

## Chapter 2

## Section 5.2

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

Revision: C-28, August 28, 2019

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>	

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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. 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 <math>\geq</math> 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 $\geq$ 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>1-110-12R</b>	IF BEGIN DATE OF CARE IS $\geq$ 01/01/2018	
<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 $\geq$ 10/01/2001 <b>OR</b>
	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE $\geq$ 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 $\geq$ 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 <b>OR</b>
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE <b>OR</b>
	412	TRS SURVIVOR NEW FAMILY COVERAGE <b>OR</b>
	413	TRS MEMBER-ONLY COVERAGE <b>OR</b>
	414	TRS MEMBER AND FAMILY COVERAGE <b>OR</b>
	418	TRICARE RETIRED RESERVE (TRR) MEMBER-ONLY COVERAGE <b>OR</b>
	419	TRR MEMBER AND FAMILY COVERAGE <b>OR</b>
	420	TRR SURVIVOR INDIVIDUAL COVERAGE <b>OR</b>
	421	TRR SURVIVOR FAMILY COVERAGE
<b>THEN ENROLLMENT/HEALTH PLAN CODE 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/ NETWORK <b>OR</b>
	MS	MEDICARE/TRICARE DUAL ELIGIBLE UNDER 65/NON 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 =	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>
	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>

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<b>ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111) (Continued)</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>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 $\neq$	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, 0023, <b>OR</b> 0024			
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			
1-130-01V	MUST BE NUMERIC.		
RELATIONAL EDITS			
1-130-01R	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
	<b>THEN</b> AMOUNT OF OTHER HEALTH INSURANCE MUST BE ≥ ZERO		
1-130-03R	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)		

ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) TYPE CODE (1-131)		
VALIDITY EDITS		
1-131-01V	MUST BE A VALID OGP TYPE CODE LISTING IN <a href="#">SECTION 2.6</a> .	
RELATIONAL EDITS		
1-131-01R	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 (1-132)	
VALIDITY EDITS	
1-132-01V	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 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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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 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		
1-145-02R	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 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 REPOSNSIBLE FOR ANY INTEREST) (EFFECTIVE DATE 07/09/2019) OR
		G 10 USC 1095c(a)(2) INTEREST PAYMENT (THE GOVERNMENT IS FISCALLY REPOSNSIBLE FOR ANY INTEREST) (EFFECTIVE DATE 07/09/2019)
1-145-04R	IF TYPE OF SUBMISSION =	C COMPLETE CANCELLATION OR
		D COMPLETE DENIAL
THEN AMOUNT INTEREST PAYMENT MUST BE = ZERO		
1-145-05R	IF TRANSACTION RECORD AMOUNT INTEREST PAYMENT < ZERO AND REASON FOR INTEREST PAYMENT =	F 10 USC 1095c(a)(2) INTEREST PAYMENT (THE CONTRACTOR IS FISCALLY REPOSNSIBLE FOR ANY INTEREST) (EFFECTIVE DATE 07/09/2019) OR
		G 10 USC 1095c(a)(2) INTEREST PAYMENT (THE GOVERNMENT IS FISCALLY REPOSNSIBLE 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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Institutional Edit Requirements (ELN 100 - 199)

ELEMENT NAME: REASON FOR INTEREST PAYMENT (1-150)		
VALIDITY EDITS		
1-150-01V	MUST BE A VALID REASON FOR INTEREST PAYMENT CODE (BASED ON BEGIN DATE OF CARE) (REFER TO SECTION 2.8).	
	AND THE BEGIN DATE OF CARE MUST BE ON OR AFTER THE CARE EFFECTIVE DATE AND ON OR BEFORE THE CARE TERMINATION DATE	
RELATIONAL EDITS		
1-150-01R	IF TRANSACTION RECORD REASON FOR INTEREST PAYMENT =	A CLAIMS PENDED AT GOVERNMENT DIRECTION (TERMINATED 07/08/2019) OR
		B CLAIMS REQUIRING GOVERNMENT INTERVENTION 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 REPOSNSIBLE FOR ANY INTEREST) (EFFECTIVE DATE 07/09/2019) OR
		G 10 USC 1095c(a)(2) INTEREST PAYMENT (THE GOVERNMENT IS FISCALLY REPOSNSIBLE FOR ANY INTEREST) (EFFECTIVE 07/09/2019)
THEN TRANSACTION RECORD 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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<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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Institutional Edit Requirements (ELN 100 - 199)

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/ 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/ 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 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/ 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/ 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 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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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
	THEN 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
	THEN 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
	THEN 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
	THEN BEGIN DATE OF CARE MUST BE < 12/31/2002		
1-185-14V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	ST	SPECIALIZED TREATMENT
	THEN 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
	THEN 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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<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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<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 <math>\geq</math> 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 $\geq$ 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 $\neq$	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>
	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>
<sup>1</sup> PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.		

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<b>ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (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>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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<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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<b>ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued)</b>		
	GT	TRICARE SELECT - GUARD/RESERVE TRANSITIONAL SURVIVORS
<b>AND</b> PATIENT ZIP CODE MUST =	PHL	PHILIPPINES
<b>AND</b> PROVIDER STATE <b>OR</b> COUNTRY CODE MUST =	PHL	PHILIPPINES
<b>1-185-52R</b>	IF BEGIN DATE OF CARE IS ≥ 01/01/2018	
<b>AND</b> 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 <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
<b>THEN</b> ENROLLMENT/HEALTH PLAN CODE MUST =	U	TRICARE PRIME, CIVILIAN CARE <b>OR</b>
	Z	TRICARE PRIME, MTF/eMSM/PCM <b>OR</b>
	ME	MEDICARE/TRICARE DUAL ELIGIBLE UNDER 65/ NETWORK <b>OR</b>
	MS	MEDICARE/TRICARE DUAL ELIGIBLE UNDER 65/NON-NETWORK <b>OR</b>
	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.		

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

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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 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 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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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		
OR 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
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	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
THEN 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 -

