

Chapter 2

Section 6.2

Non-Institutional Edit Requirements (ELN 100 - 199)

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ELEMENT NAME: TYPE OF SUBMISSION (2-100)			
VALIDITY EDITS			
2-100-01V	VALUE MUST BE A VALID TYPE OF SUBMISSION.		
2-100-02V	IF TYPE OF SUBMISSION =	B	ADJUSTMENT OF NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN ADJUSTMENT KEY CANNOT =	0	BATCH OR
		5	VOUCHER
	AND REGION INDICATOR MUST = BLANK		
2-100-03V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		B	ADJUSTMENT OF NON-TED RECORD (HCSR) DATA OR
		C	COMPLETE CANCELLATION OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN A MATCH MUST BE FOUND ON THE DHA DATABASE		
	AND TYPE OF SUBMISSION ON THE EXISTING DHA DATABASE RECORD ≠	C	COMPLETE CANCELLATION OR
		D	COMPLETE DENIAL OR
		E	COMPLETE CANCELLATION NON-TED RECORD (HCSR) DATA
	UNLESS THE RECORD HAS PROVISIONAL ERRORS		
2-100-04V	IF TYPE OF SUBMISSION =	D	COMPLETE DENIAL OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION
	THEN A TED RECORD MUST NOT BE PRESENT ON THE DATABASE WITH THE SAME TRI		
RELATIONAL EDITS			
2-100-01R	IF TYPE OF SUBMISSION =	O	ZERO PAYMENT WITH 100% OHI/TPL
	THEN THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT OF OHI MUST BE > ZERO.		
	AND THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE MUST BE > ZERO.		

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ELEMENT NAME: TYPE OF SUBMISSION (2-100) (Continued)			
AND THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO.			
2-100-02R	IF ALL OCCURRENCES/LINE ITEMS ARE DENIED (REFER TO ADDENDUM G, FIGURE 2.G-1)		
	THEN TYPE OF SUBMISSION MUST =	C	COMPLETE CANCELLATION OR
		D	COMPLETE DENIAL OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
2-100-04R	IF RESUBMISSION NUMBER = ZERO FOR THIS BATCH OR VOUCHER		
	THEN TYPE OF SUBMISSION MUST ≠	R	RESUBMISSION
2-100-05R	IF RESUBMISSION NUMBER > ZERO FOR THIS BATCH OR VOUCHER		
	THEN TYPE OF SUBMISSION MUST ≠	I	INITIAL TED RECORD SUBMISSION
2-100-06R	IF TYPE OF SUBMISSION =		
		I	INITIAL SUBMISSION OR
		R	RESUBMISSION
THEN THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT BILLED BY PROCEDURE CODE, AND THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE MUST BE > 0.			
2-100-07R	IF TYPE OF SUBMISSION =		
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN BEGIN DATE OF CARE MUST BE < 10/01/2010			
2-100-09R	IF TYPE OF SUBMISSION =		
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN TYPE OF SERVICE (SECOND POSITION) MUST ≠	M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
2-100-10R	IF THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY OTHER HEALTH INSURANCE > 0		
	AND THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED (TOTAL) BY PROCEDURE CODE > 0		
	AND THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE = 0		
	AND DATE ADJUSTMENT IDENTIFIED = ZEROES		
	THEN TYPE OF SUBMISSION MUST =	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
UNLESS THE SUM OF THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PATIENT COST-SHARE AND THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT APPLIED TOWARD DEDUCTIBLE ≥ THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE			

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

ELEMENT NAME: ADMINISTRATIVE CLIN (2-108)	
VALIDITY EDITS	
2-108-01V	MUST BE BLANKS.
RELATIONAL EDITS	
REFER TO SECTION 8.1 .	

ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (2-110)			
VALIDITY EDITS			
2-110-01V	MUST BE A VALID FOUR DIGIT DMIS-ID CODE.		
2-110-03V	IF FILING DATE ≥ 09/01/2007		
	AND PCM LOCATION DMIS-ID =	0190	JOHNS HOPKINS MEDICAL SERVICES CORPORATION OR
		0191	BRIGHTON MARINE OR
		0192	CHRISTUS HEALTH/ST JOHN'S OR
		0193	ST VINCENTS CATHOLIC MEDICAL CENTERS OF NY OR
		0194	PACIFIC MEDICAL CLINICS OR
		0196	CHRISTUS HEALTH/ST JOSEPH'S OR
		0194	CHRISTUS HEALTH/ST MARY'S OR
		0198	MARTIN'S POINT HEALTH CARE OR
		0199	FAIRVIEW HEALTH SYSTEM
	THEN THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO		
RELATIONAL EDITS			
	NONE		

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ELEMENT NAME: AMOUNT INTEREST PAYMENT (2-112)			
VALIDITY EDITS			
2-112-01V	MUST BE NUMERIC		
RELATIONAL EDITS			
2-112-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION
THEN AMOUNT INTEREST PAYMENT MUST BE ≥ ZERO			
2-112-02R	IF TYPE OF SUBMISSION =	D	COMPLETE DENIAL
THEN AMOUNT INTEREST PAYMENT MUST = ZERO			
2-112-03R	IF AMOUNT INTEREST PAYMENT ≠ ZERO		
	THEN REASON FOR INTEREST PAYMENT MUST =	A	CLAIMS PENDED AT GOVERNMENT DIRECTION OR
		B	CLAIMS REQUIRING GOVERNMENT INTERVENTION OR
		C	CLAIMS REQUIRING DEVELOPMENT FOR POTENTIAL TPL OR
		D	CLAIMS REQUIRING AN ACTION/INTERFACE WITH ANOTHER PRIME CONTRACTOR OR
		E	CLAIMS RETAINED BY THE CONTRACTOR THAT DO NOT FALL INTO ONE OF THE ABOVE CATEGORIES

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

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ELEMENT NAME: ICD VERSION (2-114)		
VALIDITY EDITS		
2-114-01V	VALUE MUST BE A VALID ICD VERSION	
RELATIONAL EDITS		
NO ERROR	IF THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO	
2-114-01R	IF ICD VERSION =	9 ICD-9
	THEN END DATE OF CARE OF EACH LINE ITEM MUST BE < 10/01/2015.	
2-114-02R	IF ICD VERSION =	0 ICD-10
	THEN BEGIN DATE OF CARE OF EACH LINE ITEM MUST BE ON OR AFTER ≥ 10/01/2015.	

ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (2-115)		
VALIDITY EDITS		
2-115-01V	IF FILING DATE IS PRIOR TO 10/01/2004	
	THEN VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE, EXCLUDING E000.0-E999.1	
2-115-02V	IF FILING DATE IS ON OR AFTER 10/01/2004	
	THEN VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE, EXCLUDING E000.0-E999.1 (ICD-9-CM) AND V00-Y99.9 (ICD-10-CM)	
	AND FOR AT LEAST ONE LINE ITEM	
	EITHER BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD DIAGNOSIS REFERENCE TABLE	
	OR END DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD DIAGNOSIS REFERENCE TABLE	
2-115-03V	POA INDICATOR (POSITION 8 OF THE PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR) MUST BE A VALID VALUE.	
RELATIONAL EDITS		
2-115-01R	IF PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) IS FOR FEMALE	
	AND PERSON SEX (PATIENT) IS MALE	
	THEN AT LEAST ONE OVERRIDE CODE MUST =	G DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE
2-115-02R	IF PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) IS FOR MALE	
	AND PERSON SEX (PATIENT) IS FEMALE	
	THEN AT LEAST ONE OVERRIDE CODE MUST =	H DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE
2-115-06R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF ECHO
	THEN PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) CANNOT =	799.9 ICD-9-CM OR
		R69 ICD-10-CM OR
		R99 ICD-10-CM
	UNLESS TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO	
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	1 MEDICAID

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ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR OCCURRENCES 1 - 24 (2-116 THROUGH 2-138, 2-340)	
VALIDITY EDITS	
2-XXX-01V¹	IF FILING DATE IS PRIOR TO 10/01/2004
THEN VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE OR BLANK FILLED.	
2-XXX-02V¹	IF FILING DATE IS ON OR AFTER 10/01/2004
THEN VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE OR BLANK FILLED.	
AND BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD DIAGNOSIS REFERENCE TABLE	
OR END DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD DIAGNOSIS REFERENCE TABLE	
2-XXX-03V¹	ALL OCCURRENCES OF SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR
2-XXX-04V	POA INDICATOR (POSITION 8 OF THE PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR) MUST BE A VALID VALUE.
RELATIONAL EDITS	
2-XXX-01R1	IF ANY SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) IS FOR FEMALE
AND PERSON SEX (PATIENT) IS MALE	
THEN AT LEAST ONE OVERRIDE CODE MUST =	G DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE
2-XXX-02R¹	IF ANY SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) IS FOR MALE
AND PERSON SEX (PATIENT) IS FEMALE	
THEN AT LEAST ONE OVERRIDE CODE MUST =	H DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE
¹ XXX EQUALS ELN (116 THROUGH 138, 2-340) FOR EACH OCCURRENCE OF SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR.	

ELEMENT NAME: TED RECORD CORRECTION INDICATOR (2-139)	
VALIDITY EDITS	
2-139-01V	VALUE MUST BE BLANK.
RELATIONAL EDITS	
NONE	

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

ELEMENT NAME: ADJUSTMENT SEQUENCE NUMBER (2-141)¹	
VALIDITY EDITS	
2-141-01V	MUST BE NUMERIC.
RELATIONAL EDITS	
2-141-01R	IF TYPE OF SUBMISSION = D COMPLETE DENIAL OR I INITIAL SUBMISSION OR O ZERO PAYMENT WITH 100% OHI/TPL OR R RESUBMISSION THEN ADJUSTMENT SEQUENCE NUMBER MUST = 000 (ZEROES)
2-141-02R	IF TYPE OF SUBMISSION = A ADJUSTMENT OR C COMPLETE CANCELLATION THEN ADJUSTMENT SEQUENCE NUMBER MUST BE ONE GREATER THAN THE CURRENT VALUE IN THE TED DATABASE
2-141-03R	IF TYPE OF SUBMISSION = B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA THEN ADJUSTMENT SEQUENCE NUMBER MUST = 000 (ZEROES)
¹ BYPASS ALL 2-141 EDITS FOR CONTRACT NUMBERS MDA906-02-C-0013 (TMOP), MDA906-03-C-0019 (TRRx), MDA906-03-C-0009 (WEST), MDA906-03-C-0010 (SOUTH), MDA906-03-C-0011 (NORTH), AND MDA906-03-C-0015 (TDEFIC).	

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

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ELEMENT NAME: BEGIN DATE OF CARE (2-150)		
VALIDITY EDITS		
2-150-01V	MUST BE A VALID GREGORIAN DATE AND CANNOT BE > DHA CURRENT SYSTEM DATE.	
2-150-02V	CANNOT BE MORE THAN 10 YEARS PRIOR TO DHA CURRENT SYSTEM DATE.	
2-150-03V	BEGIN DATE OF CARE MUST BE ≤ END DATE OF CARE.	
RELATIONAL EDITS		
2-150-01R	BEGIN DATE OF CARE MUST BE ≤ END DATE OF CARE.	
2-150-02R	BEGIN DATE OF CARE MUST BE ≤ FILING DATE.	
2-150-03R	BEGIN DATE OF CARE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION.	
2-150-04R	BEGIN DATE OF CARE MUST BE ≥ PERSON BIRTH CALENDAR DATE (PATIENT).	
2-150-05R	IF TYPE OF SUBMISSION =	A ADJUSTMENT OR
		B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		C COMPLETE CANCELLATION OR
		E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN BEGIN DATE OF CARE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED.	
2-150-06R	PROVIDER MUST BE “AUTHORIZED” ¹ ON PROVIDER FILE FOR EACH BEGIN DATE OF CARE	
	UNLESS AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO	
	OR ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM =	38 SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS OR
		52 THE REFERRING/PRESCRIBING/RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE BILLED OR
		B7 THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE
	OR PROVIDER SPECIALTY =	172A00000X (OTHER SERVICE PROVIDER/DRIVERS) OR
		344600000X (TRANSPORTATION SERVICES/TAXI)
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
		FG TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) OR
		FS TFL (SECOND PAYOR) OR
		RS MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) AND BEGIN DATE OF CARE ≥ 10/01/2001
	THEN DO NOT CHECK PROVIDER FILE	
¹ “AUTHORIZED” RECORD ON PROVIDER FILE IS BASED ON NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER MAJOR SPECIALTY, PROVIDER ZIP CODE, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (2-240-04R).		

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ELEMENT NAME: END DATE OF CARE (2-155)		
VALIDITY EDITS		
2-155-01V	MUST BE A VALID GREGORIAN DATE AND CANNOT BE > DHA CURRENT SYSTEM DATE.	
2-155-02V	CANNOT BE MORE THAN 10 YEARS PRIOR TO DHA CURRENT SYSTEM DATE.	
2-155-03V	END DATE OF CARE MUST BE > OR EQUAL TO BEGIN DATE OF CARE.	
RELATIONAL EDITS		
2-155-02R	END DATE OF CARE MUST BE ≤ FILING DATE.	
2-155-03R	END DATE OF CARE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION.	
2-155-04R	IF TYPE OF SUBMISSION =	A ADJUSTMENT OR
		B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		C COMPLETE CANCELLATION OR
		E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN END DATE OF CARE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED.		
2-155-05R	PROVIDER MUST BE "AUTHORIZED" ¹ ON PROVIDER FILE FOR EACH END DATE OF CARE	
UNLESS AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO		
	OR ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM =	38 SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS OR
		52 THE REFERRING/PRESCRIBING/RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE BILLED OR
		B7 THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE
	OR PROVIDER SPECIALTY =	172A00000X (OTHER SERVICE PROVIDER/DRIVERS) OR
		344600000X (TRANSPORTATION SERVICES/TAXI)
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
		FG TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) OR
		FS TFL (SECOND PAYOR) OR
		RS MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) AND BEGIN DATE OF CARE ≥ 10/01/2001
THEN DO NOT CHECK PROVIDER FILE		
2-155-06R	END DATE OF CARE MUST BE IN THE SAME FISCAL YEAR AS THE BEGIN DATE OF CARE	
¹ "AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER MAJOR SPECIALTY, PROVIDER ZIP CODE, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (2-240-04R).		

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ELEMENT NAME: PROCEDURE CODE (2-160)		
VALIDITY EDITS		
2-160-01V¹ FOR FILING DATE PRIOR TO 01/01/2005, VALUE MUST BE A VALID PROCEDURE CODE		
AND PROCEDURE CODE MUST MATCH ONE OF THE RECORDS IN THE PROCEDURE CODE DATABASE USING THE FOLLOWING DATE LOGIC:		
FOR TYPE OF SUBMISSION =	D	COMPLETE DENIAL OR
	I	INITIAL TED RECORD SUBMISSION OR
	O	ZERO PAYMENT WITH 100% OHI/TPL OR
	R	RESUBMISSION OF AN INITIAL TED RECORD (TYPE OF SUBMISSION WAS I) THAT WAS REJECTED DUE TO ERRORS
THE DATE TED RECORD PROCESSED TO COMPLETION MUST BE ON OR AFTER THE PROCESSING EFFECTIVE DATE AND BEFORE THE PROCESSING TERMINATION DATE		
AND THE BEGIN DATE OF CARE MUST BE ON OR AFTER THE CARE EFFECTIVE DATE AND BEFORE THE CARE TERMINATION DATE		
FOR TYPE OF SUBMISSION =	A	ADJUSTMENT TO TED RECORD DATA OR
	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	C	COMPLETE CANCELLATION OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THE DATE TED RECORD PROCESSED TO COMPLETION MUST BE ON OR AFTER THE PROCESSING EFFECTIVE DATE		
AND THE BEGIN DATE OF CARE MUST BE ON OR AFTER THE CARE EFFECTIVE DATE AND BEFORE THE CARE TERMINATION DATE		
2-160-02V¹ FOR FILING DATE ON OR AFTER 01/01/2005 VALUE MUST BE A VALID PROCEDURE CODE		
AND PROCEDURE CODE MUST MATCH ONE OF THE RECORDS IN THE PROCEDURE CODE REFERENCE TABLE USING THE FOLLOWING DATE LOGIC:		
BEGIN DATE OF CARE MUST BE ON OR AFTER THE PROCEDURE CODE CARE EFFECTIVE DATE AND NOT LATER THAN THE PROCEDURE CODE CARE TERMINATION DATE.		
RELATIONAL EDITS		
2-160-01R² IF ON THE MATCHING RECORD THE PROCEDURE CODE DATABASE GOVERNMENT PAY CODE = N		
THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE ≤ ZERO		
UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
	AD	FOREIGN ACTIVE DUTY CLAIMS (EFFECTIVE 06/30/1996) OR
	AN	SHCP - NON-MTF/eMSM-REFERRED CARE OR
	AR	SHCP - MTF/eMSM REFERRED CARE OR
	CE	SHCP - CCEP OR
	CL	CLINICAL TRIALS OR
	CP	CANCER CLINICAL TRIALS OR
	FS	TFL (SECOND PAYOR) OR
	GU	SERVICE MEMBER ENROLLED IN TPR OR
¹ PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-160-01R.		
² BYPASS EDIT 2-160-01R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.		

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ELEMENT NAME: PROCEDURE CODE (2-160) (Continued)		
	LD	LDTs DEMONSTRATION OR
	L2	NON-FDA APPROVED LDTs DEMONSTRATION OR
	MN	TSP - NETWORK OR
	MS	TSP - NON-NETWORK OR
	RD	RARE DISEASES OR
	SC	SHCP - NON-TRICARE ELIGIBLE OR
	SE	SHCP - TRICARE ELIGIBLE OR
	SM	SHCP - EMERGENCY
OR ENROLLMENT/HEALTH PLAN CODE =	X	FOREIGN SERVICE MEMBER OR
	SN	SHCP - NON-MTF/eMSM-REFERRED CARE OR
	SR	SHCP - MTF/eMSM REFERRED CARE OR
	WA	TPR - FOREIGN SERVICE MEMBER
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AS	COMPREHENSIVE AUTISM CARE DEMONSTRATION
AND PROCEDURE CODE = 0359T, 0360T, 0361T, 0364T, 0365T, 0368T, 0369T, 0370T, OR T1023		
OR FILING DATE < 11/05/2011		
AND FILING STATE COUNTRY CODE = A FOREIGN COUNTRY CODE (REFER TO ADDENDUM A)		
2-160-05R	IF PROCEDURE CODE = A0100, A0110, A0120, A0130, A0140, A0170, E0170 - E0172, E0241- E0245, E0273, E0625, E0701, L3215 - L3219, L3221 - L3223, L3230, L3250 - L3255, L3257, L3265, L3500, L3510, L3520, L3630, S8940, S9122 - S9124, V5281 - V5290, OR 99082	
AND AMOUNT ALLOWED BY PROCEDURE CODE > ZERO		
THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	PF	ECHO
UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AD	FOREIGN ACTIVE DUTY CLAIMS (EFFECTIVE 06/30/1996) OR
	AN	SHCP - NON-MTF/eMSM-REFERRED CARE OR
	AR	SHCP - MTF/eMSM REFERRED CARE OR
	CE	SHCP - CCEP OR
	GU	SERVICE MEMBER ENROLLED IN TPR OR
	MN	TSP - NETWORK OR
	MS	TSP - NON-NETWORK OR
	SC	SHCP - NON-TRICARE ELIGIBLE OR
	SE	SHCP - TRICARE ELIGIBLE OR
	SM	SHCP - EMERGENCY
OR ENROLLMENT/HEALTH PLAN CODE =	X	FOREIGN SERVICE MEMBER OR
	SN	SHCP - NON-MTF/eMSM-REFERRED CARE OR
	SR	SHCP - MTF/eMSM REFERRED CARE OR
	WA	TPR - FOREIGN SERVICE MEMBER
2-160-06R	IF TYPE OF SERVICE (FIRST POSITION) =	I INPATIENT

¹ PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-160-01R.
² BYPASS EDIT 2-160-01R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.

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Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: PROCEDURE CODE (2-160) (Continued)			
THEN PROCEDURE CODE MUST NOT BE FOR OUTPATIENT ONLY CARE (REFER TO ADDENDUM E, FIGURE 2.E-1 .			
2-160-08R	IF PROCEDURE CODE =	98800	FOR DRUGS OR
		00MN	PRESCRIPTION MEDICAL NECESSITY REVIEWS OR
		00PA	PRESCRIPTION PRIOR AUTHORIZATIONS
	THEN TYPE OF SERVICE (SECOND POSITION) MUST =	B	RETAIL DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS OR
		M	MOP DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS
AND NATIONAL DRUG CODE MUST ≠ BLANK			
UNLESS PROVIDER STATE OR COUNTRY CODE IS A FOREIGN COUNTRY CODE (ADDENDUM A)			
2-160-11R	IF PROCEDURE CODE = S5108 OR 99080		
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AP	ABA PILOT OR
		AU	AUTISM DEMONSTRATION OR
		BA	ABA (INTERIM BENEFIT)
UNLESS ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM IS A CODE LISTED IN ADDENDUM G, FIGURE 2.G-1 OR FIGURE 2.G-2 .			
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AN	SHCP - NON-MTF/eMSM-REFERRED CARE OR
		AR	SHCP - MTF/eMSM REFERRED CARE OR
		CE	SHCP - CCEP OR
		GU	SERVICE MEMBER ENROLLED IN TPR OR
		MN	TSP - NETWORK OR
		MS	TSP - NON-NETWORK OR
		SC	SHCP - NON-TRICARE ELIGIBLE OR
		SE	SHCP - TRICARE ELIGIBLE OR
		SM	SHCP - EMERGENCY
	OR ENROLLMENT/HEALTH PLAN CODE =	X	FOREIGN SERVICE MEMBER OR
		SN	SHCP - NON-MTF/eMSM-REFERRED CARE OR
		SR	SHCP - MTF/eMSM REFERRED CARE OR
		WA	TPR - FOREIGN SERVICE MEMBER
2-160-12R	IF PROCEDURE CODE = 1181F, 1450F, S5115, G8539, G8542, G9165, G9166, OR G9167		
	THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AP	ABA PILOT
	UNLESS AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO.		
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	AD	FOREIGN ACTIVE DUTY CLAIMS OR
		AN	SHCP - NON-MTF/eMSM-REFERRED CARE OR
		AR	SHCP - MTF/eMSM REFERRED CARE OR
		CE	SHCP - CCEP OR
¹ PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-160-01R.			
² BYPASS EDIT 2-160-01R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.			

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Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: PROCEDURE CODE (2-160) (Continued)		
	GU	SERVICE MEMBER ENROLLED IN TPR OR
	MN	TSP - NETWORK OR
	MS	TSP - NON-NETWORK OR
	SC	SHCP - NON-TRICARE ELIGIBLE OR
	SE	SHCP - TRICARE ELIGIBLE OR
	SM	SHCP - EMERGENCY
OR ENROLLMENT/HEALTH PLAN CODE =	X	FOREIGN SERVICE MEMBER OR
	SN	SHCP - NON-MTF/eMSM-REFERRED CARE OR
	SR	SHCP - MTF/eMSM REFERRED CARE OR
	WA	TPR - FOREIGN SERVICE MEMBER
¹ PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-160-01R.		
² BYPASS EDIT 2-160-01R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.		

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

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

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Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: NUMBER OF SERVICES (2-175)	
VALIDITY EDITS	
2-175-01V	MUST BE NUMERIC.
RELATIONAL EDITS	
2-175-01R	IF TYPE OF SUBMISSION =
	A ADJUSTMENT OR
	C COMPLETE CANCELLATION OR
	D COMPLETE DENIAL OR
	I INITIAL SUBMISSION OR
	O ZERO PAYMENT WITH 100% OHI/TPL OR
	R RESUBMISSION
	THEN NUMBER OF SERVICES FOR EACH OCCURRENCE MUST BE > ZERO
	UNLESS TYPE OF SERVICE (SECOND POSITION) =
	M MOP DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS
	AND OCCURRENCE/LINE ITEM NUMBER = 002
	THEN NUMBER OF SERVICES ON THIS LINE ITEM MUST = ZERO
2-175-02R¹	• SURGERY PROCEDURE CODES
	IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO
	AND PROCEDURE CODE = 10000-36399 OR 36800-69999 (SURGERY)
	THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM CANNOT EXCEED 10 PER DAY
	UNLESS PROCEDURE CODE = 11201, 11721, 13102, 13122, 13133, 13153, 15001, 15003, 15101, 15201, 15221, 15241, 15261, 15301, 15321, 15331, 15341, 15343, 15361, 15366, 15401, 15421, 15431, 17003, 17004, 17110, 17111, OR 17310
	OR ANY OCCURRENCE OF OVERRIDE CODE = NS CONTRACTOR HAS DETERMINED THE NUMBER OF SERVICES IS MEDICALLY NECESSARY
2-175-03R¹	• E/M PROCEDURE CODES
	IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO
	AND PROCEDURE CODE =
	99201-99205 (OFFICE VISITS - NEW PATIENTS) OR
	99211-99215 (OFFICE VISITS - ESTABLISHED PATIENTS) OR
	99217 (DISCHARGE SERVICES) OR
	99221-99233 (HOSPITAL CARE PER DAY) OR
	99234-99236 (OBSERVATION OR INPATIENT CARE SERVICES) OR
	99238-99239 (HOSPITAL DISCHARGE SERVICES) OR
	99241-99245 (OFFICE CONSULTATIONS) OR
	99251-99255 (INITIAL INPATIENT CONSULTATIONS) OR
	99261-99263 (FOLLOW-UP INPATIENT CONSULTATIONS) OR
	99271-99275 (CONFIRMATORY CONSULTATIONS) OR
	99281-99285 (EMERGENCY DEPARTMENT VISIT) OR
¹ EDITS 2-175-02R, 2-175-03R, 2-175-04R, AND 2-175-06R ARE ONLY EXECUTED FOR FILING DATES < 02/01/2010.	
² EDIT 2-175-07R IS ONLY EXECUTED FOR FILING DATES ≥ 02/01/2010. PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-175-07R. BYPASS EDIT 2-175-07R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.	
³ TO DETERMINE MAXIMUM NUMBER OF SERVICES REFER TO THE MAXIMUM NUMBER OF SERVICES CODE LIST AT HTTP://HEALTH.MIL/MILITARY-HEALTH-TOPICS/BUSINESS-SUPPORT/RATES-AND-REIMBURSEMENT .	

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Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: NUMBER OF SERVICES (2-175) (Continued)		
	99291 (CRITICAL CARE) (NOTE: CODE 99292 EXCLUDED BECAUSE UTILIZED TO REPORT FOR EACH ADDITIONAL 15 MINUTES OF CARE) OR	
	99295-99298 (NEONATAL INTENSIVE CARE) OR	
	99301-99315 (NURSING FACILITY CHARGES) OR	
	99321-99333 (DOMICILIARY, REST HOME, OR CUSTODIAL CARE SERVICES) OR	
	99341-99350 (HOME SERVICES) OR	
	99354 (PROLONGED SERVICES) (NOTE: CODE 99355 EXCLUDED BECAUSE UTILIZED TO REPORT FOR EACH ADDITIONAL 30 MINUTES OF CARE) OR	
	99356 (PROLONGED SERVICES) (NOTE: CODE 99357 EXCLUDED BECAUSE UTILIZED TO REPORT FOR EACH ADDITIONAL 30 MINUTES OF CARE) OR	
	99361-99373 (CASE MANAGEMENT SERVICES) OR	
	99374-99380 (CARE PLAN OVERSIGHT) OR	
	99381-99429 (PREVENTIVE MEDICINE SERVICES) OR	
	99431-99440 (NEWBORN CARE) OR	
	99450-99456 (SPECIAL EVALUATION AND MANAGEMENT SERVICES)	
	THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM CANNOT EXCEED THREE PER DAY	
	UNLESS ANY OCCURRENCE OF OVERRIDE	
	CODE =	NS CONTRACTOR HAS DETERMINED THAT NUMBER OF SERVICES IS MEDICALLY NECESSARY
2-175-04R¹	• MEDICAL PROCEDURE CODES	
	IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO	
	AND PROCEDURE CODE =	99500-99512 (HOME HEALTH VISIT) OR
		99551-99568 (HOME INFUSION PER DIEM CODES)
	THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM CANNOT EXCEED THREE PER DAY	
	UNLESS ANY OCCURRENCE OF OVERRIDE	
	CODE =	NS CONTRACTOR HAS DETERMINED THAT NUMBER OF SERVICES IS MEDICALLY NECESSARY
2-175-06R¹	• VACCINES (VACCINE PRODUCT ONLY) PROCEDURE CODES	
	IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO	
	AND PROCEDURE CODE =	90476-90479 (VACCINES, TOXOIDS)
	THEN NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM CANNOT EXCEED THREE PER DAY	
	UNLESS ANY OCCURRENCE OF OVERRIDE	
	CODE =	NS CONTRACTOR HAS DETERMINED THAT NUMBER OF SERVICES IS MEDICALLY NECESSARY
2-175-07R²	IF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO	
	OR PRICING RATE CODE =	P1 OPPS OR
¹ EDITS 2-175-02R, 2-175-03R, 2-175-04R, AND 2-175-06R ARE ONLY EXECUTED FOR FILING DATES < 02/01/2010.		
² EDIT 2-175-07R IS ONLY EXECUTED FOR FILING DATES ≥ 02/01/2010. PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-175-07R. BYPASS EDIT 2-175-07R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.		
³ TO DETERMINE MAXIMUM NUMBER OF SERVICES REFER TO THE MAXIMUM NUMBER OF SERVICES CODE LIST AT HTTP://HEALTH.MIL/MILITARY-HEALTH-TOPICS/BUSINESS-SUPPORT/RATES-AND-REIMBURSEMENT .		

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Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: NUMBER OF SERVICES (2-175) (Continued)		
	P2	OPPS WITH COST OUTLIER OR
	P3	OPPS WITH DISCOUNT OR
	P5	HOSPITAL-BASED PARTIAL HOSPITALIZATION PAID AS OPPS
OR NO OCCURRENCE OF SPECIAL PROCESSING CODE =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
	FS	TFL (SECOND PAYOR)
THEN BYPASS THIS EDIT		
ELSE NUMBER OF SERVICES CANNOT EXCEED THE MAXIMUM ALLOWED NUMBER OF SERVICES PER DAY FOR THE PROCEDURE CODE ON THIS LINE ITEM ³ (BEGIN DATE OF CARE MUST BE ON OR AFTER THE MAXIMUM NUMBER OF SERVICES TABLE EFFECTIVE DATE AND NOT LATER THAN THE MAXIMUM NUMBER OF SERVICES TABLE TERMINATION DATE)		
UNLESS ANY OCCURRENCE OF OVERRIDE CODE =	NS	CONTRACTOR HAS DETERMINED THAT NUMBER OF SERVICES IS MEDICALLY NECESSARY
¹ EDITS 2-175-02R, 2-175-03R, 2-175-04R, AND 2-175-06R ARE ONLY EXECUTED FOR FILING DATES < 02/01/2010. ² EDIT 2-175-07R IS ONLY EXECUTED FOR FILING DATES ≥ 02/01/2010. PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-175-07R. BYPASS EDIT 2-175-07R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V. ³ TO DETERMINE MAXIMUM NUMBER OF SERVICES REFER TO THE MAXIMUM NUMBER OF SERVICES CODE LIST AT HTTP://HEALTH.MIL/MILITARY-HEALTH-TOPICS/BUSINESS-SUPPORT/RATES-AND-REIMBURSEMENT .		

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Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: AMOUNT BILLED BY PROCEDURE CODE (2-180)	
VALIDITY EDITS	
2-180-01V	MUST BE NUMERIC.
2-180-02V	IF CONTRACT NUMBER = MDA906-02-C-0013 (TMOP)
	THEN IF PROCEDURE CODE = 000MN PRESCRIPTION MEDICAL NECESSITY REVIEWS OR
	000PA PRESCRIPTION PRIOR AUTHORIZATIONS
	THEN AMOUNT BILLED BY PROCEDURE CODE MUST > ZERO
	ELSE IF TYPE OF SUBMISSION = C COMPLETE CANCELLATION TO TED RECORD DATA
	OR ADJUSTMENT/DENIAL REASON CODE IS A DENIAL REASON CODE LISTED IN ADDENDUM G, FIGURE 2.G-1 FOR THAT OCCURRENCE/LINE ITEM
	THEN AMOUNT BILLED BY PROCEDURE CODE MUST = ZERO
	AND AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO
	AND AMOUNT PAID BY OHI MUST = ZERO
	AND AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO
	AND AMOUNT PATIENT COST-SHARE MUST = ZERO
	ELSE IF OCCURRENCE/LINE ITEM NUMBER = 002
	THEN AMOUNT BILLED BY PROCEDURE CODE MUST = ZERO
	ELSE AMOUNT BILLED BY PROCEDURE CODE MUST BE $\geq \$10.20$ AND $\leq \$11.48$
2-180-03V	IF CONTRACT NUMBER = MDA906-02-C-0013 (TMOP)
	AND AMOUNT BILLED BY PROCEDURE CODE = ZERO
	THEN TYPE OF SUBMISSION MUST = C COMPLETE CANCELLATION TO TED RECORD DATA
	OR OCCURRENCE/LINE ITEM NUMBER MUST = 002
	OR ADJUSTMENT/DENIAL REASON CODE MUST BE A DENIAL REASON CODE LISTED IN ADDENDUM G, FIGURE 2.G-1 FOR THAT OCCURRENCE/LINE ITEM
RELATIONAL EDITS	
2-180-00R	IF TYPE OF SUBMISSION \neq D COMPLETE DENIAL
	THEN TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT BILLED BY PROCEDURE CODE FOR THIS TED RECORD MUST NOT EXCEED DHA LIMIT OF \$1,000,000.00

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Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: AMOUNT ALLOWED BY PROCEDURE CODE (2-185)			
VALIDITY EDITS			
2-185-01V	MUST BE NUMERIC.		
RELATIONAL EDITS			
2-185-00R	TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE FOR THIS TED RECORD EXCEEDS DHA LIMIT OF \$1,000,000.00.		
2-185-01R	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION OR
		D	COMPLETE DENIAL
THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO FOR ALL OCCURRENCES/LINE ITEMS			
2-185-02R	IF PRICING RATE CODE =	H	NO SPECIAL RATE OR
		D	DISCOUNT RATE OR
		V	MEDICARE REIMBURSEMENT RATE
	AND NO OCCURRENCE OF SPECIAL PROCESSING CODE =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
		FS	TFL (SECOND PAYOR) OR
		16	AMBULATORY SURGERY FACILITY CHARGE
	AND TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION
THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE ≤ AMOUNT BILLED BY PROCEDURE CODE FOR EACH OCCURRENCE/LINE ITEM			
2-185-03R	IF PRICING RATE CODE =	4	PAID AS BILLED OR
		I	CLAIM AUDITING SOFTWARE-ADDED PROCEDURE, PAID AS BILLED
	AND TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION
THEN AMOUNT ALLOWED BY PROCEDURE CODE MUST BE = AMOUNT BILLED BY PROCEDURE CODE			
2-185-04R	IF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO		
	THEN ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM MUST BE A CODE LISTED IN ADDENDUM G, FIGURE 2.G-1 OR FIGURE 2.G-2 .		
	UNLESS TYPE OF SUBMISSION =	B	ADJUSTMENT NON-TED DATA (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
2-185-05R	IF TYPE OF SUBMISSION =	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO			
2-185-06R	IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO		
	THEN TYPE OF SUBMISSION MUST =	A	ADJUSTMENT OR
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		I	INITIAL SUBMISSION OR

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ELEMENT NAME: AMOUNT ALLOWED BY PROCEDURE CODE (2-185) (Continued)		
	O	ZERO PAYMENT WITH 100% OHI/TPL OR
	R	RESUBMISSION
2-185-07R	IF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO	
	THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO	
	UNLESS TYPE OF SUBMISSION =	B ADJUSTMENT NON-TED DATA (HCSR) DATA OR
		E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

ELEMENT NAME: AMOUNT PAID BY OTHER HEALTH INSURANCE (2-190)			
VALIDITY EDITS			
2-190-01V	MUST BE NUMERIC.		
RELATIONAL EDITS			
2-190-00R	TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY OTHER HEALTH INSURANCE FOR THIS TED RECORD EXCEEDS DHA LIMIT OF \$1,000,000.00.		
2-190-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		C	COMPLETE CANCELLATION OR
		D	COMPLETE DENIAL OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION
THEN AMOUNT PAID BY OTHER HEALTH INSURANCE MUST BE ≥ ZERO.			

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

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

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ELEMENT NAME: AMOUNT APPLIED TOWARD DEDUCTIBLE (2-195)			
VALIDITY EDITS			
2-195-01V	MUST BE NUMERIC.		
RELATIONAL EDITS			
2-195-00R	TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT APPLIED TOWARD DEDUCTIBLE FOR THIS TED RECORD EXCEEDS DHA LIMIT OF \$1,000,000.00.		
2-195-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION
THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST BE ≥ ZERO			
2-195-02R	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION OR
		D	COMPLETE DENIAL
THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST BE = ZERO			
2-195-03R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	NE	OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM DEMONSTRATION
AND BEGIN DATE OF CARE ≥ 09/14/2001 AND < 11/01/2008			
	AND ENROLLMENT/HEALTH PLAN CODE =	T	TRICARE STANDARD PROGRAM OR
		V	TRICARE EXTRA
THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO			
2-195-04R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	DE	TDRL PHYSICAL EXAMS OR
		PF	ECHO
THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO			

- END -