

## Chapter 2

## Section 6.2

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

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Revision: C-28, August 28, 2019

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 <b>OR</b>
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	<b>THEN</b> ADJUSTMENT KEY <b>CANNOT</b> =	0	BATCH <b>OR</b>
		5	VOUCHER
	<b>AND</b> REGION INDICATOR MUST = BLANK		
2-100-03V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT <b>OR</b>
		B	ADJUSTMENT OF 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> A MATCH MUST BE FOUND ON THE DHA DATABASE		
	<b>AND</b> TYPE OF SUBMISSION ON THE EXISTING DHA DATABASE RECORD $\neq$	C	COMPLETE CANCELLATION <b>OR</b>
		D	COMPLETE DENIAL <b>OR</b>
		E	COMPLETE CANCELLATION NON-TED RECORD (HCSR) DATA
	<b>UNLESS</b> THE RECORD HAS PROVISIONAL ERRORS		
2-100-04V	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			
2-100-01R	IF TYPE OF SUBMISSION =	O	ZERO PAYMENT WITH 100% OHI/TPL
	<b>THEN</b> THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT OF OHI MUST BE > ZERO.		
	<b>AND</b> THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE MUST BE > ZERO.		

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<b>ELEMENT NAME: TYPE OF SUBMISSION (2-100) (Continued)</b>			
<b>AND</b> THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO.			
<b>2-100-02R</b>	IF ALL OCCURRENCES/LINE ITEMS ARE DENIED (REFER TO <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
<b>2-100-04R</b>	IF RESUBMISSION NUMBER = ZERO FOR THIS BATCH OR VOUCHER		
	<b>THEN</b> TYPE OF SUBMISSION MUST ≠	R	RESUBMISSION
<b>2-100-05R</b>	IF RESUBMISSION NUMBER > ZERO FOR THIS BATCH <b>OR</b> VOUCHER		
	<b>THEN</b> TYPE OF SUBMISSION MUST ≠	I	INITIAL TED RECORD SUBMISSION
<b>2-100-06R</b>	IF TYPE OF SUBMISSION =		
		I	INITIAL SUBMISSION <b>OR</b>
		R	RESUBMISSION
<b>THEN</b> THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT BILLED BY PROCEDURE CODE, <b>AND</b> THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED BY PROCEDURE CODE MUST BE > 0.			
<b>2-100-07R</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			
<b>2-100-09R</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> TYPE OF SERVICE (SECOND POSITION) MUST ≠	M	MOP DRUGS, SUPPLIES, PRESCRIPTION AUTHORIZATIONS, AND REVIEWS
<b>2-100-10R</b>	IF THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY OTHER HEALTH INSURANCE > 0		
	<b>AND</b> THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED (TOTAL) BY PROCEDURE CODE > 0		
	<b>AND</b> THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE = 0		
	<b>AND</b> DATE ADJUSTMENT IDENTIFIED = ZEROES		
	<b>THEN</b> TYPE OF SUBMISSION MUST =	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI
<b>UNLESS</b> THE SUM OF THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PATIENT COST-SHARE <b>AND</b> 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 <a href="#">SECTION 8.1</a> .

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
		C COMPLETE CANCELLATION OR
		I INITIAL SUBMISSION OR
		O ZERO PAYMENT WITH 100% OHI/TPL OR
		R RESUBMISSION
THEN AMOUNT INTEREST PAYMENT MUST BE ≥ ZERO		
2-112-02R	IF TYPE OF SUBMISSION =	C COMPLETE CANCELLATION OR
		D COMPLETE DENIAL
THEN AMOUNT INTEREST PAYMENT MUST = ZERO		
2-112-03R	IF TRANSACTION RECORD AMOUNT INTEREST PAYMENT ≠ ZERO	
	THEN TRANSACTION RECORD REASON FOR INTEREST PAYMENT MUST =	A CLAIMS PENDED AT GOVERNMENT DIRECTION (TERMINATED 07/08/2019) OR
		B CLAIMS REQUIRING GOVERNMENT INTERVENTION (TERMINATED 07/08/2019) OR
		C CLAIMS REQUIRING DEVELOPMENT FOR POTENTIAL TPL (TERMINATED 07/08/2019) OR
		D CLAIMS REQUIRING AN ACTION/INTERFACE WITH ANOTHER PRIME CONTRACTOR (TERMINATED 07/08/2019) OR
		E CLAIMS RETAINED BY THE CONTRACTOR THAT DO NOT FALL INTO ONE OF THE ABOVE CATEGORIES (TERMINATED 07/08/2019) OR
		F 10 USC 1095c(a)(2) INTEREST PAYMENT (THE CONTRACTOR IS FISCALLY REPOSIBILE FOR ANY INTEREST) (EFFECTIVE DATE 07/09/2019) OR
		G 10 USC 1095c(a)(2) INTEREST PAYMENT (THE GOVERNMENT IS FISCALLY REPOSIBILE FOR ANY INTEREST) (EFFECTIVE DATE 07/09/2019)
2-112-04R	IF TRANSACTION RECORD AMOUNT INTEREST PAYMENT < ZERO AND REASON FOR INTEREST PAYMENT =	F 10 USC 1095c(a)(2) INTEREST PAYMENT (THE CONTRACTOR IS FISCALLY RESPONSIBLE FOR ANY INTEREST) (EFFECTIVE DATE 07/09/2019) OR
		G 10 USC 1095c(a)(2) INTEREST PAYMENT (THE GOVERNMENT IS FISCALLY RESPONSIBLE FOR ANY INTEREST) (EFFECTIVE DATE 07/09/2019)
THEN TRANSACTION RECORD REASON FOR INTEREST PAYMENT MUST = REASON FOR INTEREST PAYMENT FOUND ON DATABASE <sup>1</sup>		
<sup>1</sup> REDUCTIONS IN INTEREST MUST BE PROCESSED USING SAME REASON CODE AS PAYMENT TO ENSURE DHA ACCOUNTING SYSTEM PROCESSES TRANSACTION CORRECTLY.		

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**ELEMENT NAME: REASON FOR INTEREST PAYMENT (2-113)**

**VALIDITY EDITS**

**2-113-01V** MUST BE A VALID REASON FOR INTEREST PAYMENT CODE (BASED ON BEGIN DATE OF CARE) (REFER TO SECTION 2.8).

**AND AT LEAST ONE OCCURRENCE OF** BEGIN DATE OF CARE MUST BE ON OR AFTER THE CARE EFFECTIVE DATE **AND** ON OR BEFORE THE CARE TERMINATION DATE

**RELATIONAL EDITS**

**2-113-01R** IF TRANSACTION RECORD REASON FOR INTEREST PAYMENT =

A CLAIMS PENDED AT GOVERNMENT DIRECTION (TERMINATED 07/08/2019) **OR**

B CLAIMS REQUIRING GOVERNMENT INTERVENTION (TERMINATED 07/08/2019) **OR**

C CLAIMS REQUIRING DEVELOPMENT FOR POTENTIAL TPL (TERMINATED 07/08/2019) **OR**

D CLAIMS REQUIRING AN ACTION/INTERFACE WITH ANOTHER PRIME CONTRACTOR (TERMINATED 07/08/2019) **OR**

E CLAIMS RETAINED BY THE CONTRACTOR THAT DO NOT FALL INTO ONE OF THE ABOVE CATEGORIES (TERMINATED 07/08/2019) **OR**

F 10 USC 1095c(a)(2) INTEREST PAYMENT (THE CONTRACTOR IS FISCALLY RESPONSIBLE FOR ANY INTEREST) (EFFECTIVE DATE 07/09/2019) **OR**

G 10 USC 1095c(a)(2) INTEREST PAYMENT (THE GOVERNMENT IS FISCALLY RESPONSIBLE FOR ANY INTEREST) (EFFECTIVE DATE 07/09/2019)

**THEN** TRANSACTION RECORD AMOUNT INTEREST PAYMENT MUST ≠ ZERO

**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.

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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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<b>ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR OCCURRENCES 1 - 24 (2-116 THROUGH 2-138, 2-340)</b>	
<b>VALIDITY EDITS</b>	
<b>2-XXX-01V<sup>1</sup></b>	IF FILING DATE IS PRIOR TO 10/01/2004
<b>THEN</b> VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE OR BLANK FILLED.	
<b>2-XXX-02V<sup>1</sup></b>	IF FILING DATE IS ON OR AFTER 10/01/2004
<b>THEN</b> VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE OR BLANK FILLED.	
<b>AND</b> 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	
<b>OR</b> 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	
<b>2-XXX-03V<sup>1</sup></b>	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
<b>2-XXX-04V</b>	POA INDICATOR (POSITION 8 OF THE PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR) MUST BE A VALID VALUE.
<b>RELATIONAL EDITS</b>	
<b>2-XXX-01R1</b>	IF ANY SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) IS FOR FEMALE
<b>AND</b> PERSON SEX (PATIENT) IS MALE	
<b>THEN</b> AT LEAST ONE OVERRIDE CODE MUST =	G DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE
<b>2-XXX-02R<sup>1</sup></b>	IF ANY SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) IS FOR MALE
<b>AND</b> PERSON SEX (PATIENT) IS FEMALE	
<b>THEN</b> AT LEAST ONE OVERRIDE CODE MUST =	H DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE
<sup>1</sup> XXX EQUALS ELN (116 THROUGH 138, 2-340) FOR EACH OCCURRENCE OF SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR.	

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

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

<b>ELEMENT NAME: ADJUSTMENT SEQUENCE NUMBER (2-141)<sup>1</sup></b>	
<b>VALIDITY EDITS</b>	
<b>2-141-01V</b>	MUST BE NUMERIC.
<b>RELATIONAL EDITS</b>	
<b>2-141-01R</b>	IF TYPE OF SUBMISSION = D COMPLETE DENIAL OR I INITIAL SUBMISSION OR O ZERO PAYMENT WITH 100% OHI/TPL OR R RESUBMISSION <b>THEN</b> ADJUSTMENT SEQUENCE NUMBER MUST = 000 (ZEROES)
<b>2-141-02R</b>	IF TYPE OF SUBMISSION = A ADJUSTMENT OR C COMPLETE CANCELLATION <b>THEN</b> ADJUSTMENT SEQUENCE NUMBER MUST BE ONE GREATER THAN THE CURRENT VALUE IN THE TED DATABASE
<b>2-141-03R</b>	IF TYPE OF SUBMISSION = B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA <b>THEN</b> ADJUSTMENT SEQUENCE NUMBER MUST = 000 (ZEROES)
<sup>1</sup> 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).	

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



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ELEMENT NAME: BEGIN DATE OF CARE (2-150)		
VALIDITY EDITS		
2-150-01V	MUST BE A VALID GREGORIAN DATE <b>AND</b> 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 <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> BEGIN DATE OF CARE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED.		
2-150-06R	PROVIDER MUST BE “AUTHORIZED” <sup>1</sup> ON PROVIDER FILE FOR EACH BEGIN DATE OF CARE	
<b>UNLESS</b> AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO		
	<b>OR</b> ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM =	38 SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS <b>OR</b>
		52 THE REFERRING/PRESCRIBING/RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE BILLED <b>OR</b>
		B7 THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE
	<b>OR</b> PROVIDER SPECIALTY =	172A00000X (OTHER SERVICE PROVIDER/DRIVERS) <b>OR</b>
		344600000X (TRANSPORTATION SERVICES/TAXI)
	<b>OR</b> ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b>
		FG TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b>
		FS TFL (SECOND PAYOR) <b>OR</b>
		RS MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001
<b>THEN</b> DO NOT CHECK PROVIDER FILE		
<sup>1</sup> “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 <b>AND</b> 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 <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> END DATE OF CARE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED.		
2-155-05R	PROVIDER MUST BE “AUTHORIZED” <sup>1</sup> ON PROVIDER FILE FOR EACH END DATE OF CARE	
<b>UNLESS</b> AMOUNT ALLOWED BY PROCEDURE CODE ≤ ZERO		
	<b>OR</b> ADJUSTMENT/DENIAL REASON CODE FOR THAT OCCURRENCE/LINE ITEM =	38 SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS <b>OR</b>
		52 THE REFERRING/PRESCRIBING/RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE BILLED <b>OR</b>
		B7 THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE
	<b>OR</b> PROVIDER SPECIALTY =	172A00000X (OTHER SERVICE PROVIDER/DRIVERS) <b>OR</b>
		344600000X (TRANSPORTATION SERVICES/TAXI)
	<b>OR</b> ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b>
		FG TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b>
		FS TFL (SECOND PAYOR) <b>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 PROVIDER FILE		
2-155-06R	END DATE OF CARE <b>MUST</b> BE IN THE SAME FISCAL YEAR AS THE BEGIN DATE OF CARE	
<sup>1</sup> “AUTHORIZED” RECORD ON PROVIDER FILE IS BASED ON NON-INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER MAJOR SPECIALTY, PROVIDER ZIP CODE, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (2-240-04R).		

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Chapter 2, Section 6.2

Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: PROCEDURE CODE (2-160)		
VALIDITY EDITS		
2-160-01V <sup>1</sup> 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		
2-160-02V <sup>1</sup> 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		
2-160-01R <sup>2</sup> 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
<sup>1</sup> PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-160-01R.		
<sup>2</sup> BYPASS EDIT 2-160-01R IF RECORD FAILS EDIT 2-160-01V OR 2-160-02V.		

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Chapter 2, Section 6.2

Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: PROCEDURE CODE (2-160) (Continued)		
	LD	LDTs DEMONSTRATION <b>OR</b>
	L2	NON-FDA APPROVED LDTs DEMONSTRATION <b>OR</b>
	MN	TSP - NETWORK <b>OR</b>
	MS	TSP - NON-NETWORK <b>OR</b>
	RD	RARE DISEASES <b>OR</b>
	SC	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
	SE	SHCP - TRICARE ELIGIBLE <b>OR</b>
	SM	SHCP - EMERGENCY
<b>OR ENROLLMENT/HEALTH PLAN CODE =</b>	X	FOREIGN SERVICE MEMBER <b>OR</b>
	SN	SHCP - NON-MTF/eMSM-REFERRED CARE <b>OR</b>
	SR	SHCP - MTF/eMSM REFERRED CARE <b>OR</b>
	WA	TPR - FOREIGN SERVICE MEMBER
<b>OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =</b>	AS	COMPREHENSIVE AUTISM CARE DEMONSTRATION
<b>AND PROCEDURE CODE = 0359T, 0360T, 0361T, 0364T, 0365T, 0368T, 0369T, 0370T, T1023, 97151, 97153, 97155, OR 97156</b>		
<b>OR FILING DATE &lt; 11/05/2011</b>		
<b>AND FILING STATE COUNTRY CODE = A FOREIGN COUNTRY CODE (REFER TO <a href="#">ADDENDUM A</a>)</b>		
<b>2-160-05R</b>	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, <b>OR</b> 99082	
<b>AND AMOUNT ALLOWED BY PROCEDURE CODE &gt; ZERO</b>		
<b>THEN ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =</b>	PF	ECHO
<b>UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =</b>	AD	FOREIGN ACTIVE DUTY CLAIMS (EFFECTIVE 06/30/1996) <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>
	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
<b>OR ENROLLMENT/HEALTH PLAN CODE =</b>	X	FOREIGN SERVICE MEMBER <b>OR</b>
	SN	SHCP - NON-MTF/eMSM-REFERRED CARE <b>OR</b>
	SR	SHCP - MTF/eMSM REFERRED CARE <b>OR</b>
	WA	TPR - FOREIGN SERVICE MEMBER
<b>2-160-06R</b>	IF TYPE OF SERVICE (FIRST POSITION) =	I INPATIENT

<sup>1</sup> PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-160-01R.  
<sup>2</sup> 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 <a href="#">ADDENDUM E, FIGURE 2.E-1</a> .			
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 ( <a href="#">ADDENDUM A</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 <a href="#">ADDENDUM G, FIGURE 2.G-1</a> OR <a href="#">FIGURE 2.G-2</a> .			
	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
<sup>1</sup> PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-160-01R.			
<sup>2</sup> 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 <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
<b>OR ENROLLMENT/HEALTH PLAN CODE =</b>	X	FOREIGN SERVICE MEMBER <b>OR</b>
	SN	SHCP - NON-MTF/eMSM-REFERRED CARE <b>OR</b>
	SR	SHCP - MTF/eMSM REFERRED CARE <b>OR</b>
	WA	TPR - FOREIGN SERVICE MEMBER
<sup>1</sup> PROCEDURE CODE RECORD MATCH MADE IN 2-160-01V OR 2-160-02V WILL BE USED IN EDIT 2-160-01R.		
<sup>2</sup> 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	
<b>2-165-01V</b>	MUST BE A VALID PROCEDURE CODE MODIFIER AS DEFINED IN <a href="#">SECTION 2.7</a> .
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)

<b>ELEMENT NAME: NUMBER OF SERVICES (2-175)</b>	
<b>VALIDITY EDITS</b>	
<b>2-175-01V</b>	MUST BE NUMERIC.
<b>RELATIONAL EDITS</b>	
<b>2-175-01R</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> NUMBER OF SERVICES FOR EACH OCCURRENCE MUST BE > ZERO	
<b>UNLESS</b> TYPE OF SERVICE (SECOND POSITION) =	M MOP DRUGS, SUPPLIES, PRESCRIPTION, AUTHORIZATIONS, AND REVIEWS
<b>AND</b> OCCURRENCE/LINE ITEM NUMBER = 002	
<b>THEN</b> NUMBER OF SERVICES ON THIS LINE ITEM MUST = ZERO	
<b>2-175-02R<sup>1</sup></b>	• SURGERY PROCEDURE CODES
	IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO
	<b>AND</b> PROCEDURE CODE = 10000-36399 <b>OR</b> 36800-69999 (SURGERY)
<b>THEN</b> NUMBER OF SERVICES PER PROCEDURE CODE ON A LINE ITEM CANNOT EXCEED 10 PER DAY	
<b>UNLESS</b> 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, <b>OR</b> 17310	
<b>OR</b> ANY OCCURRENCE OF OVERRIDE CODE =	NS CONTRACTOR HAS DETERMINED THE NUMBER OF SERVICES IS MEDICALLY NECESSARY
<b>2-175-03R<sup>1</sup></b>	• E/M PROCEDURE CODES
	IF AMOUNT ALLOWED BY PROCEDURE CODE > ZERO
<b>AND</b> PROCEDURE CODE =	99201-99205 (OFFICE VISITS - NEW PATIENTS) <b>OR</b>
	99211-99215 (OFFICE VISITS - ESTABLISHED PATIENTS) <b>OR</b>
	99217 (DISCHARGE SERVICES) <b>OR</b>
	99221-99233 (HOSPITAL CARE PER DAY) <b>OR</b>
	99234-99236 (OBSERVATION OR INPATIENT CARE SERVICES) <b>OR</b>
	99238-99239 (HOSPITAL DISCHARGE SERVICES) <b>OR</b>
	99241-99245 (OFFICE CONSULTATIONS) <b>OR</b>
	99251-99255 (INITIAL INPATIENT CONSULTATIONS) <b>OR</b>
	99261-99263 (FOLLOW-UP INPATIENT CONSULTATIONS) <b>OR</b>
	99271-99275 (CONFIRMATORY CONSULTATIONS) <b>OR</b>
	99281-99285 (EMERGENCY DEPARTMENT VISIT) <b>OR</b>
<sup>1</sup> EDITS 2-175-02R, 2-175-03R, 2-175-04R, AND 2-175-06R ARE ONLY EXECUTED FOR FILING DATES < 02/01/2010.	
<sup>2</sup> 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.	
<sup>3</sup> TO DETERMINE MAXIMUM NUMBER OF SERVICES REFER TO THE MAXIMUM NUMBER OF SERVICES CODE LIST AT <a href="http://health.mil/military-health-topics/business-support/rates-and-reimbursement">HTTP://HEALTH.MIL/MILITARY-HEALTH-TOPICS/BUSINESS-SUPPORT/RATES-AND-REIMBURSEMENT</a> .	

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Non-Institutional Edit Requirements (ELN 100 - 199)

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



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Non-Institutional Edit Requirements (ELN 100 - 199)

<b>ELEMENT NAME: NUMBER OF SERVICES (2-175) (Continued)</b>		
	P2	OPPS WITH COST OUTLIER <b>OR</b>
	P3	OPPS WITH DISCOUNT <b>OR</b>
	P5	HOSPITAL-BASED PARTIAL HOSPITALIZATION PAID AS OPPS
<b>OR</b> NO OCCURRENCE OF SPECIAL PROCESSING CODE =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b>
	FS	TFL (SECOND PAYOR)
<b>THEN</b> BYPASS THIS EDIT		
<b>ELSE</b> NUMBER OF SERVICES <b>CANNOT</b> EXCEED THE MAXIMUM ALLOWED NUMBER OF SERVICES PER DAY FOR THE PROCEDURE CODE ON THIS LINE ITEM <sup>3</sup> (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)		
<b>UNLESS</b> ANY OCCURRENCE OF OVERRIDE CODE =	NS	CONTRACTOR HAS DETERMINED THAT NUMBER OF SERVICES IS MEDICALLY NECESSARY
<sup>1</sup> EDITS 2-175-02R, 2-175-03R, 2-175-04R, AND 2-175-06R ARE ONLY EXECUTED FOR FILING DATES < 02/01/2010. <sup>2</sup> 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. <sup>3</sup> TO DETERMINE MAXIMUM NUMBER OF SERVICES REFER TO THE MAXIMUM NUMBER OF SERVICES CODE LIST AT <a href="http://health.mil/military-health-topics/business-support/rates-and-reimbursement">HTTP://HEALTH.MIL/MILITARY-HEALTH-TOPICS/BUSINESS-SUPPORT/RATES-AND-REIMBURSEMENT</a> .		

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Non-Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: AMOUNT BILLED BY PROCEDURE CODE (2-180)	
VALIDITY EDITS	
<b>2-180-01V</b>	MUST BE NUMERIC.
<b>2-180-02V</b>	IF CONTRACT NUMBER = MDA906-02-C-0013 (TMOP)
	<b>THEN</b> IF PROCEDURE CODE = 000MN PRESCRIPTION MEDICAL NECESSITY REVIEWS <b>OR</b>
	000PA PRESCRIPTION PRIOR AUTHORIZATIONS
	<b>THEN</b> AMOUNT BILLED BY PROCEDURE CODE MUST > ZERO
	<b>ELSE IF</b> TYPE OF SUBMISSION = C COMPLETE CANCELLATION TO TED RECORD DATA
	<b>OR</b> ADJUSTMENT/DENIAL REASON CODE IS A DENIAL REASON CODE LISTED IN <a href="#">ADDENDUM G, FIGURE 2.G-1</a> FOR THAT OCCURRENCE/LINE ITEM
	<b>THEN</b> AMOUNT BILLED BY PROCEDURE CODE MUST = ZERO
	<b>AND</b> AMOUNT ALLOWED BY PROCEDURE CODE MUST = ZERO
	<b>AND</b> AMOUNT PAID BY OHI MUST = ZERO
	<b>AND</b> AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO
	<b>AND</b> AMOUNT PATIENT COST-SHARE MUST = ZERO
	<b>ELSE IF</b> OCCURRENCE/LINE ITEM NUMBER = 002
	<b>THEN</b> AMOUNT BILLED BY PROCEDURE CODE MUST = ZERO
	<b>ELSE</b> AMOUNT BILLED BY PROCEDURE CODE MUST BE $\geq \$10.20$ AND $\leq \$11.48$
<b>2-180-03V</b>	IF CONTRACT NUMBER = MDA906-02-C-0013 (TMOP)
	<b>AND</b> AMOUNT BILLED BY PROCEDURE CODE = ZERO
	<b>THEN</b> TYPE OF SUBMISSION MUST = C COMPLETE CANCELLATION TO TED RECORD DATA
	<b>OR</b> OCCURRENCE/LINE ITEM NUMBER MUST = 002
	<b>OR</b> ADJUSTMENT/DENIAL REASON CODE MUST BE A DENIAL REASON CODE LISTED IN <a href="#">ADDENDUM G, FIGURE 2.G-1</a> FOR THAT OCCURRENCE/LINE ITEM
RELATIONAL EDITS	
<b>2-180-00R</b>	IF TYPE OF SUBMISSION $\neq$ D COMPLETE DENIAL
	<b>THEN</b> 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)

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

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<b>ELEMENT NAME: AMOUNT ALLOWED BY PROCEDURE CODE (2-185) (Continued)</b>		
	O	ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>
	R	RESUBMISSION
<b>2-185-07R</b>	IF AMOUNT ALLOWED BY PROCEDURE CODE = ZERO	
	<b>THEN</b> AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE MUST = ZERO	
	<b>UNLESS</b> TYPE OF SUBMISSION =	B ADJUSTMENT NON-TED DATA (HCSR) DATA <b>OR</b>
		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 <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 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 <a href="#">SECTION 2.6</a> .	
RELATIONAL EDITS		
2-191-01R	IF OGP TYPE CODE =	V CHAMPVA
	THEN 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 (2-192)	
VALIDITY EDITS	
2-192-01V	MUST BE A VALID OGP BEGIN REASON CODE LISTING IN <a href="#">SECTION 2.6</a> .
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 <b>OR</b>
		I	INITIAL SUBMISSION <b>OR</b>
		O	ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>
		R	RESUBMISSION
THEN AMOUNT APPLIED TOWARD DEDUCTIBLE MUST BE ≥ ZERO			
2-195-02R	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION <b>OR</b>
		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 -

