

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

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ELEMENT NAME: TYPE OF SUBMISSION (2-100) (CONTINUED)

	THEN REGION INDICATOR MUST =	↳	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

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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 (HCSR) 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		

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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 DATABASE¹

RELATIONAL EDITS

REFER TO CHAPTER 2, SECTION 8.1.

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

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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 =	h	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.

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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.

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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.	

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ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (2-110) (CONTINUED)	
	OR REGION INDICATOR = h 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 = h BLANK OR
	NC NORTH CONTRACT
	THEN DMIS-ID MUST = 7901, 7902, 7905, OR 7917
	OR REGION INDICATOR = h BLANK OR
	SC SOUTH CONTRACT
	THEN DMIS-ID MUST = 7903, 7904, 7906, OR 7918
	OR REGION INDICATOR = h 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.	

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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

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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 \neq ZERO

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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 CODE² 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.

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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 (ADFM _s 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.

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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.	
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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 OR TYPE OF SERVICE (SECOND POSITION) = B RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS OR

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.

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TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS-1 - 7 (2-120 THROUGH 2-137)

	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-04R¹	IF SECONDARY TREATMENT DIAGNOSIS = MATERNITY (630-676 OR V22-V24 OR V270-V289)	
	AND PATIENT AGE² < 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.
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TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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 \geq 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

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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).**

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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).**

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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).**

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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).**

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PROCEDURE CODE (2-160)

VALIDITY EDITS

2-160-01V² 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

2-160-02V² 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

2-160-01R³ 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 |
| AN | SHCP - NON-MTF-REFERRED CARE 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.

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PROCEDURE CODE (2-160) (CONTINUED)	
	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)
2-160-02R³	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
2-160-03R³	IF ANY PROCEDURE CODE IS FOR MALE AND NOT FOR CIRCUMCISION (PROCEDURE CODE¹ 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
2-160-04R³	IF PROCEDURE CODE HAS AN AGE PARAMETER RESTRICTION THEN PATIENT'S AGE MUST BE CONSISTENT WITH RESTRICTIONS 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 CPT ONLY © 2006 AMERICAN MEDICAL ASSOCIATION (OR SUCH OTHER DATE OF PUBLICATION OF CPT). ALL RIGHTS RESERVED.	
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.	

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: PROCEDURE CODE (2-160) (CONTINUED)	
2-160-05R	IF PROCEDURE CODE ¹ = A0100, A0110, A0120, A0130, A0140, A0170, E0170 - E0172, E0241- E0245, E0270, E0273, E0625, E0701, E0911, E0912, L3000 - L3003, L3010, L3020, L3030, L3031, L3040, L3050, L3060, L3070, L3080, L3090, L3100, L3160, L3201 - L3207, L3212 - L3219, L3221 - L3223, L3230, L3250 -L3255, L3257, L3265, L3300, L3310, L3320, L3330, L3332, L3334, L3340, L3350, L3360, L3370, L3380, L3390, L3400, L3410, L3420, L3430, L3440, L3450, L3455, L3460, L3465, L3470, L3480, L3485, L3500, L3510, L3520, L3530, L3540, L3550, L3560, L3570, L3580, L3590, L3595, L3630, S1040, S9122 - S9124, 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.

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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.**

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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 CODE¹
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 CODE¹
MUST =

98800

FOR DRUGS OR

99070

FOR SUPPLIES OR

000MN

PRESCRIPTION MEDICAL NECESSITY
REVIEWS OR

000PA

PRESCRIPTION PRIOR AUTHORIZATIONS

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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
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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: AMOUNT ALLOWED BY PROCEDURE CODE (2-185) (CONTINUED)		
<p>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</p>		
	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
<p>THEN AMOUNT ALLOWED BY PROCEDURE CODE \leq ZERO</p>		
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	
<p>THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO</p>		
	UNLESS TYPE OF SUBMISSION =	B ADJUSTMENT NON-TED DATA (HCSR) DATA OR
		E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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
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**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

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CHAPTER 2, SECTION 6.2

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

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 < 11/01/2008
	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