

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300)	
VALIDITY EDITS	
2-300-01V	MUST BE A VALID ENROLLMENT/HEALTH PLAN CODE (REFER TO <a href="#">CHAPTER 2, SECTION 2.5</a> )
2-300-02V	IF ENROLLMENT/HEALTH PLAN CODE =
	SO SHCP - NON-TRICARE ELIGIBLE OR
	ST SHCP - TRICARE ELIGIBLE
	THEN BEGIN DATE OF CARE MUST < 06/01/2004
2-300-03V	IF ENROLLMENT/HEALTH PLAN CODE =
	TS TSS
	THEN BEGIN DATE OF CARE MUST < 12/31/2002
2-300-04V	IF ENROLLMENT/HEALTH PLAN CODE =
	BB TSP
	THEN BEGIN DATE OF CARE MUST < 12/31/2001
RELATIONAL EDITS	
2-300-02R	IF ENROLLMENT/HEALTH PLAN CODE =
	Y CHCBP - STANDARD OR
	AA CHCBP - EXTRA
	THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE MAY =
	CL CLINICAL TRIALS OR
	PF ECHO
2-300-03R	IF ENROLLMENT/HEALTH PLAN CODE =
	W TPR ADSM - USA
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =
	GU ADSM ENROLLED IN TPR
2-300-05R	IF ENROLLMENT/HEALTH PLAN CODE =
	BB TSP
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =
	MN TSP - NON-NETWORK OR
	MS TSP - NETWORK
2-300-06R	IF ENROLLMENT/HEALTH PLAN CODE =
	Z TRICARE PRIME, MTF/PCM
	THEN BEGIN DATE OF CARE MUST BE ≥ 10/01/1997

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

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

<b>ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (CONTINUED)</b>			
<b>2-300-07R</b>	IF ENROLLMENT/HEALTH PLAN CODE =	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>THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =</b>	
	AN	SHCP -NON-MTF-REFERRED CARE <b>OR</b>	
	AR	SHCP - REFERRED CARE <b>OR</b>	
	CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM <b>OR</b>	
	SC	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>	
	SE	SHCP - TRICARE ELIGIBLE <b>OR</b>	
SM	SHCP - EMERGENCY		
<b>2-300-09R</b>	IF ENROLLMENT/HEALTH PLAN CODE =	TS	TSS
		<b>THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =</b>	
	SN	TSS - NON-NETWORK <b>OR</b>	
	SS	TSS - NETWORK	
<b>2-300-10R</b>	IF ENROLLMENT/HEALTH PLAN CODE =	PS	TSRx
		<b>THEN TYPE OF SERVICE (SECOND POSITION) MUST =</b>	
	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS <b>OR</b>	
	M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS	
<b>2-300-11R</b>	IF ENROLLMENT/HEALTH PLAN CODE =	PS	TSRx
		<b>THEN BEGIN DATE OF CARE MUST BE ≥ 04/01/2001</b>	
	<b>AND NATIONAL DRUG CODE CANNOT BE BLANK.</b>		
	UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	1	MEDICAID
<b>2-300-12R</b>	<ul style="list-style-type: none"> <li>TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001. FOR EACH LINE ITEM WHERE BEGIN DATE OF CARE IS &lt; 10/01/2001, THE LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.</li> </ul>		
	IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL - EXTRA <b>OR</b>
		FS	TFL - STANDARD
	<b>THEN BEGIN DATE OF CARE MUST BE ≥ 10/01/2001</b>		
<b><sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES</b>			

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

<b>ELEMENT NAME:</b>		<b>ENROLLMENT/HEALTH PLAN CODE (2-300) (CONTINUED)</b>	
	AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	FF	TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) <b>OR</b>
		FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b>
		FS	TFL (SECOND PAYOR)
<b>ELSE IF BEGIN DATE OF CARE IS &lt; 10/01/2001 (FOR THAT DETAILED LINE ITEM)</b>			
	<b>THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE MUST =</b>	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER <b>OR</b>
		26	EXPENSES INCURRED PRIOR TO COVERAGE <b>OR</b>
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED <b>OR</b>
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS <b>OR</b>
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED <b>OR</b>
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED <b>OR</b>
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE <b>OR</b>
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS <b>OR</b>
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION <b>OR</b>
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
<b>2-300-13R</b>	<ul style="list-style-type: none"> <li>TFL CLAIMS: THE PATIENT MUST BE 64 YEARS AND 11 MONTHS OR GREATER. IF THE PATIENT IS LESS THAN THIS AGE, THE LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.</li> </ul>		
	IF ENROLLMENT/HEALTH PLAN CODE =	FE	TFL - EXTRA <b>OR</b>
		FS	TFL - STANDARD <b>OR</b>
		PS	TSRx

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

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

<b>ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (CONTINUED)</b>	
AND TYPE OF SERVICE (SECOND POSITION) ≠	M MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
<b>THEN PATIENT AGE<sup>1</sup> MUST BE ≥ 64 YEARS AND 11 MONTHS</b>	
<b>ELSE IF PATIENT AGE<sup>1</sup> IS &lt; 64 YEARS AND 11 MONTHS</b>	
<b>THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE MUST =</b>	15 PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER <b>OR</b>
	26 EXPENSES INCURRED PRIOR TO COVERAGE <b>OR</b>
	27 EXPENSES INCURRED AFTER COVERAGE TERMINATED <b>OR</b>
	30 PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS <b>OR</b>
	31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED <b>OR</b>
	32 OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED <b>OR</b>
	33 CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE <b>OR</b>
	34 CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS <b>OR</b>
	62 PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE- CERTIFICATION/AUTHORIZATION <b>OR</b>
	141 CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
<b>2-300-14R</b> IF ENROLLMENT/HEALTH PLAN CODE =	WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
<b>THEN BEGIN DATE OF CARE IS ≥ 09/01/2002</b>	
<b>2-300-15R</b> IF ENROLLMENT/HEALTH PLAN CODE =	SU SCHP - REFERRAL DESIGNATION UNKNOWN
<b>THEN TYPE OF SERVICE (SECOND POSITION) MUST =</b>	B RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS <b>OR</b>

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

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**ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (CONTINUED)**

		M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
<b>2-300-16R</b>	IF ENROLLMENT/HEALTH PLAN CODE =	SU	SCHP - REFERRAL DESIGNATION UNKNOWN
	<b>THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =</b>	SC	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
		SE	SHCP - TRICARE ELIGIBLE
<b>2-300-17R</b>	<ul style="list-style-type: none"> <li>FOR TMOP ONLY: FOR TSRx, THE PATIENT MUST BE 64 YEARS AND 8 MONTHS OR GREATER. IF THE PATIENT IS LESS THAN THIS AGE, THE LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.</li> </ul>		
	IF ENROLLMENT/HEALTH PLAN CODE =	PS	TSRx
	<b>AND TYPE OF SERVICE (SECOND POSITION) =</b>	M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	<b>THEN PATIENT AGE<sup>1</sup> MUST BE ≥ 64 YEARS AND 8 MONTHS</b>		
	<b>ELSE IF PATIENT AGE<sup>1</sup> &lt; 64 YEARS AND 8 MONTHS</b>		
	<b>THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE MUST =</b>	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER <b>OR</b>
		26	EXPENSES INCURRED PRIOR TO COVERAGE <b>OR</b>
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED <b>OR</b>
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS <b>OR</b>
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED <b>OR</b>
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED <b>OR</b>
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE <b>OR</b>
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS <b>OR</b>
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION <b>OR</b>

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

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

<b>ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (2-300) (CONTINUED)</b>	
	141 CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
<b>2-300-18R</b>	IF ENROLLMENT/HEALTH PLAN CODE =
	X FOREIGN ADMS
	<b>THEN HCC MEMBER</b>
	RELATIONSHIP CODE MUST =
	A SELF <b>OR</b>
	T FOREIGN MILITARY MEMBER
	<b>AND HCC MEMBER</b>
	CATEGORY CODE 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>
	V RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS)

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

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

**ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (2-301)**

**VALIDITY EDITS**

**2-301-01V** MUST BE A VALID HCDP PLAN COVERAGE CODE LISTED IN **ADDENDUM M**.

**2-301-02V** IF FILING DATE  $\geq$  09/01/2007

AND HCDP PLAN COVERAGE  
CODE =

109 TRICARE USFHP DIRECT CARE COVERAGE  
FOR ADFMS **OR**

114 TRICARE USFHP DIRECT CARE INDIVIDUAL  
COVERAGE FOR SURVIVORS OF ACTIVE  
DUTY DECEASED SPONSORS **OR**

115 TRICARE USFHP DIRECT CARE FAMILY  
COVERAGE FOR SURVIVORS OF ACTIVE  
DUTY DECEASED SPONSORS **OR**

118 TRICARE USFHP DIRECT CARE INDIVIDUAL  
COVERAGE FOR RETIRED SPONSORS AND  
FAMILY MEMBERS **OR**

119 TRICARE USFHP DIRECT CARE FAMILY  
COVERAGE FOR RETIRED SPONSORS AND  
FAMILY MEMBERS **OR**

133 TRICARE USFHP DIRECT CARE INDIVIDUAL  
COVERAGE FOR TRANSITIONAL  
SURVIVORS OF ACTIVE DUTY DECEASED  
SPONSORS **OR**

138 TRICARE USFHP DIRECT CARE INDIVIDUAL  
COVERAGE FOR SURVIVORS OF GUARD/  
RESERVE DECEASED SPONSORS **OR**

139 TRICARE USFHP DIRECT CARE FAMILY  
COVERAGE FOR SURVIVORS OF GUARD/  
RESERVE DECEASED SPONSORS

**THEN THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED  
BY PROCEDURE CODE MUST = ZERO**

**RELATIONAL EDITS**

**2-301-01R** IF HCDP PLAN COVERAGE  
CODE =

401 TRS TIER 1 MEMBER-ONLY COVERAGE  
(CONTINGENCY OPERATIONS) **OR**

402 TRS TIER 1 MEMBER AND FAMILY  
COVERAGE (CONTINGENCY OPERATIONS)  
**OR**

405 TRS TIER 2 MEMBER-ONLY COVERAGE  
(CERTIFIED QUALIFICATIONS) **OR**

406 TRS TIER 2 MEMBER AND FAMILY  
COVERAGE (CERTIFIED QUALIFICATIONS)  
**OR**

407 TRS TIER 3 MEMBER-ONLY COVERAGE  
(SERVICE AGREEMENT) **OR**

408 TRS TIER 3 MEMBER AND FAMILY  
COVERAGE (SERVICE AGREEMENT) **OR**

409 TRS SURVIVOR CONTINUING WITH  
INDIVIDUAL COVERAGE **OR**

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**ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (2-301)**

	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 MEMBER AND FAMILY COVERAGE <b>OR</b>
	418	TRICARE RETIRED RESERVE (TRR) MEMBER-ONLY COVERAGE <b>OR</b>
	419	TRR MEMBER AND FAMILY COVERAGE <b>OR</b>
	420	TRR SURVIVOR INDIVIDUAL COVERAGE <b>OR</b>
	421	TRR SURVIVOR FAMILY COVERAGE
THEN ENROLLMENT/ HEALTH PLAN CODE MUST =	T	TRICARE STANDARD <b>OR</b>
	V	TRICARE EXTRA <b>OR</b>
	FE	TFL - EXTRA <b>OR</b>
	FS	TFL - STANDARD <b>OR</b>
	PS	TSRx <b>OR</b>
	SR	SHCP-REFERRED CARE
<b>2-301-02R</b>	IF 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>
	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 MEMBER AND FAMILY COVERAGE <b>OR</b>
	418	TRR MEMBER-ONLY COVERAGE <b>OR</b>



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**ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (2-301)**

		419	TRR MEMBER AND FAMILY COVERAGE OR
		420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
		421	TRR SURVIVOR FAMILY COVERAGE
	THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE CAN =	PF	ECHO
2-301-03R	IF HCDP PLAN COVERAGE CODE =	417	TRANSITIONAL CARE FOR SERVICE-RELATED CONDITIONS (TCSRC)
	THEN ENROLLMENT/ HEALTH PLAN CODE MUST =	X	FOREIGN ADSM OR
		SR	SHCP - REFERRED CARE

**ELEMENT NAME: REGION INDICATOR (2-303)**

**VALIDITY EDITS**

2-303-01V	MUST BE A VALID REGION INDICATOR (REFER TO <a href="#">SECTION 2.8</a> )		
2-303-02V	IF TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	AND REGION INDICATOR =	NC	NORTH CONTRACT OR
		SC	SOUTH CONTRACT OR
		WC	WEST CONTRACT
	THEN ADJUSTMENT KEY MUST =	0	BATCH OR
		5	VOUCHER

**RELATIONAL EDITS**

NONE

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**ELEMENT NAME: SPECIAL PROCESSING CODE (2-305)**

**VALIDITY EDITS**

<b>2-305-01V</b>	OCCURRENCE NUMBER 1--MUST BE A VALID SPECIAL PROCESSING CODE <sup>1</sup>		
<b>2-305-02V</b>	OCCURRENCE NUMBER 2--MUST BE A VALID SPECIAL PROCESSING CODE <sup>1</sup>		
<b>2-305-03V</b>	OCCURRENCE NUMBER 3--MUST BE A VALID SPECIAL PROCESSING CODE <sup>1</sup>		
<b>2-305-04V</b>	OCCURRENCE NUMBER 4--MUST BE A VALID SPECIAL PROCESSING CODE <sup>1</sup>		
<b>2-305-05V</b>	A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).		
<b>2-305-06V</b>	SPECIAL PROCESSING CODE OCCURRENCES MUST BE LEFT JUSTIFIED.		
<b>2-305-07V</b>	<ul style="list-style-type: none"> <li>• SHCP REFERRED/NON-REFERRED</li> </ul>		
	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
		AR	SHCP - REFERRED CARE
	<b>THEN BEGIN DATE OF CARE MUST BE &lt; 06/01/2004</b>		
<b>2-305-08V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	GF	TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	<b>THEN BEGIN DATE OF CARE MUST BE &lt; 09/01/2002</b>		
<b>2-305-09V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	U	BRAC PHARMACY
	<b>THEN BEGIN DATE OF CARE MUST BE &lt; 04/01/2001</b>		
<b>2-305-10V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	MN	TSP - NON-NETWORK <b>OR</b>
		MS	TSP - NETWORK
	<b>THEN BEGIN DATE OF CARE MUST BE &lt; 12/31/2001</b>		
<b>2-305-11V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	SN	TSS - NON-NETWORK <b>OR</b>
		SS	TSS - NETWORK
	<b>THEN BEGIN DATE OF CARE MUST BE &lt; 12/31/2002</b>		
<b>2-305-13V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PD	PHARMACY REDESIGN PILOT PROGRAM
	<b>THEN BEGIN DATE OF CARE MUST BE &lt; 04/01/2001</b>		
<b>2-305-14V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	ST	SPECIALIZED TREATMENT
	<b>THEN BEGIN DATE OF CARE MUST BE &lt; 10/01/2004</b>		
<b>2-305-15V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	WR	MENTAL HEALTH WRAPAROUND DEMONSTRATION
	<b>THEN BEGIN DATE OF CARE MUST BE &lt; 06/30/2001</b>		

**RELATIONAL EDITS**

<b>2-305-02R</b>	IF CA/NAS EXCEPTION REASON =	6	RESOURCE SHARING
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<sup>1</sup> AS STATED IN SECTION 2.8 OR BLANK

<sup>2</sup> CPT ONLY © 2006 AMERICAN MEDICAL ASSOCIATION (OR SUCH OTHER DATE OF PUBLICATION OF CPT). ALL RIGHTS RESERVED.

<sup>3</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

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<b>ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (CONTINUED)</b>	
	THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST = S RESOURCE SHARING - EXTERNAL
<b>2-305-05R</b>	(LIVER TRANSPLANT)
	IF ANY OCCURRENCE/LINE ITEM = PROCEDURE CODES <sup>2</sup> 47133, 47135, OR 47136
	AND BEGIN DATE OF CARE < 03/01/1997
	OR (> 02/19/1998 AND < 09/01/1999)
	THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST = 5 LIVER TRANSPLANT
	ELSE IF BEGIN DATE OF CARE (≥ 03/01/1997 AND ≤ 02/19/1998)
	OR (≥ 09/01/1999 AND ≤ 05/31/2003)
	THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST = ST SPECIALIZED TREATMENT
<b>2-305-06R</b>	IF ANY OCCURRENCE/LINE ITEM = PROCEDURE CODE <sup>2</sup> 33945
	THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST = 7 HEART TRANSPLANT
<b>2-305-07R</b>	IF ANY OCCURRENCE/LINE ITEM = PROCEDURE CODE <sup>2</sup> 90199
	THEN AT LEAST ONE SPECIAL PROCESSING CODE MUST = 6 HHC
<b>2-305-08R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = PF ECHO
	THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE MAY = 6 HHC OR
	A PARTNERSHIP PROGRAM OR
	E HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP) OR
	S RESOURCE SHARING - EXTERNAL OR
	CM ICMP OR
	CT CCTP OR
	RI RESOURCE SHARING - INTERNAL
<b>2-305-09R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = X PARTIAL HOSPITALIZATION-PROVIDERS NOT CONTRACTED WITH OR EMPLOYED BY THE PARTIAL HOSPITALIZATION PROGRAM WHO BILL FOR PSYCHOTHERAPY SERVICES IN A PARTIAL HOSPITALIZATION PROGRAM
	THEN AT LEAST ONE PROCEDURE CODE <sup>2</sup> MUST = 90812, 90813, 90814, 90815, 90816, 90817, 90843, 90844, 90846, 90847, 90849, OR 90855

<sup>1</sup> AS STATED IN SECTION 2.8 OR BLANK

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<sup>3</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

<b>ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (CONTINUED)</b>			
<b>2-305-12R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	U	BRAC MEDICARE PHARMACY
	<b>THEN TYPE OF SERVICE (SECOND POSITION) MUST =</b>	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	<b>AND BEGIN DATE OF CARE MUST BE &lt; 04/01/2001</b>		
<b>2-305-13R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	16	AMBULATORY SURGERY FACILITY CHARGE
	<b>THEN PRICING RATE CODE MUST =</b>	0	PRICING NOT APPLICABLE (DENIED SERVICE/SUPPLIES AND ALLOWED DRUGS) <b>OR</b>
		1	PRICED MANUALLY <b>OR</b>
		C	AMBULATORY SURGERY FACILITY PAYMENT RATE <b>OR</b>
		D	DISCOUNTED AMBULATORY SURGERY - FACILITY PAYMENT RATE <b>OR</b>
		E	AMBULATORY SURGERY-PAID AS BILLED <b>OR</b>
		P	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-FACILITY PAYMENT RATE <b>OR</b>
		Q	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, DISCOUNTED AMBULATORY SURGERY-FACILITY PAYMENT RATE <b>OR</b>
		R	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-PAID AS BILLED <b>OR</b>
		V	MEDICARE REIMBURSEMENT RATE <b>OR</b>
		P1	OPPS <b>OR</b>
		P2	OPPS WITH COST OUTLIER <b>OR</b>
		P3	OPPS WITH DISCOUNT
	<b>2-305-14R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PO
<b>THEN ENROLLMENT/ HEALTH PLAN CODE MUST =</b>		U	TRICARE PRIME, CIVILIAN PCM <b>OR</b>
		Z	TRICARE PRIME, MTF/PCM <b>OR</b>
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM <b>OR</b>
		XF	FOREIGN ADFM
<b>2-305-15R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AD	FOREIGN ACTIVE DUTY CLAIMS <b>OR</b>

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

<b>ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (CONTINUED)</b>			
		GU	ADSM ENROLLED IN TPR
	<b>THEN ENROLLMENT/ HEALTH PLAN CODE MUST =</b>	W	TPR ADSM - USA <b>OR</b>
		X	FOREIGN ADSM <b>OR</b>
		WA	TPR FOREIGN ADSM
<b>2-305-21R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	MN	TSP - NON-NETWORK <b>OR</b>
		MS	TSP - NETWORK
	<b>THEN ENROLLMENT/ HEALTH PLAN CODE MUST =</b>	BB	TSP
<b>2-305-22R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
		AR	SHCP - REFERRED CARE <b>OR</b>
		CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM <b>OR</b>
		SC	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
		SE	SHCP - TRICARE ELIGIBLE <b>OR</b>
		SM	SHCP - EMERGENCY
	<b>THEN ENROLLMENT/ HEALTH PLAN CODE MUST =</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>2-305-23R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	SN	TSS - NON-NETWORK <b>OR</b>
		SS	TSS - NETWORK
	<b>THEN ENROLLMENT/ HEALTH PLAN CODE MUST =</b>	TS	TSS
<b>2-305-24R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	E	HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP)
	<b>THEN BEGIN DATE OF CARE MUST BE ≥ 03/15/1999</b>		
	<b>AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =</b>	CM	ICMP
<b>2-305-25R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	GF	TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADSM

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TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

**ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (CONTINUED)**

THEN BEGIN DATE OF CARE IS  $\geq$  10/30/2000 AND  $<$  09/01/2002

AND HHC MEMBER

CATEGORY CODE MUST =

A ACTIVE DUTY OR

G NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR

S RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE)

AND HCC MEMBER

RELATIONSHIP CODE

MUST =

B SPOUSE OR

C CHILD OR STEPCHILD OR

D PRE-ADOPTIVE CHILD OR

E WARD (COURT ORDERED)

**2-305-26R**

IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

FF TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) OR

FG TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) OR

FS TFL (SECOND PAYOR)

THEN BEGIN DATE OF CARE MUST BE  $\geq$  10/01/2001

AND ENROLLMENT/  
HEALTH PLAN CODE

MUST =

FE TFL EXTRA OR

FS TFL STANDARD

ELSE IF BEGIN DATE OF CARE IS  $<$  10/01/2001

THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAILED LINE MUST =

15 PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER OR

26 EXPENSES INCURRED PRIOR TO COVERAGE OR

27 EXPENSES INCURRED AFTER COVERAGE TERMINATED OR

30 PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS OR

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

<b>ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (CONTINUED)</b>	
	31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED <b>OR</b>
	32 OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED <b>OR</b>
	33 CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE <b>OR</b>
	34 CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS <b>OR</b>
	62 PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION <b>OR</b>
	141 CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
<b>2-305-29R</b>	<ul style="list-style-type: none"> <li>SPECIAL PROCESSING CODE "V" IS USED FOR CARE PROVIDED WITHIN NORMAL LIMITS - WHILE SPECIAL PROCESSING CODE "W" IS USED FOR CARE OVER AND ABOVE THOSE NORMAL LIMITS</li> </ul>
	IF BEGIN DATE OF CARE IS $\geq$ 12/28/2001
	AND ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	CT CCTP
	THEN AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =
	V FINANCIALLY UNDERWRITTEN PAYMENT BY CLAIMS PROCESSOR <b>OR</b>
	W NON-FINANCIALLY UNDERWRITTEN PAYMENT BY FINANCIALLY UNDERWRITTEN CLAIMS PROCESSOR
<b>2-305-30R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	PF ECHO
	THEN HCDP PLAN COVERAGE CODE MUST $\neq$
	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>
	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>

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

**ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (CONTINUED)**

	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 MEMBER AND FAMILY COVERAGE <b>OR</b>
	418	TRR MEMBER-ONLY COVERAGE <b>OR</b>
	419	TRR MEMBER AND FAMILY COVERAGE <b>OR</b>
	420	TRR SURVIVOR INDIVIDUAL COVERAGE <b>OR</b>
	421	TRR SURVIVOR FAMILY COVERAGE
<b>2-305-31R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = AU AUTISM DEMONSTRATION	
	THEN BEGIN DATE OF CARE MUST BE ≥ 03/15/2008	
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST = PF ECHO	
	AND PATIENT AGE <sup>3</sup> MUST BE ≥ 18 MONTHS	
<b>2-305-32R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = RB RESPITE BENEFIT FOR ADMSs	
	THEN BEGIN DATE OF CARE MUST BE ≥ 01/01/2008	
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST = AD FOREIGN ACTIVE DUTY CLAIMS <b>OR</b>	
	GU ADMS ENROLLED IN TPR <b>OR</b>	
	SE SHCP - TRICARE ELIGIBLE	
<b>2-305-35R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = DE TDRL PHYSICAL EXAMS	
	THEN BEGIN DATE OF CARE MUST BE ≥ 03/30/2009	
	AND ENROLLMENT/HEALTH PLAN CODE MUST = SR SHCP REFERRED CARE	

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**TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002**

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

**ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (CONTINUED)**

	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	SE	SHCP - TRICARE ELIGIBLE
<b>2-305-36R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	EF	TRICARE RESERVE AND NATIONAL GUARD FAMILY MEMBER BENEFITS
	THEN BEGIN DATE OF CARE MUST BE ≥ 11/01/2009		
	AND ENROLLMENT/ HEALTH PLAN CODE MUST =	T	TRICARE STANDARD PROGRAM OR
		V	TRICARE EXTRA
	AND HCDP SPECIAL ENTITLEMENT CODE MUST =	02	NOBLE EAGLE PARTICIPATION SPECIAL ENTITLEMENT OR
		03	ENDURING FREEDOM PARTICIPATION SPECIAL ENTITLEMENT
	AND AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO		
<b>2-305-37R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	DC	DCPE-DVA
	THEN BEGIN DATE OF CARE MUST BE ≥ 01/01/2011		
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	17	VA MEDICAL PROVIDER CLAIM
	AND ENROLLMENT/ HEALTH PLAN CODE MUST =	SR	SHCP - REFERRED CARE
	AND AT LEAST ONE PROCEDURE CODE <sup>2</sup> MUST = 99456		

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**ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) SPECIAL ENTITLEMENT CODE (2-306)**

**VALIDITY EDITS**

**2-306-01V** MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE LISTING IN SECTION 2.5

**RELATIONAL EDITS**

NONE

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

**ELEMENT NAME: CA/NAS NUMBER (2-310)**

**VALIDITY EDITS**

**2-310-01V** IF CA/NAS NUMBER IS NOT BLANK THEN MUST BE 1 TO 11 OR 1 TO 15 ALPHANUMERIC CHARACTERS.

**RELATIONAL EDITS**

**NO ERROR** IF TYPE OF SUBMISSION = C COMPLETE CANCELLATION OR  
D COMPLETE DENIAL

THEN BYPASS ALL CA/NAS NUMBER RELATIONAL EDITING.

**NO ERROR** IF BEGIN DATE OF CARE IS OLDER THAN 6 YEARS

THEN DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA

**NO ERROR** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = R MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NOT A MEDICARE BENEFIT) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR

T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR

AN SHCP - NON-MTF-REFERRED CARE OR

AR SHCP - REFERRED CARE OR

CE SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR

PF ECHO

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

SC SHCP - NON-TRICARE ELIGIBLE OR

SE SHCP - TRICARE ELIGIBLE OR

SM SHCP - EMERGENCY OR

ST SPECIALIZED TREATMENT OR

WR MENTAL HEALTH WRAP AROUND

THEN BYPASS ALL CA/NAS NUMBER EDITING.

**NO ERROR** IF ENROLLMENT/HEALTH PLAN CODE = U TRICARE PRIME, CIVILIAN PCM OR

W TPR ADSM - USA OR

X FOREIGN ADSM OR

Y CHCBP - STANDARD OR

Z TRICARE PRIME, MTF/PCM OR

AA CHCBP - EXTRA OR

BB TSP OR

FE TFL - EXTRA OR

FS TFL - STANDARD OR

<sup>1</sup> CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.

<sup>2</sup> MTF IS A 40 MILES CATCHMENT AREA.

**TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002**

CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

**ELEMENT NAME: CA/NAS NUMBER (2-310) (CONTINUED)**

	PS	TSRx	<b>OR</b>
	SN	SHCP - NON-MTF-REFERRED CARE	<b>OR</b>
	SR	SHCP - REFERRED CARE	<b>OR</b>
	WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM	

**THEN BYPASS ALL CA/NAS NUMBER EDITING.**

<b>NO ERROR</b>	IF HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER
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**THEN BYPASS ALL CA/NAS NUMBER EDITING.**

<b>NO ERROR</b>	IF ANY OCCURRENCE OF ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER	<b>OR</b>
		26	EXPENSES INCURRED PRIOR TO COVERAGE	<b>OR</b>
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED	<b>OR</b>
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS	<b>OR</b>
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED	<b>OR</b>
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED	<b>OR</b>
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE	<b>OR</b>
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS	<b>OR</b>
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION	<b>OR</b>
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE	

**THEN BYPASS ALL CA/NAS NUMBER EDITING**

<b>NO ERROR</b>	IF AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO		
	<b>THEN NO CA/NAS IS REQUIRED -- BYPASS ALL CA/NAS NUMBER EDITING.</b>		

<b>2-310-02R</b>	IF CA/NAS EXCEPTION REASON ≠ BLANK		
	<b>THEN CA/NAS NUMBER MUST = BLANK</b>		

<b>2-310-03R</b>	• MENTAL HEALTH CHECK		
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<sup>1</sup> CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.  
<sup>2</sup> MTF IS A 40 MILES CATCHMENT AREA.

**TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002**

CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

**ELEMENT NAME: CA/NAS NUMBER (2-310) (CONTINUED)**

IF CA/NAS EXCEPTION REASON = BLANK

AND TYPE OF SERVICE (FIRST POSITION) = I INPATIENT

AND PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316

AND PATIENT ZIP CODE IS IN AN MTF<sup>2</sup> CATCHMENT AREA<sup>1</sup>

THEN CA/NAS NUMBER MUST BE CODED

UNLESS ANY OCCURRENCE OF OVERRIDE CODE = C GOOD FAITH PAYMENT

THEN CA/NAS NUMBER MUST = BLANK

**2-310-04R** IF CA/NAS NUMBER IS CODED

THEN CA/NAS EXCEPTION REASON MUST = BLANK

<sup>1</sup> CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.

<sup>2</sup> MTF IS A 40 MILES CATCHMENT AREA.

**ELEMENT NAME: CA/NAS REASON FOR ISSUANCE (2-315)**

**VALIDITY EDITS**

**2-315-01V** VALUE MUST A VALID CA/NAS REASON FOR ISSUANCE.

**RELATIONAL EDITS**

**2-315-02R** IF CA/NAS NUMBER = BLANK

THEN CA/NAS REASON FOR ISSUANCE MUST = BLANK.

**2-315-03R** IF CA/NAS REASON FOR ISSUANCE =

7 ENROLLEE NETWORK CARE AUTHORIZATION/RESTRICTED CA/NAS OR

8 ENROLLEE NON-NETWORK CARE AUTHORIZATIONS/RESTRICTED CA/NAS OR

9 NOT ENROLLED, AUTHORIZED NETWORK CARE ONLY

THEN ENROLLMENT/HEALTH PLAN CODE MUST =

T TRICARE STANDARD PROGRAM OR

U TRICARE PRIME, CIVILIAN PCM OR

V TRICARE EXTRA OR

Z TRICARE PRIME, MTF/PCM OR

XF FOREIGN ADFM

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

<b>ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320)</b>	
<b>VALIDITY EDITS</b>	
<b>2-320-01V</b>	VALUE MUST BE A VALID CA/NAS EXCEPTION REASON.
<b>RELATIONAL EDITS</b>	
<b>NO ERROR</b>	IF TYPE OF SUBMISSION = C COMPLETE CANCELLATION <b>OR</b> D COMPLETE DENIAL  <b>THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING.</b>
<b>NO ERROR</b>	IF BEGIN DATE OF CARE IS OLDER THAN 6 YEARS  <b>THEN DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA</b>
<b>NO ERROR</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = R MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NOT A MEDICARE BENEFIT) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b> T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR-NOT A MEDICARE BENEFIT) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b> AN SHCP - NON-MTF-REFERRED CARE <b>OR</b> AR SHCP - REFERRED CARE <b>OR</b> CE SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM <b>OR</b> PF ECHO 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 <b>OR</b> SC SHCP - NON-TRICARE ELIGIBLE <b>OR</b> SE SHCP - TRICARE ELIGIBLE <b>OR</b> SM SHCP - EMERGENCY <b>OR</b> ST SPECIALIZED TREATMENT <b>OR</b> WR MENTAL HEALTH WRAP AROUND  <b>THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING.</b>
<b>NO ERROR</b>	IF ENROLLMENT/HEALTH PLAN CODE = U TRICARE PRIME, CIVILIAN PCM <b>OR</b> W TPR ADSM - USA <b>OR</b> X FOREIGN ADSM <b>OR</b> Y CHCBP - STANDARD <b>OR</b> Z TRICARE PRIME, MTF/PCM <b>OR</b> AA CHCBP - EXTRA <b>OR</b> BB TSP <b>OR</b> FE TFL - EXTRA <b>OR</b> FS TFL - STANDARD <b>OR</b>

<sup>1</sup> CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.

<sup>2</sup> MTF IS A 40 MILES CATCHMENT AREA.

**TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002**

CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

**ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320) (CONTINUED)**

	PS	TSRx OR
	SN	SHCP - NON-MTF-REFERRED CARE OR
	SR	SHCP - REFERRED CARE OR
	WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE AD5M

**THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING.**

<b>NO ERROR</b>	IF HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER
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**THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING.**

<b>NO ERROR</b>	IF ANY OCCURRENCE OF ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAIL OCCURRENCE =	15	PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER OR
		26	EXPENSES INCURRED PRIOR TO COVERAGE OR
		27	EXPENSES INCURRED AFTER COVERAGE TERMINATED OR
		30	PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS OR
		31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED OR
		32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED OR
		33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE OR
		34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS OR
		62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION OR
		141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE

**THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING**

<b>NO ERROR</b>	IF AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO
	<b>THEN NO CA/NAS IS REQUIRED -- BYPASS ALL CA/NAS EXCEPTION REASON EDITING</b>

<b>2-320-01R</b>	IF PATIENT ZIP CODE IS NOT IN AN MTF <sup>2</sup> CATCHMENT AREA <sup>1</sup>
	<b>THEN CA/NAS EXCEPTION REASON MUST = BLANK</b>

<sup>1</sup> CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.

<sup>2</sup> MTF IS A 40 MILES CATCHMENT AREA.

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

**ELEMENT NAME: CA/NAS EXCEPTION REASON (2-320) (CONTINUED)**

**2-320-02R** IF CA/NAS NUMBER IS CODED

**THEN CA/NAS EXCEPTION REASON MUST = BLANK**

**2-320-04R** IF PATIENT ZIP CODE IS IN AN MTF CATCHMENT AREA

**AND TYPE OF SERVICE  
(FIRST POSITION) = I INPATIENT**

**AND PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316**

**AND CA/NAS NUMBER NOT CODED**

**THEN CA/NAS EXCEPTION REASON MUST BE CODED**

<sup>1</sup> CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.

<sup>2</sup> MTF IS A 40 MILES CATCHMENT AREA.

**TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002**

CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

<b>ELEMENT NAME: PRICING RATE CODE (2-325)</b>			
<b>VALIDITY EDITS</b>			
<b>2-325-01V</b>	VALUE MUST A VALID NON-INSTITUTIONAL PRICING RATE CODE.		
<b>RELATIONAL EDITS</b>			
<b>2-325-01R</b>	IF PRICING RATE CODE =	C	AMBULATORY SURGERY FACILITY PAYMENT RATE <b>OR</b>
		D	DISCOUNTED AMBULATORY SURGERY FACILITY PAYMENT RATE <b>OR</b>
		E	AMBULATORY SURGERY-PAID AS BILLED <b>OR</b>
		P	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-FACILITY PAYMENT RATE <b>OR</b>
		Q	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, DISCOUNTED AMBULATORY SURGERY-FACILITY PAYMENT RATE <b>OR</b>
		R	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, AMBULATORY SURGERY-PAID AS BILLED
	<b>THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =</b>	16	AMBULATORY SURGERY FACILITY CHARGE
<b>2-325-02R</b>	IF ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM IS A CODE LISTED IN <a href="#">ADDENDUM H, FIGURE 2-H-1</a> .		
	<b>THEN PRICING RATE CODE MUST = ZERO</b>	0	PRICING NOT APPLICABLE (DENIED SERVICE/SUPPLIES AND ALLOWED DRUGS
<b>2-325-03R</b>	IF PRICING RATE CODE FOR THAT OCCURRENCE/LINE ITEM =	0	PRICING NOT APPLICABLE (DENIED SERVICE/SUPPLIES AND ALLOWED DRUGS
	<b>THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO</b>		
	<b>UNLESS TYPE OF SERVICE (SECOND POSITION) =</b>	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS <b>OR</b>
		M	MAIL ORDER PHARMACY DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
	<b>OR TYPE OF SUBMISSION =</b>	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR)
<b>2-325-04R</b>	IF PRICING RATE CODE =	V	MEDICARE REIMBURSEMENT RATE
	<b>THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =</b>	16	AMBULATORY SURGERY FACILITY CHARGE <b>OR</b>

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

<b>ELEMENT NAME: PRICING RATE CODE (2-325) (CONTINUED)</b>	
	T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b>
	FS TFL (SECOND PAYOR) <b>OR</b>
	MN TSP - NON-NETWORK <b>OR</b>
	MS TSP - NETWORK
<b>2-325-05R</b>	IF PRICING RATE CODE = U SHCP CLAIM OR ACTIVE DUTY MEMBER TPR PAID OUTSIDE NORMAL LIMITS
	<b>THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =</b>
	AR SHCP - REFERRED CARE <b>OR</b>
	AN SHCP - NON-MTF-REFERRED CARE <b>OR</b>
	CE SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM <b>OR</b>
	GU ADSM ENROLLED IN TPR <b>OR</b>
	SC SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
	SE SHCP - TRICARE ELIGIBLE <b>OR</b>
	SM SHCP - EMERGENCY
	<b>OR ENROLLMENT/HEALTH PLAN CODE MUST =</b>
	SN SHCP - NON-MTF-REFERRED CARE <b>OR</b>
	SR SHCP - REFERRED CARE
<b>2-325-06R</b>	IF PRICING CODE = W PRICED OVER CMAC
	<b>AND ENROLLMENT/HEALTH PLAN CODE =</b> T TRICARE STANDARD PROGRAM
	<b>AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE =</b> NE OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM DEMONSTRATION
	<b>AND BEGIN DATE OF CARE ≥ 09/14/2001 AND &lt; 11/01/2009</b>
	<b>THEN PROVIDER PARTICIPATING INDICATOR MUST =</b> N NO
<b>2-325-07R</b>	IF PRICING RATE CODE = GG GLOBAL RATE AGREEMENT (USED WITH CORPORATE SERVICE PROVIDERS ONLY) <b>OR</b>
	GP PER DIEM RATE AGREEMENT (USED WITH CORPORATE SERVICE PROVIDERS ONLY)
	<b>THEN PROVIDER SPECIALITY MUST =</b>
	261QS1200X (CLINIC/CENTER - SLEEP DISORDER DIAGNOSTIC) <b>OR</b>
	293D00000X (PHYSIOLOGICAL LAB) <b>OR</b>
	261QE0700X (CLINIC/CENTER END STAGE RENAL DISEASE TREATMENT) <b>OR</b>

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

**ELEMENT NAME: PRICING RATE CODE (2-325) (CONTINUED)**

			261QM1200X (CLINIC/CENTER MAGNETIC RESONANCE IMAGING) <b>OR</b>
			261QR0401X (CLINIC/CENTER REHABILITATION, COMPREHENSIVE OUTPATIENT REHAB FACILITY (CORF)) <b>OR</b>
			2514H0200X (HOME HEALTH AGENCY) <b>OR</b>
			261QR0404X (CLINIC/CENTER REHAB CARDIAC FACILITIES) <b>OR</b>
			261QX0203X (CLINIC/CENTER ONCOLOGY, RADIATION) <b>OR</b>
			261QR0200X (CLINIC/CENTER RADIOLOGY)
<b>2-325-08R</b>	IF PRICING RATE CODE =	P1	OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) <b>OR</b>
		P2	OUTPATIENT PROSPECTIVE PAYMENT SYSTEM WITH COST OUTLIER <b>OR</b>
		P3	OUTPATIENT PROSPECTIVE PAYMENT SYSTEM WITH DISCOUNT <b>OR</b>
		P5	PARTIAL HOSPITALIZATION - PAID AS OPPS
	<b>THEN AMBULATORY PAYMENT CLASSIFICATION CODE MUST ≠ BLANK OR ZEROES.</b>		
<b>2-325-09R</b>	IF PRICING RATE CODE =	CA	CAH REIMBURSEMENT
	<b>THEN BEGIN DATE OF CARE MUST BE ≥ 12/01/2009</b>		
	UNLESS PROVIDER STATE OR COUNTRY CODE =	AK	ALASKA
	<b>THEN BEGIN DATE OF CARE MUST BE ≥ 07/01/2007</b>		
<b>2-325-10R</b>	IF PRICING CODE =	W	PRICED OVER CMAC
	AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE =	EF	TRICARE RESERVE AND NATIONAL GUARD FAMILY MEMBER BENEFITS
	AND ENROLLMENT/HEALTH PLAN CODE =	T	TRICARE STANDARD PROGRAM
	THEN PROVIDER PARTICIPATING INDICATOR MUST =	N	NO

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NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

**ELEMENT NAME: AMBULATORY PAYMENT CLASSIFICATION CODE (APC) (2-330)**

**VALIDITY EDITS**

**2-330-01V** MUST BE A VALID APC CODE AS LISTED ON TMA'S OPPTS WEB SITE AT [HTTP://WWW.TRICARE.MIL/OPPS](http://www.tricare.mil/opps), BLANK, OR ALL ZEROES  
**UNLESS AMOUNT ALLOWED BY PROCEDURE CODE = ZERO**

**RELATIONAL EDITS**

**2-330-01R** IF AMBULATORY PAYMENT CLASSIFICATION CODE = BLANK OR ZEROES.  
**THEN PRICING RATE CODE ≠**

P1	OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) OR
P2	OUTPATIENT PROSPECTIVE PAYMENT SYSTEM WITH COST OUTLIER OR
P3	OUTPATIENT PROSPECTIVE PAYMENT SYSTEM WITH DISCOUNT OR
P5	PARTIAL HOSPITALIZATION - PAID AS OPPTS

**ELEMENT NAME: OPPTS PAYMENT STATUS INDICATOR CODE (2-331)**

**VALIDITY EDITS**

**2-331-01V** MUST BE A VALID OPPTS PAYMENT STATUS INDICATOR CODE (REFER TO [SECTION 2.6](#)) OR BLANK.

**RELATIONAL EDITS**

**2-331-01R** IF OPPTS PAYMENT STATUS INDICATOR CODE = BLANK  
**THEN AMBULATORY PAYMENT CLASSIFICATION CODE MUST = ALL ZEROES OR BLANK.**

