

INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS (1-300)	
VALIDITY EDITS	
1-300-01V	FOR FILING DATE PRIOR TO 10/01/2004 VALUE MUST BE A VALID DIAGNOSIS CODE, EXCLUDING E800.0-E999.1.
1-300-02V	FOR FILING DATE ON OR AFTER 10/01/2004 VALUE MUST BE A VALID DIAGNOSIS CODE, EXCLUDING E800.0-E999.1
	AND BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE
	OR END DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE
RELATIONAL EDITS	
1-300-01R	IF PRINCIPAL TREATMENT DIAGNOSIS = 799.9
	THEN TYPE OF SUBMISSION MUST = D COMPLETE DENIAL
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE = 1 MEDICAID
1-300-02R	IF ANY PRINCIPAL TREATMENT DIAGNOSIS CODE IS FOR FEMALE
	AND PERSON SEX (PATIENT) = MALE
	THEN AT LEAST ONE OVERRIDE CODE MUST = G DIAGNOSIS/PROCEDURE CODE FOR FEMALE: SEX INDICATES MALE
1-300-03R	IF ANY PRINCIPAL TREATMENT DIAGNOSIS CODE IS FOR MALE
	AND NOT FOR CIRCUMCISION (V50.2)
	AND SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-3)
	AND PERSON SEX (PATIENT) = FEMALE
	THEN AT LEAST ONE OVERRIDE CODE MUST = H DIAGNOSIS/PROCEDURE CODE FOR MALE: SEX INDICATES FEMALE
1-300-04R	IF PRINCIPAL TREATMENT DIAGNOSIS CODE HAS AN AGE PARAMETER RESTRICTION
	THEN PATIENT'S AGE MUST BE CONSISTENT WITH RESTRICTIONS
<sup>1</sup> PATIENT AGE IS CALCULATED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN CARE DATE.	

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**ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS (1-300) (CONTINUED)**

UNLESS AT LEAST ONE  
OVERRIDE CODE = R PERSON BIRTH CALENDAR DATE (PATIENT)  
IS NOT CONSISTENT WITH PROCEDURE/  
DIAGNOSIS CODE AGE RESTRICTING;  
PROCEDURE PERFORMED DUE TO  
MEDICAL NECESSITY

**1-300-05R** IF OP/NSP CODE IS CESAREAN SECTION OR REMOVAL OF FETUS (74.2, 74.0-74.99)  
**THEN** DIAGNOSIS CODE MUST BE 640 THROUGH 676.

**1-300-06R** IF OP/NSP CODE IS ECTOPIC (74.3)  
**THEN** DIAGNOSIS CODE MUST BE 633.0-633.9.

**1-300-07R** IF TYPE OF INSTITUTION = 72 RTC  
**THEN** PRINCIPAL TREATMENT DIAGNOSIS CODE MUST = 290-316  
**AND** PATIENT AGE<sup>1</sup> MUST BE < 21

**UNLESS AMOUNT ALLOWED (TOTAL) = 0**

**1-300-08R** IF PRINCIPAL TREATMENT DIAGNOSIS = MATERNITY (630-676 **OR** V22-V24 **OR** V270-  
V289)  
**AND** PATIENT AGE<sup>1</sup> < 12

**THEN** ONE OCCURRENCE  
OF OVERRIDE CODE  
MUST = E DIAGNOSIS IS MATERNITY; PATIENT IS  
UNDER 12 YEARS OF AGE

<sup>1</sup> PATIENT AGE IS CALCULATED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN  
CARE DATE.

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**ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS - 1-11 (1-305 THROUGH 1-342)**

**VALIDITY EDITS**

- 1-XXX-01V<sup>1</sup>** FOR FILING DATES PRIOR TO 10/01/2004 VALUE IF PRESENT MUST BE A VALID DIAGNOSIS CODE IF PRESENT OR BLANK FILLED.
- 1-XXX-02V<sup>1</sup>** FOR FILING DATE ON OR AFTER 10/01/2004 VALUE IF PRESENT MUST BE A VALID DIAGNOSIS CODE OR BLANK FILLED
- AND BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE.
- OR END DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD9 DIAGNOSIS REFERENCE TABLE
- 1-XXX-03V<sup>1</sup>** ALL OCCURRENCES OF SECONDARY TREATMENT DIAGNOSIS MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED SECONDARY TREATMENT DIAGNOSIS.

**RELATIONAL EDITS**

- 1-XXX-01R<sup>1</sup>** IF ANY SECONDARY TREATMENT DIAGNOSIS CODE IS FOR FEMALE  
AND PERSON SEX (PATIENT) = MALE  
THEN AT LEAST ONE  
OVERRIDE CODE MUST = G DIAGNOSIS/PROCEDURE CODE FOR FEMALE: SEX INDICATES MALE
- 1-XXX-02R<sup>1</sup>** IF ANY SECONDARY TREATMENT DIAGNOSIS CODE IS FOR MALE  
AND NOT FOR CIRCUMCISION (V50.2)  
AND SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-3)  
AND PERSON SEX (PATIENT) = FEMALE  
THEN AT LEAST ONE  
OVERRIDE CODE MUST = H DIAGNOSIS/PROCEDURE CODE FOR MALE: SEX INDICATES FEMALE
- 1-XXX-03R<sup>1</sup>** IF SECONDARY TREATMENT DIAGNOSIS CODE HAS AN AGE PARAMETER RESTRICTION  
THEN PATIENT'S AGE MUST BE CONSISTENT WITH RESTRICTIONS (i.e., NEWBORN) (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-1).  
UNLESS AT LEAST ONE  
OVERRIDE CODE = R PERSON BIRTH CALENDAR DATE (PATIENT) IS NOT CONSISTENT WITH PROCEDURE/ DIAGNOSIS CODE AGE RESTRICTING; PROCEDURE PERFORMED DUE TO MEDICAL NECESSITY
- 1-XXX-04R<sup>1</sup>** IF SECONDARY TREATMENT DIAGNOSIS = MATERNITY (630-676 OR V22-V24 OR V270-V289)  
AND PATIENT AGE<sup>2</sup> < 12

<sup>1</sup> XXX EQUALS ELN (305 THROUGH 342) FOR EACH OCCURRENCE OF SECONDARY TREATMENT DIAGNOSIS.

<sup>2</sup> PATIENT AGE IS CALCULATED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.

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**ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS - 1-11 (1-305 THROUGH 1-342)  
(CONTINUED)**

THEN ONE OCCURRENCE  
OF OVERRIDE CODE  
MUST =

E DIAGNOSIS IS MATERNITY; PATIENT IS  
UNDER 12 YEARS OF AGE

<sup>1</sup> XXX EQUALS ELN (305 THROUGH 342) FOR EACH OCCURRENCE OF SECONDARY TREATMENT DIAGNOSIS.

<sup>2</sup> PATIENT AGE IS CALCULATED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.

**ELEMENT NAME: PRINCIPAL OPERATION/NON-SURGICAL PROCEDURE CODE (1-345)**

**VALIDITY EDITS**

1-345-01V FOR FILING DATE PRIOR TO 10/01/2004 VALUE MUST BE A VALID OP/NSP CODE IF PRESENT OR BLANK FILLED.

1-345-02V FOR FILING DATE ON OR AFTER 10/01/2004 VALUE MUST BE A VALID OP/NSP CODE IF PRESENT OR BLANK FILLED

AND BEGIN DATE OF CARE MUST BE ON OR AFTER THE OP/NSP EFFECTIVE DATE AND NOT LATER THAN THE OP/NSP TERMINATION DATE ON THE OP/NSP REFERENCE TABLE

OR END DATE OF CARE MUST BE ON OR AFTER THE OP/NSP EFFECTIVE DATE AND NOT LATER THAN THE OP/NSP TERMINATION DATE ON THE OP/NSP REFERENCE TABLE

**RELATIONAL EDITS**

1-345-01R IF ANY OCCURRENCE OF REVENUE CODE = 036X OR 0722  
THEN PRINCIPAL OP/NSP PROCEDURE CODE IS REQUIRED.  
UNLESS DRG NUMBER = BLANK

1-345-02R IF ANY OCCURRENCE OF REVENUE CODE = 036X OR 0722  
AND DIAGNOSIS CODE FOR DELIVERY (640-669, V27)  
THEN PRINCIPAL OP/NSP PROCEDURE CODE MUST = 54.21, 64.0  
(CIRCUMCISION), 65.0-75.99, 87.81, 88.03, 88.46, 88.78, OR 92.17.  
ELSE IF ANY OCCURRENCE OF REVENUE CODE = 036X OR 0722  
AND THE DIAGNOSIS CODE IS FOR MATERNITY/OBSTETRICS (630-676, V27)  
EXCLUDING PRENATAL AND POSTPARTUM (REFER TO ADDENDUM E, FIGURE 2-E-4)

THEN PRINCIPAL OP/NSP PROCEDURE CODE MUST = 54.21, 65.0-75.99, 87.81, 88.03, 88.46, 88.78, OR 92.17

1-345-04R IF PERSON SEX (PATIENT) IS MALE  
THEN PRINCIPAL OP/NSP PROCEDURE CODE CANNOT BE FEMALE (RANGE 65.0-75.99 (OPERATIONS ON FEMALE GENITAL ORGANS/OBSTETRICS))

UNLESS ONE OCCURRENCE OF  
OVERRIDE CODE = G DIAGNOSIS/PROCEDURAL CODE FOR  
FEMALE: SEX INDICATES MALE

1-345-05R IF PERSON SEX (PATIENT) IS FEMALE  
THEN PRINCIPAL OP/NSP PROCEDURE CODE CANNOT BE MALE (RANGE 60.0-64.99 (OPERATIONS ON MALE GENITAL ORGAN))

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**ELEMENT NAME: PRINCIPAL OPERATION/NON-SURGICAL PROCEDURE CODE (1-345) (CONTINUED)**

UNLESS ONE OCCURRENCE OF  
OVERRIDE CODE = H DIAGNOSIS/PROCEDURAL CODE FOR  
MALE: SEX INDICATES FEMALE

**ELEMENT NAME: SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE 1-11 (1-350 THROUGH 1-373)**

**VALIDITY EDITS**

**1-XXX-01V<sup>1</sup>** FOR FILING DATE PRIOR TO 10/01/2004 VALUE MUST BE A VALID OP/NSP CODE IF PRESENT **OR** BLANK FILLED.

**1-XXX-02V<sup>1</sup>** FOR FILING DATE ON OR AFTER 10/01/2004 VALUE MUST BE VALID OP/NSP CODE IF PRESENT OR BLANK FILLED

**AND** BEGIN DATE OF CARE MUST BE ON OR AFTER THE OP/NSP EFFECTIVE DATE AND NOT LATER THAN THE OP/NSP TERMINATION DATE ON THE OP/NSP REFERENCE TABLE

**OR** DATE OF CARE MUST BE ON OR AFTER THE OP/NSP EFFECTIVE DATE AND NOT LATER THAN THE OP/NSP TERMINATION DATE ON THE OP/NSP REFERENCE TABLE

**1-XXX-03V<sup>1</sup>** ALL OCCURRENCES OF SECONDARY OP/NSP CODE FIELD MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED SECONDARY OP/NSP CODE.

**RELATIONAL EDITS**

**1-XXX-01R<sup>1</sup>** IF PRICING RATE CODE = H TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER **OR**

I TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER **OR**

J TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER

**AND** DATE OF ADMISSIONS < 10/01/1998

**THEN** SECONDARY OP/NSP PROCEDURE CODE

**CANNOT** = 37.5 HEART TRANSPLANT **OR**

50.59 LIVER TRANSPLANT

**1-XXX-02R<sup>1</sup>** IF PERSON SEX (PATIENT) IS MALE

**THEN** SECONDARY OP/NSP PROCEDURE CODE **CANNOT** BE FEMALE (RANGE 65.0 - 75.99 (OPERATIONS ON FEMALE GENITAL ORGANS/OBSTETRICS))

**UNLESS** ONE OVERRIDE CODE = G DIAGNOSIS/PROCEDURAL CODE FOR FEMALE: SEX INDICATES MALE

**1-XXX-03R<sup>1</sup>** IF PERSON SEX (PATIENT) IS FEMALE

**THEN** SECONDARY OP/NSP PROCEDURE CODE **CANNOT** BE MALE (RANGE 60.0 - 64.99 (OPERATIONS ON MALE GENITAL ORGAN))

**UNLESS** ONE OVERRIDE CODE = H DIAGNOSIS/PROCEDURAL CODE FOR MALE: SEX INDICATES FEMALE

<sup>1</sup> XXX EQUALS ELN (350 THROUGH 373) FOR EACH OCCURRENCE OF SECONDARY OPERATION/ NON-SURGICAL PROCEDURE CODE.

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**ELEMENT NAME: TED RECORD CORRECTION INDICATOR (1-374)**

**VALIDITY EDITS**

<b>1-374-01V</b>	VALUE MUST BE A VALID TED RECORD CORRECTION INDICATOR		
<b>1-374-02V</b>	IF TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) <b>SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR</b>
		2	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT CLAIM PROCESSING ERRORS OR TO UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION. <b>(NOT TO BE USED TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD) OR</b>
		3	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT <b>BOTH</b> CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD
	<b>THEN</b> TYPE OF SUBMISSION MUST =	A	ADJUSTMENT <b>OR</b>
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>
		C	COMPLETE CANCELLATION OF TED RECORD DATA <b>OR</b>
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
<b>1-374-03V</b>	IF TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OR SUBMISSION A, B, C, OR E) <b>SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR</b>
		3	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT <b>BOTH</b> CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD
	<b>THEN</b> A MATCH TO A PROVISIONALLY ACCEPTED TED RECORD <b>MUST</b> BE PRESENT ON THE TMA DATABASE.		
<b>1-374-04V</b>	IF TED RECORD CORRECTION INDICATOR =	2	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT CLAIM PROCESSING ERRORS OR TO UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION
	<b>THEN</b> A CORRESPONDING PROVISIONALLY ACCEPTED TED RECORD <b>MUST NOT</b> BE PRESENT ON THE TMA DATABASE.		

**RELATIONAL EDITS**

NONE

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**ELEMENT NAME: TOTAL OCCURRENCE/LINE ITEM COUNT (1-375)**

**VALIDITY EDITS**

**1-375-01V** VALUE MUST BE IN RANGE 001-450.

**AND MUST EQUAL THE PHYSICAL COUNT OF THE DETAIL LINE ITEMS ON THE TED RECORD**

**1-375-02V** 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 TOTAL OCCURRENCE/LINE ITEM COUNT MUST BE ≥ TOTAL OCCURRENCE/LINE ITEM COUNT FROM TMA DATABASE**

**RELATIONAL EDITS**

NONE

**ELEMENT NAME: OCCURRENCE/LINE ITEM NUMBER (1-380)**

**VALIDITY EDITS**

**1-380-01V** EACH VALUE MUST BE NUMERIC.

**1-380-02V** OCCURRENCE/LINE ITEM NUMBER MUST BE CODED FOR EACH NUMBER OF OCCURRENCES SPECIFIED BY THE TOTAL OCCURRENCE/LINE ITEM COUNT.

**1-380-03V** OCCURRENCE/LINE ITEM NUMBER MUST BE REPORTED IN ASCENDING CONSECUTIVE ORDER.

**RELATIONAL EDITS**

NONE



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**ELEMENT NAME: REVENUE CODE (1-385) (CONTINUED)**

		0652	CONTINUOUS HOME CARE OR
		0655	INPATIENT RESPITE CARE OR
		0656	GENERAL INPATIENT CARE - NON RESPITE OR
		0657	PHYSICIAN SERVICES OR
		0659	OTHER HOSPICE
	THEN TYPE OF INSTITUTION MUST =	78	NON-HOSPITAL BASED HOSPICE OR
		79	HOSPITAL BASED HOSPICE
	<b>UNLESS AMOUNT ALLOWED (TOTAL) = ZERO</b>		
<b>1-385-11R</b>	IF REVENUE CODE =	0023	HOME HEALTH AGENCY (HHA-PPS)
	AND BEGIN DATE OF CARE ≥ 06/01/2004		
	THEN TYPE OF INSTIUTION MUST =	70	HOME HEALTH AGENCY

**ELEMENT NAME: UNITS OF SERVICE BY REVENUE CODE (1-390)**

**VALIDITY EDITS**

<b>1-390-01V</b>	VALUE MUST BE SIGNED NUMERIC, 0 TO 9,999,999.		
	UNLESS TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN VALUE MUST BE SIGNED NUMERIC, - 9,999,999 TO 9,999,999		

**RELATIONAL EDITS**

<b>1-390-01R</b>	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 UNITS OF SERVICE BY REVENUE CODE MUST BE > ZERO FOR ALL OCCURRENCES/LINE ITEMS		
	EXCLUDING REVENUE CODE 0001 AND 0023.		
<b>1-390-02R</b>	IF UNITS OF SERVICE BY REVENUE CODE = 0		
	AND TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN TOTAL CHARGE BY REVENUE CODE MUST ALSO = 0 (FOR THAT OCCURRENCE)		
	EXCEPT FOR REVENUE CODE 0001 OR 0022		
<b>1-390-03R</b>	IF UNITS OF SERVICE BY REVENUE CODE > 0		

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**ELEMENT NAME: UNITS OF SERVICE BY REVENUE CODE (1-390) (CONTINUED)**

	AND 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 TOTAL CHARGE BY REVENUE CODE MUST ALSO &gt; 0 (FOR THAT OCCURRENCE)</b>		
	<b>UNLESS REVENUE CODE =</b>	<b>018X</b>	<b>LEAVE OF ABSENCE OR</b>
		0022	SKILLED NURSING FACILITY
	<b>OR REVENUE CODE =</b>	0023	HOME HEALTH AGENCY
	<b>AND THE OCCURRENCE/LINE ITEM CONTAINS AN ADJUSTMENT/DENIAL REASON CODE LISTED IN <a href="#">ADDENDUM H</a>, <a href="#">FIGURE 2-H-1</a> OR <a href="#">FIGURE 2-H-2</a>.</b>		
<b>1-390-04R</b>	IF REVENUE CODE 0001		
	<b>THEN UNITS OF SERVICE BY REVENUE CODE MUST = ZERO.</b>		
<b>1-390-05R</b>	IF REVENUE CODE =	0023	HOME HEALTH AGENCY (HHA-PPS)
	AND 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 UNITS OF SERVICE BY REVENUE CODE MUST = 1</b>		
	<b>UNLESS THE OCCURRENCE/LINE ITEM CONTAINS AN ADJUSTMENT/DENIAL REASON CODE LISTED IN <a href="#">ADDENDUM H</a>, <a href="#">FIGURE 2-H-1</a> OR <a href="#">FIGURE 2-H-2</a>.</b>		
	<b>THEN UNITS OF SERVICE BY REVENUE CODE MUST = 0 <b>OR</b> 1</b>		

**ELEMENT NAME: TOTAL CHARGE BY REVENUE CODE (1-395)**

**VALIDITY EDITS**

<b>1-395-01V</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 MUST BE - 999,999.99 TO 999,999.99</b>		
	<b>UNLESS REVENUE CODE = 0001</b>		
	<b>THEN MUST BE - 9,999,999.99 TO 9,999,999.99</b>		
	<b>ELSE MUST BE 0 TO 999,999.99</b>		
	<b>UNLESS REVENUE CODE = 0001</b>		
	<b>THEN MUST BE 0 TO 9,999,999.99</b>		

**RELATIONAL EDITS**

<b>1-395-01R</b>	IF TYPE OF SUBMISSION =	A	ADJUSTMENT <b>OR</b>
		C	COMPLETE CANCELLATION <b>OR</b>
		D	COMPLETE DENIAL <b>OR</b>
		I	INITIAL SUBMISSION <b>OR</b>
		O	ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>
		R	RESUBMISSION

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**ELEMENT NAME: TOTAL CHARGE BY REVENUE CODE (1-395) (CONTINUED)**

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THEN TOTAL CHARGE BY REVENUE CODE MUST BE > ZERO ON EACH OCCURRENCE/LINE ITEM (EXCLUDING REVENUE CODE 018X, 0001, 0022 AND 0023)

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**1-395-02R** THE SUM OF ALL TOTAL CHARGE BY REVENUE CODE FOR REVENUE CODES OTHER THAN 0001 MUST EQUAL THE TOTAL CHARGE BY REVENUE CODE FOR REVENUE CODE 0001.

