

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 OR |
| | | M | MALE OR |
| | | Z | UNKNOWN |
| RELATIONAL EDITS | | | |
| NONE | | | |

| ELEMENT NAME: PATIENT ZIP CODE (1-105) | |
|--|--|
| VALIDITY EDITS | |
| 1-105-01V | MUST BE NINE DIGITS OR FIVE DIGITS WITH FOUR BLANKS |
| | MUST BE A VALID ZIP CODE (BASED ON ADMISSION DATE) IN THE GOVERNMENT PROVIDED ELECTRONIC ZIP CODE FILE OR |
| | MUST BE A THREE CHARACTER FOREIGN COUNTRY CODE (BASED ON THE COUNTRY CODES TABLE ¹) FOLLOWED BY SIX BLANKS |
| RELATIONAL EDITS | |
| NONE | |
| ¹ WHEN FOREIGN COUNTRY CODES ARE SUBMITTED, THE FIRST THREE CHARACTERS WILL BE EDITED AGAINST ADDENDUM 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 SECTION 2.5). | | |
| RELATIONAL EDITS | | |
| 1-110-02R | IF ENROLLMENT/HEALTH PLAN CODE = | Y CHCBP - NON-NETWORK OR |
| | | AA CHCBP - NETWORK |
| | THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE CAN = | CL CLINICAL TRIALS OR |
| | | PF ECHO |
| 1-110-06R | IF ENROLLMENT/HEALTH PLAN CODE = | SN SHCP - NON-MTF/eMSM-REFERRED CARE OR |
| | | SO SHCP - NON-TRICARE ELIGIBLE OR |
| | | SR SHCP - MTF/eMSM REFERRED CARE OR |
| | | ST SHCP - TRICARE ELIGIBLE |
| | 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 |
| | | CE SHCP - CCEP OR |
| | | SC SHCP - NON-TRICARE ELIGIBLE OR |
| | | SE SHCP - TRICARE ELIGIBLE OR |
| | | 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 OR |
| | | FS TFL - NON-NETWORK |
| | AND TYPE OF INSTITUTION ≠ | 10 GENERAL MEDICAL AND SURGICAL |
| | THEN BEGIN DATE OF CARE MUST BE ≥ 10/01/2001 | |
| | AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | FF TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) OR |
| | | FG TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) OR |
| | | FS TFL (SECOND PAYOR) |
| | ELSE IF BEGIN DATE OF CARE IS < 10/01/2001 | |
| | THEN 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, 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 | |

¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.

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| ELEMENT NAME: ENROLLMENT/HEALTH PLAN CODE (1-110) (Continued) | | |
|--|--|---|
| | 30 | PAYMENT ADJUSTED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY, SPEND DOWN, WAITING OR RESIDENCY REQUIREMENTS O |
| | 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 NEWBORN 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 |
| 1-110-10R | <ul style="list-style-type: none"> TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE \geq 10/01/2001 UNLESS THE BENEFICIARY IS AN INPATIENT AND THE ADMISSION DATE WAS PRIOR TO 10/01/2001, TFL WILL PAY FOR THE ENTIRE HOSPITAL STAY. | |
| IF ENROLLMENT/HEALTH PLAN CODE = | FE | TFL - NETWORK OR |
| | FS | TFL - NON-NETWORK |
| AND TYPE OF INSTITUTION = | 10 | GENERAL MEDICAL AND SURGICAL |
| THEN END DATE OF CARE \geq 10/01/2001 | | |
| AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | FF | TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) OR |
| | FG | TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) OR |
| | FS | TFL (SECOND PAYOR) |
| 1-110-12R | IF BEGIN DATE OF CARE IS \geq 01/01/2018 | |
| AND ENROLLMENT/HEALTH PLAN CODE = | ME | MEDICARE/TRICARE DUAL ELIGIBLE UNDER 65/ NETWORK OR |
| | MS | MEDICARE/TRICARE DUAL ELIGIBLE UNDER 65/NON-NETWORK |
| THEN 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 OR |
| | T | MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE \geq 10/01/2001 OR |
| | RS | MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) AND BEGIN DATE OF CARE \geq 10/01/2001 |
| ¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE. | | |

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| ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111) | | |
|---|--|---|
| VALIDITY EDITS | | |
| 1-111-01V | MUST BE A VALID HCDP PLAN COVERAGE CODE LISTED IN ADDENDUM L . | |
| 1-111-02V | IF FILING DATE ≥ 09/01/2007 | |
| AND HCDP PLAN COVERAGE CODE = | 109 | TRICARE USFHP DIRECT CARE COVERAGE FOR ADFMs OR |
| | 114 | TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR |
| | 115 | TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR |
| | 118 | TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR RETIRED SPONSORS AND FAMILY MEMBERS OR |
| | 119 | TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR RETIRED SPONSORS AND FAMILY MEMBERS OR |
| | 133 | TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR |
| | 138 | TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR |
| | 139 | TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR |
| | 316 | USFHP PRIME - SPONSOR AND FAMILY MEMBERS (PRESENTATION ONLY) |
| THEN AMOUNT ALLOWED (TOTAL) MUST = ZERO | | |
| RELATIONAL EDITS | | |
| 1-111-01R | IF HCDP PLAN COVERAGE CODE = | 306 TRICARE SELECT - RESERVE SELECT SPONSORS AND FAMILY MEMBERS OR |
| | | 307 TRICARE SELECT - RETIRED RESERVE SPONSORS AND FAMILY MEMBERS OR |
| | | 401 TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR |
| | | 402 TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR |
| | | 405 TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR |
| | | 406 TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR |
| | | 407 TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR |
| | | 408 TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR |
| | | 409 TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR |

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| ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111) (Continued) | | |
|---|-----|---|
| | 410 | TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR |
| | 411 | TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR |
| | 412 | TRS SURVIVOR NEW FAMILY COVERAGE OR |
| | 413 | TRS MEMBER-ONLY COVERAGE OR |
| | 414 | TRS MEMBER AND FAMILY COVERAGE OR |
| | 418 | TRICARE RETIRED RESERVE (TRR) MEMBER-ONLY COVERAGE OR |
| | 419 | TRR MEMBER AND FAMILY COVERAGE OR |
| | 420 | TRR SURVIVOR INDIVIDUAL COVERAGE OR |
| | 421 | TRR SURVIVOR FAMILY COVERAGE |
| THEN ENROLLMENT/HEALTH PLAN CODE MUST = | T | TRICARE STANDARD OR |
| | V | TRICARE EXTRA OR |
| | FE | TFL - NETWORK OR |
| | FS | TFL - NON-NETWORK OR |
| | ME | MEDICARE/TRICARE DUAL ELIGIBLE UNDER 65/ NETWORK OR |
| | MS | MEDICARE/TRICARE DUAL ELIGIBLE UNDER 65/NON NETWORK OR |
| | PS | TSRx OR |
| | SR | SHCP - MTF/eMSM REFERRED CARE |
| | TV | TRICARE SELECT |
| 1-111-02R IF HCDP PLAN COVERAGE CODE = | 305 | TRICARE SELECT - RETIRED SPONSORS AND FAMILY MEMBERS OR |
| | 306 | TRICARE SELECT - RESERVE SELECT SPONSORS AND FAMILY MEMBERS OR |
| | 307 | TRICARE SELECT - RETIRED RESERVE SPONSORS AND FAMILY MEMBERS OR |
| | 401 | TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR |
| | 402 | TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR |
| | 405 | TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR |
| | 406 | TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR |
| | 407 | TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR |
| | 408 | TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR |
| | 409 | TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR |
| | 410 | TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR |

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| ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111) (Continued) | | |
|---|-----|--|
| | 411 | TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR |
| | 412 | TRS SURVIVOR NEW FAMILY COVERAGE OR |
| | 413 | TRS MEMBER-ONLY COVERAGE OR |
| | 414 | TRS MEMBER AND FAMILY COVERAGE OR |
| | 418 | TRR MEMBER-ONLY COVERAGE OR |
| | 419 | TRR MEMBER AND FAMILY COVERAGE OR |
| | 420 | TRR SURVIVOR INDIVIDUAL COVERAGE OR |
| | 421 | TRR SURVIVOR FAMILY COVERAGE |
| THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE CAN = | PF | ECHO |
| 1-111-03R IF HCDP PLAN COVERAGE CODE = | 417 | TCSRC |
| THEN ENROLLMENT/HEALTH PLAN CODE MUST = | X | FOREIGN SERVICE MEMBER OR |
| | SR | SHCP - MTF/eMSM REFERRED CARE |

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

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| ELEMENT NAME: PCM LOCATION DMIS-ID (ENROLLMENT) CODE (1-115) | | |
|---|--|--|
| VALIDITY EDITS | | |
| 1-115-01V | MUST BE A VALID FOUR DIGIT PCM LOCATION DMIS-ID. | |
| 1-115-03V | 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 |
| | 0197 | CHRISTUS HEALTH/ST MARY'S OR |
| | 0198 | MARTIN'S POINT HEALTH CARE OR |
| | 0199 | FAIRVIEW HEALTH SYSTEM |
| THEN AMOUNT ALLOWED (TOTAL) MUST = ZERO | | |
| RELATIONAL EDITS | | |
| 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 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 BILLED (TOTAL) MUST BE > ZERO | | |
| UNLESS ANY OCCURRENCE/LINE ITEM REVENUE CODE = 0022, 0023, OR 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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Institutional Edit Requirements (ELN 100 - 199)

| 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 OR |
| | | 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 ADDENDUM G, FIGURE 2.G-1 OR FIGURE 2.G-2 . | | |
| 1-125-02R | IF ALL DETAIL ADJUSTMENT/DENIAL REASON CODES CONTAIN A DENIAL CODE (REFER TO ADDENDUM G, FIGURE 2.G-1 OR FIGURE 2.G-2). | |
| | AND TYPE OF SUBMISSION = | B ADJUSTMENT NON-TED RECORD (HCSR) DATA OR |
| | | 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 OR |
| | | I INITIAL SUBMISSION OR |
| | | O ZERO PAYMENT WITH 100% OHI/TPL OR |
| | | 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 OR |
| | | 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 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 OF OTHER HEALTH INSURANCE MUST BE ≥ ZERO | |
| 1-130-03R | IF AMOUNT PAID BY OTHER HEALTH INSURANCE > ZERO | |
| | AND AMOUNT ALLOWED (TOTAL) > ZERO | |
| | AND AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) = ZERO | |
| | AND DATE ADJUSTMENT IDENTIFIER = ZEROES | |
| | THEN TYPE OF SUBMISSION MUST = | O ZERO PAYMENT TED RECORD DUE TO 100% OHI |
| | UNLESS 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 SECTION 2.6 . | |
| RELATIONAL EDITS | | |
| 1-131-01R | 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 (1-132) | |
|--|--|
| VALIDITY EDITS | |
| 1-132-01V | MUST BE A VALID OGP BEGIN REASON CODE LISTING IN SECTION 2.6 . |
| 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 OR |
| | | I | INITIAL SUBMISSION OR |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL OR |
| | | R | RESUBMISSION |
| THEN AMOUNT PATIENT COST-SHARE MUST BE ≥ ZERO | | | |
| 1-135-02R | IF TYPE OF SUBMISSION = | C | COMPLETE CANCELLATION OR |
| | | 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 SECTION 2.5 . |
| 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 OR |
| | | I | INITIAL SUBMISSION OR |
| | | R | RESUBMISSION |
| THEN AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) MUST BE ≥ ZERO | | | |
| 1-140-02R | IF TYPE OF SUBMISSION = | C | COMPLETE CANCELLATION OR |
| | | D | COMPLETE DENIAL OR |
| | | 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 ¹ | | |
| ¹ 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 (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 REPONSIBLE FOR ANY INTEREST) (EFFECTIVE DATE 07/09/2019) OR |
| | | G 10 USC 1095c(a)(2) INTEREST PAYMENT (THE GOVERNMENT IS FISCALLY REPONSIBLE FOR ANY INTEREST) (EFFECTIVE 07/09/2019) |
| THEN TRANSACTION RECORD AMOUNT INTEREST PAYMENT MUST ≠ ZERO | | |

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Chapter 2, Section 5.2

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 SECTION 2.6). | | |
| 1-160-02V | OCCURRENCE NUMBER 2--MUST BE A VALID OVERRIDE CODE (REFER TO SECTION 2.6). | | |
| 1-160-03V | OCCURRENCE NUMBER 3--MUST BE A VALID OVERRIDE CODE (REFER TO SECTION 2.6). | | |
| 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 OR |
| | | AN | SHCP - NON-MTF/eMSM-REFERRED CARE OR |
| | | AR | SHCP - MTF/eMSM REFERRED CARE OR |
| | | CE | SHCP - CCEP OR |
| | | EU | EMERGENCY SERVICES RENDERED BY AN UNAUTHORIZED PROVIDER 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 MUST = | SN | SHCP - NON-MTF/eMSM-REFERRED CARE OR |
| | | SR | SHCP - MTF/eMSM REFERRED CARE |

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Chapter 2, Section 5.2

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 OR |
| | | E | COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA |
| | THEN ADJUSTMENT KEY CANNOT = | 0 | BATCH OR |
| | | 5 | VOUCHER |
| 1-165-03V | 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 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 OF NON-TED RECORD (HCSR) DATA |
| | UNLESS THE RECORD HAS PROVISIONAL ERRORS | | |
| 1-165-04V | 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 | | | |
| 1-165-01R | IF TYPE OF SUBMISSION = | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | THEN THE AMOUNT OF OHI MUST BE > ZERO | | |
| | AND AMOUNT ALLOWED (TOTAL) MUST BE > ZERO | | |
| | AND 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 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 |
| 1-165-04R | IF BATCH/VOUCHER RESUBMISSION NUMBER = ZERO FOR THIS BATCH OR VOUCHER | | |
| | THEN TYPE OF SUBMISSION MUST ≠ | R | RESUBMISSION |
| 1-165-05R | IF BATCH/VOUCHER RESUBMISSION NUMBER > ZERO FOR THIS BATCH OR VOUCHER | | |
| | THEN TYPE OF SUBMISSION MUST BE ≠ | I | INITIAL TED RECORD SUBMISSION |
| 1-165-06R | IF TYPE OF SUBMISSION = | I | INITIAL SUBMISSION OR |
| | | R | RESUBMISSION |
| | AND TYPE OF INSTITUTION ≠ | 70 | HHA OR |
| | | 71 | SNF |

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Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: TYPE OF SUBMISSION (1-165) (Continued) | | |
|--|----|---|
| AND SPECIAL PROCESSING CODE ≠ | 11 | HOSPICE |
| THEN AMOUNT BILLED (TOTAL), AMOUNT ALLOWED (TOTAL), COVERED DAYS, AND TOTAL CHARGE BY REVENUE CODE MUST BE > 0. | | |
| 1-165-07R 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 | | |

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Chapter 2, Section 5.2

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 OR |
| | | 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, 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 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 NOT BLANK | | |
| THEN CA/NAS NUMBER MUST = BLANK | | | |
| 1-170-03R | IF CA/NAS EXCEPTION REASON = BLANK | | |
| | AND PRINCIPAL TREATMENT DIAGNOSIS/ POA INDICATOR (POSITIONS 1-7) = 290-316 (MENTAL HEALTH, ICD-9-CM) | | |
| | AND PATIENT ZIP CODE IS IN AN MTF/eMSM ² CATCHMENT AREA ¹ | | |
| | AND BEGIN DATE OF CARE IS < 03/28/2013 | | |
| THEN CA/NAS NUMBER MUST BE CODED | | | |
| | UNLESS 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 | | | |
| 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 REASON FOR ISSUANCE (1-175) | |
|---|--|
| VALIDITY EDITS | |
| 1-175-01V | IF BEGIN DATE OF CARE ≥ 03/28/2013 |
| | THEN CA/NAS REASON FOR ISSUANCE MUST BE BLANK |
| | ELSE VALUE MUST BE A VALID CA/NAS REASON OF ISSUANCE OR BLANK. |
| RELATIONAL EDITS | |
| 1-175-02R | IF CA/NAS NUMBER IS BLANK |
| | THEN 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 SECTION 2.4). | | |
| 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 ² CATCHMENT AREA ¹ | | | |
| | 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 ² CATCHMENT AREA ¹ | | | |
| | 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 | |

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

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Chapter 2, Section 5.2

Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) | | | |
|--|---|----|---|
| VALIDITY EDITS | | | |
| 1-185-01V | OCCURRENCE NUMBER 1--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8). | | |
| 1-185-02V | OCCURRENCE NUMBER 2--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8). | | |
| 1-185-03V | OCCURRENCE NUMBER 3--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8). | | |
| 1-185-04V | OCCURRENCE NUMBER 4--MUST BE A VALID SPECIAL PROCESSING CODE (REFER TO SECTION 2.8). | | |
| 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 OR |
| | | 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 OR |
| | | 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 OR |
| | | 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) OR |
| | | Z | TRICARE PRIME, MTF/eMSM/PCM OR |
| | | WF | TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE SERVICE MEMBER OR |
| | | XF | FOREIGN ADFM |
| 1-185-14R | IF 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 |
| | | SC | SHCP - NON-TRICARE ELIGIBLE OR |
| | | SE | SHCP - TRICARE ELIGIBLE OR |
| | | SM | SHCP - EMERGENCY |
| ¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES. | | | |

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Institutional Edit Requirements (ELN 100 - 199)

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

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Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued) | | |
|--|--|--|
| | 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 |
| 1-185-35R | <ul style="list-style-type: none"> TFL CLAIMS: THE BEGIN DATE OF CARE MUST BE \geq 10/01/2001 UNLESS THE BENEFICIARY IS AN INPATIENT AND THE ADMISSION DATE WAS PRIOR TO 10/01/2001, TFL WILL PAY FOR THE ENTIRE HOSPITAL STAY. | |
| IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | FF | TFL (FIRST PAYOR-NOT A MEDICARE BENEFIT) OR |
| | FG | TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) OR |
| | FS | TFL (SECOND PAYOR) |
| AND TYPE OF INSTITUTION = | 10 | GENERAL MEDICAL AND SURGICAL |
| THEN END DATE OF CARE MUST BE \geq 10/01/2001 | | |
| AND ENROLLMENT/HEALTH PLAN CODE MUST = | FE | TFL - NETWORK OR |
| | FS | TFL - NON-NETWORK |
| 1-185-39R | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | |
| | PF | ECHO |
| THEN HCDP PLAN COVERAGE CODE MUST \neq | 305 | TRICARE SELECT - RETIRED SPONSORS AND FAMILY MEMBERS OR |
| | 306 | TRICARE SELECT - RESERVE SELECT SPONSORS AND FAMILY MEMBERS OR |
| | 307 | TRICARE SELECT - RETIRED RESERVE SPONSORS AND FAMILY MEMBERS OR |
| | 401 | TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR |
| | 402 | TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR |
| | 405 | TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR |
| | 406 | TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR |
| | 407 | TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR |
| | 408 | TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR |
| | 409 | TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR |
| | 410 | TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR |
| | 411 | TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR |
| | 412 | TRS SURVIVOR NEW FAMILY COVERAGE OR |
| ¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES. | | |

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| ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued) | | |
|--|--|--|
| | 413 | TRS MEMBER-ONLY COVERAGE OR |
| | 414 | TRS MEMBER AND FAMILY COVERAGE OR |
| | 418 | TRR MEMBER-ONLY COVERAGE OR |
| | 419 | TRR MEMBER AND FAMILY COVERAGE OR |
| | 420 | TRR SURVIVOR INDIVIDUAL COVERAGE OR |
| | 421 | TRR SURVIVOR FAMILY COVERAGE |
| 1-185-49R | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | |
| | AU | AUTISM DEMONSTRATION |
| | THEN BEGIN DATE OF CARE MUST BE ≥ 03/15/2008 | |
| | AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | |
| | PF | ECHO |
| | AND PATIENT AGE ¹ MUST BE ≥ 18 MONTHS | |
| 1-185-50R | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | |
| | 49 | HOSPITAL REIMBURSEMENT REDUCED BY MANUFACTURER CREDIT/REPLACEMENT OF DEVICE DURING WARRANTY PERIOD OR |
| | 50 | HOSPITAL REIMBURSEMENT REDUCED BY MANUFACTURER CREDIT/RECALLED DEVICE |
| | THEN DRG NUMBER MUST EQUAL A DRG SUBJECT TO THE REPLACEMENT DEVICE POLICY POSTED ON TRICARE'S DRG WEB PAGE AT HTTP://WWW.HEALTH.MIL/DRG . | |
| | AND IF END DATE OF CARE < 10/01/2014 | |
| | THEN 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 HTTP://WWW.HEALTH.MIL/DRG . | |
| | ELSE END DATE OF CARE MUST BE ≥ THE DRG EFFECTIVE DATE AND ≤ THE DRG TERMINATION DATE | |
| 1-185-51R | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | |
| | PH | PHILIPPINES DEMONSTRATION PROJECT |
| | THEN BEGIN DATE OF CARE MUST BE ≥ 01/01/2013 | |
| | AND HCDP PLAN COVERAGE CODE MUST = | |
| | 003 | TRICARE STANDARD FOR ADFMs OR |
| | 005 | TRICARE STANDARD SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR |
| | 007 | TRICARE STANDARD TRANSITIONAL ASSISTANCE SPONSORS AND FAMILY MEMBERS OR |
| | 009 | TRICARE STANDARD RETIRED AND MOH SPONSORS AND FAMILY MEMBERS OR |
| | 010 | TRICARE STANDARD TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR |
| | 015 | TRICARE STANDARD TRANSITIONAL SURVIVORS OF NG/RESERVE DECEASED SPONSORS OR |
| | 017 | TRICARE STANDARD SURVIVORS OF NG/RESERVE DECEASED SPONSORS OR |
| | 018 | TFL RETIRED SPONSORS AND FAMILY MEMBERS AND MOH OR |
| ¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES. | | |

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| ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued) | | |
|--|-----|--|
| | 020 | TFL TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR |
| | 021 | TFL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR |
| | 022 | TFL TRANSITIONAL SURVIVORS OF NG/RESERVE DECEASED SPONSORS OR |
| | 023 | TFL SURVIVORS OF NG/RESERVE DECEASED SPONSORS OR |
| | 028 | TRICARE STANDARD FOR MEDICALLY RETIRED SPONSORS AND FAMILY MEMBERS OR |
| | 029 | TFL FOR MEDICALLY RETIRED SPONSORS AND FAMILY MEMBERS OR |
| | 303 | TRICARE SELECT - ADFMs OR |
| | 304 | TRICARE SELECT - TAMP SPONSORS AND FAMILY MEMBERS OR |
| | 305 | TRICARE SELECT - RETIRED SPONSORS AND FAMILY MEMBERS OR |
| | 306 | TRICARE SELECT - RESERVE SELECT SPONSORS AND FAMILY MEMBERS OR |
| | 307 | TRICARE SELECT - RETIRED RESERVE SPONSORS AND FAMILY MEMBERS OR |
| | 308 | TRICARE SELECT - YOUNG ADULT OR |
| | 409 | TRS SURVIVOR CONTINUING INDIVIDUAL COVERAGE OR |
| | 410 | TRS SURVIVOR CONTINUING FAMILY COVERAGE OR |
| | 411 | TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR |
| | 412 | TRS SURVIVOR NEW FAMILY COVERAGE OR |
| | 413 | TRS MEMBER-ONLY COVERAGE OR |
| | 414 | TRS MEMBER AND FAMILY COVERAGE OR |
| | 418 | TRR MEMBER-ONLY COVERAGE OR |
| | 419 | TRR MEMBER AND FAMILY COVERAGE OR |
| | 420 | TRR SURVIVOR INDIVIDUAL COVERAGE OR |
| | 421 | TRR SURVIVOR FAMILY COVERAGE OR |
| | 422 | TYA STANDARD FOR ADFMs OR |
| | 423 | TYA STANDARD FOR RETIRED AND MOH FAMILY MEMBERS OR |
| | 424 | TYA RESERVE SELECT OR |
| | 425 | TYA RETIRED RESERVE OR |
| | 999 | UNVERIFIED NEWBORN |
| OR ENROLLMENT/HEALTH PLAN CODE = | AS | TRICARE SELECT - ACTIVE DUTY SURVIVORS OR |
| | AT | TRICARE SELECT - ACTIVE DUTY TRANSITIONAL SURVIVORS OR |
| | GS | TRICARE SELECT - GUARD/RESERVE SURVIVORS OR |
| ¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES. | | |

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Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (Continued) | | |
|--|---------------------------------------|--|
| | GT | TRICARE SELECT - GUARD/RESERVE TRANSITIONAL SURVIVORS |
| AND PATIENT ZIP CODE MUST = | PHL | PHILIPPINES |
| AND PROVIDER STATE OR COUNTRY CODE MUST = | PHL | PHILIPPINES |
| 1-185-52R | IF BEGIN DATE OF CARE IS ≥ 01/01/2018 | |
| AND ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | R | MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NOT A MEDICARE BENEFIT) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR |
| | T | MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR |
| | RS | MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) AND BEGIN DATE OF CARE ≥ 10/01/2001 |
| THEN ENROLLMENT/HEALTH PLAN CODE MUST = | U | TRICARE PRIME, CIVILIAN CARE OR |
| | Z | TRICARE PRIME, MTF/eMSM/PCM OR |
| | ME | MEDICARE/TRICARE DUAL ELIGIBLE UNDER 65/ NETWORK OR |
| | MS | MEDICARE/TRICARE DUAL ELIGIBLE UNDER 65/NON-NETWORK OR |
| | WF | TPR FOR ENROLLMENT ADFM RESIDING WITH A TPR ELIGIBLE SERVICE MEMBER |
| ¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES. | | |

| ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) SPECIAL ENTITLEMENT CODE (1-186) | |
|---|--|
| VALIDITY EDITS | |
| 1-186-01V | MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE (REFER TO SECTION 2.5). |
| RELATIONAL EDITS | |
| NONE | |

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Institutional Edit Requirements (ELN 100 - 199)

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

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Institutional Edit Requirements (ELN 100 - 199)

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

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Institutional Edit Requirements (ELN 100 - 199)

| ELEMENT NAME: PROVIDER STATE OR COUNTRY CODE (1-195) | | |
|---|--|--|
| VALIDITY EDITS | | |
| 1-195-01V | VALUE MUST BE A VALID STATE OR COUNTRY CODE (REFER TO ADDENDUMS A OR B). | |
| RELATIONAL EDITS | | |
| 1-195-01R | PROVIDER STATE/COUNTRY CODE MUST MATCH THE CORRESPONDING RECORD ¹ IN THE PROVIDER FILE. | |
| UNLESS AMOUNT ALLOWED (TOTAL) ≤ ZERO | | |
| OR ADJUSTMENT/DENIAL REASON CODE = | 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 |
| | T | MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 |
| | FG | TFL (FIRST PAYOR - NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) 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 FOR MATCH ON PROVIDER FILE | | |
| ¹ “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 -

