Chapter 2 Addendum M

Data Requirements - Default Values For Complete Claims Denials

Revision: C-21, January 31, 2019

The values used as defaults can be used only on complete claim denials and only when the appropriate value is not available from the claim and/or supporting documents, history, provider file, or other available resources. Thus, the defaults are element-specific and are not to be used as a "blanket" approach for complete claim denials, edits are in place to ensure appropriate reporting of defaults.

The following is arranged in alphabetical order, with those elements that are common to both Institutional and Non-Institutional addressed first, then the Institutional-specific elements followed by the Non-Institutional-specific elements. Where **N/D** (No Default) appears, the TRICARE Encounter Data (TED) must be reported in accordance with current requirements. Wherever a group level element is listed, the value shown applies to all subordinate elements unless shown separately.

FIGURE 2.M-1 COMMON ELEMENTS

ELEMENT NAME	DEFAULT VALUE
Adjustment Sequence Number	000
Adjustment/Denial Reason Code	N/D
Administrative CLIN	N/D
AGR Legal Authority Code	Z
Amount Interest Payment	Zeroes
Amount Network Provider Discount	Zeroes
Amount Paid By Other Health Insurance	Zeroes
Amount Patient Cost-share	Zeroes
Begin Date Of Care	N/D
CA/NAS Exception Reason	N/D
CA/NAS Number	N/D
CA/NAS Reason For Issuance	N/D
Claim Form Type/EMC Indicator	N/D
Date Adjustment Identified	N/D
Date Ted Record Processed To Completion	N/D
DEERS Identifier (Patient)	Zeroes

* Prior to October 1, 2015.
** On or after October 1, 2015.

FIGURE 2.M-1 COMMON ELEMENTS (CONTINUED)

ELEMENT NAME	DEFAULT VALUE
End Date Of Care	N/D
Enrollment/Health Plan Code	N/D
Health Care Coverage Copayment Factor Code	Z
Health Care Coverage Member Category Code	Z
Health Care Coverage Member Relationship Code	Z
Health Care Delivery Program Plan Coverage Code	000
Health Care Delivery Program Special Entitlement Code	00
Occurrence/Line Item Number	N/D
Other Government Program Begin Reason Code	W
Other Government Program Type Code	N
Override Code	N/D
Patient Identifier (DoD)	Zeroes
Patient Zip Code	N/D
Pay Grade Code (Sponsor)	00
Pay Plan Code (Sponsor)	ZZ
PCM Location DMIS-ID (Enrollment) Code	N/D
Person Birth Calendar Date (Patient)	19111111
Person Cadency Name (Patient)	Blanks
Person First Name (Patient)	Blanks
Person Identifier (Patient)	Zeroes
Person Identifier (Sponsor)	N/D
Person Identifier Type Code (Patient)	Z
Person Identifier Type Code (Sponsor)	Z
Person Last Name (Patient)	N/D
Person Middle Name (Patient)	Blanks
Person Sex (Patient)	Z
Pricing Rate Code	Blanks
Principal Treatment Diagnosis	7999* R69**
Provider Group NPI Number (Reserved)	Reserved
Provider Individual NPI Number (Reserved)	Reserved
Provider Network Status Indicator	N/D
Provider Participation Indicator	N/D
Provider State Or Country Code	N/D
Provider Sub-Identifier	N/D
Provider Taxpayer Number	N/D
Provider Zip Code	N/D
Reason For Interest Payment	Blanks
Record Type Indicator	N/D

* Prior to October 1, 2015.
** On or after October 1, 2015.

FIGURE 2.M-1 COMMON ELEMENTS (CONTINUED)

ELEMENT NAME	DEFAULT VALUE
Region Indicator	N/D
Secondary Treatment Diagnosis	N/D
Service Branch Classification Code (Sponsor)	Z
Special Processing Code	N/D
TED Record Indicator	N/D
Total Occurrence/Line Item Count	N/D
Type Of Submission	D

* Prior to October 1, 2015.
** On or after October 1, 2015.

FIGURE 2.M-2 INSTITUTIONAL-SPECIFIC ELEMENTS

ELEMENT NAME	DEFAULT VALUE
Admission Date	Report same date as Begin Date of Care
Admission Diagnosis	7999* R69**
Amount Allowed (Total)	Zeroes
Amount Billed (Total)	N/D
Amount Paid By Government Contractor (Total)	Zeroes
Covered Days	Zeroes
DRG Number	Zeroes
Frequency Code	1 (N/D on DRG interim billing)
Patient Status	01 (N/D on DRG interim billing)
Principal Op/Nonsurgical Procedure Code	Blanks
Revenue Code	N/D
Secondary Op/Nonsurgical Procedure Code	Blanks
SNF HIPPS Code	N/D
Sole Community Hospital DRG Calculation	Zeroes
Sole Community Hospital DRG Number	Blanks
Point of Origin	9
Total Charge by Revenue Code	N/D
Type of Admission	3
Type of Institution	N/D
Units of Service by Revenue Code	0000000001

* Prior to October 1, 2015.
** On or after October 1, 2015.

FIGURE 2.M-3 NON-INSTITUTIONAL-SPECIFIC ELEMENTS

ELEMENT NAME	DEFAULT VALUE
Amount Allowed By Procedure Code	Zeroes
Amount Applied Toward Deductible	Zeroes
Amount Billed By Procedure Code	N/D
Amount Paid By Government Contractor By Procedure Code	Zeroes
DEERS Dependent Suffix	75
National Drug Code	Blanks
Number of Services	001
Physician Referral Number	Blanks
Place of Service	99
Procedure Code	See *NOTE
Procedure Code Modifier	N/D
Provider Specialty	N/D
Type of Service	Must agree with Place of Service and Procedure Code

Note: Defaults for procedure code must be the "Miscellaneous" code in the range for services provided. For example, a service shown only as "laboratory" or with a non-acceptable lab code should be coded 89399. Any such defaults used by the contractor must still agree with Type of Service.

- END -