENROLLMENT STATUS = | S | CRI STANDARD PROGRAM |
| | D | MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM |
| | J | MANAGED CARE SUPPORT - HOMESTEAD STANDARD PROGRAM |
| | M | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM |
| | T | MANAGED CARE SUPPORT - STANDARD PROGRAM |
| | Q | NEW ORLEANS STANDARD PROGRAM |

¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).

² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.

³ SEE 1-140-16R AND 1-145-16R.

⁴ SEE 1-145-15R.

⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.

⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.

⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)

| | | |
|--|--|--|
| | F | FI STANDARD PROGRAM |
| | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| SPECIAL RATE CODE = | K | HOSPITAL-SPECIFIC PSYCHIATRIC PER DIEM |
| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | R | RESUBMISSION OF ERROR REJECT |
| | O | ZERO PAYMENT |
| | F | ADJUSTMENT NEW SUFFIX |
| OR | | |
| TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | C | CANCELLATION WITH AMOUNT > ZERO |
| WITH FILING DATE WITHIN THE AND NUMBER OF MONTHS OF HCSRS STORED ON THE DATABASE | | |
| NO OCCURRENCE OF SPECIAL PROCESSING CODE = | R | MEDICARE/TRICARE DUAL ENTITLEMENT |
| NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | L | NON-DRG REIMBURSEMENT USING DRG-RELATED COST-SHARE CALCULATION |
| | N | RETROSPECTIVE PAYMENT-INPATIENT MENTAL HEALTH |
| | T | MHPD RECALCULATION OF RATES, NO COST-SHARE APPLIED |
| NOTE: IF THE HCSR BEGIN/END DATES OF CARE CROSSOVER A CHANGE IN THE ACTIVE DUTY DAILY RATE, THE DRG DAILY RATE, OR THE PSYCH PER DIEM COST-SHARES DAILY RATE (WHICHEVER APPLIES TO THAT HCSR), THE RATES MUST BE APPLIED APPROPRIATELY TO EACH PERIOD OF TIME, FOR COST-SHARE CALCULATIONS. | | |
| <ul style="list-style-type: none"> EDITS FOR TRICARE, ARMY CAM DEMONSTRATIONS, RETIRED SPONSORS AND THEIR FAMILY MEMBERS, AND FAMILY MEMBERS OF DECEASED SPONSORS, (OR FORMER SPOUSE). | | |
| 1-140-20R | PATIENT COINSURANCE MUST BE 50% (ALLOW \$.01 ROUNDING ERROR) OF AMOUNT ALLOWED AND | |
| | PATIENT COPAYMENT MUST BE ZERO WHEN : | |
| ENROLLMENT STATUS = | U | MANAGED CARE SUPPORT PRIME |
| | Z | MANAGED CARE SUPPORT - PRIME, MTF/PCM |

¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).

² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.

³ SEE 1-140-16R AND 1-145-16R.

⁴ SEE 1-145-15R.

⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.

⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.

⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)

| | | |
|---|---|---|
| SPECIAL PROCESSING CODE = | | PO TRICARE PRIME - POINT OF SERVICE |
| 1-140-21R | PATIENT COINSURANCE MUST BE 20% (ALLOW 1 ^c ROUNDING ERROR) OF AMOUNT ALLOWED AND | |
| 1-145-21R | PATIENT COPAYMENT MUST BE ZERO WHEN: | |
| PROGRAM INDICATOR = | I | INSTITUTIONAL |
| SPONSOR STATUS = | F | FORMER MEMBER |
| | I | PERMANENTLY DISABLED |
| | O | TEMPORARILY DISABLED |
| | R | RETIRED |
| | H | MEDAL OF HONOR |
| | K | DECEASED |
| | D | 100% DISABLED |
| | W | TITLE III RETIREE |
| PATIENT RELATIONSHIP TO SPONSOR = | T | FORMER SPOUSE |
| | H | |
| | R | |
| | Y | |
| ENROLLMENT STATUS = | S | CRI STANDARD PROGRAM |
| | Q | NEW ORLEANS STANDARD PROGRAM |
| | F | FI STANDARD PROGRAM |
| | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | F | ARMY CAM DEMONSTRATIONS |
| | G | |
| SPECIAL RATE CODE = | b | NO SPECIAL RATE |
| | D | DISCOUNT RATE AGREEMENT |
| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | R | RESUBMISSION OF ERROR REJECT |
| | O | ZERO PAYMENT |
| | F | ADJUSTMENT NEW SUFFIX |
| TYPE OF SUBMISSION = | A | ADJUSTMENT |

¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).

² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.

³ SEE 1-140-16R AND 1-145-16R.

⁴ SEE 1-145-15R.

⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.

⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.

⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)

| | | |
|---|--|--|
| | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON DATABASE; | | |
| NO OCCURRENCE OF SPECIAL PROCESSING CODE = | R | MEDICARE/TRICARE DUAL ENTITLEMENT |
| | # | HOSPICE |
| NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | L | NON-DRG REIMBURSEMENT USING DRG-RELATED COST-SHARE CALCULATION |
| | U | BENEFICIARY INDEMNIFICATION PAYMENT |
| <ul style="list-style-type: none"> EDITS FOR RETIRED SPONSORS AND THEIR FAMILY MEMBERS, AND FAMILY MEMBERS OF DECEASED SPONSORS, (OR FORMER SPOUSE), TRICARE/CHAMPUS-DRG RECORDS, (PATIENT NOT NEWBORN), FOR ARMY CAM DEMONSTRATIONS | | |
| 1-140-23R | PATIENT COINSURANCE MUST EQUAL ZERO ² UNLESS | |
| 1-140-24R | 20% OF [AMOUNT BILLED MINUS TOTAL CHARGES BY REVENUE CODE FOR (DRG NON-REIMBURSABLE REVENUE CODES ¹ AND DUPLICATE BILLING (1) DENIAL REASON CODE)] IS LESS THAN [AUTHORIZED BED DAYS TIMES THE DRG DAILY RATE] WHEN: | |
| PROGRAM INDICATOR = | I | INSTITUTIONAL |
| PATIENT DATE OF BIRTH ≠ BEGIN DATE OF CARE (NOT NEWBORN); | | |
| ENROLLMENT STATUS = | S | CRI STANDARD PROGRAM |
| | Q | NEW ORLEANS STANDARD PROGRAM |
| | F | FI STANDARD PROGRAM |
| | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| SPECIAL RATE CODE = | G | DRG LONG STAY |
| | H | DRG SHORT STAY |
| | I | DRG COST OUTLIER |
| | J | DRG NO OUTLIER |
| | M | DISCOUNTED DRG LONG STAY |
| | N | DISCOUNTED DRG SHORT STAY |
| | O | DISCOUNTED DRG COST OUTLIER |
| | Q | DISCOUNTED DRG NO OUTLIER |

¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).

² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.

³ SEE 1-140-16R AND 1-145-16R.

⁴ SEE 1-145-15R.

⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.

⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.

⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)

| | |
|---|--|
| ANY SPECIAL OCCURRENCE OF SPECIAL PROCESSING CODE = | F ARMY CAM DEMONSTRATIONS G |
| TYPE OF SUBMISSION = | I INITIAL SUBMISSION R RESUBMISSION OF ERROR REJECT O ZERO PAYMENT F ADJUSTMENT NEW SUFFIX G ADDITIONAL DRG INTERIM BILLING |
| OR TYPE OF SUBMISSION = | A ADJUSTMENT C CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR _s STORED ON THE DATA BASE; | |
| SPONSOR STATUS = | F FORMER MEMBER I PERMANENTLY DISABLED O TEMPORARILY DISABLED R RETIRED H MEDAL OF HONOR K DECEASED D 100% DISABLED W TITLE III RETIREE |
| OR PATIENT RELATIONSHIP TO SPONSOR = | T FORMER SPOUSE H R Y |
| NO OCCURRENCE OF SPECIAL PROCESSING CODE = | R MEDICARE/TRICARE DUAL ENTITLEMENT # HOSPICE |
| NO OCCURRENCE OF OVERRIDE CODE = | K CATASTROPHIC LOSS |

- ¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).
- ² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.
- ³ SEE 1-140-16R AND 1-145-16R.
- ⁴ SEE 1-145-15R.
- ⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.
- ⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.
- ⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)L NON-DRG REIMBURSEMENT USING DRG-RELATED
COST-SHARE CALCULATION

U BENEFICIARY INDEMNIFICATION PAYMENT

- EDITS FOR RETIRED SPONSORS AND THEIR FAMILY MEMBERS, AND FAMILY MEMBERS OF DECEASED SPONSORS, TRICARE/CHAMPUS-DRG, PATIENT IS NEWBORN, FOR ARMY CAM DEMONSTRATIONS.

1-140-25R PATIENT COINSURANCE MUST EQUAL ZERO⁶ UNLESS**1-140-26R** 20% OF AMOUNT BILLED MINUS TOTAL CHARGES BY REVENUE CODE FOR DRG NON-REIMBURSABLE REVENUE CODES¹ AND DUPLICATE BILLING (1) DENIAL REASON CODE IS LESS THAN [(AUTHORIZED BED DAYS MINUS 3) TIMES THE DRG DAILY RATE] **WHEN:**

PROGRAM INDICATOR = I INSTITUTIONAL

PATIENT DATE OF BIRTH = BEGIN DATE OF CARE (NEWBORN);

ENROLLMENT STATUS = S CRI STANDARD PROGRAM

Q NEW ORLEANS STANDARD PROGRAM

F FI STANDARD PROGRAM

Y CONTINUED HEALTH CARE BENEFIT PROGRAM
STANDARD

SPECIAL RATE CODE = G DRG LONG STAY

H DRG SHORT STAY

I DRG COST OUTLIER

J DRG NO OUTLIER

M DISCOUNTED DRG LONG STAY OUTLIER

N DISCOUNTED DRG SHORT STAY

O DISCOUNTED DRG COST OUTLIER

Q DISCOUNTED DRG NO OUTLIER

TYPE OF SUBMISSION = I INITIAL SUBMISSION

R RESUBMISSION OF ERROR REJECT

O ZERO PAYMENT

F ADJUSTMENT NEW SUFFIX

G ADDITIONAL DRG INTERIM BILLING

OR

TYPE OF SUBMISSION = A ADJUSTMENT

C CANCELLATION WITH AMOUNT ALLOWED >
ZERO¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.³ SEE 1-140-16R AND 1-145-16R.⁴ SEE 1-145-15R.⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)

WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE;

ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

F ARMY CAM DEMONSTRATIONS
 G

SPONSOR STATUS =

F FORMER MEMBER
 I PERMANENTLY DISABLED
 O TEMPORARILY DISABLED
 R RETIRED
H MEDAL OF HONOR
 K DECEASED
 D 100% DISABLED
 W TITLE III RETIREE

NO OCCURRENCE OF SPECIAL PROCESSING CODE =

R MEDICARE/TRICARE DUAL ENTITLEMENT
 # HOSPICE

NO OCCURRENCE OF OVERRIDE CODE =

K CATASTROPHIC LOSS
 L NON-DRG REIMBURSEMENT USING DRG-RELATED COST-SHARE CALCULATION
 U BENEFICIARY INDEMNIFICATION PAYMENT

IN WHICH CASE PATIENT COINSURANCE MUST EQUAL 20% (ALLOW 1^c ROUNDING ERROR) OF AMOUNT BILLED MINUS TOTAL CHARGES BY REVENUE CODE FOR (DRG NON-REIMBURSABLE REVENUE CODES AND DUPLICATE BILLING (1) DENIAL REASON CODE).

1-140-25R WHEN THE ABOVE CALCULATIONS RESULT IN EQUAL VALUES, PATIENT COINSURANCE MUST BE ZERO IF PATIENT COPAYMENT IS NOT ZERO.

1-140-27R PATIENT COINSURANCE MUST EQUAL ZERO WHEN:

ANY OCCURRENCE OF OVERRIDE CODE =

U BENEFICIARY INDEMNIFICATION PAYMENT

- EDITS FOR RETIRED SPONSORS AND THEIR FAMILY MEMBERS, AND FAMILY MEMBERS OF DECEASED SPONSORS, CHAMPUS SELECT.

¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).

² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.

³ SEE 1-140-16R AND 1-145-16R.

⁴ SEE 1-145-15R.

⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.

⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.

⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)**1-140-29R** PATIENT COINSURANCE MUST = ZERO **WHEN:**

SPONSOR STATUS = ANY VALUE LISTED UNDER ACTIVE DUTY OR TAMP DESIGNEE
 ANY OCCURRENCE OF SPECIAL PROCESSING CODE = (N) CHAMPUS SELECT
 ANY OCCURRENCE OF SPECIAL PROCESSING CODE = (#) HOSPICE
 SPECIAL PROCESSING CODE - (AD) ACTIVE DUTY

- COST SHARE EDIT FOR TRICARE PRIME - POINT OF SERVICE PROGRAM

1-140-30R PATIENT COST SHARE MUST BE 50% (ALLOW \$.01 ROUNDING ERROR) OF AMOUNT ALLOWED **WHEN:**

ENROLLMENT STATUS = U MANAGED CARE-SUPPORT PRIME, CIVILIAN PCM

Z MANAGED CARE SUPPORT-PRIME, MTF/PCM

SPECIAL PROCESSING
 CODE =

PO TRICARE PRIME-POINT OF SERVICE

1-140-33R PATIENT COINSURANCE MUST BE 20% (ALLOW 1^c ROUNDING ERROR) OF AMOUNT ALLOWED AND**1-145-33R** PATIENT COPAYMENT MUST BE ZERO **WHEN:**

SPONSOR STATUS = F FORMER MEMBER

I PERMANENTLY DISABLED

O TEMPORARILY DISABLED

R RETIRED

H MEDAL OF HONOR

K DECEASED

D 100% DISABLED

W TITLE III RETIREE

OR

PATIENT RELATIONSHIP = T FORMER SPOUSE

H
R
Y

ANY OCCURRENCE OF
 SPECIAL PROCESSING
 CODE =

! NORTHERN REGION COORDINATED CARE

NO OCCURRENCE OF
 OVERRIDE CODE =

K CATASTROPHIC LOSS

SPECIAL RATE CODE =

K HOSPITAL SPECIFIC PSYCHIATRIC PER DIEM

L REGION SPECIFIC PSYCHIATRIC PER DIEM

¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).

² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.

³ SEE 1-140-16R AND 1-145-16R.

⁴ SEE 1-145-15R.

⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.

⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.

⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)

OR

TYPE OF INSTITUTION = 72 RESIDENTIAL TREATMENT CENTER

TYPE OF SUBMISSION = I INITIAL SUBMISSION

R RESUBMISSION OF REJECT

O ZERO PAYMENT

F ADJUSTMENT NEW SUFFIX

G ADDITION DRG INTERIM BILLING

OR

TYPE OF SUBMISSION = A ADJUSTMENT

C CANCELLATION WITH AMOUNT ALLOWED > ZERO

WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR_s STORED ON THE DATABASE

1-140-34R PATIENT COST SHARE MUST BE THE LESSOR OF:

A.) 25% (ALLOW 1^c ROUNDING ERROR) OF AMOUNT BILLED

OR

B.) AUTHORIZED BED DAYS TIMES THE APPLICABLE DAILY RATE

1-145-34R **WHEN:**

SPONSOR STATUS = F FORMER MEMBER

I PERMANENTLY DISABLED

O TEMPORARILY DISABLED

R RETIRED

H MEDAL OF HONOR

K DECEASED

D 100% DISABLED

W TITLE III RETIREE

OR

PATIENT RELATIONSHIP = T FORMER SPOUSE

H

R

Y

ANY OCCURRENCE OF SPECIAL PROCESSING CODE = ! NORTHERN REGION COORDINATED CARE

NO OCCURRENCE OF OVERRIDE CODE = K CATASTROPHIC LOSS

- ¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).
- ² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.
- ³ SEE 1-140-16R AND 1-145-16R.
- ⁴ SEE 1-145-15R.
- ⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.
- ⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.
- ⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)

| | | |
|---|---|---|
| SPECIAL RATE CODE = | G | DRG LONG STAY |
| | H | DRG SHORT STAY |
| | I | DRG COST OUTLIER |
| | J | DRG NO OUTLIER |
| | M | DISCOUNTED DRG LONG STAY |
| | N | DISCOUNTED DRG SHORT STAY |
| | O | DISCOUNTED DRG COST OUTLIER |
| | Q | DISCOUNTED DRG NO OUTLIER |
| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | R | RESUBMISSION OF ERROR REJECT |
| | O | ZERO PAYMENT |
| | F | ADJUSTMENT NEW SUFFIX |
| | G | ADDITIONAL DRG INTERIM BILLING |
| OR | | |
| TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR _s STORED ON THE DATABASE; | | |
| 1-140-35R | COST-SHARE MUST BE IN COINSURANCE BUCKET IF CALCULATION RESULTS IN A.) ABOVE, IN WHICH CASE COPAYMENT MUST BE ZERO | |
| 1-145-35R | COST-SHARE MUST BE IN COPAYMENT BUCKET IF CALCULATION RESULTS IN B.) ABOVE, IN WHICH CASE COINSURANCE MUST BE ZERO. | |
| 1-140-36R | PATIENT COST SHARE MUST BE THE LESSOR OF: | |
| | A.) 25% (ALLOW 1 ^c ROUNDING ERROR) OF AMOUNT ALLOWED | |
| OR | | |
| | B.) AUTHORIZED BED DAYS TIMES THE APPLICABLE DAILY RATE | |
| 1-145-36R | WHEN: | |
| SPONSOR STATUS = | F | FORMER MEMBER |
| | I | PERMANENTLY DISABLED |
| | O | TEMPORARILY DISABLED |
| | R | RETIRED |
| | H | MEDAL OF HONOR |

¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).

² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.

³ SEE 1-140-16R AND 1-145-16R.

⁴ SEE 1-145-15R.

⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.

⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.

⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)

| | | |
|---|------------------|---|
| | K | DECEASED |
| | D | 100% DISABLED |
| | W | TITLE III RETIREE |
| OR | | |
| PATIENT RELATIONSHIP = | T H R Y | FORMER SPOUSE |
| ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | ! | NORTHERN REGION COORDINATED CARE |
| NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| SPECIAL RATE CODE ≠ | G | DRG LONG STAY |
| | H | DRG SHORT STAY |
| | I | DRG COST OUTLIER |
| | J | DRG NO OUTLIER |
| | K | HOSPITAL SPECIFIC PSYCHIATRIC PER DIEM |
| | L | REGION SPECIFIC PSYCHIATRIC PER DIEM |
| | M | DISCOUNTED DRG LONG STAY |
| | N | DISCOUNTED DRG SHORT STAY |
| | O | DISCOUNTED DRG COST OUTLIER |
| | Q | DISCOUNTED DRG NO OUTLIER |
| TYPE OF INSTITUTION ≠ | 72 | RESIDENTIAL TREATMENT CENTER |
| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | R | RESUBMISSION OF ERROR REJECT |
| | O | ZERO PAYMENT |
| | F | ADJUSTMENT NEW SUFFIX |
| | G | ADDITIONAL DRG INTERIM BILLING |
| OR | | |
| TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE; | | |

- 1 REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).**
- 2 IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.**
- 3 SEE 1-140-16R AND 1-145-16R.**
- 4 SEE 1-145-15R.**
- 5 IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.**
- 6 IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.**
- 7 IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.**

ELEMENT NAME: PATIENT COINSURANCE (1-140) (CONTINUED)

| | |
|------------------------------|---|
| 1-140-37R | COST-SHARE MUST BE IN COINSURANCE BUCKET IF CALCULATION RESULTS IN A.) ABOVE, IN WHICH CASE COPAYMENT MUST BE ZERO |
| 1-145-37R | COST-SHARE MUST BE IN COPAYMENT BUCKET IF CALCULATION RESULTS IN B.) ABOVE, IN WHICH CASE COINSURANCE MUST BE ZERO. |
| 1-140-38R | PATIENT COINSURANCE MUST BE ZERO WHEN: |
| SPECIAL PROCESSING CODE = | AD ACTIVE DUTY OR |
| | AN SUPPLEMENTAL HEALTH CARE PROGRAM - NON-MTF-REFERRED CARE OR |
| | AR SUPPLEMENTAL HEALTH CARE PROGRAM - REFERRED CARE OR |
| | CE SUPPLEMENTAL HEALTH CARE PROGRAM - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR |
| | GU ACTIVE DUTY SERVICE MEMBER ENROLLED IN TRICARE PRIME REMOTE: NOT AT RISK PAYMENT BY CONTRACTOR OR |
| | SC SUPPLEMENTAL HEALTH CARE PROGRAM - NON-TRICARE ELIGIBLE OR |
| | SE SUPPLEMENTAL HEALTH CARE PROGRAM - TRICARE ELIGIBLE OR |
| | SM SUPPLEMENTAL HEALTH CARE PROGRAM - EMERGENCY |

¹ REVENUE CODES FOR HOSPITAL BASED PROFESSIONALS, HOSPITAL OUTPATIENT CHARGES AND ORGAN ACQUISITION COSTS (REVENUE CODES 901, 914 - 918, 96X, 97X, 98X, AND 81X).

² IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-07R AND 1-145-08R.

³ SEE 1-140-16R AND 1-145-16R.

⁴ SEE 1-145-15R.

⁵ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-17R AND 1-145-18R.

⁶ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-25R AND 1-145-26R.

⁷ IF PATIENT COINSURANCE = ZERO, SEE PATIENT COPAYMENT EDITS 1-145-28R.

