

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

<b>ELEMENT NAME: AMOUNT PATIENT COST-SHARE (2-200)</b>	
<b>VALIDITY EDITS</b>	
2-200-01V	MUST BE NUMERIC.
<b>RELATIONAL EDITS</b>	
2-200-00R	TOTAL OF ALL OCCURRENCES OF AMOUNT PATIENT COST-SHARE FOR THIS TED RECORD EXCEEDS TMA LIMIT OF \$1,000,000.00.
2-200-01R	IF TYPE OF SUBMISSION =
	A ADJUSTMENT OR
	I INITIAL SUBMISSION OR
	O ZERO PAYMENT WITH 100% OHI/TPL OR
	R RESUBMISSION
	THEN AMOUNT PATIENT COST-SHARE MUST BE ≥ ZERO
2-200-02R	IF TYPE OF SUBMISSION =
	C COMPLETE CANCELLATION OR
	D COMPLETE DENIAL
	THEN AMOUNT PATIENT COST-SHARE MUST BE = ZERO
<b>ELEMENT NAME: HEALTH CARE COVERAGE (HCC) COPAYMENT FACTOR CODE (2-201)</b>	
<b>VALIDITY EDITS</b>	
2-201-01V	MUST BE A VALID HCC COPAYMENT FACTOR CODE LISTED IN <a href="#">CHAPTER 2, SECTION 2.5</a> .
<b>RELATIONAL EDITS</b>	
	NONE

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

**ELEMENT NAME: AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE (2-205)**

**VALIDITY EDITS**

2-205-01V MUST BE NUMERIC.

**RELATIONAL EDITS**

2-205-00R TOTAL OF ALL OCCURRENCES OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE FOR THIS TED RECORD EXCEEDS TMA LIMIT OF \$1,000,000.00.

2-205-01R IF TYPE OF SUBMISSION =

A	ADJUSTMENT OR
I	INITIAL SUBMISSION OR
O	ZERO PAYMENT WITH 100% OHI/TPL OR
R	RESUBMISSION

THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST BE ≥ ZERO

2-205-02R IF TYPE OF SUBMISSION =

C	COMPLETE CANCELLATION OR
D	COMPLETE DENIAL

THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST BE = ZERO

**ELEMENT NAME: ADJUSTMENT/DENIAL REASON CODE (2-220)**

**VALIDITY EDITS**

2-220-01V VALUE MUST BE A VALID ADJUSTMENT/DENIAL REASON CODE (REFER TO [CHAPTER 2, ADDENDUM H](#)).

**RELATIONAL EDITS**

2-220-01R IF TYPE OF SUBMISSION =

C	COMPLETE CANCELLATION OR
D	COMPLETE DENIAL

THEN ALL OCCURRENCE/LINE ITEMS MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN [FIGURE 2-H-1](#) OR [FIGURE 2-H-2](#)

2-220-02R IF ADJUSTMENT/DENIAL REASON CODE IS A DENIAL REASON CODE LISTED IN [FIGURE 2-H-1](#), FOR THAT OCCURRENCE/LINE ITEM

AND 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 ALLOWED BY PROCEDURE CODE MUST = ZERO**

2-220-03R IF TYPE OF SUBMISSION =

B	ADJUSTMENT TO NON-TED (HCSR) DATA OR
E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

AND ADJUSTMENT/DENIAL REASON CODE IS A DENIAL REASON CODE LISTED IN [FIGURE 2-H-1](#), FOR THAT OCCURRENCE/LINE ITEM

THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE ≤ZERO

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**ELEMENT NAME: PROVIDER INDIVIDUAL NPI NUMBER (RESERVED) (2-225)**

**VALIDITY EDITS**

2-225-01V MUST BE BLANK FILLED.

**RELATIONAL EDITS**

NONE

**ELEMENT NAME: PROVIDER GROUP NPI NUMBER (RESERVED) (2-230)**

**VALIDITY EDITS**

2-230-01V MUST BE BLANK FILLED.

**RELATIONAL EDITS**

NONE

**ELEMENT NAME: PROVIDER STATE OR COUNTRY CODE (2-235)**

**VALIDITY EDITS**

2-235-01V VALUE MUST BE A VALID STATE (REFER TO [CHAPTER 2, ADDENDUM B](#))  
OR COUNTRY CODE (REFER TO [CHAPTER 2, ADDENDUM A](#)).

2-235-02V ALL OCCURRENCES OF PROVIDER STATE OR COUNTRY CODE FOR THIS RECORD MUST BE ALL CONUS OR ALL OCONUS.

**RELATIONAL EDITS**

2-235-01R PROVIDER STATE/COUNTRY CODE MUST MATCH THE CORRESPONDING RECORD<sup>1</sup> IN THE PROVIDER FILE.

**UNLESS AMOUNT ALLOWED BY PROCEDURE CODE IS ≤ 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)

**OR ANY OCCURRENCE OF  
SPECIAL PROCESSING CODE =** T MEDICARE/TRICARE DUAL ENTITLEMENT  
(SECOND PAYOR) **AND** BEGIN DATE OF  
CARE ≥ 10/01/2001 **OR**

<sup>1</sup> "CORRESPONDING RECORD" ON PROVIDER FILE IS BASED ON NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER MAJOR SPECIALTY, PROVIDER SUB-IDENTIFIER, 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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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

**ELEMENT NAME: PROVIDER STATE OR COUNTRY CODE (2-235) (CONTINUED)**

FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b>
FS	TFL (SECOND PAYOR) <b>OR</b>
RS	MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001

THEN DO NOT CHECK PROVIDER FILE

<sup>1</sup> **“CORRESPONDING RECORD” ON PROVIDER FILE IS BASED ON NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER MAJOR SPECIALTY, PROVIDER SUB-IDENTIFIER, 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: PROVIDER TAXPAYER NUMBER (2-240)**

**VALIDITY EDITS**

2-240-01V	MUST BE NUMERIC
	<b>OR</b> (FIRST 3 POSITIONS MUST BE A VALID STATE/COUNTRY CODE <b>AND</b> LAST 6 POSITIONS MUST BE NUMERIC)
	<b>OR</b> (FIRST 3 POSITIONS MUST BE A VALID STATE/COUNTRY CODE <b>AND</b> FOURTH POSITION MUST BE = ‘A’ <b>AND</b> LAST 5 POSITIONS MUST BE NUMERIC)

**RELATIONAL EDITS**

<b>NO ERROR</b>	IF ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM =	38	SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS <b>OR</b>
		52	THE REFERRING/PRESCRIBING/ RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE BILLED <b>OR</b>
		B7	THIS PROVIDER WAS NOT CERTIFIED/ ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE

THEN DO NOT CHECK FOR MATCH ON PROVIDER FILE FOR THAT PROVIDER

<b>NO ERROR</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE FOR THAT OCCURRENCE =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b>
		FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b>

<sup>1</sup> **ONLY THE FIRST 5 DIGITS OF THE PROVIDER ZIP CODE IS USED IN THE MATCH.**

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<b>ELEMENT NAME: PROVIDER TAXPAYER NUMBER (2-240) (CONTINUED)</b>	
	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
	<b>THEN DO NOT CHECK FOR MATCH ON PROVIDER FILE FOR THAT PROVIDER</b>
<b>NO ERROR</b>	IF AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO
	<b>THEN DO NOT CHECK PROVIDER FILE FOR THAT PROVIDER</b>
<b>NO ERROR</b>	IF PROVIDER SPECIALTY = 172A00000X (OTHER SERVICE PROVIDERS/DRIVER) OR 344600000X (TRANSPORTATION SERVICES/TAXI)
	<b>THEN DO NOT CHECK PROVIDER FILE FOR THAT PROVIDER</b>
<b>2-240-02R</b>	IF PROVIDER TAXPAYER NUMBER IS ALL NINES
	<b>THEN PROVIDER SPECIALTY MUST =</b> 172A00000X (OTHER SERVICE PROVIDERS/DRIVER) OR 344600000X (TRANSPORTATION SERVICES/TAXI)
	<b>AND PROVIDER PARTICIPATION INDICATOR MUST =</b> N NO
<b>2-240-03R</b>	PROVIDER TAXPAYER NUMBER <b>CANNOT</b> BE ALL NINES.
	<b>UNLESS PROVIDER SPECIALTY =</b> 172A00000X (OTHER SERVICE PROVIDERS/DRIVER) OR 344600000X (TRANSPORTATION SERVICES/TAXI)
	<b>AND PROVIDER PARTICIPATION INDICATOR =</b> N NO
<b>2-240-04R</b>	IF <b>ANY OCCURRENCE OF</b> OVERRIDE CODE = NC NON-CERTIFIED PROVIDER
	<b>THEN THE NON-CERTIFIED PROVIDER MUST MATCH THE PROVIDER ON THE PROVIDER FILE USING THE FOLLOWING:</b> NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER <b>AND PROVIDER MAJOR SPECIALTY</b> <b>AND PROVIDER ZIP CODE<sup>1</sup></b> <b>AND PROVIDER SUB-IDENTIFIER</b> <b>AND ACCEPTANCE AND TERMINATION DATES MUST = ZEROES</b> <b>AND PROVIDER CONTRACT AFFILIATION CODE MUST = '5' (NON-CERTIFIED PROVIDER)</b>
	IF NO OCCURRENCE OF OVERRIDE CODE = NC NON-CERTIFIED PROVIDER
	<b>THEN THE CERTIFIED PROVIDER MUST MATCH THE PROVIDER ON THE PROVIDER FILE USING THE FOLLOWING:</b> NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER <b>AND PROVIDER MAJOR SPECIALTY</b> <b>AND PROVIDER ZIP CODE<sup>1</sup></b> <b>AND PROVIDER SUB-IDENTIFIER</b>

**<sup>1</sup> ONLY THE FIRST 5 DIGITS OF THE PROVIDER ZIP CODE IS USED IN THE MATCH.**

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

**ELEMENT NAME: PROVIDER SUB-IDENTIFIER (2-245)**

**VALIDITY EDITS**

2-245-01V MUST BE 4 CHARACTERS  
FIRST CHARACTER ALPHANUMERIC, LAST 3 CHARACTERS NUMERIC  
OR FIRST 2 CHARACTERS ALPHANUMERIC, LAST 2 CHARACTERS NUMERIC  
OR ALL 4 NUMERIC

**RELATIONAL EDITS**

NONE

**ELEMENT NAME: PROVIDER ZIP CODE (2-250)**

**VALIDITY EDITS**

2-250-01V MUST BE 9 DIGITS OR 5 DIGITS WITH 4 BLANKS  
MUST BE A VALID ZIP CODE (BASED ON BEGIN DATE OF CARE) IN THE  
GOVERNMENT PROVIDED ELECTRONIC ZIP CODE FILE OR  
MUST BE A 3 CHARACTER FOREIGN COUNTRY CODE (BASED ON THE COUNTRY  
CODES TABLE<sup>1</sup>) FOLLOWED BY 6 BLANKS

**RELATIONAL EDITS**

NONE

<sup>1</sup> WHEN FOREIGN COUNTRY CODES ARE SUBMITTED, THE FIRST 3 CHARACTERS WILL BE EDITED AGAINST CHAPTER 2, ADDENDUM A.

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

**ELEMENT NAME: PROVIDER SPECIALTY (2-255)**

**VALIDITY EDITS**

**2-255-01V** THIS FIELD MUST BE A VALID PROVIDER SPECIALTY (REFER TO [CHAPTER 2, ADDENDUM C](#)).

**RELATIONAL EDITS**

**2-255-01R** IF PROVIDER SPECIALTY = 172A00000X (OTHER SERVICE PROVIDERS/DRIVER)  
OR  
344600000X (TRANSPORTATION SERVICES/TAXI)

**THEN PROVIDER TAXPAYER NUMBER MUST BE ALL NINES.**

**AND ONE OCCURRENCE  
OF SPECIAL PROCESSING  
CODE MUST =**

PF **ECHO**

**UNLESS ADJUSTMENT/DENIAL REASON CODE IS A DENIAL CODE LISTED IN  
[CHAPTER 2, ADDENDUM H, FIGURE 2-H-1](#), FOR THAT OCCURRENCE/LINE ITEM**

**2-255-03R** IF PROVIDER SPECIALTY = 333600000X (SUPPLIERS/PHARMACY)

**THEN TYPE OF SERVICE  
(SECOND POSITION) =**

B RETAIL DRUGS, SUPPLIES, PRESCRIPTION  
AUTHORIZATIONS, AND REVIEWS

**2-255-04R** IF PROVIDER SPECIALTY = 183500000X (PHARMACY SERVICE PROVIDERS/  
PHARMACIST)

**THEN TYPE OF SERVICE  
(SECOND POSITION) =**

M MAIL ORDER PHARMACY DRUGS,  
SUPPLIES, PRESCRIPTION  
AUTHORIZATIONS, AND REVIEWS

**ELEMENT NAME: PROVIDER PARTICIPATION INDICATOR (2-260)**

**VALIDITY EDITS**

**2-260-01V** MUST BE A VALID PROVIDER PARTICIPATION INDICATOR.

**RELATIONAL EDITS**

**2-260-01R** IF ANY OCCURRENCE OF  
SPECIAL PROCESSING CODE = A PARTNERSHIP (INTERNAL PROVIDERS  
WITH SIGNED AGREEMENT) OR

S RESOURCE SHARING - EXTERNAL OR

RI RESOURCE SHARING - INTERNAL

**THEN PROVIDER  
PARTICIPATION INDICATOR  
MUST =**

Y YES

**ELEMENT NAME: PROVIDER NETWORK STATUS INDICATOR (2-265)**

**VALIDITY EDITS**

**2-265-01V** MUST BE = 1 NETWORK PROVIDER OR

2 NON-NETWORK PROVIDER

**RELATIONAL EDITS**

NONE

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**ELEMENT NAME: PHYSICIAN REFERRAL NUMBER (2-270)**

**VALIDITY EDITS**

NONE

**RELATIONAL EDITS**

NONE

**ELEMENT NAME: PLACE OF SERVICE (2-275)**

**VALIDITY EDITS**

**2-275-01V** VALUE MUST BE A VALID PLACE OF SERVICE.

**RELATIONAL EDITS**

**2-275-01R** IF ADJUSTMENT/DENIAL REASON CODE IS **NOT** A CODE LISTED IN [CHAPTER 2, ADDENDUM H, FIGURE 2-H-1 OR FIGURE 2-H-2](#)

**THEN PLACE OF SERVICE MUST BE CONSISTENT WITH TYPE OF SERVICE, REFER TO [CHAPTER 2, ADDENDUM G.](#)**

**2-275-03R** IF CA/NAS EXCEPTION REASON = 5 RTC

**THEN PLACE OF SERVICE MUST = 56 RTC**

**2-275-04R** IF CA/NAS EXCEPTION REASON = 7 STF

**THEN PLACE OF SERVICE MUST = 55 STF**

**2-275-05R** IF CA/NAS EXCEPTION REASON = 3 COLLEGE INFIRMARY

**THEN PLACE OF SERVICE MUST = 99 OTHER LOCATIONS**

**2-275-06R** IF PLACE OF SERVICE = 21 INPATIENT HOSPITAL

**THEN TYPE OF SERVICE (FIRST POSITION) MUST = I INPATIENT**

**2-275-07R** IF PLACE OF SERVICE = 19 PHARMACY

**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**

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

<b>ELEMENT NAME: TYPE OF SERVICE (2-280)</b>	
<b>VALIDITY EDITS</b>	
<b>2-280-01V</b>	FIRST POSITION MUST BE = 'A', 'C', 'I', 'K', 'M', 'N', 'O', <b>OR</b> 'P'. SECOND POSITION MUST BE = 1-9; A-M. IF FIRST POSITION = 'A'; SECOND POSITION MUST ≠ 'C'. IF FIRST POSITION = 'P'; SECOND POSITION MUST = 'H'. IF FIRST POSITION = 'N'; SECOND POSITION MUST = 'I'.
<b>2-280-02V</b>	<b>IF CONTRACT NUMBER = MDA90602C0013</b> <b>THEN TYPE OF SERVICE (SECOND POSITION) MUST = M MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS</b>
<b>RELATIONAL EDITS</b>	
<b>2-280-01R</b>	IF AMOUNT ALLOWED BY PROCEDURE CODE > 0. <b>THEN TYPE OF SERVICE (SECOND POSITION) MUST BE CONSISTENT WITH PROCEDURE CODE (REFER TO <a href="#">ADDENDUM F</a>).</b>
<b>2-280-02R</b>	IF PROCEDURE CODE <sup>1</sup> = 92891, 92892, 92893, 92895, 92898, 92899, H0035, <b>OR</b> H0037. <b>AND ADJUSTMENT/ DENIAL REASON CODE CANNOT EQUAL ANY CODE LISTED IN <a href="#">ADDENDUM H</a>, <a href="#">FIGURE 2-H-1</a> <b>OR</b> <a href="#">FIGURE 2-H-2</a></b> <b>THEN TYPE OF SERVICE (FIRST POSITION) MUST = P PARTIAL PSYCHIATRIC OUTPATIENT</b>
<b>2-280-04R</b>	IF PROVIDER SPECIALTY = 261QB0400X (AMBULATORY HEALTH CARE FACILITIES/CLINIC/CENTER BIRTHING) <b>THEN TYPE OF SERVICE (FIRST POSITION) MUST = M MATERNITY <b>OR</b> O OUTPATIENT</b>
<b>2-280-05R</b>	IF TYPE OF SERVICE (FIRST POSITION) = M OUTPATIENT MATERNITY CARE COST-SHARED AS INPATIENT <b>THEN PRINCIPAL <b>OR</b> SECONDARY TREATMENT DIAGNOSIS MUST BE MATERNITY (630-676 <b>OR</b> V22-V24 <b>OR</b> V270-289)</b>
<b>2-280-06R</b>	IF TYPE OF SERVICE (SECOND POSITION) = C AMBULATORY SURGERY <b>THEN HCC MEMBER CATEGORY CODE MUST ≠ A ACTIVE DUTY <b>OR</b> G NATIONAL GUARD MEMBER (MOBILIZED <b>OR</b> ON ACTIVE DUTY FOR 31 DAYS <b>OR</b> MORE) <b>OR</b> J ACADEMY STUDENT <b>OR</b> P TAMP MEMBER <b>OR</b> S RESERVE MEMBER (MOBILIZED <b>OR</b> ON ACTIVE DUTY FOR 31 DAYS <b>OR</b> MORE) <b>OR</b> T FOREIGN MILITARY MEMBER</b>
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<b>ELEMENT NAME: TYPE OF SERVICE (2-280) (CONTINUED)</b>			
<b>2-280-07R</b>	IF TYPE OF SERVICE (FIRST POSITION) =	A	AMBULATORY SURGERY COST-SHARED AS INPATIENT (ACTIVE DUTY DEPENDENTS ONLY) <b>OR</b>
		M	OUTPATIENT MATERNITY COST-SHARED AS INPATIENT <b>OR</b>
		N	OUTPATIENT COST-SHARED AS INPATIENT <b>OR</b>
		O	OUTPATIENT, EXCLUDING M, P, <b>OR</b> N <b>OR</b>
		P	OUTPATIENT PARTIAL PSYCHIATRIC HOSPITALIZATION COST-SHARED AS INPATIENT
	<b>THEN PLACE OF SERVICE CANNOT =</b>	21	INPATIENT HOSPITAL
<b>2-280-08R</b>	IF TYPE OF SERVICE (SECOND POSITION) =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	<b>THEN NATIONAL DRUG CODE MUST ≠ BLANK</b>		
	<b>UNLESS PROVIDER STATE OR COUNTRY CODE IS A FOREIGN COUNTRY CODE (ADDENDUM A)</b>		
<b>2-280-09R</b>	IF TYPE OF SERVICE (SECOND POSITION) =	M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	<b>THEN TYPE OF SUBMISSION MUST ≠</b>	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	<b>AND AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO</b>		
	<b>AND CA/NAS EXCEPTION REASON MUST = BLANK</b>		
	<b>AND CA/NAS NUMBER MUST = BLANK</b>		
	<b>AND CA/NAS REASON FOR ISSUANCE MUST = BLANK</b>		
	<b>AND NATIONAL DRUG CODE MUST ≠ BLANK</b>		
	<b>AND PLACE OF SERVICE MUST =</b>	19	PHARMACY
	<b>AND PRICING RATE CODE MUST = 0</b>		
<b>AND PROVIDER NETWORK STATUS INDICATOR MUST =</b>	1	NETWORK PROVIDER	
<b>AND PROVIDER PARTICIPATING INDICATOR MUST =</b>	Y	YES	
<b>AND PROVIDER SPECIALTY MUST = 183500000X (PHARMACY SERVICE PROVIDERS/PHARMACIST)</b>			

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<b>ELEMENT NAME: TYPE OF SERVICE (2-280) (CONTINUED)</b>	
	<p><b>AND IF PROCEDURE CODE =</b> 000MN PRESCRIPTION MEDICAL NECESSITY REVIEWS <b>OR</b></p> <p>000PA PRESCRIPTION PRIOR AUTHORIZATIONS</p>
	<b>THEN</b> AMOUNT PATIENT COST-SHARE MUST = ZERO
	<p><b>AND CLAIM FORM TYPE/EMC INDICATOR MUST =</b> J OTHER</p>
	<b>ELSE IF OCCURRENCE/LINE ITEM NUMBER = 002</b>
	<b>THEN</b> AMOUNT BILLED BY PROCEDURE CODE ON THIS LINE ITEM MUST = ZERO
	<b>AND</b> AMOUNT PATIENT COST-SHARE ON THIS LINE ITEM MUST = ZERO
	<b>AND</b> NUMBER OF SERVICES ON THIS LINE ITEM MUST = ZERO
	<p><b>ELSE</b> CLAIM FORM TYPE/EMC INDICATOR MUST = I ELECTRONIC DRUG CLAIM SUBMISSION</p>
	<b>AND</b> NUMBER OF SERVICES = 1
<b>2-280-10R</b>	<p>IF TYPE OF SERVICE (SECOND POSITION) = B RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS <b>OR</b></p> <p>M MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS</p>
	<b>THEN</b> REGION INDICATOR MUST = BLANK
	<b>UNLESS</b> PROVIDER STATE OR COUNTRY CODE IS A FOREIGN COUNTRY CODE (ADDENDUM A)
<b>2-280-11R</b>	<p>IF TYPE OF SERVICE (SECOND POSITION) = M MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS</p>
	<b>AND</b> OCCURRENCE/LINE ITEM COUNT = 002
	<b>THEN</b> PROCEDURE CODE <sup>1</sup> MUST = 99070 SUPPLIES
<b>2-280-12R</b>	<p>IF TYPE OF SERVICE (SECOND POSITION) = G DENTAL</p>
	<b>THEN</b> PROCEDURE CODE <sup>1</sup> ≠ 00100 - 09999
<b>2-280-13R</b>	<p>IF TYPE OF SERVICE (SECOND POSITION) = B RETAIL PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS <b>OR</b></p> <p>M MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS</p>
	<b>AND</b> CLAIM FORM TYPE/EMC INDICATOR = J OTHER

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**ELEMENT NAME: TYPE OF SERVICE (2-280) (CONTINUED)**

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THEN PROCEDURE CODE  
MUST =

000MN PRESCRIPTION MEDICAL NECESSITY  
REVIEWS **OR**

000PA PRESCRIPTION PRIOR AUTHORIZATIONS

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<b>ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER CATEGORY CODE (2-285)</b>	
<b>VALIDITY EDITS</b>	
<b>2-285-01V</b>	MUST BE A VALID HCC MEMBER CATEGORY CODE (REFER TO SECTION 2.5)
<b>RELATIONAL EDITS</b>	
<b>2-285-01R</b>	IF HCC MEMBER RELATIONSHIP CODE =
	A SELF
	THEN HCC MEMBER CATEGORY MUST ≠
	A ACTIVE DUTY <b>OR</b>
	G NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) <b>OR</b>
	J ACADEMY STUDENT <b>OR</b>
	N NATIONAL GUARD (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) <b>OR</b>
	S RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) <b>OR</b>
	T FOREIGN MILITARY MEMBER <b>OR</b>
	V RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS)
	UNLESS ENROLLMENT/HEALTH PLAN CODE =
	W TPR AD SM - USA <b>OR</b>
	X FOREIGN AD SM <b>OR</b>
	Y CHCBP - STANDARD <b>OR</b>
	AA CHCBP - EXTRA <b>OR</b>
	SN SHCP - NON-MTF-REFERRED CARE <b>OR</b>
	SO SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
	SR SHCP - REFERRED CARE <b>OR</b>
	ST SHCP - TRICARE ELIGIBLE <b>OR</b>
	SU SHCP - REFERRAL DESIGNATION UNKNOWN <b>OR</b>
	WA TPR FOREIGN AD SM
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	SC SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
	SE SHCP - TRICARE ELIGIBLE <b>OR</b>
	SM SHCP - EMERGENCY
	OR HCDP PLAN COVERAGE CODE =
	401 TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
	402 TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) <b>OR</b>
	405 TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

<b>ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER CATEGORY CODE (2-285) (CONTINUED)</b>	
	406 TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) <b>OR</b>
	407 TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
	408 TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) <b>OR</b>
	409 TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE <b>OR</b>
	410 TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE <b>OR</b>
	411 TRS SURVIVOR NEW INDIVIDUAL COVERAGE <b>OR</b>
	412 TRS SURVIVOR NEW FAMILY COVERAGE <b>OR</b>
	413 TRS MEMBER-ONLY COVERAGE <b>OR</b>
	414 TRS MEMEBER AND FAMILY COVERAGE
<b>2-285-02R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = PF ECHO
	<b>THEN HHC MEMBER CATEGORY CODE MUST =</b>
	A ACTIVE DUTY <b>OR</b>
	G NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) <b>OR</b>
	J ACADEMY STUDENT <b>OR</b>
	P TAMP MEMBER <b>OR</b>
	S RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE)
<b>2-285-03R</b>	IF TYPE OF SERVICE (FIRST POSITION) = A AMBULATORY SURGERY COST-SHARED AS INPATIENT
	<b>THEN HCC MEMBER CATEGORY CODE MUST =</b>
	A ACTIVE DUTY <b>OR</b>
	G NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) <b>OR</b>
	J ACADEMY STUDENT <b>OR</b>
	P TRANSITIONAL ASSISTANCE MANAGEMENT PROGRAM (TAMP) MEMBER <b>OR</b>
	S RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) <b>OR</b>
	T FOREIGN MILITARY MEMBER <b>OR</b>
	Z UNKNOWN

UNLESS AMOUNT ALLOWED BY PROCEDURE CODE = 0

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

**ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER CATEGORY CODE (2-285) (CONTINUED)**

<b>2-285-04R</b>	IF TYPE OF SERVICE (SECOND POSITION) =	C	AMBULATORY SURGERY
	<b>THEN HCC MEMBER CATEGORY CODE MUST =</b>	D	DISABLED AMERICAN VETERAN <b>OR</b>
		F	FORMER MEMBER <b>OR</b>
		H	MEDAL OF HONOR RECIPIENT <b>OR</b>
		R	RETIRED <b>OR</b>
		W	FORMER SPOUSE <b>OR</b>
		Z	UNKNOWN
	<b>UNLESS AMOUNT ALLOWED BY PROCEDURE CODE = 0</b>		

<b>2-285-05R</b>	IF HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER
	<b>THEN ONE OCCURRENCE OF OVERRIDE CODE =</b>	M	NATO

**ELEMENT NAME: PAY GRADE CODE (SPONSOR) (2-291)**

**VALIDITY EDITS**

<b>2-291-01V</b>	MUST BE A VALID PAY GRADE CODE (SPONSOR) (REFER TO <a href="#">SECTION 2.7</a> )
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**RELATIONAL EDITS**

NONE

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

**ELEMENT NAME: PAY PLAN CODE (SPONSOR) (2-292)**

**VALIDITY EDITS**

**2-292-01V** MUST BE A VALID PAY PLAN CODE (SPONSOR) (REFER TO [SECTION 2.7](#))

**RELATIONAL EDITS**

<b>2-292-01R</b>	IF HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER
	<b>THEN PAY PLAN CODE (SPONSOR) MUST =</b>	FA	FOREIGN SERVICE CHIEFS OF MISSION <b>OR</b>
		FC	FOREIGN COMPENSATION AGENCY FOR INTERNATIONAL DEVELOPMENT <b>OR</b>
		FD	FOREIGN DEFENSE <b>OR</b>
		FE	SENIOR FOREIGN SERVICE <b>OR</b>
		FO	FOREIGN SERVICE OFFICERS <b>OR</b>
		FP	FOREIGN SERVICE PERSONNEL <b>OR</b>
		FZ	CONSULAR AGENT DEPARTMENT OF STATE <b>OR</b>
		MC	CADET <b>OR</b>
		ME	ENLISTED <b>OR</b>
		MO	OFFICER <b>OR</b>
		MW	WARRANT OFFICER <b>OR</b>
		ZZ	NOT APPLICABLE
<b>2-292-02R</b>	IF SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) =	H	PHS <b>OR</b>
		O	NOAA
	<b>THEN PAY PLAN CODE (SPONSOR) MUST ≠</b>	ME	ENLISTED
<b>2-292-03R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF	ECHO
	<b>THEN PAY PLAN CODE (SPONSOR) MUST =</b>	ME	ENLISTED <b>OR</b>
		MO	OFFICER <b>OR</b>
		MW	WARRANT OFFICER <b>OR</b>
		ZZ	NOT APPLICABLE

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

<b>ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER RELATIONSHIP CODE (2-295)</b>	
<b>VALIDITY EDITS</b>	
<b>2-295-01V</b>	MUST BE A VALID HCC MEMBER RELATIONSHIP CODE (REFER TO SECTION 2.5)
<b>RELATIONAL EDITS</b>	
<b>2-295-01R</b>	IF PATIENT AGE <sup>1</sup> < 17. <b>THEN</b> HCC MEMBER RELATIONSHIP CODE MUST ≠ A SELF
<b>2-295-02R</b>	IF PATIENT AGE <sup>1</sup> < 12 <b>THEN</b> HCC MEMBER RELATIONSHIP CODE MUST ≠ B SPOUSE <b>OR</b> G SURVIVING SPOUSE <b>UNLESS</b> ONE OCCURRENCE OF OVERRIDE CODE = B PATIENT IS A SPOUSE UNDER 12 YEARS OF AGE
<b>2-295-03R</b>	IF PATIENT AGE <sup>1</sup> ≥ 21 <b>AND</b> PERSON BIRTH CALENDAR DATE (PATIENT) ≠ 19111111 <b>THEN</b> HCC MEMBER RELATIONSHIP CODE MUST ≠ C CHILD OR STEPCHILD <b>OR</b> D PRE-ADOPTIVE CHILD <b>OR</b> E WARD (COURT ORDERED) <b>UNLESS</b> ONE OCCURRENCE OF OVERRIDE CODE MUST = D PATIENT IS DEPENDENT 21 YEARS OF AGE
<b>2-295-04R</b>	IF PERSON BIRTH CALENDAR DATE (PATIENT) INDICATES AGE <sup>1</sup> < 34 <b>THEN</b> HCC MEMBER RELATIONSHIP CODE ≠ H FORMER SPOUSE (20/20/20) <b>OR</b> I FORMER SPOUSE (20/20/15) <b>OR</b> J FORMER SPOUSE (10/20/10) <b>OR</b> K FORMER SPOUSE (TRANSITIONAL ASSISTANCE (COMPOSITE)) <b>AND</b> HCC MEMBER CATEGORY CODE ≠ W FORMER SPOUSE <b>UNLESS</b> ONE OCCURRENCE OF OVERRIDE CODE = I PATIENT IS A FORMER SPOUSE UNDER 34 YEARS OF AGE
<b>2-295-05R</b>	IF HCC MEMBER CATEGORY CODE = T FOREIGN MILITARY MEMBER <b>AND</b> HCC MEMBER RELATIONSHIP CODE ≠ A SELF <b>THEN</b> HCC MEMBER RELATIONSHIP CODE MUST CODE MUST = B SPOUSE <b>OR</b> C CHILD OR STEPCHILD <b>OR</b>
<sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN CARE DATE.	

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

<b>ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER RELATIONSHIP CODE (2-295) (CONTINUED)</b>	
	D PRE-ADOPTIVE CHILD <b>OR</b>
	E WARD (COURT ORDERED)
<b>2-295-06R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = PF ECHO
	<b>THEN HCC MEMBER RELATIONSHIP CODE MUST =</b>
	B SPOUSE <b>OR</b>
	C CHILD OR STEPCHILD <b>OR</b>
	D PRE-ADOPTIVE CHILD <b>OR</b>
	E WARD (COURT ORDERED) <b>OR</b>
	G SURVIVING SPOUSE
<b>2-295-07R</b>	IF TYPE OF SERVICE (FIRST POSITION) = A AMBULATORY SURGERY COST-SHARED AS INPATIENT
	<b>THEN HCC MEMBER RELATIONSHIP CODE MUST =</b>
	A SELF <b>OR</b>
	B SPOUSE <b>OR</b>
	C CHILD OR STEPCHILD <b>OR</b>
	D PRE-ADOPTIVE CHILD <b>OR</b>
	E WARD (COURT ORDERED) <b>OR</b>
	G SURVIVING SPOUSE <b>OR</b>
	Z UNKNOWN
	<b>AND HCC MEMBER CATEGORY CODE ≠</b>
	W FORMER SPOUSE
	<b>UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =</b>
	SC SHCP - NON-TRICARE ELIGIBLE
<b>2-295-08R</b>	IF HCC MEMBER CATEGORY CODE = H MEDAL OF HONOR RECIPIENT
	<b>THEN HCC MEMBER RELATIONSHIP CODE MUST =</b>
	A SELF <b>OR</b>
	B SPOUSE <b>OR</b>
	C CHILD OR STEPCHILD <b>OR</b>
	G SURVIVING SPOUSE
<b>2-295-10R</b>	IF HCC MEMBER CATEGORY CODE = T FOREIGN MILITARY MEMBER
	<b>AND HCC MEMBER RELATIONSHIP CODE =</b>
	A SELF
	<b>THEN ANY OCCURRENCE OF SPECIAL PROCESSING CODE MUST =</b>
	AN SHCP - NON-REFERRED CARE <b>OR</b>
	AR SHCP - REFERRED CARE <b>OR</b>
	SC SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
	SM SHCP - EMERGENCY

<sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN CARE DATE.

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

**ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER RELATIONSHIP CODE  
(2-295) (CONTINUED)**

OR ENROLLMENT/  
HEALTH PLAN CODE  
CODE MUST =

SN SHCP - NON-MTF REFERRED **OR**

SO SHCP - NON-TRICARE ELIGIBLE **OR**

SR SHCP - REFERRED **OR**

SU SHCP - REFERRAL DESIGNATION  
UNKNOWN

UNLESS AMOUNT ALLOWED BY PROCEDURE CODE = ZERO

THEN BYPASS THIS EDIT

<sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND  
BEGIN CARE DATE.

