

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PERSON SEX (PATIENT) (1-100)	
VALIDITY EDITS	
1-100-01V	MUST BE 'F' (FEMALE) OR 'M' (MALE)
RELATIONAL EDITS	
NONE	
ELEMENT NAME: PATIENT ZIP CODE (1-105)	
VALIDITY EDITS	
1-105-01V	MUST BE A VALID ZIP CODE ¹ ; EITHER 9 DIGITS, OR 5 DIGITS (NOT 5 ZEROES), OR 5 NINES, FOLLOWED BY 4 BLANKS OR 3 CHARACTERS FOREIGN COUNTRY CODE FOLLOWED BY 6 BLANKS. MUST NOT BE ALL ZEROES OR ALL NINES.
1-105-02V	MUST BE A VALID ZIP CODE IN THE ELECTRONIC ZIP CODE FILE BASED ON THE ADMISSION DATE OR THE FIRST 3 CHARACTERS AGAINST COUNTRY CODES TABLE ² .
RELATIONAL EDITS	
NO ERROR	IF ADMISSION DATE IS OLDER THAN 6 YEARS THEN DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA
1-105-01R	IF CA/NAS EXCEPTION REASON IS CODED THEN PATIENT ZIP CODE MUST BE WITHIN AN MTF ⁴ CATCHMENT AREA ³
1-105-02R	IF CA/NAS NUMBER IS PRESENT THEN PATIENT ZIP CODE MUST BE WITHIN AN MTF ⁴ CATCHMENT AREA ³ UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	R MEDICARE/TRICARE DUAL ENROLLMENT (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
¹ 5 DIGIT ZIP CODE WILL BE EDITED AGAINST A GOVERNMENT PROVIDED FILE. ² WHEN FOREIGN COUNTRY IS SUBMITTED, THE FIRST 3 CHARACTERS WILL BE EDITED AGAINST CHAPTER 2, ADDENDUM A . ³ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE. ⁴ MTF IS A 40 MILES CATCHMENT AREA.	

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ELEMENT NAME: PATIENT ZIP CODE (1-105) (CONTINUED)

RS MEDICARE/TRICARE DUAL ENROLLMENT (FIRST PAYOR - NO TRICARE PROVIDER CERTIFICATION I.E., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**

ST⁴ SPECIALIZED TREATMENT

THEN BYPASS THIS EDIT

- ¹ 5 DIGIT ZIP CODE WILL BE EDITED AGAINST A GOVERNMENT PROVIDED FILE.
- ² WHEN FOREIGN COUNTRY IS SUBMITTED, THE FIRST 3 CHARACTERS WILL BE EDITED AGAINST [CHAPTER 2, ADDENDUM A](#).
- ³ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.
- ⁴ MTF IS A 40 MILES CATCHMENT AREA.

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (1-110)

VALIDITY EDITS

1-110-01V MUST BE A VALID ENROLLMENT/HEALTH PLAN CODE (REFER TO [CHAPTER 2, SECTION 2.5](#))

1-110-02V IF ENROLLMENT/HEALTH PLAN CODE =

SO SHCP-NON-TRICARE ELIGIBLE OR

ST SHCP-TRICARE ELIGIBLE

THEN BEGIN DATE OF CARE MUST BE < 09/01/2002

1-110-03V IF ENROLLMENT/HEALTH PLAN CODE =

TS TSS

THEN BEGIN DATE OF CARE MUST BE < 12/31/2002

1-110-04V IF ENROLLMENT/HEALTH PLAN CODE =

BB TPS

THEN BEGIN DATE OF CARE MUST BE < 12/31/2001

RELATIONAL EDITS

1-110-01R IF ANY OCCURRENCE OF OVERRIDE CODE =

Z ENHANCED BENEFIT

THEN ENROLLMENT/HEALTH PLAN CODE MUST =

U TRICARE PRIME, CIVILIAN PCM **OR**

Z TRICARE PRIME, MTF/PCM

1-110-02R IF ENROLLMENT/HEALTH PLAN CODE =

Y CHCBP STANDARD **OR**

AA CHCBP EXTRA

THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE CAN =

CL CLINICAL TRIALS **OR**

PF PFPWD

1-110-03R IF ENROLLMENT/HEALTH PLAN CODE =

W TPR ACTIVE DUTY-USA

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

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ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (1-110) (CONTINUED)			
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	GU	ADSM ENROLLED IN TPR
1-110-05R	IF ENROLLMENT/HEALTH PLAN CODE =	BB	TSP
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	MN	TSP-NON-NETWORK OR
		MS	TSP-NETWORK
1-110-06R	IF BEGIN DATE OF CARE ≤ 06/01/2001		
	AND ENROLLMENT/HEALTH PLAN CODE =	SN	SHCP-NON-MTF-REFERRED CARE OR
		SO	SHCP-NON-TRICARE ELIGIBLE OR
		SR	SHCP-REFERRED CARE OR
		ST	SHCP-TRICARE ELIGIBLE
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AN	SHCP-NON-MTF-REFERRED CARE OR
		AR	SHCP-REFERRED CARE OR
		CE	SHCP-COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
		SC	SHCP-NON-TRICARE ELIGIBLE OR
		SE	SHCP-TRICARE ELIGIBLE OR
		SM	SHCP-EMERGENCY
1-110-07R	IF ENROLLMENT/HEALTH PLAN CODE =	Z	TRICARE PRIME, MTF/PCM
	THEN ADMISSION DATE MUST BE ≥ 10/01/1997		
1-110-08R	IF ENROLLMENT/HEALTH PLAN CODE =	TS	TSS
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	SN	TSS-NON-NETWORK OR
		SS	TSS-NETWORK
1-110-09R	IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL-EXTRA OR
		FS	TFL-STANDARD
	AND PRICING RATE CODE ≠	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER OR
		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER
	THEN BEGIN DATE OF CARE MUST BE ≥ 10/01/2001		

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

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ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (1-110) (CONTINUED)

	AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	FF	TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) OR
		FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) OR
		FS	TFL (SECOND PAYOR)
1-110-10R	IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL-EXTRA OR
		FS	TFL-STANDARD
	AND PRICING RATE CODE =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER OR
		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER
	THEN END DATE OF CARE ≥ 10/01/2001		
	AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	FF	TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) OR
		FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) OR
		FS	TFL (SECOND PAYOR)
1-110-11R	IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL-EXTRA OR
		FS	TFL-STANDARD
	THEN PERSON BIRTH CALENDAR DATE (PATIENT) MUST BE ≥ 64 YEARS AND 11 MONTHS¹		
1-110-12R	IF ENROLLMENT/HEALTH PLAN CODE =	WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	THEN BEGIN DATE OF CARE IS ≥ 09/01/2002		

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

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111)

VALIDITY EDITS

1-111-01V MUST BE A VALID HCDP PLAN COVERAGE CODE LISTED IN [ADDENDUM M](#).

RELATIONAL EDITS

NONE

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: REGION INDICATOR (1-112)

VALIDITY EDITS

1-112-01V	MUST BE VALID REGION INDICATOR (REFER TO CHAPTER 2, SECTION 2.8)		
1-112-02V	IF REGION INDICATOR =	NC	NORTH CONTRACT
		SC	SOUTH CONTRACT
		WC	WEST CONTRACT
	THEN ADJUSTMENT KEY MUST =	0	BATCH
		5	VOUCHER

RELATIONAL EDITS

NONE

ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (1-115)

VALIDITY EDITS

1-115-01V	MUST BE VALID PCM LOCATION DMIS-ID.
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RELATIONAL EDITS

NO ERROR	IF ANY OCCURRENCE OF OVERRIDE CODE =	S	ZIP CODE OVERRIDE TO BE USED WHEN A BENEFICIARY HAS MOVED OUT OF A REGION AND THE CONTRACTOR IS STILL RESPONSIBLE FOR THE CARE CLAIMED; OR IF A BENEFICIARY RESIDES IN A REGION DIFFERENT FROM THE REGION THEY ARE ENROLLED IN-- WITHIN THE SAME CONTRACT JURISDICTION (i.e., 2/5, 3/4, OR 9/10)
	THEN BYPASS ALL PCM LOCATION DMIS-ID RELATIONAL EDITING.		
1-115-01R	IF DATE OF ADMISSION ≥ 10/01/1997 AND ENROLLMENT/HEALTH PLAN CODE =	Z BB	TRICARE PRIME, MTF/CLINIC OR TSP
	THEN PCM LOCATION DMIS-ID MUST BE A VALID MTF/CLINIC DMIS-ID¹ AND CANNOT = 6501, 6901-6915, 7901-7912, 7916², 8000-8099, OR BLANK.		
1-115-02R	IF DATE OF ADMISSION ≥ 10/01/1999 AND ENROLLMENT/HEALTH PLAN CODE =	SR	SHCP-REFERRED CARE
	THEN PCM LOCATION DMIS-ID MUST EQUAL A VALID MTF/CLINIC DMIS-ID¹ AND CANNOT = 6501, 6901-6915, 7901-7912, 7916², 8000-8099 OR BLANK.		
1-115-03R	IF DATE OF ADMISSION ≥ 10/01/1997 AND < 10/01/1999 AND ENROLLMENT/HEALTH PLAN CODE =	U	TRICARE PRIME, CIVILIAN PCM
	AND REGION INDICATOR = NC OR BLANK THEN DMIS-ID MUST = 6501 OR 6902 OR 8000-8099		

¹ A VALID MTF/CLINIC DMIS-ID MEANS ONE THAT MATCHES THE DOD DMIS-ID LISTING.

² 7916 IS THE DMIS-ID FOR ALASKA.

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ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (1-115) (CONTINUED)

1-115-04R	IF DATE OF ADMISSION ≥ 10/01/1997 AND < 09/01/2002
	AND ENROLLMENT/HEALTH PLAN CODE = U TRICARE PRIME, CIVILIAN PCM
	AND REGION INDICATOR = NC OR BLANK THEN DMIS-ID MUST = 6901, 6902, 6905 OR 8000-8099
1-115-05R	IF DATE OF ADMISSION ≥ 10/01/1997 AND < 10/01/1999
	AND ENROLLMENT/HEALTH PLAN CODE = W TPR ACTIVE DUTY CLAIMS-USA
	AND REGION INDICATOR = NC OR BLANK THEN DMIS-ID MUST = 7901, 7902, 7905 OR 8000-8099 OR BLANK
1-115-06R	IF DATE OF ADMISSION ≥ 10/01/1999 AND < 09/01/2002
	AND ENROLLMENT/HEALTH PLAN CODE = W TPR ACTIVE DUTY CLAIMS-USA
	AND REGION INDICATOR = NC OR BLANK THEN DMIS-ID MUST = 7901, 7902, 7905 OR 8000-8099
	OR REGION INDICATOR = SC OR BLANK THEN DMIS-ID MUST = 7903, 7904 OR 7906
	OR REGION INDICATOR = WC OR BLANK THEN DMIS-ID MUST = 7907, 7908, 7909, 7910, 7911, 7912 OR 7916
1-115-07R	IF DATE OF ADMISSION ≥ 10/01/1997
	AND ENROLLMENT/HEALTH PLAN CODE ≠ U TRICARE PRIME, CIVILIAN PCM OR
	W TPR ACTIVE DUTY CLAIMS-USA OR
	Z TRICARE PRIME, MTF/CLINIC OR
	BB TSP OR
	SR SHCP-REFERRED CARE OR
	WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	THEN PCM LOCATION DMIS-ID MUST = BLANK
1-115-08R	IF DATE OF ADMISSION ≥ 09/01/2002
	AND ENROLLMENT/HEALTH PLAN CODE = U TRICARE PRIME, CIVILIAN PCM
	AND REGION INDICATOR = NC OR BLANK THEN DMIS-ID MUST = 6901, 6902, 8007, 8009 OR 6905
	OR REGION INDICATOR = SC OR BLANK THEN DMIS-ID MUST = 6903, 6904, 6906, 6913, 6914 OR 6915
	OR REGION INDICATOR = WC OR BLANK THEN DMIS-ID MUST = 6907, 6908, 6909, 6910, 6911 OR 6912

¹ A VALID MTF/CLINIC DMIS-ID MEANS ONE THAT MATCHES THE DOD DMIS-ID LISTING.

² 7916 IS THE DMIS-ID FOR ALASKA.

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ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (1-115) (CONTINUED)

1-115-09R	IF DATE OF ADMISSION ≥ 09/01/2002
	AND ENROLLMENT/HEALTH PLAN CODE =
	W TPR ACTIVE DUTY CLAIMS-USA OR
	WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	AND REGION INDICATOR = NC OR BLANK THEN DMIS-ID MUST = 7901, 7902, OR 7905
	OR REGION INDICATOR = SC OR BLANK THEN DMIS-ID MUST = 7903, 7904, 7906, 7913, 7914 OR 7915
	OR REGION INDICATOR = WC OR BLANK THEN DMIS-ID MUST = 7907, 7908, 7909, 7910, 7911, 7912 OR 7916

¹ A VALID MTF/CLINIC DMIS-ID MEANS ONE THAT MATCHES THE DOD DMIS-ID LISTING.
² 7916 IS THE DMIS-ID FOR ALASKA.

ELEMENT NAME: AMOUNT BILLED (TOTAL) (1-120)

VALIDITY EDITS

1-120-01V MUST BE NUMERIC.

RELATIONAL EDITS

1-120-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		C	COMPLETE CANCELLATION OR
		D	COMPLETE DENIAL OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION

THEN AMOUNT BILLED (TOTAL) MUST BE > ZERO

1-120-02R AMOUNT BILLED (TOTAL) MUST = TOTAL CHARGE BY REVENUE CODE FOR REVENUE CODE 001

ELEMENT NAME: AMOUNT ALLOWED (TOTAL) (1-125)

VALIDITY EDITS

1-125-01V MUST BE NUMERIC.

RELATIONAL EDITS

1-125-01R	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION OR
		D	COMPLETE DENIAL

THEN AMOUNT ALLOWED (TOTAL) MUST = ZERO

AND ALL DETAIL ADJUSTMENT/DENIAL REASON CODES MUST CONTAIN A DENIAL CODE LISTED IN [FIGURE 2-H-1](#) OR [FIGURE 2-H-2](#)

1-125-02R IF ALL DETAIL ADJUSTMENT/DENIAL REASON CODES CONTAIN A DENIAL CODE (REFER TO [FIGURE 2-H-1](#) OR [FIGURE 2-H-2](#))

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ELEMENT NAME: AMOUNT ALLOWED (TOTAL) (1-125) (CONTINUED)		
	AND TYPE OF SUBMISSION =	B ADJUSTMENT NON-TED RECORD (HCSR) DATA OR
		E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN AMOUNT ALLOWED (TOTAL) MUST BE ≤ ZERO		
1-125-03R	IF TYPE OF SUBMISSION =	A ADJUSTMENT OR
		I INITIAL SUBMISSION OR
		O ZERO PAYMENT WITH 100% OHI/TPL OR
		R RESUBMISSION
THEN AMOUNT ALLOWED (TOTAL) MUST BE > ZERO		
1-125-04R	IF AMOUNT ALLOWED (TOTAL) = ZERO	
THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST = ZERO		
	UNLESS TYPE OF SUBMISSION =	B ADJUSTMENT NON-TED RECORD (HCSR) DATA OR
		E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

ELEMENT NAME: AMOUNT PAID BY OTHER HEALTH INSURANCE (1-130)		
VALIDITY EDITS		
1-130-01V	MUST BE NUMERIC.	
RELATIONAL EDITS		
1-130-01R	IF TYPE OF SUBMISSION =	A ADJUSTMENT OR
		C COMPLETE CANCELLATION OR
		D COMPLETE DENIAL OR
		I INITIAL SUBMISSION OR
		O ZERO PAYMENT WITH 100% OHI/TPL OR
		R RESUBMISSION
THEN AMOUNT OF OTHER HEALTH INSURANCE MUST BE ≥ ZERO		
1-130-02R	IF ONE OCCURRENCE OF OVERRIDE CODE =	U BENEFICIARY INDEMINIFICATION PAYMENT
THEN AMOUNT OF OTHER HEALTH INSURANCE MUST = ZERO		
1-130-03R	IF AMOUNT PAID BY OTHER HEALTH INSURANCE > 0	
AND AMOUNT ALLOWED (TOTAL) > 0		
AND AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) = 0		
	THEN TYPE OF SUBMISSION MUST =	O ZERO PAYMENT TED RECORD DUE TO 100% OHI

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ELEMENT NAME: AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) (1-140) (CONTINUED)

D COMPLETE DENIAL OR

O ZERO PAYMENT WITH 100% OHI/TPL

THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST = ZERO

ELEMENT NAME: AMOUNT INTEREST PAYMENT (1-145)

VALIDITY EDITS

1-145-01V MUST BE NUMERIC

RELATIONAL EDITS

1-145-01R IF TYPE OF SUBMISSION = A ADJUSTMENT OR

C COMPLETE CANCELLATION OR

I INITIAL SUBMISSION OR

O ZERO PAYMENT WITH 100% OHI/TPL OR

R RESUBMISSION

THEN AMOUNT INTEREST PAYMENT MUST BE ≥ ZERO

1-145-02R IF AMOUNT INTEREST PAYMENT ≠ ZERO

THEN REASON FOR INTEREST
PAYMENT MUST =

A CLAIMS PENDED AT GOVERNMENT
DIRECTION OR

B CLAIMS REQUIRING GOVERNMENT
INTERVENTION OR

C CLAIMS REQUIRING DEVELOPMENT FOR
POTENTIAL TPL OR

D CLAIMS REQUIRING AN ACTION/
INTERFACE WITH ANOTHER PRIME
CONTRACTOR OR

E CLAIMS RETAINED BY THE CONTRACTOR
THAT DO NOT FALL INTO ONE OF THE
ABOVE CATEGORIES

1-145-03R IF FILING STATE/ COUNTRY CODE = A FOREIGN COUNTRY
EXCEPT FOR PUERTO RICO (PRI)

THEN AMOUNT INTEREST PAYMENT MUST = ZERO

ELEMENT NAME: REASON FOR INTEREST PAYMENT (1-150)

VALIDITY EDITS

1-150-01V MUST BE A VALID REASON FOR INTEREST PAYMENT CODE (REFER TO [CHAPTER 2, SECTION 2.8](#))

RELATIONAL EDITS

1-150-01R IF REASON FOR INTEREST
PAYMENT =

A CLAIMS PENDED AT GOVERNMENT
DIRECTION OR

B CLAIMS REQUIRING GOVERNMENT
INTERVENTION OR

C CLAIMS REQUIRING DEVELOPMENT FOR
POTENTIAL TPL OR

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ELEMENT NAME: REASON FOR INTEREST PAYMENT (1-150) (CONTINUED)	
D	CLAIMS REQUIRING AN ACTION/ INTERFACE WITH ANOTHER PRIME CONTRACTOR OR
E	CLAIMS RETAINED BY THE CONTRACTOR THAT DO NOT FALL INTO ONE OF THE ABOVE CATEGORIES
THEN AMOUNT INTEREST PAYMENT MUST ≠ BLANK	

ELEMENT NAME: OVERRIDE CODE (1-160)	
VALIDITY EDITS	
1-160-01V	OCCURRENCE NUMBER 1--MUST BE A VALID OVERRIDE CODE ²
1-160-02V	OCCURRENCE NUMBER 2--MUST BE A VALID OVERRIDE CODE ²
1-160-03V	OCCURRENCE NUMBER 3--MUST BE A VALID OVERRIDE CODE ²
1-160-04V	A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).
1-160-05V	OVERRIDE CODE OCCURRENCES MUST BE LEFT JUSTIFIED.
RELATIONAL EDITS	
1-160-01R	IF PERSON BIRTH CALENDAR DATE (PATIENT) INDICATES AGE ¹ ≥ 65 THEN ONE OCCURRENCE OF OVERRIDE CODE MUST =
	A PATIENT IS OVER 65
	UNLESS ENROLLMENT/HEALTH PLAN CODE =
	BB TSP OR
	FE TFL-EXTRA OR
	FS TFL-STANDARD OR
	TS TSS
1-160-02R	IF ANY OCCURRENCE OF OVERRIDE CODE =
	A PATIENT IS OVER 65
	THEN PATIENT AGE¹ MUST BE ≥ 65
1-160-03R	IF ANY OCCURRENCE OF OVERRIDE CODE =
	B PATIENT IS A SPOUSE UNDER 12 YEARS OF AGE
	THEN PATIENT AGE¹ MUST BE < 12
	AND HCC MEMBER RELATIONSHIP CODE MUST =
	B SPOUSE OR
	G SURVIVING SPOUSE
1-160-04R	IF ANY OCCURRENCE OF OVERRIDE CODE =
	D PATIENT IS FAMILY MEMBER 21 YEARS OF AGE OR OLDER
	THEN PERSON BIRTH CALENDAR DATE (PATIENT) INDICATES AGE¹ ≥ 21
	AND HCC MEMBER RELATIONSHIP CODE MUST =
	C CHILD OR STEPCHILD OR
¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.	
² AS STATED IN CHAPTER 2, SECTION 2.6	

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ELEMENT NAME: OVERRIDE CODE (1-160) (CONTINUED)	
	D WARD (NOT COURT ORDERED) OR
	E WARD (COURT ORDERED)
1-160-05R	IF ANY OCCURRENCE OF OVERRIDE CODE =
	I PATIENT IS A FORMER SPOUSE UNDER 34 YEARS OF AGE
	THEN PATIENT AGE¹ MUST BE < 34
	AND HCC MEMBER RELATIONSHIP CODE =
	H FORMER SPOUSE (20/20/20) OR
	I FORMER SPOUSE (20/20/15) OR
	J FORMER SPOUSE (10/20/10) OR
	K FORMER SPOUSE (TRANSITIONAL ASSISTANCE (COMPOSITE))
1-160-06R	IF ANY OCCURRENCE OF OVERRIDE CODE =
	M NATO
	THEN HCC MEMBER CATEGORY CODE =
	T FOREIGN MILITARY MEMBER
1-160-07R	IF ANY OCCURRENCE OF OVERRIDE CODE =
	E DIAGNOSIS IS MATERNITY; PATIENT IS UNDER 12 YEARS OF AGE
	THEN PATIENT AGE¹ MUST BE < 12
	AND AT LEAST ONE TREATMENT DIAGNOSIS MUST = MATERNITY (630-676 OR V22-V24 OR V270-V289)
1-160-08R	IF ANY OCCURRENCE OF OVERRIDE CODE =
	G DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE
	THEN AT LEAST ONE OP/NSP OR DIAGNOSIS CODE MUST BE FOR FEMALE
	AND PERSON SEX (PATIENT) MUST BE MALE.
1-160-09R	IF ANY OCCURRENCE OF OVERRIDE CODE =
	H DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE
	THEN AT LEAST ONE OP/NSP OR DIAGNOSIS CODE MUST BE FOR MALE
	AND PERSON SEX (PATIENT) MUST BE FEMALE.
1-160-10R	IF ANY OCCURRENCE OF OVERRIDE CODE =
	N RETROSPECTIVE PAYMENT-INPATIENT MENTAL HEALTH
	THEN PRICING RATE CODE MUST =
	K HOSPITAL-SPECIFIC PSYCH PER DIEM RATE OR
	L REGION-SPECIFIC PSYCH PER DIEM RATE
	AND TYPE OF SUBMISSION MUST =
	A ADJUSTMENT OR
	B ADJUSTMENT NON-TED RECORD (HCSR) DATA OR
	C COMPLETE CANCELLATION OR

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

² AS STATED IN [CHAPTER 2, SECTION 2.6](#)

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ELEMENT NAME: OVERRIDE CODE (1-160) (CONTINUED)

		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
1-160-11R	IF ANY OCCURRENCE OF OVERRIDE CODE =	Y	NEWBORN IN MOTHER'S ROOM WITHOUT NURSERY CHARGES
	THEN PATIENT MUST BE NEWBORN (PERSON BIRTH CALENDAR DATE (PATIENT) EQUAL TO ADMISSION DATE).		
1-160-12R	IF ANY OCCURRENCE OF OVERRIDE CODE =	R	PERSON BIRTH CALENDAR DATE (PATIENT) IS NOT CONSISTENT WITH PROCEDURE/ DIAGNOSIS CODE AGE RESTRICTING; PROCEDURE PERFORMED DUE TO MEDICAL NECESSITY
	THEN PRINCIPAL TREATMENT DIAGNOSIS CODE HAS AN AGE PARAMETER RESTRICTION		
	AND PATIENT'S AGE IS NOT CONSISTENT WITH RESTRICTIONS.		
1-160-13R	IF ANY OCCURRENCE OF OVERRIDE CODE =	NC	NON-CERTIFIED PROVIDER (DOES NOT INCLUDE SANCTIONED/SUSPENDED PROVIDERS)
	THEN ANY OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AN	SHCP-NON-MTF-REFERRED CARE OR
		AR	SHCP-REFERRED CARE OR
		CE	SHCP-COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
		EU	EMERGENCY SERVICES RENDERED BY AN UNAUTHORIZED PROVIDER OR
		GU	ADSM ENROLLED IN TPR OR
		MN	TSP-NETWORK OR
		MS	TSP-(NON-NETWORK OR
		SC	SHCP-NON-TRICARE ELIGIBLE OR
		SE	SHCP-TRICARE ELIGIBLE OR
		SM	SHCP-EMERGENCY

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

² AS STATED IN [CHAPTER 2, SECTION 2.6](#)

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: TYPE OF SUBMISSION (1-165)

VALIDITY EDITS

1-165-01V VALUE MUST BE A VALID TYPE OF SUBMISSION.

1-165-02V IF TYPE OF SUBMISSION = B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
 E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

THEN ADJUSTMENT KEY CANNOT BE 0 OR 5

1-165-03V IF TYPE OF SUBMISSION = A ADJUSTMENT **OR**
 B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
 C COMPLETE CANCELLATION **OR**
 E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

THEN MATCH MUST BE FOUND ON THE TMA DATABASE

AND TYPE OF SUBMISSION ON THE EXISTING TMA DATABASE RECORD ≠

C COMPLETE CANCELLATION **OR**
 D COMPLETE DENIAL **OR**
 E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

UNLESS THE RECORD HAS PROVISIONAL ERRORS

1-165-04V IF TYPE OF SUBMISSION = D COMPLETE DENIAL **OR**
 I INITIAL SUBMISSION **OR**
 O ZERO PAYMENT WITH 100% OHI/TPL **OR**
 R RESUBMISSION

THEN A TED RECORD MUST NOT BE PRESENT ON THE DATABASE WITH THE SAME TED RECORD INDICATOR.

1-165-05V IF TYPE OF SUBMISSION = A ADJUSTMENT **OR**
 C COMPLETE CANCELLATION **OR**
 D COMPLETE DENIAL **OR**
 I INITIAL SUBMISSION **OR**
 O ZERO PAYMENT WITH 100% OHI/TPL **OR**
 R RESUBMISSION

THEN REGION INDICATOR MUST =

NC NORTH CONTRACT **OR**
 SC SOUTH CONTRACT **OR**
 WC WEST CONTRACT **OR**
 BLANK

RELATIONAL EDITS

1-165-01R IF TYPE OF SUBMISSION = O ZERO PAYMENT WITH 100% OHI/TPL
THEN THE AMOUNT OF OHI MUST BE > ZERO
AND AMOUNT ALLOWED (TOTAL) MUST BE > ZERO
AND AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST BE = 0

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: TYPE OF SUBMISSION (1-165) (CONTINUED)

1-165-02R	IF ALL OCCURRENCE/LINE ITEMS ARE DENIED (REFER TO FIGURE 2-H-1 OR FIGURE 2-H-2)		
	THEN TYPE OF SUBMISSION MUST =	C	COMPLETE CANCELLATION OR
		D	COMPLETE DENIAL OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
1-165-04R	IF RESUBMISSION NUMBER = ZERO FOR THIS BATCH OR VOUCHER		
	THEN TYPE OF SUBMISSION MUST ≠	R	RESUBMISSION
1-165-05R	IF RESUBMISSION NUMBER > ZERO FOR THIS BATCH OR VOUCHER		
	THEN TYPE OF SUBMISSION MUST BE ≠	I	INITIAL TED RECORD SUBMISSION
1-165-06R	IF TYPE OF SUBMISSION =	I	INITIAL SUBMISSION OR
		R	RESUBMISSION
	THEN AMOUNT BILLED (TOTAL), AMOUNT ALLOWED (TOTAL), COVERED DAYS, AND TOTAL CHARGE BY REVENUE CODE MUST BE > 0.		
1-165-07R	IF TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN BEGIN DATE OF CARE MUST BE < 10/01/2007		
1-165-08R	IF DATE TED RECORD PROCESSED TO COMPLETION > 01/01/1996		
	AND SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) =	X	NOT APPLICABLE
	THEN TYPE OF SUBMISSION MUST =	C	COMPLETE CANCELLATION OR
		D	COMPLETE DENIAL

ELEMENT NAME: CA/NAS NUMBER (1-170)

VALIDITY EDITS

1-170-01V	IF CA/NAS NUMBER IS NOT BLANK		
	THEN POSITIONS 1-4 (MTF FACILITY #), MUST BE VALID (USE MTF NUMBERS). 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.		

RELATIONAL EDITS

NO ERROR	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION OR
		D	COMPLETE DENIAL
	THEN BYPASS ALL CA/NAS NUMBER RELATIONAL EDITING.		
NO ERROR	IF ADMISSION DATE IS OLDER THAN 6 YEARS		
	THEN DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA		

¹ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.

² MTF IS A 40 MILES CATCHMENT AREA.

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: CA/NAS NUMBER (1-170) (CONTINUED)

NO ERROR	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	R	MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NOT A MEDICARE BENEFIT) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
		T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
		AN	SHCP-NON-MTF-REFERRED CARE OR
		AR	SHCP-REFERRED CARE OR
		CE	SHCP-COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
		PF	PPPWD OR
		RS	MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
		SC	SHCP-NON-TRICARE ELIGIBLE OR
		SE	SHCP-TRICARE ELIGIBLE OR
		SM	SHCP-EMERGENCY OR
		ST	SPECIALIZED TREATMENT OR
		WR	MENTAL HEALTH WRAP AROUND

THEN BYPASS ALL CA/NAS NUMBER EDITING

NO ERROR	IF ENROLLMENT/HEALTH PLAN CODE =	U	TRICARE PRIME, CIVILIAN PCM OR
		W	TPR FOR ACTIVE DUTY-USA OR
		X	FOREIGN ADSM OR
		Y	CHCBP - STANDARD OR
		Z	TRICARE PRIME, MTF/PCM OR
		AA	CHCBP - EXTRA OR
		BB	TSP OR
		FE	TFL-EXTRA OR
		FS	TFL-STANDARD OR
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM

THEN BYPASS ALL CA/NAS NUMBER EDITING

NO ERROR	IF HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER
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THEN BYPASS ALL CA/NAS NUMBER EDITING

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

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: CA/NAS NUMBER (1-170) (CONTINUED)

NO ERROR	IF ANY OCCURRENCE OF ADJUSTMENT/DENIAL REASON CODE =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER OR
		26	EXPENSES INCURRED PRIOR TO COVERAGE OR
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED OR
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS OR
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED OR
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED OR
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE OR
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS OR
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE- CERTIFICATION/AUTHORIZATION OR
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
			OR AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO
			THEN BYPASS ALL CA/NAS NUMBER EDITING
1-170-01R	IF PATIENT ZIP CODE IS NOT IN AN MTF ² CATCHMENT AREA ¹		THEN CA/NAS NUMBER MUST = BLANK
1-170-02R	IF CA/NAS EXCEPTION REASON IS NOT BLANK		THEN CA/NAS NUMBER MUST = BLANK
1-170-03R	IF CA/NAS EXCEPTION REASON = BLANK		AND PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316 (MENTAL HEALTH)
			AND PATIENT ZIP CODE IS IN AN MTF ² CATCHMENT AREA ¹
			THEN CA/NAS NUMBER MUST BE CODED
	UNLESS ANY OCCURRENCE OF OVERRIDE CODE =	C	GOOD FAITH PAYMENT

¹ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.

² MTF IS A 40 MILES CATCHMENT AREA.

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: CA/NAS REASON FOR ISSUANCE (1-175)

VALIDITY EDITS

1-175-01V VALUE MUST BE A VALID CA/NAS REASON OF ISSUANCE.

RELATIONAL EDITS

1-175-01R IF CA/NAS NUMBER IS CODED
THEN CA/NAS REASON FOR ISSUANCE MUST **NOT** BE BLANK.

1-175-02R IF CA/NAS NUMBER IS BLANK
THEN CA/NAS REASON FOR ISSUANCE MUST = BLANK.

1-175-03R IF CA/NAS REASON FOR ISSUANCE =

7	ENROLLEE NETWORK CARE AUTHORIZATIONS/RESTRICTED CA/NAS OR
8	ENROLLEE NON-NETWORK CARE AUTHORIZATIONS/RESTRICTED CA/NAS OR
9	NOT ENROLLED, AUTHORIZED NETWORK CARE ONLY
THEN ENROLLMENT/HEALTH PLAN CODE MUST =	
T	TRICARE STANDARD OR
U	TRICARE PRIME, CIVILIAN PCM OR
V	TRICARE EXTRA OR
Z	TRICARE PRIME, MTF/PCM

ELEMENT NAME: CA/NAS EXCEPTION REASON (1-180)

VALIDITY EDITS

1-180-01V VALUE MUST BE A VALID CA/NAS EXCEPTION REASON CODE **OR** BLANK (REFER TO CHAPTER 2, SECTION 2.4)

RELATIONAL EDITS

NO ERROR IF TYPE OF SUBMISSION =

C	COMPLETE CANCELLATION OR
D	COMPLETE DENIAL

THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING.

NO ERROR IF ADMISSION DATE IS OLDER THAN 6 YEARS
THEN DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA

NO ERROR IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

R	MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NOT A MEDICARE BENEFIT) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
AN	SHCP-NON-MTF-REFERRED CARE OR
AR	SHCP-REFERRED CARE OR

¹ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.

² MTF IS A 40 MILES CATCHMENT AREA.

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: CA/NAS EXCEPTION REASON (1-180) (CONTINUED)	
	CE SHCP-COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
	PF PFPWD OR
	RS MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
	SC SHCP-NON-TRICARE ELIGIBLE OR
	SE SHCP-TRICARE ELIGIBLE OR
	SM SHCP-EMERGENCY OR
	ST SPECIALIZED TREATMENT OR
	WR MENTAL HEALTH WRAP AROUND
THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING	
NO ERROR	IF ENROLLMENT/HEALTH PLAN CODE =
	U TRICARE PRIME, CIVILIAN PCM OR
	W TPR ACTIVE DUTY CLAIMS-USA OR
	Y CHCBP - STANDARD OR
	Z TRICARE PRIME, MTF/PCM OR
	AA CHCBP - EXTRA OR
	BB TSP OR
	FE TFL-EXTRA OR
	FS TFL-STANDARD
THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING	
NO ERROR	IF HCC MEMBER CATEGORY CODE =
	T FOREIGN MILITARY MEMBER
THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING	
NO ERROR	IF ANY OCCURRENCE OF ADJUSTMENT/DENIAL REASON CODE =
	15 PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER OR
	26 EXPENSES INCURRED PRIOR TO COVERAGE OR
	27 EXPENSES INCURRED AFTER COVERAGE TERMINATED OR
	30 PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS OR
	31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED OR

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

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: CA/NAS EXCEPTION REASON (1-180) (CONTINUED)

	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
		OR AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO
		THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING
1-180-01R		IF PATIENT ZIP CODE IS NOT IN AN MTF ² CATCHMENT AREA ¹
		THEN CA/NAS EXCEPTION REASON MUST = BLANK
1-180-02R		IF CA/NAS NUMBER IS CODED
		THEN CA/NAS EXCEPTION REASON MUST = BLANK
1-180-03R		IF PATIENT ZIP CODE IS IN A CATCHMENT AREA ¹
		AND CA/NAS NUMBER IS NOT CODED
		THEN CA/NAS EXCEPTION REASON MUST BE CODED
1-180-06R		IF ENROLLMENT/HEALTH PLAN CODE =
	X	FOREIGN ADMS
		AND PATIENT ZIP CODE IS IN A CATCHMENT AREA ¹
		THEN CA/NAS EXCEPTION REASON MUST =
	Q	ACTIVE DUTY CLAIMS
1-180-07R		IF CA/NAS EXCEPTION REASON =
	5	RTC
		AND PATIENT ZIP CODE IS IN A CATCHMENT AREA ¹
		THEN TYPE OF INSTITUTION =
	72	RTC
1-180-08R		IF NAS EXCEPTION REASON =
	S	HOME HEALTH AGENCY (HHA-PPS)
		THEN TYPE OF INSTITUTION MUST =
	70	HOME HEALTH AGENCY
		AND REVENUE CODE MUST =
	023	HOME HEALTH AGENCY (HHA-PPS)

¹ CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.

² MTF IS A 40 MILES CATCHMENT AREA.

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (CONTINUED)	
	THEN ENROLLMENT/ HEALTH PLAN CODE MUST = X FOREIGN AD SM
1-185-04R	IF PRINCIPAL/SECONDARY OP/NSP CODE IS 41.02 OR 41.03
	THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST = 3 ALLOGENEIC BONE MARROW RECIPIENT- WILFORD HALL REFERRED ONLY
1-185-05R	IF BEGIN DATE OF CARE < 03/01/1997 OR (> 02/19/1998 AND < 09/01/1999)
	AND PRINCIPAL/SECONDARY OP/NSP CODE IS 50.51 OR 50.59
	THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST = 5 LIVER TRANSPLANT
	ELSE BEGIN DATE OF CARE (≥ 03/01/1997 AND ≤ 02/19/1998) OR ≥ 09/01/1999
	AND PRINCIPAL/SECONDARY OP/NSP CODE IS 50.51 OR 50.59
	THEN SPECIAL PROCESSING CODE MUST = ST ¹ SPECIALIZED TREATMENT
1-185-06R	IF PRINCIPAL/SECONDARY OP/NSP CODE IS 37.5
	THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST = 7 HEART TRANSPLANT
1-185-07R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = R MEDICARE/TRICARE DUAL ENROLLMENT (NORMAL COB PROCESSING)
	AND BEGIN DATE OF CARE < 10/01/2001
	THEN AMOUNT PAID BY OTHER HEALTH INSURANCE MUST NOT = ZERO
1-185-08R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = PO TRICARE PRIME-POINT OF SERVICE
	THEN ENROLLMENT/ HEALTH PLAN CODE MUST = U TRICARE PRIME (CIVILIAN PCM) OR
	Z TRICARE PRIME, MTF/PCM OR
	WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE AD SM
1-185-09R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = GU AD SM ENROLLED IN TPR
	THEN ENROLLMENT/ HEALTH PLAN CODE MUST = W TPR ACTIVE DUTY-USA
1-185-13R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = MN TSP-NON-NETWORK OR
	MS TSP-NETWORK
	THEN ENROLLMENT/ HEALTH PLAN CODE MUST = BB TSP
1-185-14R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = AN SHCP-NON-MTF-REFERRED CARE OR
	AR SHCP-REFERRED CARE OR
	CE SHCP-COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR

¹ AS STATED IN CHAPTER 2, SECTION 2.8 OR BLANK

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (CONTINUED)		
		SC SHCP-NON-TRICARE ELIGIBLE OR
		SE SHCP-TRICARE ELIGIBLE OR
		SM SHCP-EMERGENCY
	THEN ENROLLMENT/ HEALTH PLAN CODE MUST =	SR SHCP-REFERRED CARE OR
		SN SHCP-NON-MTF REFERRED CARE OR
		SO SHCP-NON-TRICARE ELIGIBLE OR
		ST SHCP-TRICARE ELIGIBLE
1-185-31R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	SN TSS-NON-NETWORK OR
		SS TSS-NETWORK
	THEN ENROLLMENT/ HEALTH PLAN CODE MUST =	TS TSS
1-185-32R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	E HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP)
	THEN BEGIN DATE OF CARE IS ≥ 03/15/1999	
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	CM ICMP
1-185-33R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	GF TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	THEN BEGIN DATE OF CARE IS ≥ 10/30/2000 AND < 09/01/2002	
	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
		S RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE)
	AND HCC MEMBER RELATIONSHIP CODE MUST =	B SPOUSE OR
		C CHILD OR STEPCHILD OR
		D WARD (NOT COURT ORDERED) OR
		E WARD (COURT ORDERED)
1-185-34R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	FF TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) OR
		FG TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) OR
		FS TFL (SECOND PAYOR)

¹ AS STATED IN [CHAPTER 2, SECTION 2.8](#) OR BLANK

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (CONTINUED)		
	AND PRICING RATE CODE ≠	H TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER OR
		J TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER
THEN BEGIN DATE OF CARE MUST BE ≥ 10/01/2001		
	AND ENROLLMENT/ HEALTH PLAN CODE MUST =	FE TFL-EXTRA OR
		FS TFL-STANDARD
1-185-35R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	FF TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) OR
		FG TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) OR
		FS TFL (SECOND PAYOR)
	AND PRICING RATE CODE =	H TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER OR
		J TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER
THEN END DATE OF CARE MUST BE ≥ 10/01/2001		
	AND ENROLLMENT/ HEALTH PLAN CODE MUST =	FE TFL-EXTRA OR
		FS TFL-STANDARD
1-185-36R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	NE OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM
THEN BEGIN DATE OF CARE MUST BE ≥ 09/14/2001 AND < 11/01/2003		
1-185-37R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	17 VA MEDICAL PROVIDER CLAIM (CARE RENDERED BY A VA PROVIDER)
	THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE MAY =	T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
		FG TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) OR
		FS TFL (SECOND PAYOR) OR

¹ AS STATED IN [CHAPTER 2, SECTION 2.8](#) OR BLANK

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

RS MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) (EFFECTIVE 10/01/2001)

¹ AS STATED IN [CHAPTER 2, SECTION 2.8](#) OR BLANK

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) SPECIAL ENTITLEMENT CODE (1-186)

VALIDITY EDITS

1-186-01V MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE LISTING IN [SECTION 2.5](#).

RELATIONAL EDITS

NONE

ELEMENT NAME: PRICING RATE CODE (1-190)

VALIDITY EDITS

1-190-01V VALUE MUST BE A VALID INSTITUTIONAL PRICING RATE CODE.

RELATIONAL EDITS

1-190-01R	IF FILING STATE/COUNTRY CODE =	MD	MARYLAND
	THEN PRICING RATE CODE MUST ≠	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER OR
		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER
1-190-02R	IF DRG NUMBER IS CODED (OTHER THAN ZERO)		
	THEN PRICING RATE CODE MUST =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER OR
		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER OR
		U	SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS OR
		V	MEDICARE REIMBURSEMENT RATE
1-190-03R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	11	HOSPICE
	THEN PRICING RATE CODE MUST =	D	DISCOUNT RATE AGREEMENT OR
		P	PER DIEM RATE AGREEMENT OR

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PRICING RATE CODE (1-190) (CONTINUED)	
	U SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS OR
	V MEDICARE REIMBURSEMENT RATE
UNLESS TYPE OF SUBMISSION =	D COMPLETE DENIAL
1-190-04R IF PRICING RATE CODE =	V MEDICARE REIMBURSEMENT RATE
THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 OR
	FS TFL (SECOND PAYOR) OR
	MN TSP-NON-NETWORK OR
	MS TSP-NETWORK
OR TYPE OF INSTITUTION =	70 HOME HEALTH AGENCY OR
	76 SKILLED NURSING FACILITY
1-190-05R IF PRICING RATE CODE =	U SHCP CLAIM OR ACTIVE DUTY MEMBER TPR CLAIM PAID OUTSIDE NORMAL LIMITS
THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AN SHCP-NON-MTF-REFERRED CARE OR
	AR SHCP-REFERRED CARE OR
	CE SHCP-COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR
	GU ADSM ENROLLED IN TPR OR
	SC SHCP-NON-TRICARE ELIGIBLE OR
	SE SHCP-TRICARE ELIGIBLE OR
	SM SHCP-EMERGENCY
1-190-06R IF REVENUE CODE =	022 SKILLED NURSING FACILITY CHARGE
THEN PRICING RATE CODE MUST =	D DISCOUNT RATE AGREEMENT OR
	V MEDICARE REIMBURSEMENT RATE
1-190-07R IF REVENUE CODE =	023 HOME HEALTH AGENCY (HHA-PPS)
THEN PRICING RATE CODE MUST =	D DISCOUNT RATE AGREEMENT OR
	V MEDICARE REIMBURSEMENT RATE

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PROVIDER STATE OR COUNTRY CODE (1-195)

VALIDITY EDITS

1-195-01V VALUE MUST BE A VALID STATE OR COUNTRY CODE (REFER TO [CHAPTER 2, ADDENDUM A](#) OR [ADDENDUM B](#))

RELATIONAL EDITS

1-195-01R PROVIDER STATE/COUNTRY CODE MUST MATCH THE CORRESPONDING RECORD¹ IN THE PROVIDER FILE

UNLESS AMOUNT ALLOWED (TOTAL) ≤ ZERO

THEN DO NOT CHECK FOR MATCH ON PROVIDER FILE

¹ THE "CORRESPONDING RECORD" IS BASED ON CARE DATES, INSTITUTIONAL PROVIDER KEY, PROVIDER TAXPAYER NUMBER, PROVIDER ZIP CODE, AND TYPE OF INSTITUTION.

