NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: TYPE OF SUBMISSION (2-100)			
	VALIDITY EDITS		
2-100-01V	VALUE MUST BE A VALID TYPE OF SUBMISSION.		
2-100-02V	IF TYPE OF SUBMISSION =	B	ADJUSTMENT OF NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN ADJUSTMENT KEY **CANNOT** =	0	BATCH **OR**
		5	VOUCHER
	AND REGION INDICATOR MUST = BLANK		
2-100-03V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		B	ADJUSTMENT OF 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 NON-TED RECORD (HCSR) DATA
	UNLESS THE RECORD HAS PROVISIONAL ERRORS		
2-100-04V	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		
2-100-05V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT TO TED **OR**
		C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION

ELEMENT NAME:	TYPE OF SUBMISSION (2-100) (CONTINUED)		
	THEN REGION INDICATOR MUST =	~~b~~	BLANK **OR**
		NC	NORTH CONTRACT **OR**
		SC	SOUTH CONTRACT **OR**
		WC	WEST CONTRACT
2-100-06V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		C	COMPLETE CANCELLATION TO TED RECORD DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN TED RECORD CORRECTION INDICATOR MUST =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) **SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR**
		2	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT CLAIM PROCESSING ERRORS OR TO UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION **OR**
		3	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT **BOTH** CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD
	RELATIONAL EDITS		
2-100-01R	IF TYPE OF SUBMISSION =	O	ZERO PAYMENT WITH 100% OHI/TPL
	THEN THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT OF OHI MUST BE > ZERO		
	AND THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE MUST > ZERO		
	AND THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO		
2-100-02R	IF ALL OCCURRENCE/LINE ITEMS ARE DENIED (REFER TO CHAPTER 2, ADDENDUM H, FIGURE 2-H-1)		
	THEN TYPE OF SUBMISSION MUST =	C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	UNLESS THE TED RECORD CORRECTION INDICATION =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD **OR**

ELEMENT NAME: TYPE OF SUBMISSION (2-100) (CONTINUED)			
		3	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT BOTH EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD AND TO CORRECT CLAIM PROCESSING ERRORS OR UPDATE PRIOR DATA WITH MORE CURRENT/ ACCURATE INFORMATION
2-100-04R	IF RESUBMISSION NUMBER = ZERO FOR THIS BATCH **OR** VOUCHER		
	THEN TYPE OF SUBMISSION MUST ≠	R	RESUBMISSION
2-100-05R	IF RESUBMISSION NUMBER > ZERO FOR THIS BATCH **OR** VOUCHER		
	THEN TYPE OF SUBMISSION MUST ≠	I	INITIAL TED RECORD SUBMISSION
2-100-06R	IF TYPE OF SUBMISSION =	I	INITIAL SUBMISSION **OR**
		R	RESUBMISSION
	THEN THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT BILLED BY PROCEDURE CODE, **AND** THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE MUST BE > 0.		
2-100-07R	IF TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HSCR) DATA
	THEN BEGIN DATE OF CARE MUST BE < 10/01/2010		
2-100-09R	IF TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN TYPE OF SERVICE (SECOND POSITION) MUST ≠	M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
2-100-10R	IF THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT PAID BY OTHER HEALTH INSURANCE > 0		
	AND THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT ALLOWED (TOTAL) BY PROCEDURE CODE > 0		
	AND THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE = 0		
	THEN TYPE OF SUBMISSION MUST =	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
	UNLESS THE SUM OF THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT PATIENT COST-SHARE **AND** THE TOTAL OF ALL OCCURRENCE/LINE ITEMS OF AMOUNT APPLIED TOWARD DEDUCTIBLE > THE TOTAL OF ALL OCCURRENCE/ LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE		
	OR THE TED RECORD CORRECTION INDICATOR ≠ BLANK		

ELEMENT NAME: CLAIM FORM TYPE/EMC INDICATOR (2-105)			
VALIDITY EDITS			
2-105-01V	MUST BE A VALID CLAIM FORM TYPE/EMC INDICATOR.		
RELATIONAL EDITS			
2-105-01R	IF CLAIM FORM TYPE/EMC INDICATOR =	I	ELECTRONIC DRUG CLAIM SUBMISSION
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS **OR**
		M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
2-105-02R	IF CLAIM FORM TYPE/EMC INDICATOR =	J	OTHER
	AND TYPE OF SERVICE SECOND POSITION =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS **OR**
		M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	THEN PROCEDURE CODE MUST =	000MN	PRESCRIPTION MEDICAL NECESSITY REVIEWS **OR**
		000PA	PRESCRIPTION PRIOR AUTHORIZATIONS

ELEMENT NAME: ADMINISTRATIVE CLIN (2-108)			
VALIDITY EDITS			
2-108-01V	MUST BE BLANKS **OR** A VALID CLIN FOR THE CONTRACT NUMBER ON THE TMA DATABASE		
2-108-02V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		B	HCSR ADJUSTMENT **OR**
		C	COMPLETE CANCELLATION **OR**
		E	HCSR CANCELLATION
	AND ADMINISTRATIVE CLAIM COUNT CODE (TMA DERIVED FIELD) ON TMA FILE =	1	CLAIM RATE HAS BEEN PAID
	THEN ADMINISTRATIVE CLIN ON THE ADJUSTMENT MUST = ADMINISTRATIVE CLIN ON TMA DATABASE[1]		
RELATIONAL EDITS			
	REFER TO CHAPTER 2, SECTION 8.1.		

[1] THIS EDIT IS CHECKED DURING THE MATCH AND MARRY PROCESS.

ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (2-110)			
VALIDITY EDITS			
2-110-01V	MUST BE A VALID 4 DIGIT DMIS-ID CODE.		
2-110-02V	• REVISED FINANCING		
	IF HEADER TYPE INDICATOR =	5	VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE **OR**
		6	VOUCHER HEADER ADMIN CLAIM RATE-ELIGIBLE
	AND ENROLLMENT/HEALTH PLAN CODE =	Z	TRICARE PRIME, MTF/CLINIC
	AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT NON-TED RECORD (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN PCM LOCATION DMIS-ID MUST EQUAL A VALID MTF/CLINIC DMIS-ID[1]		
	AND CANNOT = 6501, 6901-6915, 6917-6919, 7901-7912, 7916[2]-7919, 8000-8099, **OR** BLANK		
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**
	THEN BYPASS ALL PCM LOCATION DMIS-ID RELATIONAL EDITING.		
2-110-01R	IF BEGIN DATE OF CARE ≥ 10/01/1997		
	AND ENROLLMENT/HEALTH PLAN CODE =	BB	TSP
	THEN PCM LOCATION DMIS-ID MUST BE A VALID MTF/CLINIC DMIS-ID[1]		
	AND CANNOT = 6501, 6901-6915, 6917-6919, 7901-7912, 7916[2]-7919, 8000-8099, **OR** BLANK		
2-110-02R	IF BEGIN DATE OF CARE ≥ 10/01/1999		
	AND ENROLLMENT/HEALTH PLAN CODE =	SR	SHCP - REFERRED CARE
	THEN PCM LOCATION DMIS-ID MUST BE A VALID MTF/CLINIC DMIS-ID[1]		
	AND CANNOT = 6501, 6901-6915, 6917-6919, 7901-7912, 7916[2]-7919, **OR** 8000-8099		
2-110-04R	IF BEGIN DATE OF CARE ≥ 10/01/1997 **AND** < 09/01/2002		
	AND ENROLLMENT/HEALTH PLAN CODE =	U	TRICARE PRIME, CIVILIAN PCM
	AND REGION INDICATOR =	~~b~~	BLANK **OR**
		NC	NORTH CONTRACT
	THEN DMIS-ID MUST = 6901, 6902, 6905, **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.

ELEMENT NAME:	**PCM LOCATION DMIS-ID (ENROLLMENT) CODE (2-110) (CONTINUED)**		
	OR REGION INDICATOR =	~~b~~	BLANK **OR**
		SC	SOUTH CONTRACT
	THEN DMIS-ID MUST = 6903, 6904, 6906, 6913, 6914, **OR** 6915		
	OR REGION INDICATOR =	~~b~~	BLANK **OR**
		WC	WEST CONTRACT
	THEN DMIS-ID MUST = 6907, 6908, 6909, 6910, 6911, **OR** 6912		
2-110-05R	IF BEGIN DATE OF CARE ≥ 10/01/1997 **AND** < 10/01/1999		
	AND ENROLLMENT/HEALTH PLAN CODE =	W	TPR ADSM - USA
	AND REGION INDICATOR =	~~b~~	BLANK **OR**
		NC	NORTH CONTRACT
	THEN DMIS-ID MUST = 7901, 7902, 7905, **OR** 8000-8099 **OR** BLANK		
	OR REGION INDICATOR =	~~b~~	BLANK **OR**
		WC	WEST CONTRACT
	THEN DMIS-ID MUST = 6911 **OR** BLANK		
2-110-06R	IF BEGIN DATE OF CARE ≥ 10/01/1999 **AND** < 09/01/2002		
	AND ENROLLMENT/HEALTH PLAN CODE =	W	TPR ADSM - USA
	AND REGION INDICATOR =	~~b~~	BLANK **OR**
		NC	NORTH CONTRACT
	THEN DMIS-ID MUST = 7901, 7902, 7905 **OR** 8000-8099		
	OR REGION INDICATOR =	~~b~~	BLANK **OR**
		SC	SOUTH CONTRACT
	THEN DMIS-ID MUST = 7903, 7904 **OR** 7906		
	OR REGION INDICATOR =	~~b~~	BLANK **OR**
		WC	WEST CONTRACT
	THEN DMIS-ID MUST = 7907, 7908, 7909, 7910, 7911, 7912 **OR** 7916[2]		
2-110-07R	IF BEGIN DATE OF CARE ≥ 10/01/1997		
	AND ENROLLMENT/HEALTH PLAN CODE ≠	U	TRICARE PRIME, CIVILIAN PCM **OR**
		W	TPR ADSM - USA **OR**
		X	FOREIGN ADSM **OR**
		Z	TRICARE PRIME, MTF/CLINIC **OR**
		BB	TSP **OR**
		SN	SHCP - NON-MTF REFERRED CARE **OR**
		SR	SHCP - REFERRED CARE **OR**
		SU	SHCP - REFERRAL DESIGNATION UNKNOWN **OR**
		WA	TPR FOREIGN ADSM **OR**
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM **OR**

[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:	PCM LOCATION DMIS-ID (ENROLLMENT) CODE (2-110) (CONTINUED)		
		WO	TPR FOREIGN ADFM **OR**
		XF	FOREIGN ADFM
	THEN PCM LOCATION DMIS-ID MUST = BLANK		
	UNLESS HCDP PLAN COVERAGE CODE =	140	TRICARE PLUS WITH CHC COVERAGE FOR ADFMs **OR**
		141	TRICARE PLUS COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		142	TRICARE PLUS WITH CHC COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		143	TRICARE PLUS COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		144	TRICARE PLUS WITH CHC COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS **OR**
		145	TRICARE PLUS COVERAGE FOR RETIRED SPONSORS, FAMILY MEMBERS AND MEDAL OF HONOR **OR**
		146	TRICARE PLUS WITH CHC COVERAGE FOR RETIRED SPONSORS, FAMILY MEMBERS AND MEDAL OF HONOR **OR**
		147	TRICARE PLUS WITH CHC COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/ RESERVE DECEASED SPONSORS **OR**
		148	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS **OR**
		149	TRICARE PLUS COVERAGE WITH CHC FOR SURVIVORS OF GUARD/RESERVE DECEASED **OR**
		150	TRICARE PLUS COVERAGE FOR ADFMs **OR**
		151	TRICARE PLUS COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/ RESERVE DECEASED SPONSORS
2-110-08R	IF BEGIN DATE OF CARE ≥ 09/01/2002		
	AND ENROLLMENT/HEALTH PLAN CODE CODE =	U	TRICARE PRIME, CIVILIAN PCM
	AND REGION INDICATOR =	~~b~~	BLANK **OR**
		NC	NORTH CONTRACT
	THEN DMIS-ID MUST = 6901, 6902, 6917, 8007, 8009, **OR** 6905		
	OR REGION INDICATOR =	~~b~~	BLANK **OR**
		SC	SOUTH CONTRACT
	THEN DMIS-ID MUST = 6903, 6904, 6906, 6913, 6914, 6915, **OR** 6918		

[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:	PCM LOCATION DMIS-ID (ENROLLMENT) CODE (2-110) (CONTINUED)		
	OR REGION INDICATOR =	~~b~~	BLANK **OR**
		WC	WEST CONTRACT
	THEN DMIS-ID MUST = 6907, 6908, 6909, 6910, 6911, 6912, **OR** 6919		
2-110-09R	IF BEGIN DATE OF CARE ≥ 09/01/2002		
	AND ENROLLMENT/HEALTH PLAN CODE CODE =	W	TPR ADSM - USA **OR**
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	AND REGION INDICATOR =	~~b~~	BLANK **OR**
		NC	NORTH CONTRACT
	THEN DMIS-ID MUST = 7901, 7902, 7905, **OR** 7917		
	OR REGION INDICATOR =	~~b~~	BLANK **OR**
		SC	SOUTH CONTRACT
	THEN DMIS-ID MUST = 7903, 7904, 7906, **OR** 7918		
	OR REGION INDICATOR =	~~b~~	BLANK **OR**
		WC	WEST CONTRACT
	THEN DMIS-ID MUST = 7907, 7908, 7909, 7910, 7911, 7912, 7916[2], **OR** 7919		
2-110-10R	IF BEGIN DATE OF CARE ≥ 09/01/2003		
	AND ENROLLMENT/HEALTH PLAN CODE =	WA	TPR FOREIGN ADSM **OR**
		WO	TPR FOREIGN ADFM **OR**
		XF	FOREIGN ADFM
	THEN DMIS-ID MUST ≠ BLANK		

[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 INTEREST PAYMENT (2-112)		
	VALIDITY EDITS		
2-112-01V	MUST BE NUMERIC		
	RELATIONAL EDITS		
2-112-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
	THEN AMOUNT INTEREST PAYMENT MUST BE ≥ ZERO		
2-112-02R	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL
	THEN AMOUNT INTEREST PAYMENT MUST = ZERO		
2-112-03R	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
2-112-04R	IF FILING STATE/COUNTRY CODE = FOREIGN COUNTRY INCLUDING PUERTO RICO (PRI)		
	THEN AMOUNT INTEREST PAYMENT MUST BE = ZERO		

ELEMENT NAME:	REASON FOR INTEREST PAYMENT (2-113)		
	VALIDITY EDITS		
2-113-01V	MUST BE A VALID REASON FOR INTEREST PAYMENT CODE (REFER TO CHAPTER 2, SECTION 2.8).		
	RELATIONAL EDITS		
2-113-01R	IF REASON FOR INTEREST PAYMENT =	A	CLAIMS PENDED AT GOVERNMENT DIRECTION **OR**
		B	CLAIMS REQUIRING GOVERNMENT INTERVENTION **OR**
		C	CLAIMS REQUIRING DEVELOPMENT FOR POTENTIAL TPL **OR**
		D	CLAIMS REQUIRING AN ACTION/ INTERFACE WITH ANOTHER PRIME CONTRACTOR **OR**
		E	CLAIMS RETAINED BY THE CONTRACTOR THAT DO NOT FALL INTO ONE OF THE ABOVE CATEGORIES
	THEN AMOUNT INTEREST PAYMENT MUST ≠ ZERO		

ELEMENT NAME:	PRINCIPAL TREATMENT DIAGNOSIS (2-115)		
	VALIDITY EDITS		
2-115-01V	FOR FILING DATE PRIOR TO 10/01/2004 VALUE MUST BE A VALID DIAGNOSIS CODE, EXCLUDING E800.0-E999.1.		
2-115-02V	FOR FILING DATE ON OR AFTER 10/01/2004 VALUE MUST BE A VALID DIAGNOSIS CODE, EXCLUDING E800.0-E999.1		
	AND FOR AT LEAST ONE LINE ITEM		
	EITHER BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE		
	OR END DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE		
	RELATIONAL EDITS		
2-115-01R	IF ANY PRINCIPAL TREATMENT DIAGNOSIS CODE IS FOR FEMALE		
	AND PERSON SEX (PATIENT) IS MALE		
	THEN AT LEAST ONE OVERRIDE CODE MUST =	G	DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE
2-115-02R	IF ANY PRINCIPAL TREATMENT DIAGNOSIS CODE IS FOR MALE		
	AND NOT FOR CIRCUMCISION (PROCEDURE CODE[2] 54150 **OR** 54160)		
	AND SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-3)		
	AND PERSON SEX (PATIENT) IS FEMALE		
	THEN AT LEAST ONE OVERRIDE CODE MUST =	H	DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE
2-115-03R	IF PRINCIPAL TREATMENT DIAGNOSIS CODE HAS AN AGE PARAMETER RESTRICTION		
	THEN PATIENT'S AGE MUST BE CONSISTENT WITH RESTRICTIONS (i.e., NEWBORN (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-1)		
	UNLESS AT LEAST ONE OVERRIDE CODE =	R	PERSON BIRTH CALENDAR DATE (PATIENT) IS NOT CONSISTENT WITH PROCEDURE/ DIAGNOSIS CODE AGE RESTRICTING; PROCEDURE PERFORMED DUE TO MEDICAL NECESSITY
	OR TYPE OF SERVICE (SECOND POSITION) =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS **OR**
		M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS

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

[2] **CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2005 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS APPLY TO GOVERNMENT USE.**

ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS (2-115) (CONTINUED)			
	OR AT LEAST ONE OCCURRENCE OF PROCEDURE CODE =	A4281	TUBING FOR BREAST PUMP, REPLACEMENT **OR**
		A4282	ADAPTER FOR BREAST PUMP, REPLACEMENT **OR**
		A4283	CAP FOR BREAST PUMP, REPLACEMENT **OR**
		A4284	BREAST SHIELD AND SPLASH PROTECTOR FOR USE WITH BREAST PUMP, REPLACEMENT **OR**
		A4285	POLYCARBONATE BOTTLE FOR USE WITH BREAST PUMP, REPLACEMENT **OR**
		A4286	LOCKING RING FOR BREAST PUMP, REPLACEMENT **OR**
		E0604	BREAST PUMP, HEAVY DUTY, HOSPITAL GRADE, PISTON OPERATED, PULSATILE VACUUM SUCTION/RELEASE CYCLES, VACUUM REGULATOR, SUPPLIES, TRANSFORMER, ELECTRIC (AC AND/OR DC)
2-115-04R	IF SECONDARY TREATMENT DIAGNOSIS = MATERNITY (630-676 **OR** V22-V24 **OR** V270-V289)		
	AND PATIENT AGE[1] < 12		
	THEN ONE OCCURRENCE OF OVERRIDE CODE MUST =	E	DIAGNOSIS IS MATERNITY; PATIENT IS UNDER 12 YEARS OF AGE
2-115-05R	IF PRINCIPAL TREATMENT DIAGNOSIS = 799.9		
	THEN CALCULATED AMOUNT BILLED (TOTAL) MUST > ZERO **AND** ≤ $200.00		
	AND TYPE OF SERVICE (FIRST POSITION) MUST =	A	AMBULATORY SURGERY COST-SHARED AS INPATIENT (ADFMs ONLY) **OR**
		I	INPATIENT **OR**
		N	OUTPATIENT COST-SHARED AS INPATIENT **OR**
		O	OUTPATIENT, EXCLUDING M, P, OR N
	AND TYPE OF SERVICE (SECOND POSITION) MUST =	4	DIAGNOSTIC/THERAPEUTIC X-RAY **OR**
		5	DIAGNOSTIC LABORATORY **OR**
		7	ANESTHESIA
	UNLESS TYPE OF SUBMISSION =	D	COMPLETE DENIAL

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

ELEMENT NAME:	PRINCIPAL TREATMENT DIAGNOSIS (2-115) (CONTINUED)		
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	1	MEDICAID
2-115-06R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF	ECHO
	THEN PRINCIPAL DIAGNOSIS **CANNOT** = 799.9		
	UNLESS TYPE OF SUBMISSION =	D	COMPLETE DENIAL
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	1	MEDICAID

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

ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS-1 - 7 (2-120 THROUGH 2-137)			
VALIDITY EDITS			
2-XXX-01V[1]	FOR FILING DATES PRIOR TO 10/01/2004, VALUE IF PRESENT, MUST BE VALID DIAGNOSIS CODE **OR** BLANK-FILLED.		
2-XXX-02V[1]	FOR FILING DATE ON OR AFTER 10/01/2004 VALUE IF PRESENT MUST BE A VALID DIAGNOSIS CODE		
	AND FOR AT LEAST ONE LINE ITEM		
	EITHER BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE		
	OR END DATE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE		
2-XXX-03V[1]	ALL OCCURRENCES OF SECONDARY TREATMENT DIAGNOSIS MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED SECONDARY TREATMENT DIAGNOSIS		
RELATIONAL EDITS			
2-XXX-01R[1]	IF ANY SECONDARY TREATMENT DIAGNOSIS CODE IS FOR FEMALE		
	AND PERSON SEX (PATIENT) IS MALE		
	THEN AT LEAST ONE OVERRIDE CODE MUST =	G	DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE
2-XXX-02R[1]	IF ANY SECONDARY TREATMENT DIAGNOSIS CODE IS FOR MALE		
	AND NOT FOR CIRCUMCISION (PROCEDURE CODE[3] 54150 **OR** 54160)		
	AND SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY (CHAPTER 2, ADDENDUM E, FIGURE 2-E-3)		
	AND PERSON SEX (PATIENT) IS FEMALE		
	THEN AT LEAST ONE OVERRIDE CODE MUST =	H	DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE
2-XXX-03R[1]	IF SECONDARY TREATMENT DIAGNOSIS CODE HAS AN AGE PARAMETER RESTRICTION		
	THEN PATIENT'S AGE MUST BE CONSISTENT WITH RESTRICTIONS (i.e., NEWBORN (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-1)		
	UNLESS AT LEAST ONE OVERRIDE CODE =	R	PERSON BIRTH CALENDAR DATE (PATIENT) IS NOT CONSISTENT WITH PROCEDURE/ DIAGNOSIS CODE AGE RESTRICTING; PROCEDURE PERFORMED DUE TO MEDICAL NECESSITY

[1] XXX EQUALS ELN (120 THROUGH 137) FOR EACH OCCURRENCE OF SECONDARY TREATMENT DIAGNOSIS.
[2] PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.
[3] CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2005 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS APPLY TO GOVERNMENT USE.

ELEMENT NAME:	SECONDARY TREATMENT DIAGNOSIS-1 - 7 (2-120 THROUGH 2-137)		
	OR TYPE OF SERVICE (SECOND POSITION) =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS **OR**
		M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	OR AT LEAST ONE OCCURRENCE OF PROCEDURE CODE =	A4281	TUBING FOR BREAST PUMP, REPLACEMENT **OR**
		A4282	ADAPTER FOR BREAST PUMP, REPLACEMENT **OR**
		A4283	CAP FOR BREAST PUMP, REPLACEMENT **OR**
		A4284	BREAST SHIELD AND SPLASH PROTECTOR FOR USE WITH BREAST PUMP, REPLACEMENT **OR**
		A4285	POLYCARBONATE BOTTLE FOR USE WITH BREAST PUMP, REPLACEMENT **OR**
		A4286	LOCKING RING FOR BREAST PUMP, REPLACEMENT **OR**
		E0604	BREAST PUMP, HEAVY DUTY, HOSPITAL GRADE, PISTON OPERATED, PULSATILE VACUUM SUCTION/RELEASE CYCLES, VACUUM REGULATOR, SUPPLIES, TRANSFORMER, ELECTRIC (AC AND/OR DC)
2-XXX-04R[1]	IF SECONDARY TREATMENT DIAGNOSIS = MATERNITY (630-676 **OR** V22-V24 **OR** V270-V289)		
	AND PATIENT AGE[2] < 12		
	THEN ONE OCCURRENCE OF OVERRIDE CODE MUST =	E	DIAGNOSIS IS MATERNITY; PATIENT IS UNDER 12 YEARS OF AGE

[1] XXX EQUALS ELN (120 THROUGH 137) FOR EACH OCCURRENCE OF SECONDARY TREATMENT DIAGNOSIS.
[2] PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.
[3] CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2005 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS APPLY TO GOVERNMENT USE.

ELEMENT NAME: TED RECORD CORRECTION INDICATOR (2-139)			
	VALIDITY EDITS		
2-139-01V	VALUE MUST BE A VALID TED RECORD CORRECTION INDICATOR		
2-139-02V	IF TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) **SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR**
		2	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT CLAIM PROCESSING ERRORS OR TO UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION. (**NOT TO BE USED TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD**) **OR**
		3	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT **BOTH** CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD
	THEN TYPE OF SUBMISSION MUST =	A	ADJUSTMENT **OR**
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		C	COMPLETE CANCELLATION OF TED RECORD DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
2-139-03V	IF TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) **SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR**
		3	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT **BOTH** CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD
	THEN A MATCH TO A PROVISIONALLY ACCEPTED TED RECORD **MUST** BE PRESENT ON THE TMA DATABASE.		
2-139-04V	IF TED RECORD CORRECTION INDICATOR =	2	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT CLAIM PROCESSING ERRORS OR TO UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION
	THEN A CORRESPONDING PROVISIONALLY ACCEPTED TED RECORD **MUST NOT** BE PRESENT ON THE TMA DATABASE.		
	RELATIONAL EDITS		
	NONE		

ELEMENT NAME: TOTAL OCCURRENCE/LINE ITEM COUNT (2-140)			
VALIDITY EDITS			
2-140-01V	VALUE MUST BE IN RANGE: 001-099		
	AND MUST EQUAL THE PHYSICAL COUNT OF THE DETAIL LINE ITEMS ON THE TED RECORD.		
2-140-02V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		B	ADJUSTMENT OF NON-TED RECORD (HCSR) DATA **OR**
		C	COMPLETE CANCELLATION **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN TOTAL OCCURRENCE/LINE ITEM COUNT MUST BE ≥ TOTAL OCCURRENCE/ LINE ITEM COUNT FROM TMA DATABASE		
RELATIONAL EDITS			
	NONE		

ELEMENT NAME: OCCURRENCE/LINE ITEM NUMBER (2-145)	
VALIDITY EDITS	
2-145-01V	EACH VALUE MUST BE NUMERIC AND NOT EQUAL TO ZERO.
2-145-02V	OCCURRENCE/LINE ITEM NUMBER MUST BE CODED FOR EACH NUMBER OF OCCURRENCES SPECIFIED BY THE TOTAL OCCURRENCE/LINE ITEM COUNT.
2-145-03V	OCCURRENCE/LINE ITEM NUMBER MUST BE REPORTED IN ASCENDING CONSECUTIVE ORDER.
RELATIONAL EDITS	
	NONE

ELEMENT NAME: BEGIN DATE OF CARE (2-150)			
VALIDITY EDITS			
2-150-01V	MUST BE A VALID GREGORIAN DATE **AND** CANNOT BE > TMA CURRENT SYSTEM DATE.		
2-150-02V	CANNOT BE MORE THAN 10 YEARS PRIOR TO TMA CURRENT SYSTEM DATE.		
2-150-03V	BEGIN DATE OF CARE MUST BE ≤ END DATE OF CARE.		
RELATIONAL EDITS			
2-150-01R	BEGIN DATE OF CARE MUST BE ≤ END DATE OF CARE.		
2-150-02R	BEGIN DATE OF CARE MUST BE ≤ FILING DATE.		
2-150-03R	BEGIN DATE OF CARE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION.		
2-150-04R	BEGIN DATE OF CARE MUST BE ≥ PERSON BIRTH CALENDAR DATE (PATIENT).		
2-150-05R	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 BEGIN DATE OF CARE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED.		
	UNLESS TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) **SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD**
	AND DATE ADJUSTMENT IDENTIFIED = ZEROES.		
2-150-06R	PROVIDER MUST BE "AUTHORIZED"[1] ON PROVIDER FILE FOR EACH BEGIN DATE OF CARE		
	UNLESS AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO		
	OR ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM =	38	SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS **OR**
		52	THE REFERRING/PRESCRIBING/ RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE BILLED **OR**
		B7	THIS PROVIDER WAS NOT CERTIFIED/ ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE
	OR PROVIDER SPECIALTY =	172A00000X (OTHER SERVICE PROVIDER/DRIVERS) **OR**	
		344600000X (TRANSPORTATION SERVICES/TAXI)	

[1] **"AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER MAJOR SPECIALTY, PROVIDER ZIP CODE, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (2-240-04R).**

ELEMENT NAME:	BEGIN DATE OF CARE (2-150) (CONTINUED)		
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	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., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) **OR**
		FS	TFL (SECOND PAYOR) **OR**
		RS	MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) **AND** BEGIN DATE OF CARE ≥ 10/01/2001
	THEN DO NOT CHECK PROVIDER FILE		

[1] **"AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER MAJOR SPECIALTY, PROVIDER ZIP CODE, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (2-240-04R).**

ELEMENT NAME: END DATE OF CARE (2-155)			
VALIDITY EDITS			
2-155-01V	MUST BE A VALID GREGORIAN DATE **AND** CANNOT BE > TMA CURRENT SYSTEM DATE.		
2-155-02V	CANNOT BE MORE THAN 10 YEARS PRIOR TO TMA CURRENT SYSTEM DATE.		
2-155-03V	END DATE OF CARE MUST BE > OR EQUAL TO BEGIN DATE OF CARE.		
RELATIONAL EDITS			
2-155-02R	END DATE OF CARE MUST BE ≤FILING DATE.		
2-155-03R	END DATE OF CARE MUST BE ≤DATE TED RECORD PROCESSED TO COMPLETION.		
2-155-04R	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 END DATE OF CARE MUST BE ≤DATE ADJUSTMENT IDENTIFIED.		
	UNLESS TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) **SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD**
	AND DATE ADJUSTMENT IDENTIFIED = ZEROES.		
2-155-05R	PROVIDER MUST BE "AUTHORIZED"[1] ON PROVIDER FILE FOR EACH END DATE OF CARE		
	UNLESS AMOUNT ALLOWED BY PROCEDURE CODE ≤ZERO		
	OR ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM =	38	SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS **OR**
		52	THE REFERRING/PRESCRIBING/ RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE BILLED **OR**
		B7	THIS PROVIDER WAS NOT CERTIFIED/ ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE
	OR PROVIDER SPECIALTY =	172A00000X (OTHER SERVICE PROVIDER/DRIVERS) **OR**	
		344600000X (TRANSPORTATION SERVICES/TAXI)	

[1] **"AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER MAJOR SPECIALTY, PROVIDER ZIP CODE, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (2-240-04R).**

ELEMENT NAME:	END DATE OF CARE (2-155) (CONTINUED)		
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	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., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) **OR**
		FS	TFL (SECOND PAYOR) **OR**
		RS	MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) **AND** BEGIN DATE OF CARE ≥ 10/01/2001
	THEN DO NOT CHECK PROVIDER FILE		
2-155-06R	END DATE OF CARE **MUST** BE IN THE SAME FISCAL YEAR AS THE BEGIN DATE OF CARE		

[1] **"AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER MAJOR SPECIALTY, PROVIDER ZIP CODE, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (2-240-04R).**

ELEMENT NAME: PROCEDURE CODE (2-160)			
VALIDITY EDITS			
2-160-01V[2]	FOR FILING DATE PRIOR TO 01/01/2005, VALUE MUST BE A VALID PROCEDURE CODE		
	AND PROCEDURE CODE MUST MATCH ONE OF THE RECORDS IN THE PROCEDURE CODE DATABASE USING THE FOLLOWING DATE LOGIC:		
	FOR TYPE OF SUBMISSION =	D	COMPLETE DENIAL **OR**
		I	INITIAL TED RECORD SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION OF AN INITIAL TED RECORD (TYPE OF SUBMISSION WAS 'I') THAT WAS REJECTED DUE TO ERRORS
	THE DATE TED RECORD PROCESSED TO COMPLETION MUST BE ON OR AFTER THE PROCESSING EFFECTIVE DATE **AND** BEFORE THE PROCESSING TERMINATION DATE		
	AND THE BEGIN DATE OF CARE MUST BE ON **OR** AFTER THE CARE EFFECTIVE DATE **AND** BEFORE THE CARE TERMINATION DATE		
	FOR TYPE OF SUBMISSION =	A	ADJUSTMENT TO TED RECORD DATA **OR**
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		C	COMPLETE CANCELLATION **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THE DATE TED RECORD PROCESSED TO COMPLETION MUST BE ON **OR** AFTER THE PROCESSING EFFECTIVE DATE		
	AND THE BEGIN DATE OF CARE MUST BE ON **OR** AFTER THE CARE EFFECTIVE DATE **AND** BEFORE THE CARE TERMINATION DATE		
2-160-02V[2]	FOR FILING DATE ON OR AFTER 01/01/2005 VALUE MUST BE A VALID PROCEDURE CODE		
	AND PROCEDURE CODE MUST MATCH ONE OF THE RECORDS IN THE PROCEDURE CODE REFERENCE TABLE USING THE FOLLOWING DATE LOGIC:		
	BEGIN DATE OF CARE MUST BE ON **OR** AFTER THE PROCEDURE CODE EFFECTIVE DATE **AND** NOT LATER THAN THE PROCEDURE CODE TERMINATION DATE.		
RELATIONAL EDITS			
2-160-01R[3]	IF ON THE MATCHING RECORD THE PROCEDURE CODE DATABASE GOVERNMENT PAY CODE = 'N'		
	THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE ≤ ZERO		
	UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 **OR**

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[2] **PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDITS 2-160-01R, 2-160-02R, 2-160-03R, AND 2-160-04R.**

[3] **BYPASS EDITS 2-160-01R, 2-160-02R, 2-160-03R, AND 2-160-04R IF RECORD FAILS EDIT 2-160-01V OR 2-160-01-2V.**

ELEMENT NAME:	PROCEDURE CODE (2-160) (CONTINUED)		
		AN	SHCP - NON-MTF-REFERRED CARE **OR**
		AR	SHCP - REFERRED CARE **OR**
		CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM **OR**
		CL	CLINICAL TRIALS **OR**
		FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) **OR**
		FS	TFL (SECOND PAYOR) **OR**
		GU	ADSM ENROLLED IN TPR **OR**
		MN	TSP - NETWORK **OR**
		MS	TSP - NON-NETWORK **OR**
		SC	SHCP - NON-TRICARE ELIGIBLE **OR**
		SE	SHCP - TRICARE ELIGIBLE **OR**
		SM	SHCP - EMERGENCY
	OR ENROLLMENT/HEALTH PLAN CODE MUST =	SN	SHCP - NON-MTF-REFERRED CARE **OR**
		SR	SHCP - REFERRED CARE
	OR FILING STATE AND COUNTRY CODE MUST = A FOREIGN COUNTRY CODE (REFER TO CHAPTER 2, ADDENDUM A)		
2-160-02R[3]	IF ANY PROCEDURE CODE IS FOR FEMALE		
	AND PERSON SEX (PATIENT) IS MALE		
	THEN AT LEAST ONE OVERRIDE CODE MUST =	G	DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE
2-160-03R[3]	IF ANY PROCEDURE CODE IS FOR MALE		
	AND NOT FOR CIRCUMCISION (PROCEDURE CODE[1] 54150 **OR** 54160)		
	AND SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY (CHAPTER 2, ADDENDUM E, FIGURE 2-E-3)		
	AND PERSON SEX (PATIENT) IS FEMALE		
	THEN AT LEAST ONE OVERRIDE CODE MUST =	H	DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE
2-160-04R[3]	IF PROCEDURE CODE HAS AN AGE PARAMETER RESTRICTION		
	THEN PATIENT'S AGE MUST BE CONSISTENT WITH RESTRICTIONS		

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[2] **PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDITS 2-160-01R, 2-160-02R, 2-160-03R, AND 2-160-04R.**

[3] **BYPASS EDITS 2-160-01R, 2-160-02R, 2-160-03R, AND 2-160-04R IF RECORD FAILS EDIT 2-160-01V OR 2-160-01-2V.**

ELEMENT NAME: PROCEDURE CODE (2-160) (CONTINUED)			
	UNLESS AT LEAST ONE OVERRIDE CODE =	R	PERSON BIRTH CALENDAR DATE (PATIENT) IS NOT CONSISTENT WITH PROCEDURE/ DIAGNOSIS CODE AGE RESTRICTING; PROCEDURE PERFORMED DUE TO MEDICAL NECESSITY
2-160-05R	IF PROCEDURE CODE[1] = A0100, A0110, A0120, A0130, A0140, A0170, L3000 - L3649, 99082		
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	PF	ECHO
	UNLESS ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM IS A CODE LISTED IN CHAPTER 2, ADDENDUM H, FIGURE 2-H-1 **OR** FIGURE 2-H-2		
	OR 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**
		GU	ADSM ENROLLED IN TPR **OR**
		MN	TSP - NETWORK **OR**
		MS	TSP - NON-NETWORK **OR**
		SC	SHCP - NON-TRICARE ELIGIBLE **OR**
		SE	SHCP - TRICARE ELIGIBLE **OR**
		SM	SHCP - EMERGENCY
	OR ENROLLMENT/HEALTH PLAN CODE =	X	FOREIGN ADSM **OR**
		SN	SHCP - NON-MTF-REFERRED CARE **OR**
		SR	SHCP - REFERRED CARE **OR**
		WA	TPR - FOREIGN ADSM
2-160-06R	IF TYPE OF SERVICE (FIRST POSITION) =	I	INPATIENT
	THEN PROCEDURE CODE MUST NOT BE FOR OUTPATIENT ONLY CARE (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-2).		
2-160-07R	IF PROCEDURE CODE[1] = 90892-90898		
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	WR	MENTAL HEALTH WRAPAROUND DEMONSTRATION
2-160-08R	IF PROCEDURE CODE[1] =	98800	FOR DRUGS **OR**
		000MN	PRESCRIPTION MEDICAL NECESSITY REVIEWS **OR**

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[2] **PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDITS 2-160-01R, 2-160-02R, 2-160-03R, AND 2-160-04R.**

[3] **BYPASS EDITS 2-160-01R, 2-160-02R, 2-160-03R, AND 2-160-04R IF RECORD FAILS EDIT 2-160-01V OR 2-160-01-2V.**

ELEMENT NAME:	PROCEDURE CODE (2-160) (CONTINUED)		
		000PA	PRESCRIPTION PRIOR AUTHORIZATIONS
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS **OR**
		M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS
	AND NATIONAL DRUG CODE MUST ≠ BLANK		
	UNLESS PROVIDER STATE OR COUNTRY CODE IS A FOREIGN COUNTRY CODE (CHAPTER 2, ADDENDUM A)		
2-160-10R	IF PROCEDURE CODE = A4281 - A4286 **OR** E0604		
	AND AMOUNT ALLOWED BY PROCEDURE CODE > ZERO.		
	THEN EITHER PRIMARY OR ANY OCCURRENCE OF SECONDARY DIAGNOSIS CODE MUST = 765.00 - 765.09, 765.10 - 765.19, **OR** 765.21 - 765.28.		

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[2] **PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDITS 2-160-01R, 2-160-02R, 2-160-03R, AND 2-160-04R.**

[3] **BYPASS EDITS 2-160-01R, 2-160-02R, 2-160-03R, AND 2-160-04R IF RECORD FAILS EDIT 2-160-01V OR 2-160-01-2V.**

ELEMENT NAME:	PROCEDURE CODE MODIFIER (2-165)		
	VALIDITY EDITS		
2-165-01V	MUST BE A VALID PROCEDURE CODE MODIFIER AS DEFINED IN CHAPTER 2, SECTION 2.7		
	RELATIONAL EDITS		
	NONE		

ELEMENT NAME:	NATIONAL DRUG CODE (2-170)		
	VALIDITY EDITS		
2-170-01V	MUST BE A VALID NATIONAL DRUG CODE **OR** BLANK		
	RELATIONAL EDITS		
2-170-01R	IF NATIONAL DRUG CODE = BLANK		
	THEN TYPE OF SERVICE (SECOND POSITION) MUST ≠	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS **OR**
		M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS
	AND PROCEDURE CODE[1] MUST ≠	98800	FOR DRUGS
	UNLESS PROVIDER STATE OR COUNTRY CODE IS A FOREIGN COUNTRY CODE (CHAPTER 2, ADDENDUM A)		
2-170-02R	IF NATIONAL DRUG CODE ≠ BLANK		
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS **OR**
		M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS
	AND PROCEDURE CODE[1] MUST =	98800	FOR DRUGS **OR**
		99070	FOR SUPPLIES **OR**
		000MN	PRESCRIPTION MEDICAL NECESSITY REVIEWS **OR**
		000PA	PRESCRIPTION PRIOR AUTHORIZATIONS

ELEMENT NAME: NUMBER OF SERVICES (2-175)			
VALIDITY EDITS			
2-175-01V	MUST BE NUMERIC.		
RELATIONAL EDITS			
2-175-01R	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 NUMBER OF SERVICES FOR EACH OCCURRENCE MUST BE > ZERO		
	UNLESS TYPE OF SERVICE (SECOND POSITION) =	M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS
	AND OCCURRENCE/LINE ITEM NUMBER = 002		
	THEN NUMBER OF SERVICES ON THIS LINE ITEM MUST = ZERO		
2-175-02R	• SURGERY PROCEDURE CODES		
	IF PROCEDURE CODE[1] = 10000-36399 **OR** 36800-69999 (SURGERY)		
	THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM CANNOT EXCEED 10		
2-175-03R	• E/M PROCEDURE CODES		
	IF PROCEDURE CODE[1] =		99201-99205 (OFFICE VISITS - NEW PATIENTS) **OR**
			99211-99215 (OFFICE VISITS - ESTABLISHED PATIENTS) **OR**
			99217 (DISCHARGE SERVICES) **OR**
			99221-99233 (HOSPITAL CARE PER DAY) **OR**
			99234-99236 (OBSERVATION OR IMPATIENT CARE SERVICES) **OR**
			99238-99239 (HOSPITAL DISCHARGE SERVICES) **OR**
			99241-99245 (OFFICE CONSULTATIONS) **OR**
			99251-99255 (INITIAL INPATIENT CONSULTATIONS) **OR**
			99261-99263 (FOLLOW-UP INPATIENT CONSULTATIONS) **OR**
			99271-99275 (CONFIRMATORY CONSULTATIONS) **OR**
			99281-99285 (EMERGENCY DEPARTMENT VISIT) **OR**

ELEMENT NAME: NUMBER OF SERVICES (2-175) (CONTINUED)		
		99291 (CRITICAL CARE) (NOTE: CODE 99292 EXCLUDED BECAUSE UTILIZED TO REPORT FOR EACH ADDITIONAL 15 MINUTES OF CARE) **OR**
		99295-99298 (NEONATAL INTENSIVE CARE) **OR**
		99301-99315 (NURSING FACILITY CHARGES) **OR**
		99321-99333 (DOMICILIARY, REST HOME, OR CUSTODIAL CARE SERVICES) **OR**
		99341-99350 (HOME SERVICES) **OR**
		99354 (PROLONGED SERVICES) (NOTE: CODE 99355 EXCLUDED BECAUSE UTILIZED TO REPORT FOR EACH ADDITIONAL 30 MINUTES OF CARE) **OR**
		99356 (PROLONGED SERVICES) (NOTE: CODE 99357 EXCLUDED BECAUSE UTILIZED TO REPORT FOR EACH ADDITIONAL 30 MINUTES OF CARE) **OR**
		99361-99373 (CASE MANAGEMENT SERVICES) **OR**
		99374-99380 (CARE PLAN OVERSIGHT) **OR**
		99381-99429 (PREVENTIVE MEDICINE SERVICES) **OR**
		99431-99440 (NEWBORN CARE) **OR**
		99450-99456 (SPECIAL EVALUATION AND MANAGEMENT SERVICES)
	THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM **CANNOT** EXCEED 3 PER DAY	
2-175-04R	• MEDICAL PROCEDURE CODES	
	IF PROCEDURE CODE[1] =	99500-99512 (HOME HEALTH VISIT) **OR**
		99551-99568 (HOME INFUSION PER DIEM CODES)
	THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM **CANNOT** EXCEED 3 PER DAY	
2-175-05R	• ANESTHESIOLOGY PROCEDURE CODES	
	IF PROCEDURE CODE[1] =	00100-01999 (ANESTHESIA)
	THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM **CANNOT** EXCEED 10	
2-175-06R	• VACCINES (VACCINE PRODUCT ONLY) PROCEDURE CODES	
	IF PROCEDURE CODE[1] =	90476-90479 (VACCINES, TOXOIDS) **OR**
	THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM **CANNOT** EXCEED 3 PER DAY	

ELEMENT NAME: AMOUNT BILLED BY PROCEDURE CODE (2-180)			
	VALIDITY EDITS		
2-180-01V	MUST BE NUMERIC.		
	RELATIONAL EDITS		
2-180-00R	IF TYPE OF SUBMISSION ≠	D	COMPLETE DENIAL
	THEN TOTAL OF ALL OCCURRENCES OF AMOUNT BILLED BY PROCEDURE CODE FOR THIS TED RECORD MUST NOT EXCEED TMA LIMIT OF $1,000,000.00		

ELEMENT NAME: AMOUNT ALLOWED BY PROCEDURE CODE (2-185)			
	VALIDITY EDITS		
2-185-01V	MUST BE NUMERIC.		
	RELATIONAL EDITS		
2-185-00R	TOTAL OF ALL OCCURRENCES OF AMOUNT ALLOWED BY PROCEDURE CODE FOR THIS TED RECORD EXCEEDS TMA LIMIT OF $1,000,000.00.		
2-185-01R	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL
	THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO **FOR ALL OCCURRENCE/LINE ITEM**		
2-185-02R	IF PRICING RATE CODE =	~~b~~	NO SPECIAL RATE **OR**
		D	DISCOUNT RATE **OR**
		V	MEDICARE REIMBURSEMENT RATE
	AND NO OCCURRENCE OF SPECIAL PROCESSING CODE =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**
		FS	TFL (SECOND PAYOR)
	AND TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
	THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE ≤ AMOUNT BILLED BY PROCEDURE CODE **FOR EACH OCCURRENCE/LINE ITEM**		
2-185-03R	IF PRICING RATE CODE =	4	PAID AS BILLED **OR**
		I	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, PAID AS BILLED
	AND TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
	THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE = AMOUNT BILLED BY PROCEDURE CODE		
2-185-04R	IF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO		

ELEMENT NAME:	AMOUNT ALLOWED BY PROCEDURE CODE (2-185) (CONTINUED)		
	THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM MUST BE A CODE LISTED IN CHAPTER 2, ADDENDUM H, FIGURE 2-H-1 **OR** FIGURE 2-H-2		
	UNLESS TYPE OF SUBMISSION =	B	ADJUSTMENT NON-TED DATA (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
2-185-05R	IF TYPE OF SUBMISSION =		
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN AMOUNT ALLOWED BY PROCEDURE CODE ≤ZERO		
2-185-06R	IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO		
	THEN TYPE OF SUBMISSION MUST =	A	ADJUSTMENT **OR**
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
2-185-07R	IF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO		
	THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO		
	UNLESS TYPE OF SUBMISSION =	B	ADJUSTMENT NON-TED DATA (HCSR) DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

ELEMENT NAME: AMOUNT PAID BY OTHER HEALTH INSURANCE (2-190)			
VALIDITY EDITS			
2-190-01V	MUST BE NUMERIC.		
RELATIONAL EDITS			
2-190-00R	TOTAL OF ALL OCCURRENCES OF AMOUNT PAID BY OTHER HEALTH INSURANCE FOR THIS TED RECORD EXCEEDS TMA LIMIT OF $1,000,000.00.		
2-190-01R	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 PAID BY OTHER HEALTH INSURANCE MUST BE ≥ ZERO.		
2-190-02R	IF ANY OCCURRENCE OF OVERRIDE CODE =	U	BENEFICIARY INDEMNIFICATION PAYMENT
	THEN AMOUNT PAID BY OTHER HEALTH INSURANCE MUST EQUAL ZERO.		

ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) TYPE CODE (2-191)			
VALIDITY EDITS			
2-191-01V	MUST BE A VALID OGP TYPE CODE LISTING IN CHAPTER 2, SECTION 2.6.		
RELATIONAL EDITS			
2-191-01R	IF OGP TYPE CODE =	V	CHAMPVA
	THEN TYPE OF SUBMISSION MUST =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		C	COMPLETE CANCELLATION **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) BEGIN REASON CODE (2-192)	
VALIDITY EDITS	
2-192-01V	MUST BE A VALID OGP BEGIN REASON CODE LISTING IN CHAPTER 2, SECTION 2.6.
RELATIONAL EDITS	
	NONE

ELEMENT NAME: AMOUNT APPLIED TOWARD DEDUCTIBLE (2-195)			
	VALIDITY EDITS		
2-195-01V	MUST BE NUMERIC.		
	RELATIONAL EDITS		
2-195-00R	TOTAL OF ALL OCCURRENCES OF AMOUNT APPLIED TOWARD DEDUCTIBLE FOR THIS TED RECORD EXCEEDS TMA LIMIT OF $1,000,000.00.		
2-195-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
	THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST BE ≥ ZERO		
2-195-02R	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL
	THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST BE = ZERO		
2-195-03R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	NE	OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM
	AND BEGIN DATE OF CARE ≥ 09/14/2001 **AND** < 11/01/2007		
	AND ENROLLMENT/HEALTH PLAN CODE =	T	TRICARE STANDARD PROGRAM **OR**
		V	TRICARE EXTRA
	THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO		
2-195-04R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF	ECHO
	THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO		