

## Chapter 2

## Section 5.2

### Institutional Edit Requirements (ELN 100 - 199)

Revision: C-16, June 22, 2018

| ELEMENT NAME: PERSON SEX (PATIENT) (1-100) |                             |   |                  |
|--|-----------------------------|---|------------------|
| VALIDITY EDITS                             |                             |   |                  |
| 1-100-01V                                  | PERSON SEX (PATIENT) MUST = | F | FEMALE <b>OR</b> |
|  |                             | M | MALE <b>OR</b>   |
|  |                             | Z | UNKNOWN          |
| RELATIONAL EDITS                           |                             |   |                  |
| NONE                                       |                             |   |                  |

| ELEMENT NAME: PATIENT ZIP CODE (1-105)   |  |
|--|--|
| VALIDITY EDITS   |  |
| <b>1-105-01V</b>   | MUST BE NINE DIGITS <b>OR</b> FIVE DIGITS WITH FOUR BLANKS   |
|  | MUST BE A VALID ZIP CODE (BASED ON ADMISSION DATE) IN THE GOVERNMENT PROVIDED ELECTRONIC ZIP CODE FILE <b>OR</b>       |
|  | MUST BE A THREE CHARACTER FOREIGN COUNTRY CODE (BASED ON THE COUNTRY CODES TABLE <sup>1</sup> ) FOLLOWED BY SIX BLANKS |
| RELATIONAL EDITS   |  |
| NONE   |  |
| <sup>1</sup> WHEN FOREIGN COUNTRY CODES ARE SUBMITTED, THE FIRST THREE CHARACTERS WILL BE EDITED AGAINST <a href="#">ADDENDUM A.</a> |  |

# TRICARE Systems Manual 7950.3-M, April 1, 2015

## Chapter 2, Section 5.2

### Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (1-110)  |  |  |
|--|--|--|
| VALIDITY EDITS   |  |  |
| 1-110-01V MUST BE A VALID ENROLLMENT/HEALTH PLAN CODE (REFER TO <a href="#">SECTION 2.5</a> ).               |  |  |
| RELATIONAL EDITS   |  |  |
| 1-110-02R  | IF ENROLLMENT/HEALTH PLAN CODE =   | Y CHCBP - NON-NETWORK <b>OR</b>  |
|  |  | AA CHCBP - NETWORK   |
|  | <b>THEN NO</b> OCCURRENCE OF SPECIAL PROCESSING CODE CAN =   | CL CLINICAL TRIALS <b>OR</b>   |
|  |  | PF ECHO  |
| 1-110-06R  | IF ENROLLMENT/HEALTH PLAN CODE =   | SN SHCP - NON-MTF/eMSM-REFERRED CARE <b>OR</b>   |
|  |  | SO SHCP - NON-TRICARE ELIGIBLE <b>OR</b>   |
|  |  | SR SHCP - MTF/eMSM REFERRED CARE <b>OR</b>   |
|  |  | ST SHCP - TRICARE ELIGIBLE   |
|  | <b>THEN AT LEAST ONE</b> OCCURRENCE OF SPECIAL PROCESSING CODE MUST =  | AN SHCP - NON-MTF/eMSM-REFERRED CARE <b>OR</b>   |
|  |  | AR SHCP - MTF/eMSM REFERRED CARE <b>OR</b>   |
|  |  | CE SHCP - CCEP <b>OR</b>   |
|  |  | SC SHCP - NON-TRICARE ELIGIBLE <b>OR</b>   |
|  |  | SE SHCP - TRICARE ELIGIBLE <b>OR</b>   |
|  |  | SM SHCP - EMERGENCY  |
| 1-110-09R  | • TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001.<br>WHEN BEGIN DATE OF CARE IS < 10/01/2001, THE OCCURRENCE/LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT. |  |
|  | IF ENROLLMENT/HEALTH PLAN CODE =   | FE TFL - NETWORK <b>OR</b>   |
|  |  | FS TFL - NON-NETWORK   |
|  | <b>AND</b> TYPE OF INSTITUTION ≠   | 10 GENERAL MEDICAL AND SURGICAL  |
|  | <b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 10/01/2001  |  |
|  | <b>AND AT LEAST ONE</b> 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., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b>  |
|  |  | FS TFL (SECOND PAYOR)  |
|  | <b>ELSE IF</b> BEGIN DATE OF CARE IS < 10/01/2001  |  |
|  | <b>THEN</b> ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAILED OCCURRENCE/ LINE ITEM (EXCEPT FOR LINE CONTAINING REVENUE CODE 0001) MUST =  | 15 PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, <b>OR</b> DOES NOT APPLY TO THE BILLED SERVICES <b>OR</b> PROVIDER <b>OR</b> |
|  | 26 EXPENSES INCURRED PRIOR TO COVERAGE <b>OR</b>   |  |
|  | 27 EXPENSES INCURRED AFTER COVERAGE TERMINATED <b>OR</b>   |  |
| <sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE. |  |  |

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| <b>ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (1-110) (Continued)</b>   |  |   |
|--|--|---|
|  | 30   | PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING <b>OR</b> RESIDENCY REQUIREMENTS <b>O</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 NEWBORN <b>OR</b>   |
|  | 62   | PAYMENT DENIED/REDUCED FOR ABSENCE OF, <b>OR</b> EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION <b>OR</b>  |
|  | 141  | CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE  |
| <b>1-110-10R</b>   | <ul style="list-style-type: none"> <li>TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001 <b>UNLESS</b> THE BENEFICIARY IS AN INPATIENT AND THE ADMISSION DATE WAS PRIOR TO 10/01/2001, TFL WILL PAY FOR THE ENTIRE HOSPITAL STAY.</li> </ul>           |   |
| IF ENROLLMENT/HEALTH PLAN CODE =   | FE   | TFL - NETWORK <b>OR</b>   |
|  | FS   | TFL - NON-NETWORK   |
| <b>AND</b> TYPE OF INSTITUTION =   | 10   | GENERAL MEDICAL AND SURGICAL  |
| <b>THEN</b> END DATE OF CARE ≥ 10/01/2001  |  |   |
| <b>AND</b> 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., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b>  |
|  | FS   | TFL (SECOND PAYOR)  |
| <b>1-110-11R</b>   | <ul style="list-style-type: none"> <li>TFL CLAIMS: THE PATIENT MUST BE 64 YEARS AND 11 MONTHS <b>OR</b> GREATER. IF THE PATIENT IS LESS THAN THIS AGE THE OCCURRENCE/LINE ITEM MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.</li> </ul> |   |
| IF ENROLLMENT/HEALTH PLAN CODE =   | FE   | TFL - NETWORK <b>OR</b>   |
|  | FS   | TFL - NON-NETWORK   |
| <b>THEN</b> PATIENT AGE <sup>1</sup> MUST BE ≥ 64 YEARS AND 11 MONTHS  |  |   |
| <b>ELSE IF</b> PATIENT AGE <sup>1</sup> IS < 64 YEARS AND 11 MONTHS  |  |   |
| <b>THEN</b> ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAILED OCCURRENCE/LINE ITEM (EXCEPT LINE CONTAINING REVENUE CODE 0001) MUST = | 15   | PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, <b>OR</b> DOES NOT APPLY TO THE BILLED SERVICES <b>OR</b> PROVIDER <b>OR</b> |
|  | 26   | EXPENSES INCURRED PRIOR TO COVERAGE <b>OR</b>   |
|  | 27   | EXPENSES INCURRED AFTER COVERAGE TERMINATED <b>OR</b>   |
| <sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.                       |  |   |

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| <b>ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (1-110) (Continued)</b>   |   |   |
|--|---|---|
|  | 30  | PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, <b>OR</b> 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, <b>OR</b> EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION <b>OR</b>  |
|  | 141   | CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE  |
| <b>1-110-12R</b>   | <b>IF BEGIN DATE OF CARE IS ≥ 01/01/2018</b>              |   |
| <b>AND</b>   | ENROLLMENT/HEALTH PLAN CODE =                             | ME MEDICARE/TRICARE DUAL ELIGIBLE UNDER 65/ NETWORK <b>OR</b>   |
|  |   | MS MEDICARE/TRICARE DUAL ELIGIBLE UNDER 65/NON-NETWORK  |
| <b>THEN</b>  | AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | R MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NOT A MEDICARE BENEFIT) AND BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b>  |
|  |   | T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b>  |
|  |   | 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 |
| <sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE. |   |   |

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| <b>ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111)</b> |  |   |
|---|--|---|
| <b>VALIDITY EDITS</b>   |  |   |
| <b>1-111-01V</b>  | MUST BE A VALID HCDP PLAN COVERAGE CODE LISTED IN <a href="#">ADDENDUM L</a> . |   |
| <b>1-111-02V</b>  | IF FILING DATE ≥ 09/01/2007  |   |
| <b>AND</b> HCDP PLAN COVERAGE CODE =  | 109  | TRICARE USFHP DIRECT CARE COVERAGE FOR ADFMs <b>OR</b>  |
|   | 114  | TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b>              |
|   | 115  | TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b>                  |
|   | 118  | TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR RETIRED SPONSORS AND FAMILY MEMBERS <b>OR</b>                     |
|   | 119  | TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR RETIRED SPONSORS AND FAMILY MEMBERS <b>OR</b>                         |
|   | 133  | TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b> |
|   | 138  | TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS <b>OR</b>            |
|   | 139  | TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS <b>OR</b>                |
|   | 316  | USFHP PRIME - SPONSOR AND FAMILY MEMBERS (PRESENTATION ONLY)  |
| <b>THEN</b> AMOUNT ALLOWED (TOTAL) MUST = ZERO                                      |  |   |
| <b>RELATIONAL EDITS</b>   |  |   |
| <b>1-111-01R</b>  | IF HCDP PLAN COVERAGE CODE =   | 306 TRICARE SELECT - RESERVE SELECT SPONSORS AND FAMILY MEMBERS <b>OR</b>   |
|   |  | 307 TRICARE SELECT - RETIRED RESERVE SPONSORS AND FAMILY MEMBERS <b>OR</b>  |
|   |  | 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>  |

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| <b>ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111) (Continued)</b> |     |   |
|---|-----|---|
|   | 410 | TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE<br><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<br>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>THEN ENROLLMENT/HEALTH PLAN CODE<br/>MUST =</b>  | T   | TRICARE STANDARD <b>OR</b>  |
|   | V   | TRICARE EXTRA <b>OR</b>   |
|   | FE  | TFL - NETWORK <b>OR</b>   |
|   | FS  | TFL - NON-NETWORK <b>OR</b>   |
|   | ME  | MEDICARE/TRICARE DUAL ELIGIBLE UNDER 65/<br>NETWORK <b>OR</b>                 |
|   | MS  | MEDICARE/TRICARE DUAL ELIGIBLE UNDER 65/NON<br>NETWORK <b>OR</b>              |
|   | PS  | TSRx <b>OR</b>  |
|   | SR  | SHCP - MTF/eMSM REFERRED CARE   |
|   | TV  | TRICARE SELECT  |
| <b>1-111-02R</b> IF HCDP PLAN COVERAGE CODE =   | 306 | TRICARE SELECT - RESERVE SELECT SPONSORS AND<br>FAMILY MEMBERS <b>OR</b>      |
|   | 307 | TRICARE SELECT - RETIRED RESERVE SPONSORS AND<br>FAMILY MEMBERS <b>OR</b>     |
|   | 401 | TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY<br>OPERATIONS) <b>OR</b>         |
|   | 402 | TRS TIER 1 MEMBER AND FAMILY COVERAGE<br>(CONTINGENCY OPERATIONS) <b>OR</b>   |
|   | 405 | TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED<br>QUALIFICATIONS) <b>OR</b>       |
|   | 406 | TRS TIER 2 MEMBER AND FAMILY COVERAGE<br>(CERTIFIED QUALIFICATIONS) <b>OR</b> |
|   | 407 | TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE<br>AGREEMENT) <b>OR</b>              |
|   | 408 | TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE<br>AGREEMENT) <b>OR</b>        |
|   | 409 | TRS SURVIVOR CONTINUING WITH INDIVIDUAL<br>COVERAGE <b>OR</b>                 |
|   | 410 | TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE<br><b>OR</b>                     |
|   | 411 | TRS SURVIVOR NEW INDIVIDUAL COVERAGE <b>OR</b>                                |
|   | 412 | TRS SURVIVOR NEW FAMILY COVERAGE <b>OR</b>                                    |

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| <b>ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111) (Continued)</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>THEN NO</b> OCCURRENCE OF SPECIAL PROCESSING CODE CAN =                                      | PF  | ECHO                                       |
| <b>1-111-03R</b> IF HCDP PLAN COVERAGE CODE =   | 417 | TCSRC                                      |
| <b>THEN</b> ENROLLMENT/HEALTH PLAN CODE MUST =  | X   | FOREIGN SERVICE MEMBER <b>OR</b>           |
|   | SR  | SHCP - MTF/eMSM REFERRED CARE              |

| <b>ELEMENT NAME: REGION INDICATOR (1-112)</b> |   |   |
|---|---|---|
| <b>VALIDITY EDITS</b>                         |   |   |
| <b>1-112-01V</b>                              | MUST BE VALID REGION INDICATOR (REFER TO <a href="#">SECTION 2.8</a> ). |   |
| <b>1-112-02V</b>                              | IF TYPE OF SUBMISSION ≠   | B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>  |
|   |   | E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA |
|   | <b>AND</b> REGION INDICATOR =   | NC NORTH CONTRACT <b>OR</b>                           |
|   |   | OC OVERSEAS CONTRACT <b>OR</b>                        |
|   |   | SC SOUTH CONTRACT <b>OR</b>                           |
|   |   | WC WEST CONTRACT <b>OR</b>                            |
|   |   | E7 EAST CONTRACT 2017 <b>OR</b>                       |
|   |   | W7 WEST CONTRACT 2017                                 |
|   | <b>THEN</b> ADJUSTMENT KEY MUST =                                       | 0 BATCH <b>OR</b>                                     |
|   |   | 5 VOUCHER   |
| <b>RELATIONAL EDITS</b>                       |   |   |
| NONE  |   |   |

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| <b>ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (1-115)</b> |  |  |
|---|--|--|
| <b>VALIDITY EDITS</b>   |  |  |
| <b>1-115-01V</b>  | MUST BE A VALID FOUR DIGIT PCM LOCATION DMIS-ID. |  |
| <b>1-115-03V</b>  | IF FILING DATE ≥ 09/01/2007                      |  |
| <b>AND</b> PCM LOCATION DMIS-ID =                                   | 0190   | JOHNS HOPKINS MEDICAL SERVICES CORPORATION <b>OR</b> |
|   | 0191   | BRIGHTON MARINE <b>OR</b>                            |
|   | 0192   | CHRISTUS HEALTH/ST JOHN'S <b>OR</b>                  |
|   | 0193   | ST VINCENTS CATHOLIC MEDICAL CENTERS OF NY <b>OR</b> |
|   | 0194   | PACIFIC MEDICAL CLINICS <b>OR</b>                    |
|   | 0196   | CHRISTUS HEALTH/ST JOSEPH'S <b>OR</b>                |
|   | 0197   | CHRISTUS HEALTH/ST MARY'S <b>OR</b>                  |
|   | 0198   | MARTIN'S POINT HEALTH CARE <b>OR</b>                 |
|   | 0199   | FAIRVIEW HEALTH SYSTEM                               |
| <b>THEN</b> AMOUNT ALLOWED (TOTAL) MUST = ZERO                      |  |  |
| <b>RELATIONAL EDITS</b>   |  |  |
| NONE  |  |  |

| ELEMENT NAME: AMOUNT BILLED (TOTAL) (1-120)                        |   |   |  |
|--|---|---|--|
| VALIDITY EDITS   |   |   |  |
| 1-120-01V  | MUST BE NUMERIC.  |   |  |
| RELATIONAL EDITS   |   |   |  |
| 1-120-01R  | IF TYPE OF SUBMISSION =   | A | ADJUSTMENT <b>OR</b>                     |
|  |   | C | COMPLETE CANCELLATION <b>OR</b>          |
|  |   | D | COMPLETE DENIAL <b>OR</b>                |
|  |   | I | INITIAL SUBMISSION <b>OR</b>             |
|  |   | O | ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b> |
|  |   | R | RESUBMISSION                             |
| THEN AMOUNT BILLED (TOTAL) MUST BE > ZERO                          |   |   |  |
| UNLESS ANY OCCURRENCE/LINE ITEM REVENUE CODE = 0022 <b>OR</b> 0023 |   |   |  |
| AND AMOUNT ALLOWED (TOTAL) = ZERO                                  |   |   |  |
| 1-120-02R  | AMOUNT BILLED (TOTAL) MUST = TOTAL CHARGE BY REVENUE CODE FOR REVENUE CODE 0001 |   |  |



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| ELEMENT NAME: AMOUNT ALLOWED (TOTAL) (1-125)  |   |  |
|---|---|--|
| VALIDITY EDITS  |   |  |
| 1-125-01V   | MUST BE NUMERIC.  |  |
| RELATIONAL EDITS  |   |  |
| 1-125-01R   | IF TYPE OF SUBMISSION =   | C    COMPLETE CANCELLATION <b>OR</b>                     |
|   |   | D    COMPLETE DENIAL                                     |
| THEN AMOUNT ALLOWED (TOTAL) MUST = ZERO   |   |  |
| AND ALL OCCURRENCES/LINE ITEMS (EXCLUDING REVENUE CODE 0001) MUST CONTAIN A DENIAL CODE LISTED IN <a href="#">ADDENDUM G, FIGURE 2.G-1</a> <b>OR</b> <a href="#">FIGURE 2.G-2</a> . |   |  |
| 1-125-02R   | IF ALL DETAIL ADJUSTMENT/DENIAL REASON CODES CONTAIN A DENIAL CODE (REFER TO <a href="#">ADDENDUM G, FIGURE 2.G-1</a> <b>OR</b> <a href="#">FIGURE 2.G-2</a> ). |  |
|   | AND TYPE OF SUBMISSION =  | B    ADJUSTMENT NON-TED RECORD (HCSR) DATA <b>OR</b>     |
|   |   | E    COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA |
| THEN AMOUNT ALLOWED (TOTAL) MUST BE ≤ ZERO  |   |  |
| 1-125-03R   | IF TYPE OF SUBMISSION =   | A    ADJUSTMENT <b>OR</b>                                |
|   |   | I    INITIAL SUBMISSION <b>OR</b>                        |
|   |   | O    ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>            |
|   |   | R    RESUBMISSION  |
| THEN AMOUNT ALLOWED (TOTAL) MUST BE > ZERO  |   |  |
| 1-125-04R   | IF AMOUNT ALLOWED (TOTAL) = ZERO  |  |
| THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST = ZERO   |   |  |
|   | UNLESS TYPE OF SUBMISSION =   | B    ADJUSTMENT NON-TED RECORD (HCSR) DATA <b>OR</b>     |
|   |   | E    COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA |

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| ELEMENT NAME: AMOUNT PAID BY OTHER HEALTH INSURANCE (1-130)   |   |
|---|---|
| VALIDITY EDITS  |   |
| <b>1-130-01V</b>  | MUST BE NUMERIC.  |
| RELATIONAL EDITS  |   |
| <b>1-130-01R</b>  | IF TYPE OF SUBMISSION = A ADJUSTMENT <b>OR</b>                                  |
|   | C COMPLETE CANCELLATION <b>OR</b>   |
|   | D COMPLETE DENIAL <b>OR</b>   |
|   | I INITIAL SUBMISSION <b>OR</b>  |
|   | O ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>                                      |
|   | R RESUBMISSION  |
| <b>THEN</b> AMOUNT OF OTHER HEALTH INSURANCE MUST BE $\geq$ ZERO  |   |
| <b>1-130-03R</b>  | IF AMOUNT PAID BY OTHER HEALTH INSURANCE > ZERO                                 |
|   | <b>AND</b> AMOUNT ALLOWED (TOTAL) > ZERO  |
|   | <b>AND</b> AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) = ZERO                  |
|   | <b>AND</b> DATE ADJUSTMENT IDENTIFIER = ZEROES                                  |
|   | <b>THEN</b> TYPE OF SUBMISSION MUST = O ZERO PAYMENT TED RECORD DUE TO 100% OHI |
| <b>UNLESS</b> THE AMOUNT PATIENT COST-SHARE = THE AMOUNT ALLOWED (TOTAL) <b>OR</b> THE TED RECORD CORRECTION INDICATOR $\neq$ BLANK |   |

| ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) TYPE CODE (1-131) |   |
|--|---|
| VALIDITY EDITS   |   |
| <b>1-131-01V</b>   | MUST BE A VALID OGP TYPE CODE LISTING IN <a href="#">SECTION 2.6</a> .  |
| RELATIONAL EDITS   |   |
| <b>1-131-01R</b>   | IF OGP TYPE CODE = V CHAMPVA  |
|  | <b>THEN</b> TYPE OF SUBMISSION MUST = C COMPLETE CANCELLATION <b>OR</b> |
|  | E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA                   |

| ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) BEGIN REASON CODE (1-132) |  |
|--|--|
| VALIDITY EDITS   |  |
| <b>1-132-01V</b>   | MUST BE A VALID OGP BEGIN REASON CODE LISTING IN <a href="#">SECTION 2.6</a> . |
| RELATIONAL EDITS   |  |
| NONE   |  |

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Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: AMOUNT PATIENT COST-SHARE (1-135) |                         |   |
|---|-------------------------|---|
| VALIDITY EDITS                                  |                         |   |
| 1-135-01V                                       | MUST BE NUMERIC.        |   |
| RELATIONAL EDITS                                |                         |   |
| 1-135-01R                                       | IF TYPE OF SUBMISSION = | A    ADJUSTMENT <b>OR</b>                     |
|   |                         | I    INITIAL SUBMISSION <b>OR</b>             |
|   |                         | O    ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b> |
|   |                         | R    RESUBMISSION                             |
| THEN AMOUNT PATIENT COST-SHARE MUST BE ≥ ZERO   |                         |   |
| 1-135-02R                                       | IF TYPE OF SUBMISSION = | C    COMPLETE CANCELLATION <b>OR</b>          |
|   |                         | D    COMPLETE DENIAL                          |
| THEN AMOUNT PATIENT COST-SHARE MUST BE = ZERO   |                         |   |

| ELEMENT NAME: HEALTH CARE COVERAGE (HCC) COPAYMENT FACTOR CODE (1-136) |  |
|--|--|
| VALIDITY EDITS   |  |
| 1-136-01V  | MUST BE A VALID HCC COPAYMENT FACTOR CODE LISTING IN <a href="#">SECTION 2.5</a> . |
| RELATIONAL EDITS   |  |
| NONE   |  |

| ELEMENT NAME: AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) (1-140) |                         |   |                                 |
|--|-------------------------|---|---------------------------------|
| VALIDITY EDITS   |                         |   |                                 |
| 1-140-01V  | MUST BE NUMERIC.        |   |                                 |
| RELATIONAL EDITS   |                         |   |                                 |
| 1-140-01R  | IF TYPE OF SUBMISSION = | A | ADJUSTMENT <b>OR</b>            |
|  |                         | I | INITIAL SUBMISSION <b>OR</b>    |
|  |                         | R | RESUBMISSION                    |
| THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST BE ≥ ZERO   |                         |   |                                 |
| 1-140-02R  | IF TYPE OF SUBMISSION = | C | COMPLETE CANCELLATION <b>OR</b> |
|  |                         | D | COMPLETE DENIAL <b>OR</b>       |
|  |                         | O | ZERO PAYMENT WITH 100% OHI/TPL  |
| THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST = ZERO      |                         |   |                                 |

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Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: AMOUNT INTEREST PAYMENT (1-145) |   |  |
|---|---|--|
| VALIDITY EDITS                                |   |  |
| 1-145-01V    MUST BE NUMERIC.                 |   |  |
| RELATIONAL EDITS                              |   |  |
| 1-145-01R                                     | IF TYPE OF SUBMISSION =                 | A    ADJUSTMENT <b>OR</b>  |
|   |   | C    COMPLETE CANCELLATION <b>OR</b>   |
|   |   | I    INITIAL SUBMISSION <b>OR</b>  |
|   |   | O    ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>  |
|   |   | R    RESUBMISSION  |
| THEN AMOUNT INTEREST PAYMENT MUST BE ≥ ZERO   |   |  |
| 1-145-02R                                     | IF AMOUNT INTEREST PAYMENT ≠ ZERO       |  |
|   | THEN REASON FOR INTEREST PAYMENT MUST = | A    CLAIMS PENDED AT GOVERNMENT DIRECTION <b>OR</b>                                     |
|   |   | B    CLAIMS REQUIRING GOVERNMENT INTERVENTION <b>OR</b>                                  |
|   |   | C    CLAIMS REQUIRING DEVELOPMENT FOR POTENTIAL TPL <b>OR</b>                            |
|   |   | D    CLAIMS REQUIRING AN ACTION/INTERFACE WITH ANOTHER PRIME CONTRACTOR <b>OR</b>        |
|   |   | E    CLAIMS RETAINED BY THE CONTRACTOR THAT DO NOT FALL INTO ONE OF THE ABOVE CATEGORIES |
| 1-145-04R                                     | IF TYPE OF SUBMISSION =                 | D    COMPLETE DENIAL   |
| THEN AMOUNT INTEREST PAYMENT MUST BE = ZERO   |   |  |

| ELEMENT NAME: REASON FOR INTEREST PAYMENT (1-150) |   |   |
|---|---|---|
| VALIDITY EDITS                                    |   |   |
| 1-150-01V   | MUST BE A VALID REASON FOR INTEREST PAYMENT CODE (REFER TO <a href="#">SECTION 2.8</a> ). |   |
| RELATIONAL EDITS                                  |   |   |
| 1-150-01R   | IF REASON FOR INTEREST PAYMENT =  | A CLAIMS PENDED AT GOVERNMENT DIRECTION <b>OR</b>                                     |
|   |   | B CLAIMS REQUIRING GOVERNMENT INTERVENTION <b>OR</b>                                  |
|   |   | C CLAIMS REQUIRING DEVELOPMENT FOR POTENTIAL TPL <b>OR</b>                            |
|   |   | D CLAIMS REQUIRING AN ACTION/INTERFACE WITH ANOTHER PRIME CONTRACTOR <b>OR</b>        |
|   |   | E CLAIMS RETAINED BY THE CONTRACTOR THAT DO NOT FALL INTO ONE OF THE ABOVE CATEGORIES |
| THEN AMOUNT INTEREST PAYMENT MUST ≠ ZERO          |   |   |

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Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: OVERRIDE CODE (1-160) |   |    |  |
|-------------------------------------|---|----|--|
| VALIDITY EDITS                      |   |    |  |
| 1-160-01V                           | OCCURRENCE NUMBER 1--MUST BE A VALID OVERRIDE CODE (REFER TO <a href="#">SECTION 2.6</a> ).                           |    |  |
| 1-160-02V                           | OCCURRENCE NUMBER 2--MUST BE A VALID OVERRIDE CODE (REFER TO <a href="#">SECTION 2.6</a> ).                           |    |  |
| 1-160-03V                           | OCCURRENCE NUMBER 3--MUST BE A VALID OVERRIDE CODE (REFER TO <a href="#">SECTION 2.6</a> ).                           |    |  |
| 1-160-04V                           | A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).  |    |  |
| 1-160-05V                           | ALL OCCURRENCES OF OVERRIDE CODE MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED OVERRIDE CODE. |    |  |
| RELATIONAL EDITS                    |   |    |  |
| 1-160-13R                           | IF ANY OCCURRENCE OF OVERRIDE CODE =  | NC | NON-CERTIFIED PROVIDER (DOES NOT INCLUDE SANCTIONED/SUSPENDED PROVIDERS) |
|                                     | THEN ANY OCCURRENCE OF SPECIAL PROCESSING CODE MUST =   | AD | FOREIGN ACTIVE DUTY CLAIMS <b>OR</b>                                     |
|                                     |   | AN | SHCP - NON-MTF/eMSM-REFERRED CARE <b>OR</b>                              |
|                                     |   | AR | SHCP - MTF/eMSM REFERRED CARE <b>OR</b>                                  |
|                                     |   | CE | SHCP - CCEP <b>OR</b>  |
|                                     |   | EU | EMERGENCY SERVICES RENDERED BY AN UNAUTHORIZED PROVIDER <b>OR</b>        |
|                                     |   | GU | SERVICE MEMBER ENROLLED IN TPR <b>OR</b>                                 |
|                                     |   | MN | TSP - NETWORK <b>OR</b>  |
|                                     |   | MS | TSP - NON-NETWORK <b>OR</b>  |
|                                     |   | SC | SHCP - NON-TRICARE ELIGIBLE <b>OR</b>                                    |
|                                     |   | SE | SHCP - TRICARE ELIGIBLE <b>OR</b>  |
|                                     |   | SM | SHCP - EMERGENCY   |
|                                     | OR ENROLLMENT/HEALTH PLAN CODE MUST =   | SN | SHCP - NON-MTF/eMSM-REFERRED CARE <b>OR</b>                              |
|                                     |   | SR | SHCP - MTF/eMSM REFERRED CARE  |

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Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: TYPE OF SUBMISSION (1-165) |   |    |   |
|--|---|----|---|
| VALIDITY EDITS                           |   |    |   |
| 1-165-01V                                | VALUE MUST BE A VALID TYPE OF SUBMISSION.   |    |   |
| 1-165-02V                                | IF TYPE OF SUBMISSION =   | B  | ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>  |
|  |   | E  | COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA |
|  | <b>THEN</b> ADJUSTMENT KEY CANNOT =   | 0  | BATCH <b>OR</b>                                     |
|  |   | 5  | VOUCHER   |
| 1-165-03V                                | IF TYPE OF SUBMISSION =   | A  | ADJUSTMENT <b>OR</b>                                |
|  |   | B  | ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>  |
|  |   | C  | COMPLETE CANCELLATION <b>OR</b>                     |
|  |   | E  | COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA |
|  | <b>THEN</b> MATCH MUST BE FOUND ON THE DHA DATABASE   |    |   |
|  | <b>AND</b> TYPE OF SUBMISSION ON THE EXISTING DHA DATABASE RECORD ≠   | C  | COMPLETE CANCELLATION <b>OR</b>                     |
|  |   | D  | COMPLETE DENIAL <b>OR</b>                           |
|  |   | E  | COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA |
|  | <b>UNLESS</b> THE RECORD HAS PROVISIONAL ERRORS   |    |   |
| 1-165-04V                                | IF TYPE OF SUBMISSION =   | D  | COMPLETE DENIAL <b>OR</b>                           |
|  |   | I  | INITIAL SUBMISSION <b>OR</b>                        |
|  |   | O  | ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>            |
|  |   | R  | RESUBMISSION  |
|  | <b>THEN</b> A TED RECORD MUST NOT BE PRESENT ON THE DATABASE WITH THE SAME TRI.   |    |   |
| RELATIONAL EDITS                         |   |    |   |
| 1-165-01R                                | IF TYPE OF SUBMISSION =   | O  | ZERO PAYMENT WITH 100% OHI/TPL                      |
|  | <b>THEN</b> THE AMOUNT OF OHI MUST BE > ZERO  |    |   |
|  | <b>AND</b> AMOUNT ALLOWED (TOTAL) MUST BE > ZERO  |    |   |
|  | <b>AND</b> AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST BE = ZERO  |    |   |
| 1-165-02R                                | IF ALL OCCURRENCES/LINE ITEMS (EXCLUDING REVENUE CODE 0001) CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN <a href="#">ADDENDUM G, FIGURE 2.G-1</a> ) |    |   |
|  | <b>THEN</b> TYPE OF SUBMISSION MUST =   | C  | COMPLETE CANCELLATION <b>OR</b>                     |
|  |   | D  | COMPLETE DENIAL <b>OR</b>                           |
|  |   | E  | COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA |
| 1-165-04R                                | IF BATCH/VOUCHER RESUBMISSION NUMBER = ZERO FOR THIS BATCH <b>OR</b> VOUCHER  |    |   |
|  | <b>THEN</b> TYPE OF SUBMISSION MUST ≠   | R  | RESUBMISSION  |
| 1-165-05R                                | IF BATCH/VOUCHER RESUBMISSION NUMBER > ZERO FOR THIS BATCH <b>OR</b> VOUCHER  |    |   |
|  | <b>THEN</b> TYPE OF SUBMISSION MUST BE ≠  | I  | INITIAL TED RECORD SUBMISSION                       |
| 1-165-06R                                | IF TYPE OF SUBMISSION =   | I  | INITIAL SUBMISSION <b>OR</b>                        |
|  |   | R  | RESUBMISSION  |
|  | <b>AND</b> TYPE OF INSTITUTION ≠  | 70 | HHA <b>OR</b>                                       |
|  |   | 71 | SNF   |

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Institutional Edit Requirements (ELN 100 - 199)

| <b>ELEMENT NAME: TYPE OF SUBMISSION (1-165) (Continued)</b>  |                         |   |
|--|-------------------------|---|
| <b>AND</b> SPECIAL PROCESSING CODE ≠ 11 HOSPICE  |                         |   |
| <b>THEN</b> AMOUNT BILLED (TOTAL), AMOUNT ALLOWED (TOTAL), COVERED DAYS, AND TOTAL CHARGE BY REVENUE CODE MUST BE > 0. |                         |   |
| <b>1-165-07R</b>   | IF TYPE OF SUBMISSION = | B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>  |
|  |                         | E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA |
| <b>THEN</b> BEGIN DATE OF CARE MUST BE < 10/01/2010  |                         |   |

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Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: CA/NAS NUMBER (1-170)                        |  |    |   |
|--|--|----|---|
| VALIDITY EDITS   |  |    |   |
| 1-170-01V  | IF BEGIN DATE OF CARE ≥ 03/28/2013                       |    |   |
|  | THEN CA/NAS NUMBER MUST BE BLANK                         |    |   |
|  | ELSE 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 ADMISSION DATE IS OLDER THAN SIX 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/eMSM-REFERRED CARE OR  |
|  |  | AR | SHCP - MTF/eMSM REFERRED CARE OR  |
|  |  | CE | SHCP - CCEP OR  |
|  |  | PF | ECHO OR   |
|  |  | RS | MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR |
|  |  | SC | SHCP - NON-TRICARE ELIGIBLE OR  |
|  |  | SE | SHCP - TRICARE ELIGIBLE OR  |
|  |  | SM | SHCP - EMERGENCY OR   |
|  |  | ST | SPECIALIZED TREATMENT OR  |
|  |  | WR | MENTAL HEALTH WRAP AROUND   |
|  | THEN BYPASS ALL CA/NAS NUMBER EDITING                    |    |   |
| NO ERROR   | IF ENROLLMENT/HEALTH PLAN CODE =                         | U  | TRICARE PRIME, CIVILIAN PCM OR  |
|  |  | W  | TPR SERVICE MEMBER - USA OR   |
|  |  | X  | FOREIGN SERVICE MEMBER OR   |
|  |  | Y  | CHCBP - NON-NETWORK OR  |
|  |  | Z  | TRICARE PRIME, MTF/eMSM/PCM OR  |
|  |  | AA | CHCBP - NETWORK OR  |
|  |  | BB | TSP OR  |
|  |  | FE | TFL - NETWORK OR  |
|  |  | FS | TFL - NON-NETWORK OR  |
|  |  | SN | SHCP - NON-MTF/eMSM-REFERRED CARE OR  |
| 1 CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE. |  |    |   |
| 2 MTF/eMSM IS A 40 MILES CATCHMENT AREA.                   |  |    |   |



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| ELEMENT NAME: CA/NAS NUMBER (1-170) (Continued)                       |  |     |   |
|---|--|-----|---|
|   |  | SR  | SHCP - MTF/eMSM REFERRED CARE <b>OR</b>   |
|   |  | WF  | TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE SERVICE MEMBER   |
| THEN BYPASS ALL CA/NAS NUMBER EDITING                                 |  |     |   |
| NO ERROR  | IF HCC MEMBER CATEGORY CODE =  | T   | FOREIGN MILITARY MEMBER   |
| THEN BYPASS ALL CA/NAS NUMBER EDITING                                 |  |     |   |
| NO ERROR  | IF ANY OCCURRENCE OF ADJUSTMENT/<br>DENIAL REASON CODE =   | 15  | PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, <b>OR</b> DOES NOT APPLY TO THE BILLED SERVICES <b>OR</b> 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, <b>OR</b> 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, <b>OR</b> 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                                 |  |     |   |
| NO ERROR  | IF AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO   |     |   |
| THEN NO CA/NAS IS REQUIRED -- BYPASS ALL CA/NAS NUMBER EDITING.       |  |     |   |
| 1-170-02R   | IF CA/NAS EXCEPTION REASON IS <b>NOT</b> BLANK   |     |   |
| THEN CA/NAS NUMBER MUST = BLANK                                       |  |     |   |
| 1-170-03R   | IF CA/NAS EXCEPTION REASON = BLANK   |     |   |
|   | <b>AND</b> PRINCIPAL TREATMENT DIAGNOSIS/<br>POA INDICATOR (POSITIONS 1-7) = 290-316 (MENTAL HEALTH, ICD-9-CM) |     |   |
|   | <b>AND</b> PATIENT ZIP CODE IS IN AN MTF/eMSM <sup>2</sup> CATCHMENT AREA <sup>1</sup>                         |     |   |
|   | <b>AND</b> BEGIN DATE OF CARE IS < 03/28/2013  |     |   |
| THEN CA/NAS NUMBER MUST BE CODED                                      |  |     |   |
|   | <b>UNLESS</b> ANY OCCURRENCE OF OVERRIDE<br>CODE =   | C   | GOOD FAITH PAYMENT  |
| 1-170-04R   | IF CA/NAS NUMBER IS CODED  |     |   |
| THEN CA/NAS EXCEPTION REASON MUST = BLANK                             |  |     |   |
| <sup>1</sup> CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE. |  |     |   |
| <sup>2</sup> MTF/eMSM IS A 40 MILES CATCHMENT AREA.                   |  |     |   |

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| ELEMENT NAME: CA/NAS REASON FOR ISSUANCE (1-175) |  |
|--|--|
| VALIDITY EDITS                                   |  |
| <b>1-175-01V</b>                                 | <b>IF</b> BEGIN DATE OF CARE $\geq$ 03/28/2013                               |
|  | <b>THEN</b> CA/NAS REASON FOR ISSUANCE MUST BE BLANK                         |
|  | <b>ELSE</b> VALUE MUST BE A VALID CA/NAS REASON OF ISSUANCE <b>OR</b> BLANK. |
| RELATIONAL EDITS                                 |  |
| <b>1-175-02R</b>                                 | <b>IF</b> CA/NAS NUMBER IS BLANK   |
|  | <b>THEN</b> CA/NAS REASON FOR ISSUANCE MUST = BLANK.                         |

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Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: CA/NAS EXCEPTION REASON (1-180)              |   |    |   |
|--|---|----|---|
| VALIDITY EDITS   |   |    |   |
| 1-180-01V  | IF BEGIN DATE OF CARE ≥ 03/28/2013  |    |   |
|  | THEN CA/NAS EXCEPTION REASON MUST BE BLANK  |    |   |
|  | ELSE VALUE MUST BE A VALID CA/NAS EXCEPTION REASON CODE OR BLANK (REFER TO <a href="#">SECTION 2.4</a> ). |    |   |
| RELATIONAL EDITS   |   |    |   |
| NO ERROR   | IF TYPE OF SUBMISSION =   | C  | COMPLETE CANCELLATION OR  |
|  |   | D  | COMPLETE DENIAL   |
|  | THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING.  |    |   |
| NO ERROR   | IF ADMISSION DATE IS OLDER THAN SIX 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/eMSM-REFERRED CARE OR  |
|  |   | AR | SHCP - MTF/eMSM REFERRED CARE OR  |
|  |   | CE | SHCP - CCEP OR  |
|  |   | PF | ECHO OR   |
|  |   | RS | MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR |
|  |   | SC | SHCP - NON-TRICARE ELIGIBLE OR  |
|  |   | SE | SHCP - TRICARE ELIGIBLE OR  |
|  |   | SM | SHCP - EMERGENCY OR   |
|  |   | ST | SPECIALIZED TREATMENT OR  |
|  |   | WR | MENTAL HEALTH WRAP AROUND   |
|  | THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING   |    |   |
| NO ERROR   | IF ENROLLMENT/HEALTH PLAN CODE =  | U  | TRICARE PRIME, CIVILIAN PCM OR  |
|  |   | W  | TPR SERVICE MEMBER - USA OR   |
|  |   | X  | FOREIGN SERVICE MEMBER OR   |
|  |   | Y  | CHCBP - NON-NETWORK OR  |
|  |   | Z  | TRICARE PRIME, MTF/eMSM/PCM OR  |
|  |   | AA | CHCBP - NETWORK OR  |
|  |   | BB | TSP OR  |
|  |   | FE | TFL - NETWORK OR  |
|  |   | FS | TFL - NON-NETWORK OR  |
|  |   | SN | SHCP - NON-MTF/eMSM-REFERRED CARE OR  |
|  |   | SR | SHCP - MTF/eMSM REFERRED CARE OR  |
| 1 CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE. |   |    |   |
| 2 MTF/eMSM IS A 40 MILES CATCHMENT AREA.                   |   |    |   |

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Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: CA/NAS EXCEPTION REASON (1-180) (Continued)                 |   |                                   |  |  |
|---|---|-----------------------------------|--|--|
|   |   | WF                                | TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE SERVICE MEMBER  |  |
| THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING                           |   |                                   |  |  |
| NO ERROR  | IF HCC MEMBER CATEGORY CODE =   | T                                 | FOREIGN MILITARY MEMBER  |  |
| THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING                           |   |                                   |  |  |
| NO ERROR  | IF ANY OCCURRENCE OF ADJUSTMENT/<br>DENIAL REASON CODE =                        | 15                                | PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER OR |  |
|   |   | 26                                | EXPENSES INCURRED PRIOR TO COVERAGE OR   |  |
|   |   | 27                                | EXPENSES INCURRED AFTER COVERAGE TERMINATED OR   |  |
|   |   | 30                                | PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING, OR RESIDENCY REQUIREMENTS OR             |  |
|   |   | 31                                | CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED OR   |  |
|   |   | 32                                | OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED OR  |  |
|   |   | 33                                | CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE OR   |  |
|   |   | 34                                | CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS OR  |  |
|   |   | 62                                | PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION OR   |  |
|   |   | 141                               | CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE   |  |
| THEN BYPASS ALL CA/NAS EXCEPTION REASON EDITING                           |   |                                   |  |  |
| NO ERROR  | IF AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO                              |                                   |  |  |
| THEN NO CA/NAS IS REQUIRED -- BYPASS ALL CA/NAS EXCEPTION REASON EDITING. |   |                                   |  |  |
| 1-180-03R   | IF PATIENT ZIP CODE IS IN AN MTF/eMSM <sup>2</sup> CATCHMENT AREA <sup>1</sup>  |                                   |  |  |
|   | AND PRINCIPAL TREATMENT DIAGNOSIS/<br>POA INDICATOR (POSITIONS 1-7) =           | 290-316 (MENTAL HEALTH, ICD-9-CM) |  |  |
|   | AND CA/NAS NUMBER IS NOT CODED  |                                   |  |  |
|   | AND BEGIN DATE OF CARE IS < 03/28/2013  |                                   |  |  |
| THEN CA/NAS EXCEPTION REASON MUST BE CODED                                |   |                                   |  |  |
| 1-180-07R   | IF CA/NAS EXCEPTION REASON =  | 5                                 | RTC  |  |
|   | AND PATIENT ZIP CODE IS IN AN MTF/eMSM <sup>2</sup> CATCHMENT AREA <sup>1</sup> |                                   |  |  |
|   | THEN TYPE OF INSTITUTION =  | 72                                | RTC  |  |
| 1-180-08R   | IF CA/NAS EXCEPTION REASON =  | 5                                 | HHA PPS  |  |
|   | THEN TYPE OF INSTITUTION MUST =   | 70                                | HHA  |  |
|   | AND ONE OCCURRENCE OF REVENUE<br>CODE MUST =                                    | 0023                              | HHA PPS  |  |

<sup>1</sup> CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.  
<sup>2</sup> MTF/eMSM IS A 40 MILES CATCHMENT AREA.

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Chapter 2, Section 5.2

Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: SPECIAL PROCESSING CODE (1-185)  |   |    |   |
|--|---|----|---|
| VALIDITY EDITS   |   |    |   |
| 1-185-01V  | OCCURRENCE NUMBER 1--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO <a href="#">SECTION 2.8</a> ).                                     |    |   |
| 1-185-02V  | OCCURRENCE NUMBER 2--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO <a href="#">SECTION 2.8</a> ).                                     |    |   |
| 1-185-03V  | OCCURRENCE NUMBER 3--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO <a href="#">SECTION 2.8</a> ).                                     |    |   |
| 1-185-04V  | OCCURRENCE NUMBER 4--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO <a href="#">SECTION 2.8</a> ).                                     |    |   |
| 1-185-05V  | A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).  |    |   |
| 1-185-06V  | ALL OCCURRENCES OF SPECIAL PROCESSING CODE MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED SPECIAL PROCESSING CODE. |    |   |
| 1-185-07V  | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =  | AN | SHCP - NON-MTF/eMSM-REFERRED CARE <b>OR</b>                                 |
|  |   | AR | SHCP - MTF/eMSM REFERRED CARE   |
|  | <b>THEN</b> BEGIN DATE OF CARE MUST BE < 06/01/2004   |    |   |
| 1-185-08V  | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =  | GF | TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE SERVICE MEMBER           |
|  | <b>THEN</b> BEGIN DATE OF CARE MUST BE < 09/01/2002   |    |   |
| 1-185-10V  | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =  | MN | TSP - NON-NETWORK <b>OR</b>   |
|  |   | MS | TSP - NETWORK   |
|  | <b>THEN</b> BEGIN DATE OF CARE MUST BE < 12/31/2001   |    |   |
| 1-185-11V  | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =  | SN | TSS - NON-NETWORK <b>OR</b>   |
|  |   | SS | TSS - NETWORK   |
|  | <b>THEN</b> BEGIN DATE OF CARE MUST BE < 12/31/2002   |    |   |
| 1-185-14V  | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =  | ST | SPECIALIZED TREATMENT   |
|  | <b>THEN</b> BEGIN DATE OF CARE MUST BE < 10/01/2004   |    |   |
| RELATIONAL EDITS   |   |    |   |
| 1-185-08R  | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =  | PO | TRICARE PRIME - POS   |
|  | <b>THEN</b> ENROLLMENT/HEALTH PLAN CODE MUST =  | U  | TRICARE PRIME (CIVILIAN PCM) <b>OR</b>                                      |
|  |   | Z  | TRICARE PRIME, MTF/eMSM/PCM <b>OR</b>                                       |
|  |   | WF | TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE SERVICE MEMBER <b>OR</b> |
|  |   | XF | FOREIGN ADFM  |
| 1-185-14R  | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =  | AN | SHCP - NON-MTF/eMSM-REFERRED CARE <b>OR</b>                                 |
|  |   | AR | SHCP - MTF/eMSM REFERRED CARE <b>OR</b>                                     |
|  |   | CE | SHCP - CCEP <b>OR</b>   |
|  |   | SC | SHCP - NON-TRICARE ELIGIBLE <b>OR</b>                                       |
|  |   | SE | SHCP - TRICARE ELIGIBLE <b>OR</b>   |
|  |   | SM | SHCP - EMERGENCY  |
| <sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES. |   |    |   |

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Institutional Edit Requirements (ELN 100 - 199)

| <b>ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)</b>  |  |   |
|---|--|---|
| <b>THEN</b> ENROLLMENT/HEALTH PLAN CODE MUST =  | SR   | SHCP - MTF/eMSM REFERRED CARE <b>OR</b>   |
|   | SN   | SHCP - NON-MTF/eMSM REFERRED CARE <b>OR</b>   |
|   | SO   | SHCP - NON-TRICARE ELIGIBLE <b>OR</b>   |
|   | ST   | SHCP - TRICARE ELIGIBLE   |
| <b>1-185-32R</b> IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =   | E  | HHC/CM DEMO (AFTER 03/15/1999, GRANDFATHERED INTO THE ICMP)   |
| <b>THEN</b> BEGIN DATE OF CARE IS $\geq$ 03/15/1999   |  |   |
| <b>AND</b> AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =  |  |   |
|   | CM   | ICMP  |
| <b>1-185-34R</b>  | <ul style="list-style-type: none"> <li>TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE <math>\geq</math> 10/01/2001.</li> <li>IF BEGIN DATE OF CARE IS <math>&lt;</math> 10/01/2001, THE LINE ITEMS MUST CONTAIN AN ADJUSTMENT/DENIAL REASON CODE LISTED IN THIS EDIT.</li> </ul> |   |
| IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =  | FF   | TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) <b>OR</b>  |
|   | FG   | TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b>  |
|   | FS   | TFL (SECOND PAYOR)  |
| <b>AND</b> TYPE OF INSTITUTION $\neq$   | 10   | GENERAL MEDICAL AND SURGICAL  |
| <b>THEN</b> BEGIN DATE OF CARE MUST BE $\geq$ 10/01/2001  |  |   |
| <b>AND</b> ENROLLMENT/HEALTH PLAN CODE MUST =   |  |   |
|   | FE   | TFL - NETWORK <b>OR</b>   |
|   | FS   | TFL - NON-NETWORK   |
| <b>ELSE IF</b> BEGIN DATE OF CARE IS $<$ 10/01/2001   |  |   |
| <b>THEN</b> ADJUSTMENT/DENIAL REASON CODE FOR THAT DETAILED LINE ITEM (EXCEPT LINE CONTAINING REVENUE CODE 0001) MUST = | 15   | PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, <b>OR</b> DOES NOT APPLY TO THE BILLED SERVICES <b>OR</b> 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, <b>OR</b> 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>   |
| <sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.                    |  |   |

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Institutional Edit Requirements (ELN 100 - 199)

| <b>ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)</b>                                     |  |  |
|--|--|--|
|  | 34   | CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS <b>OR</b>   |
|  | 62   | PAYMENT DENIED/REDUCED FOR ABSENCE OF, <b>OR</b> EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION <b>OR</b>       |
|  | 141  | CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE                       |
| <b>1-185-35R</b>   | <ul style="list-style-type: none"> <li>TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE ≥ 10/01/2001 <b>UNLESS</b> THE BENEFICIARY IS AN INPATIENT AND THE ADMISSION DATE WAS PRIOR TO 10/01/2001, TFL WILL PAY FOR THE ENTIRE HOSPITAL STAY.</li> </ul> |  |
| IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =   | FF   | TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) <b>OR</b>   |
|  | FG   | TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b> |
|  | FS   | TFL (SECOND PAYOR)   |
| <b>AND</b> TYPE OF INSTITUTION =   | 10   | GENERAL MEDICAL AND SURGICAL   |
| <b>THEN</b> END DATE OF CARE MUST BE ≥ 10/01/2001  |  |  |
| <b>AND</b> ENROLLMENT/HEALTH PLAN CODE MUST =  | FE   | TFL - NETWORK <b>OR</b>  |
|  | FS   | TFL - NON-NETWORK  |
| <b>1-185-39R</b>   | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =   |  |
|  | PF   | ECHO   |
| <b>THEN</b> HCDP PLAN COVERAGE CODE MUST ≠   | 306  | TRICARE SELECT - RESERVE SELECT SPONSORS AND FAMILY MEMBERS <b>OR</b>                                      |
|  | 307  | TRICARE SELECT - RETIRED RESERVE SPONSORS AND FAMILY MEMBERS <b>OR</b>                                     |
|  | 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>   |
| <sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES. |  |  |

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Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)  |  |  |
|--|--|--|
|  | 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>1-185-49R</b>   | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = AU AUTISM DEMONSTRATION   |  |
|  | <b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 03/15/2008  |  |
|  | <b>AND</b> AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST = PF ECHO   |  |
|  | <b>AND</b> PATIENT AGE <sup>1</sup> MUST BE ≥ 18 MONTHS  |  |
| <b>1-185-50R</b>   | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = 49 HOSPITAL REIMBURSEMENT REDUCED BY MANUFACTURER CREDIT/REPLACEMENT OF DEVICE DURING WARRANTY PERIOD <b>OR</b>   |  |
|  | 50   | HOSPITAL REIMBURSEMENT REDUCED BY MANUFACTURER CREDIT/RECALLED DEVICE              |
|  | <b>THEN</b> DRG NUMBER MUST EQUAL A DRG SUBJECT TO THE REPLACEMENT DEVICE POLICY POSTED ON TRICARE'S DRG WEB PAGE AT <a href="http://www.health.mil/drg">HTTP://WWW.HEALTH.MIL/DRG</a> .   |  |
|  | <b>AND</b> IF END DATE OF CARE < 10/01/2014  |  |
|  | <b>THEN</b> DATE OF ADMISSION MUST BE ≥ THE DRG EFFECTIVE DATE AND ≤ THE DRG TERMINATION DATE AS PER THE REPLACEMENT DEVICE POLICY POSTED ON TRICARE'S DRG WEB PAGE AT <a href="http://www.health.mil/drg">HTTP://WWW.HEALTH.MIL/DRG</a> . |  |
|  | <b>ELSE</b> END DATE OF CARE MUST BE ≥ THE DRG EFFECTIVE DATE AND ≤ THE DRG TERMINATION DATE   |  |
| <b>1-185-51R</b>   | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = PH PHILIPPINES DEMONSTRATION PROJECT  |  |
|  | <b>THEN</b> BEGIN DATE OF CARE MUST BE ≥ 01/01/2013  |  |
|  | <b>AND</b> HCDP PLAN COVERAGE CODE MUST = 003 TRICARE STANDARD FOR ADFMs <b>OR</b>   |  |
|  | 005  | TRICARE STANDARD SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b>              |
|  | 007  | TRICARE STANDARD TRANSITIONAL ASSISTANCE SPONSORS AND FAMILY MEMBERS <b>OR</b>     |
|  | 009  | TRICARE STANDARD RETIRED AND MOH SPONSORS AND FAMILY MEMBERS <b>OR</b>             |
|  | 010  | TRICARE STANDARD TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b> |
|  | 015  | TRICARE STANDARD TRANSITIONAL SURVIVORS OF NG/RESERVE DECEASED SPONSORS <b>OR</b>  |
|  | 017  | TRICARE STANDARD SURVIVORS OF NG/RESERVE DECEASED SPONSORS <b>OR</b>               |
|  | 018  | TFL RETIRED SPONSORS AND FAMILY MEMBERS AND MOH <b>OR</b>                          |
| <sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES. |  |  |



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Institutional Edit Requirements (ELN 100 - 199)

| <b>ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)</b>                                     |     |  |
|--|-----|--|
|  | 020 | TFL TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b>        |
|  | 021 | TFL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS <b>OR</b>                     |
|  | 022 | TFL TRANSITIONAL SURVIVORS OF NG/RESERVE DECEASED SPONSORS <b>OR</b>         |
|  | 023 | TFL SURVIVORS OF NG/RESERVE DECEASED SPONSORS <b>OR</b>                      |
|  | 028 | TRICARE STANDARD FOR MEDICALLY RETIRED SPONSORS AND FAMILY MEMBERS <b>OR</b> |
|  | 029 | TFL FOR MEDICALLY RETIRED SPONSORS AND FAMILY MEMBERS <b>OR</b>              |
|  | 303 | TRICARE SELECT - ADFMs <b>OR</b>   |
|  | 304 | TRICARE SELECT - TAMP SPONSORS AND FAMILY MEMBERS <b>OR</b>                  |
|  | 305 | TRICARE SELECT - RETIRED SPONSORS AND FAMILY MEMBERS <b>OR</b>               |
|  | 306 | TRICARE SELECT - RESERVE SELECT SPONSORS AND FAMILY MEMBERS <b>OR</b>        |
|  | 307 | TRICARE SELECT - RETIRED RESERVE SPONSORS AND FAMILY MEMBERS <b>OR</b>       |
|  | 308 | TRICARE SELECT - YOUNG ADULT <b>OR</b>                                       |
|  | 409 | TRS SURVIVOR CONTINUING INDIVIDUAL COVERAGE <b>OR</b>                        |
|  | 410 | TRS SURVIVOR CONTINUING 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>OR</b>                                       |
|  | 422 | TYA STANDARD FOR ADFMs <b>OR</b>   |
|  | 423 | TYA STANDARD FOR RETIRED AND MOH FAMILY MEMBERS <b>OR</b>                    |
|  | 424 | TYA RESERVE SELECT <b>OR</b>   |
|  | 425 | TYA RETIRED RESERVE <b>OR</b>  |
|  | 999 | UNVERIFIED NEWBORN   |
| <b>OR ENROLLMENT/HEALTH PLAN CODE =</b>  | AS  | TRICARE SELECT - ACTIVE DUTY SURVIVORS <b>OR</b>                             |
|  | AT  | TRICARE SELECT - ACTIVE DUTY TRANSITIONAL SURVIVORS <b>OR</b>                |
|  | GS  | TRICARE SELECT - GUARD/RESERVE SURVIVORS <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: SPECIAL PROCESSING CODE (1-185) (Continued)  |                                       |  |
|--|---------------------------------------|--|
|  | GT                                    | TRICARE SELECT - GUARD/RESERVE TRANSITIONAL SURVIVORS  |
| AND PATIENT ZIP CODE MUST =  | PHL                                   | PHILIPPINES  |
| AND PROVIDER STATE OR COUNTRY CODE MUST =  | PHL                                   | PHILIPPINES  |
| <b>1-185-52R</b>   | IF BEGIN DATE OF CARE IS ≥ 01/01/2018 |  |
| AND 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  |
|  | 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 ENROLLMENT/HEALTH PLAN CODE MUST =  | U                                     | TRICARE PRIME, CIVILIAN CARE OR  |
|  | Z                                     | TRICARE PRIME, MTF/eMSM/PCM OR   |
|  | ME                                    | MEDICARE/TRICARE DUAL ELIGIBLE UNDER 65/ NETWORK OR  |
|  | MS                                    | MEDICARE/TRICARE DUAL ELIGIBLE UNDER 65/NON-NETWORK OR   |
|  | WF                                    | TPR FOR ENROLLMENT ADFM RESIDING WITH A TPR ELIGIBLE SERVICE MEMBER  |
| <sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES. |                                       |  |

| ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) SPECIAL ENTITLEMENT CODE (1-186) |  |
|--|--|
| VALIDITY EDITS   |  |
| <b>1-186-01V</b>   | MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE (REFER TO <a href="#">SECTION 2.5</a> ). |
| RELATIONAL EDITS   |  |
| NONE   |  |

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Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: PRICING RATE CODE (1-190) |  |    |  |
|---|--|----|--|
| VALIDITY EDITS                          |  |    |  |
| 1-190-01V                               | VALUE MUST BE A VALID INSTITUTIONAL PRICING RATE CODE.         |    |  |
| RELATIONAL EDITS                        |  |    |  |
| 1-190-01R                               | IF FILING STATE/COUNTRY CODE =                                 | MD | MARYLAND   |
|   | THEN PRICING RATE CODE MUST ≠                                  | H  | TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR   |
|   |  | I  | TRICARE DRG REIMBURSEMENT WITH COST OUTLIER OR   |
|   |  | J  | TRICARE DRG REIMBURSEMENT WITH NO OUTLIER OR   |
|   |  | DD | DISCOUNTED DRG   |
| 1-190-02R                               | IF DRG NUMBER IS CODED (OTHER THAN ZERO)                       |    |  |
|   | THEN PRICING RATE CODE MUST =                                  | H  | TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR   |
|   |  | I  | TRICARE DRG REIMBURSEMENT WITH COST OUTLIER OR   |
|   |  | J  | TRICARE DRG REIMBURSEMENT WITH NO OUTLIER OR   |
|   |  | U  | SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS OR                         |
|   |  | V  | MEDICARE REIMBURSEMENT RATE OR   |
|   |  | DD | DISCOUNTED DRG   |
| 1-190-03R                               | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =                 | 11 | HOSPICE  |
|   | THEN PRICING RATE CODE MUST =                                  | D  | DISCOUNT RATE AGREEMENT OR   |
|   |  | P  | PER DIEM RATE AGREEMENT OR   |
|   |  | U  | SHCP CLAIM OR ACTIVE DUTY MEMBER GSU CLAIM PAID OUTSIDE NORMAL LIMITS OR                         |
|   |  | V  | MEDICARE REIMBURSEMENT RATE  |
|   | UNLESS TYPE OF SUBMISSION =                                    | D  | COMPLETE DENIAL  |
|   | OR AMOUNT ALLOWED (TOTAL) = ZERO                               |    |  |
| 1-190-04R                               | IF PRICING RATE CODE =   | V  | MEDICARE REIMBURSEMENT RATE  |
|   | THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | T  | MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 OR |
|   |  | FS | TFL (SECOND PAYOR) OR  |
|   |  | MN | TSP - NON-NETWORK OR   |
|   |  | MS | TSP - NETWORK  |
|   | OR TYPE OF INSTITUTION =                                       | 70 | HHA OR   |
|   |  | 76 | SNF  |
| 1-190-05R                               | IF PRICING RATE CODE =   | U  | SHCP CLAIM OR ACTIVE DUTY MEMBER TPR CLAIM PAID OUTSIDE NORMAL LIMITS                            |
|   | THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | AN | SHCP - NON-MTF/eMSM-REFERRED CARE OR   |
|   |  | AR | SHCP - MTF/eMSM REFERRED CARE OR   |

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| <b>ELEMENT NAME: PRICING RATE CODE (1-190) (Continued)</b> |      |                                   |           |
|--|------|-----------------------------------|-----------|
|  | CE   | SHCP - CCEP                       | <b>OR</b> |
|  | GU   | SERVICE MEMBER 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</b> ENROLLMENT/HEALTH PLAN CODE<br>MUST =            | SN   | SHCP - NON-MTF/eMSM-REFERRED CARE | <b>OR</b> |
|  | SR   | SHCP - MTF/eMSM REFERRED CARE     |           |
| <b>1-190-06R</b> IF ANY OCCURRENCE OF REVENUE CODE =       | 0022 | SNF - PPS                         |           |
| <b>THEN</b> PRICING RATE CODE MUST =                       | D    | DISCOUNT RATE AGREEMENT           | <b>OR</b> |
|  | V    | MEDICARE REIMBURSEMENT RATE       |           |
| <b>UNLESS</b> AMOUNT ALLOWED (TOTAL) = ZERO                |      |                                   |           |
| <b>1-190-07R</b> IF ANY OCCURRENCE OF REVENUE CODE =       | 0023 | HHA PPS                           |           |
| <b>THEN</b> PRICING RATE CODE MUST =                       | D    | DISCOUNT RATE AGREEMENT           | <b>OR</b> |
|  | V    | MEDICARE REIMBURSEMENT RATE       |           |
| <b>UNLESS</b> AMOUNT ALLOWED (TOTAL) = ZERO                |      |                                   |           |
| <b>1-190-08R</b> IF PRICING RATE CODE =                    | CA   | CAH REIMBURSEMENT                 |           |
| <b>THEN</b> ADMISSION DATE MUST BE ≥ 12/01/2009            |      |                                   |           |
| <b>UNLESS</b> PROVIDER STATE <b>OR</b> COUNTRY<br>CODE =   | AK   | ALASKA                            |           |
| <b>THEN</b> ADMISSION DATE MUST BE ≥ 07/01/2007            |      |                                   |           |
| <b>1-190-09R</b> IF PRICING RATE CODE =                    | CR   | CCR                               |           |
| <b>THEN</b> ADMISSION DATE MUST BE ≥ 01/01/2014.           |      |                                   |           |
| <b>1-190-10R</b> IF PRICING RATE CODE =                    | CA   | CAH REIMBURSEMENT                 |           |
| <b>AND</b> ADMISSION DATE ≥ 01/01/2014.                    |      |                                   |           |
| <b>THEN</b> TYPE OF INSTITUTION MUST =                     | 93   | CAH                               |           |

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Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: PROVIDER STATE OR COUNTRY CODE (1-195)  |  |  |
|---|--|--|
| VALIDITY EDITS  |  |  |
| 1-195-01V   | VALUE MUST BE A VALID STATE <b>OR</b> COUNTRY CODE (REFER TO <a href="#">ADDENDUMS A OR B</a> ).   |  |
| RELATIONAL EDITS  |  |  |
| 1-195-01R   | PROVIDER STATE/COUNTRY CODE MUST MATCH THE CORRESPONDING RECORD <sup>1</sup> IN THE PROVIDER FILE. |  |
| UNLESS AMOUNT ALLOWED (TOTAL) ≤ ZERO  |  |  |
| <b>OR</b> ADJUSTMENT/DENIAL REASON CODE =   | 38   | SERVICES NOT PROVIDED <b>OR</b> 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   |
|   | T  | MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001   |
|   | FG   | TFL (FIRST PAYOR - NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL 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) AND BEGIN DATE OF CARE ≥ 10/01/2001 |
| <b>THEN</b> DO NOT CHECK FOR MATCH ON PROVIDER FILE   |  |  |
| <sup>1</sup> “CORRESPONDING RECORD” ON PROVIDER FILE IS BASED ON INSTITUTIONAL TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER ZIP CODE, AND TYPE OF INSTITUTION. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (1-200-02R). |  |  |

- END -

