INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME:	**PROVIDER TAXPAYER NUMBER (1-200)**		
	VALIDITY EDITS		
1-200-01V	MUST BE NUMERIC		
	OR (FIRST 3 POSITIONS MUST BE A VALID STATE/COUNTRY CODE **AND** LAST 6 POSITIONS MUST BE NUMERIC)		
	OR (FIRST 3 POSITIONS MUST BE A VALID STATE/COUNTRY CODE **AND** FOURTH POSITION MUST BE = 'A' **AND** LAST 5 POSITIONS MUST BE NUMERIC)		
	RELATIONAL EDITS		
NO ERROR	IF 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
	THEN DO NOT CHECK PROVIDER FILE		
NO ERROR	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**
		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 PROVIDER FILE		
NO ERROR	IF AMOUNT ALLOWED (TOTAL) ≤ ZERO		
	THEN DO NOT CHECK PROVIDER FILE		
1-200-02R	IF ANY OCCURRENCE OF OVERRIDE CODE =	NC	NON-CERTIFIED PROVIDER

ELEMENT NAME:	PROVIDER TAXPAYER NUMBER (1-200) (CONTINUED)
	THEN THE NON-CERTIFIED PROVIDER MUST MATCH THE PROVIDER ON THE PROVIDER FILE USING THE FOLLOWING: INSTITUTIONAL PROVIDER TAXPAYER NUMBER **AND** TYPE OF INSTITUTION **AND** PROVIDER ZIP CODE **AND** PROVIDER SUB-IDENTIFIER **AND** ACCEPTANCE AND TERMINATION DATES MUST = ZEROES **AND** PROVIDER CONTRACT AFFILIATION CODE MUST = '5' (NON-CERTIFIED PROVIDER)
	IF NO OCCURRENCE OF OVERRIDE CODE = NC NON-CERTIFIED PROVIDER
	THEN CERTIFIED PROVIDER MUST MATCH THE PROVIDER ON THE PROVIDER FILE USING THE FOLLOWING: INSTITUTIONAL PROVIDER TAXPAYER NUMBER **AND** TYPE OF INSTITUTION **AND** PROVIDER ZIP CODE **AND** PROVIDER SUB-IDENTIFIER
	AND PROVIDER MUST BE CERTIFIED TO PROVIDE SERVICES ON THE CLAIM DATE(S) OF CARE.

ELEMENT NAME:	PROVIDER SUB-IDENTIFIER (1-205)
	VALIDITY EDITS
1-205-01V	MUST BE ALPHA **OR** NUMERIC--**NO BLANKS**
	RELATIONAL EDITS
	NONE

ELEMENT NAME:	PROVIDER INDIVIDUAL NPI NUMBER (RESERVED) (1-210)
	VALIDITY EDITS
1-210-01V	MUST BE BLANK FILLED.
	RELATIONAL EDITS
	NONE

ELEMENT NAME:	PROVIDER GROUP NPI NUMBER (RESERVED) (1-215)
	VALIDITY EDITS
1-215-01V	MUST BE BLANK FILLED.
	RELATIONAL EDITS
	NONE

ELEMENT NAME:	PROVIDER ZIP CODE (1-220)		
	VALIDITY EDITS		
1-220-01V	MUST BE 9 DIGITS **OR** 5 DIGITS WITH 4 BLANKS		
	MUST BE A VALID ZIP CODE (BASED ON ADMISSION DATE) IN THE GOVERNMENT PROVIDED ELECTRONIC ZIP CODE FILE **OR**		
	MUST BE A 3 CHARACTER FOREIGN COUNTRY CODE (BASED ON THE COUNTRY CODES TABLE[1]) FOLLOWED BY 6 BLANKS		
	RELATIONAL EDITS		
	NONE		

[1] **WHEN FOREIGN COUNTRY CODES ARE SUBMITTED, THE FIRST 3 CHARACTERS WILL BE EDITED AGAINST CHAPTER 2, ADDENDUM A.**

ELEMENT NAME:	PROVIDER PARTICIPATION INDICATOR (1-225)		
	VALIDITY EDITS		
1-225-01V	MUST BE A VALID PROVIDER PARTICIPATION INDICATOR.		
	RELATIONAL EDITS		
1-225-01R	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
	THEN PROVIDER PARTICIPATION INDICATOR MUST =	Y	YES
1-225-02R	IF THERE IS A MEDICARE NUMBER PRESENT ON THE PROVIDER FILE FOR THAT PROVIDER (IF MATCH WAS FOUND AND CORRECT HISTORY RECORD BASED ON CARE DATES WAS IDENTIFIED)		
	THEN THE PROVIDER PARTICIPATION INDICATOR ON TED MUST =	Y	YES

ELEMENT NAME:	PROVIDER NETWORK STATUS INDICATOR (1-230)		
	VALIDITY EDITS		
1-230-01V	MUST BE ONE OF THE FOLLOWING VALUES	1	NETWORK PROVIDER **OR**
		2	NON-NETWORK PROVIDER
	RELATIONAL EDITS		
	NONE		

ELEMENT NAME: TYPE OF INSTITUTION (1-235)			
VALIDITY EDITS			
1-235-01V	VALUE MUST BE A VALID TYPE OF INSTITUTION CODE.		
RELATIONAL EDITS			
1-235-01R	IF TYPE OF INSTITUTION =	72	RTC
	AND PATIENT ZIP CODE IS IN AN MTF CATCHMENT AREA		
	THEN CA/NAS EXCEPTION REASON MUST =	5	RTC
1-235-02R	IF PRICING RATE CODE =	K	HOSPITAL-SPECIFIC PSYCHIATRIC PER DIEM RATE **OR**
		L	REGION SPECIFIC PSYCHIATRIC PER DIEM RATE
	THEN TYPE OF INSTITUTION MUST =	22	PSYCHIATRIC HOSPITAL/UNIT **OR**
		52	CHILDREN'S PSYCHIATRIC HOSPITAL/ UNIT
1-235-03R	IF TYPE OF INSTITUTION =	70	HOME HEALTH AGENCY
	AND BEGIN DATE OF CARE ≥ 06/01/2004		
	THEN ONE OCCURRENCE OF REVENUE CODE MUST =	0023	HOME HEALTH AGENCY (HHA-PPS)

ELEMENT NAME: CLAIM FORM TYPE/EMC INDICATOR (1-240)	
VALIDITY EDITS	
1-240-01V	VALUE MUST BE A VALID CLAIM FORM TYPE/EMC INDICATOR.
RELATIONAL EDITS	
	NONE

ELEMENT NAME: FREQUENCY CODE (1-250)

VALIDITY EDITS

1-250-01V MUST BE A VALID FREQUENCY CODE **AND** MUST = THE VALUES IN THE FOLLOWING TABLE:

FREQUENCY CODE	PREVIOUS TED RECORD FREQUENCY CODE	BEGIN DATE OF CARE
1	= 1 **OR** NO PREVIOUS TED RECORD	N/A
2	= 2 **OR** NO PREVIOUS TED RECORD	N/A
3	= 2 **OR** 3	PLUS 1 DAY OF ENDING DATE OF CARE ON EXISTING PREVIOUS TED NET RECORD
4	= 2 **OR** 3	PLUS 1 DAY OF ENDING DATE OF CARE ON EXISTING PREVIOUS TED NET RECORD

RELATIONAL EDITS

1-250-01R	IF PATIENT STATUS =	30	STILL A PATIENT
	THEN FREQUENCY CODE MUST =	2	INTERIM-INITIAL **OR**
		3	INTERIM-INTERIM
	UNLESS TYPE OF INSTITUTION =	70	HOME HEALTH AGENCY
	THEN FREQUENCY CODE MUST =	2	INTERIM-INITIAL **OR**
		3	INTERIM-INTERIM **OR**
		7	REPLACEMENT OF PRIOR CLAIM **OR**
		8	VOID/CANCEL OF PRIOR CLAIM **OR**
		9	FINAL CLAIM FOR HOME HEALTH AGENCY EPISODE
1-250-02R	IF PATIENT STATUS =	01	DISCHARGED **OR**
		02	TRANSFERRED **OR**
		20	EXPIRED
	THEN FREQUENCY CODE MUST =	1	ADMIT THRU DISCHARGE **OR**
		4	INTERIM-FINAL
1-250-03R	IF PRICING RATE CODE =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER
	THEN FREQUENCY CODE MUST =	1	ADMIT THRU DISCHARGE
1-250-04R	IF FREQUENCY CODE =	3	INTERIM-INTERIM **OR**
		4	INTERIM-FINAL
	THEN TYPE OF SUBMISSION MUST ≠	I	INITIAL SUBMISSION **OR**
		R	RESUBMISSION
1-250-05R	IF FREQUENCY CODE =	0	NON-PAYMENT/ZERO CLAIM

ELEMENT NAME:	**FREQUENCY CODE (1-250) (CONTINUED)**		
	THEN TYPE OF INSTITUTION MUST =	70	HOME HEALTH AGENCY **OR**
		76	SKILLED NURSING FACILITY

ELEMENT NAME:	TYPE OF ADMISSION (1-255)		
	VALIDITY EDITS		
1-255-01V	VALUE MUST BE A VALID TYPE OF ADMISSIONS CODE.		
	RELATIONAL EDITS		
1-255-02R	IF CA/NAS EXCEPTION REASON =	2	EMERGENCY
	THEN TYPE OF ADMISSION MUST =	1	EMERGENCY **OR**
		4	NEWBORN
1-255-03R	IF TYPE OF ADMISSION =	4	NEWBORN
	THEN PRINCIPAL DIAGNOSIS MUST BE A NEWBORN DIAGNOSIS (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-7).		

ELEMENT NAME:	SOURCE OF ADMISSION (1-260)		
	VALIDITY EDITS		
1-260-01V	VALUE MUST BE A VALID SOURCE OF ADMISSION.		
	RELATIONAL EDITS		
1-260-01R	IF TYPE OF ADMISSION =	4	NEWBORN
	THEN SOURCE OF ADMISSION MUST =	1	NORMAL DELIVERY **OR**
		2	PREMATURE DELIVERY **OR**
		3	SICK BABY **OR**
		4	EXTRAMURAL BIRTH
	AND PRINCIPAL DIAGNOSIS MUST BE A NEWBORN DIAGNOSIS (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-7).		

ELEMENT NAME: ADMISSION DATE (1-265)			
VALIDITY EDITS			
1-265-01V	MUST BE A VALID GREGORIAN DATE.		
RELATIONAL EDITS			
1-265-01R	ADMISSION DATE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION		
1-265-02R	ADMISSION DATE MUST BE ≤ END DATE OF CARE		
1-265-03R	IF FREQUENCY CODE =	1	ADMIN THRU DISCHARGE **OR**
		2	INTERIM-INITIAL
	THEN ADMISSION DATE MUST = BEGIN DATE OF CARE		
1-265-04R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		B	ADJUSTMENT OF NON-TED RECORD (HCSR) DATA **OR**
		C	COMPLETE CANCELLATION **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	THEN ADMISSION DATE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED		
	UNLESS TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) **SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD**
	AND DATE ADJUSTMENT IDENTIFIED ON TMA DATABASE = ZEROES.		

ELEMENT NAME:	PATIENT STATUS (1-270)		
	VALIDITY EDITS		
1-270-01V	VALUE MUST BE A VALID PATIENT STATUS CODE.		
	RELATIONAL EDITS		
1-270-01R	IF FREQUENCY CODE =	2	INTERIM-INITIAL **OR**
		3	INTERIM-INTERIM
	THEN PATIENT STATUS MUST =	30	STILL A PATIENT
1-270-02R	IF FREQUENCY CODE =	1	ADMIT THRU DISCHARGE
	THEN PATIENT STATUS MUST =	01	DISCHARGED **OR**
		02	TRANSFERRED **OR**
		03	DISCHARGED/TRANSFERRED TO SKILLED NURSING FACILITY (SNF) **OR**
		04	DISCHARGED/TRANSFERRED TO INTERMEDIATE CARE FACILITY (ICF) **OR**
		05	DISCHARGED/TRANSFERRED TO ANOTHER TYPE OF INSTITUTION FOR INPATIENT CARE, OR REFERRED FOR OUTPATIENT CARE TO ANOTHER INSTITUTION **OR**
		06	DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF ORGANIZED HOME HEALTH SERVICE ORGANIZATION **OR**
		07	LEFT AGAINST MEDICAL ADVICE OR DISCONTINUED CARE **OR**
		08	DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF A HOME IV PROVIDER **OR**
		20	EXPIRED **OR**
		40	DIED AT HOME **OR**
		41	DIED IN MEDICAL FACILITY, SUCH AS HOSPITAL, SNF OR FREE-STANDING HOSPICE **OR**
		42	PLACE OF DEATH UNKNOWN **OR**
		43	DISCHARGED/TRANSFERRED TO A FEDERAL HOSPITAL **OR**
		50	HOSPICE-HOME **OR**
		51	HOSPICE-MEDICAL FACILITY **OR**
		61	DISCHARGED/TRANSFERRED WITHIN THIS INSTITUTION TO A HOSPITAL-BASED MEDICARE APPROVED SWING BED **OR**
		62	DISCHARGED/TRANSFERRED TO ANOTHER REHABILITATION FACILITY INCLUDING REHABILITATION DISTINCT PART UNITS OF A HOSPITAL **OR**
		63	DISCHARGED/TRANSFERRED TO A LONG TERM CARE HOSPITAL **OR**

ELEMENT NAME:	PATIENT STATUS (1-270) (CONTINUED)		
		64	DISCHARGED/TRANSFERRED TO A NURSING FACILITY CERTIFIED UNDER MEDICAID BUT NOT CERTIFIED UNDER MEDICARE **OR**
		65	DISCHARGED/TRANSFERRED TO A PSYCHIATRIC HOSPITAL OR PSYCHIATRIC DISTINCT PART OF A HOSPITAL
1-270-03R	IF PRICING RATE CODE =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER **OR**
		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER
	THEN PATIENT STATUS MUST ≠	30	STILL A PATIENT

ELEMENT NAME: BEGIN DATE OF CARE (1-275)			
VALIDITY EDITS			
1-275-01V	MUST BE A VALID GREGORIAN DATE.		
RELATIONAL EDITS			
1-275-01R	BEGIN DATE OF CARE MUST BE ≤ END DATE OF CARE		
1-275-02R	BEGIN DATE OF CARE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION		
1-275-03R	BEGIN DATE OF CARE MUST BE ≥ PERSON BIRTH CALENDAR DATE (PATIENT)		
1-275-04R	BEGIN DATE OF CARE MUST BE ≥ ADMISSION DATE		
1-275-05R	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 BEGIN DATE OF CARE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED		
	UNLESS TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) **SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD**
	AND DATE ADJUSTMENT IDENTIFIED ON TMA DATABASE = ZEROES.		
1-275-06R	PROVIDER MUST BE "AUTHORIZED"[1] ON PROVIDER FILE FOR THIS BEGIN DATE OF CARE		
	UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**
		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 PROVIDER FILE		

[1] **"AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON PROVIDER TAXPAYER NUMBER, ZIP CODE, TYPE OF INSTITUTION, PROVIDER ACCEPTANCE AND TERMINATION DATES, AND PROVIDER RECORD EFFECTIVE DATE.**

ELEMENT NAME: END DATE OF CARE (1-280)			
VALIDITY EDITS			
1-280-01V	MUST BE A VALID GREGORIAN DATE.		
RELATIONAL EDITS			
1-280-01R	END DATE OF CARE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION		
1-280-02R	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 END DATE OF CARE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED		
	UNLESS TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) **SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD**
	AND DATE ADJUSTMENT IDENTIFIED ON TMA DATABASE = ZEROES.		
1-280-03R	PROVIDER MUST BE "AUTHORIZED"[1] ON PROVIDER FILE FOR THIS END DATE OF CARE		
	UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) **AND** BEGIN DATE OF CARE ≥ 10/01/2001 **OR**
		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 PROVIDER FILE		

[1] **"AUTHORIZED" RECORD ON PROVIDER FILE IS BASED ON PROVIDER TAXPAYER NUMBER, ZIP CODE, TYPE OF INSTITUTION, PROVIDER ACCEPTANCE AND TERMINATION DATES, AND PROVIDER RECORD EFFECTIVE DATE.**

ELEMENT NAME:	**ADMINISTRATIVE CLIN (1-283)**		
	VALIDITY EDITS		
1-283-01V	MUST BE ALPHANUMERIC **OR** BLANKS		
1-283-02V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		C	COMPLETE CANCELLATION
	AND ADMINISTRATIVE CLAIM COUNT CODE (TMA DERIVED FIELD) ON TMA FILE =	1	CLAIM RATE HAS BEEN PAID
	THEN ADMINISTRATIVE CLIN ON THE ADJUSTMENT MUST = ADMINISTRATIVE CLIN ON TMA DATABASE[1]		
	RELATIONAL EDITS		
	REFER TO CHAPTER 2, SECTION 8.1.		

[1] **THIS EDIT IS CHECKED DURING THE MATCH AND MARRY PROCESS.**

ELEMENT NAME: COVERED DAYS (1-285)			
VALIDITY EDITS			
1-285-01V	MUST BE NUMERIC.		
RELATIONAL EDITS			
NO ERROR	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	11	HOSPICE
	THEN BYPASS ALL COVERED DAYS		
1-285-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
	AND TYPE OF INSTITUTION ≠	70	HOME HEALTH AGENCY
	THEN COVERED DAYS MUST BE > ZERO		
1-285-02R	IF TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL
	THEN COVERED DAYS MUST = ZERO		
1-285-03R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
	THEN COVERED DAYS MUST BE ≤ SUM OF UNITS OF SERVICE BY REVENUE CODE FOR REVENUE CODES THAT INDICATE THAT A ROOM WAS USED (010X-018X, 020X-021X, 0724, **OR** 0762)		
1-285-04R	IF TYPE OF INSTITUTION =	70	HOME HEALTH AGENCY
	AND TYPE OF SUBMISSION =	I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT TED RECORD DUE 100% OHI **OR**
		R	RESUBMISSION OF ERROR REJECT
	THEN COVERED DAYS MUST = ZERO		

ELEMENT NAME: DRG NUMBER (1-290)			
	VALIDITY EDITS		
1-290-01V	MUST BE A VALID DRG NUMBER **OR** BLANK FILLED.		
	RELATIONAL EDITS		
1-290-01R	IF PRICING RATE CODE =	~~b~~	NO SPECIAL RATE CODE **OR**
		K	HOSPITAL SPECIFIC PSYCHIATRIC PER DIEM RATE **OR**
		L	REGIONAL-SPECIFIC PSYCHIATRIC PER DIEM RATE **OR**
		P	PER DIEM RATE AGREEMENT
	THEN DRG NUMBER MUST = BLANK		
1-290-02R	IF ANY OCCURRENCE OF OVERRIDE CODE =	Y	NEWBORN IN MOTHER'S ROOM WITHOUT NURSERY CHARGES
	THEN DRG NUMBER MUST = BLANK.		
1-290-08R	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 ADMISSION ≥ 10/01/1996 **AND** < 10/01/1997		
	THEN DRG NUMBER MUST = 001-102, 104-108, 110-384, 391-434, 436-437, 439-473, 475-479, 481-495, 600-619, 621-624, 626-628, 630-636, **OR** 900-901.		
1-290-09R	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 ADMISSION ≥ 10/01/1997 **AND** < 10/01/1998		
	THEN DRG NUMBER MUST = 001-102, 104-108, 110-213, 216-220, 223-384, 391-434, 436-437, 439-473, 475-479, 481-503, 600-619, 621-624, 626-628, 630-636, **OR** 900-901.		
1-290-10R	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 ADMISSION ≥ 10/01/1998 **AND** < 10/01/1999		
	THEN DRG NUMBER MUST = 001-213, 216-220, 223-384, 391-437, 439-455, 461-471, 473, 475-511, 600-619, 621-624, 626-628, 630-636, **OR** 900-901.		
1-290-21R	IF PRICING RATE CODE =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER **OR**
		I	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER **OR**

ELEMENT NAME: DRG NUMBER (1-290) (CONTINUED)			
		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER
	AND DATE OF ADMISSION ≥ 10/01/1999 **AND** < 10/01/2000		
	THEN DRG NUMBER MUST = 001-213, 216-220, 223-384, 391-437, 439-455, 461-473, 475-511, 600-619, 621-624, 626-628, 630-636, **OR** 900-901.		
1-290-23R	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 ADMISSION ≥ 10/01/2000 **AND** < 10/01/2001		
	THEN DRG NUMBER MUST = 001-213, 216-220, 223-384, 391-437, 439-455, 461-471, 473, 475-511, 600-619, 621-624, 626-628, 630-636, 900-901		
1-290-24R	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 ADMISSION ≥ 10/01/2001 **AND** ≤ 09/30/2002		
	THEN DRG NUMBER MUST = 001-111, 113-213, 216-220, 223-384, 391-433, 439-455, 461-471, 473, 475-523, 600-619, 621-624, 626-628, 630-636, 900-901		
1-290-25R	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 ADMISSION ≥ 10/01/2002 **AND** ≤ 09/30/2003		
	THEN DRG NUMBER MUST = 001-111, 113-213, 216-220, 223-384, 391-433, 439-455, 461-471, 473, 475-527, 600-619, 621-624, 626-628, 630-636, 900-901		
1-290-26R	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 ADMISSION ≥ 10/01/2003 **AND** < 10/01/2004		
	THEN DRG NUMBER MUST = 001-003, 006-111, 113-213, 216-220, 223-230, 232-384, 391-399, 401-433, 439-455, 461-471, 473, 475-513, 515-540, 600-619, 621-624, 626-628, 630-636, 900-901.		
1-290-27R	IF PRICING RATE CODE =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER **OR**
		I	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER **OR**

ELEMENT NAME:	DRG NUMBER (1-290) (CONTINUED)		
		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER
	AND DATE OF ADMISSION ≥ 10/01/2004 **AND** < 10/01/2005		
	THEN DRG NUMBER MUST = 001-111, 113-213, 216-220, 223-384, 391-433, 439-455, 461-471, 473, 475-482, 484-513, 515-543, 600-619, 621-624, 626-628, 630-636, 900-901.		
1-290-28R	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 ADMISSION ≥ 10/01/2005		
	THEN DRG NUMBER MUST = 001-003, 006-106, 108, 110-111, 113-114, 117-208, 210-213, 216-220, 223-230, 232-384, 391-399, 401-433, 439-455, 461-471, 473, 475-477, 479-482, 484-513, 515, 518-525, 528-559, 600-619, 621-624, 626-628, 630-636, 900-901.		

ELEMENT NAME:	HIPPS CODE (1-292)		
	VALIDITY EDITS		
1-292-01V	MUST BE VALID HIPPS CODES REFER TO CHAPTER 2, SECTION 2.8		
	RELATIONAL EDITS		
1-292-01R	IF HIPPS CODE = BLANK		
	THEN NO OCCURRENCE OF REVENUE CODE CAN =	0022	SKILLED NURSING FACILITY **OR**
		0023	HOME HEALTH AGENCY

ELEMENT NAME:	ADMISSION DIAGNOSIS (1-295)
	VALIDITY EDITS
1-295-01V	VALUE MUST BE VALID DIAGNOSIS CODE, EXCLUDING E800.0-E999.1.
	RELATIONAL EDITS
	NONE