

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
¹ 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 AGE¹ 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 AGE¹ < 12

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

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

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

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

VALIDITY EDITS

- 1-XXX-01V¹** FOR FILING DATES PRIOR TO 10/01/2004 VALUE IF PRESENT MUST BE A VALID DIAGNOSIS CODE IF PRESENT OR BLANK FILLED.
- 1-XXX-02V¹** 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-03V¹** 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-01R¹** 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-02R¹** 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-03R¹** 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-04R¹** IF SECONDARY TREATMENT DIAGNOSIS = MATERNITY (630-676 OR V22-V24 OR V270-V289)
AND PATIENT AGE² < 12

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

² 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

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

² 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-01V¹ FOR FILING DATE PRIOR TO 10/01/2004 VALUE MUST BE A VALID OP/NSP CODE IF PRESENT **OR** BLANK FILLED.

1-XXX-02V¹ 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-03V¹ 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-01R¹ 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-02R¹ 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-03R¹ 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

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

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

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

VALIDITY EDITS

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

VALIDITY EDITS

1-385-01V VALUE MUST BE A VALID REVENUE CODE.
UNLESS ADJUSTMENT/DENIAL REASON CODE IS A DENIAL REASON CODE LISTING IN [ADDENDUM H, FIGURE 2-H-1](#) **OR** [FIGURE 2-H-2](#)
 NOTE: THE FOLLOWING VALID OUTPATIENT REVENUE CODES ARE ALLOWED ON AN INSTITUTIONAL TED RECORD ONLY **WHEN** BEING DENIED
 049X, 051X-054X, 0630-0635, 064X, 0661, 0662, 082X-085X, 0882, **AND** 310X.

1-385-02V FIRST DETAILED LINE MUST CONTAIN REVENUE CODE 0001.

RELATIONAL EDITS

1-385-01R ONLY ONE OCCURRENCE OF REVENUE CODE MUST = 0001.

1-385-02R AT LEAST ONE OCCURRENCE OF REVENUE CODE FOR ROOM ACCOMMODATION CHARGES MUST = 010X-021X **OR** 0724

UNLESS ONE OCCURRENCE OF
 OVERRIDE CODE = Y NEWBORN IN MOTHER'S ROOM WITHOUT NURSERY CHARGES

OR ANY OCCURRENCE OF
 SPECIAL PROCESSING CODE = 11 HOSPICE

OR ANY OCCURRENCE OF REVENUE CODE = 0023

OR AMOUNT ALLOWED (TOTAL) = ZERO

1-385-03R 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 **OR**

DD DISCOUNTED DRG

THEN PROFESSIONAL SERVICE REVENUE CODES = 0901, 0914-0918, **OR** 096X-098X

AND ORGAN CODES (081X) MUST BE DENIED.

1-385-04R IF ANY REVENUE CODE = 0723
THEN PERSON SEX (PATIENT) MUST = MALE.

1-385-05R IF ANY REVENUE CODE = 072X BUT **NOT** 0723
THEN PERSON SEX (PATIENT) MUST = FEMALE

1-385-06R IF TYPE OF SUBMISSION = A ADJUSTMENT **OR**
 C COMPLETE CANCELLATION

THEN REVENUE CODES MUST OCCUR IN THE SAME ORDER

AND ON THE SAME OCCURRENCE/LINE ITEM NUMBER AS TMA DATABASE.

1-385-07R IF REVENUE CODE = 0022 SKILLED NURSING FACILITY CHARGE
THEN ADMISSION DATE ≥ 08/01/2003

AND TYPE OF
 INSTITUTION MUST = 76 SKILLED NURSING FACILITY

AND HIPPS CODE ≠ BLANK

UNLESS PATIENT AGE IS < 10 YEARS OF AGE ON DATE OF ADMISSION

1-385-09R IF ANY REVENUE CODE = 0650 GENERAL CLASSIFICATION **OR**
 0651 ROUTINE HOME CARE **OR**

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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
	UNLESS AMOUNT ALLOWED (TOTAL) = ZERO		
1-385-11R	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

1-390-01V	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

1-390-01R	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 UNITS OF SERVICE BY REVENUE CODE MUST BE > ZERO FOR ALL OCCURRENCES/LINE ITEMS		
	EXCLUDING REVENUE CODE 0001 AND 0023.		
1-390-02R	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		
1-390-03R	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 OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN TOTAL CHARGE BY REVENUE CODE MUST ALSO > 0 (FOR THAT OCCURRENCE)	
UNLESS REVENUE CODE =	018X LEAVE OF ABSENCE OR
	0022 SKILLED NURSING FACILITY
OR REVENUE CODE =	0023 HOME HEALTH AGENCY
AND THE OCCURRENCE/LINE ITEM CONTAINS AN ADJUSTMENT/DENIAL REASON CODE LISTED IN ADDENDUM H, FIGURE 2-H-1 OR FIGURE 2-H-2.	
1-390-04R	IF REVENUE CODE 0001
THEN UNITS OF SERVICE BY REVENUE CODE MUST = ZERO.	
1-390-05R	IF REVENUE CODE = 0023 HOME HEALTH AGENCY (HHA-PPS)
AND TYPE OF SUBMISSION ≠	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN UNITS OF SERVICE BY REVENUE CODE MUST = 1	
UNLESS THE OCCURRENCE/LINE ITEM CONTAINS AN ADJUSTMENT/DENIAL REASON CODE LISTED IN ADDENDUM H, FIGURE 2-H-1 OR FIGURE 2-H-2.	
THEN UNITS OF SERVICE BY REVENUE CODE MUST = 0 OR 1	

ELEMENT NAME: TOTAL CHARGE BY REVENUE CODE (1-395)	
VALIDITY EDITS	
1-395-01V	IF TYPE OF SUBMISSION =
	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN MUST BE - 999,999.99 TO 999,999.99	
UNLESS REVENUE CODE = 0001	
THEN MUST BE - 9,999,999.99 TO 9,999,999.99	
ELSE MUST BE 0 TO 999,999.99	
UNLESS REVENUE CODE = 0001	
THEN MUST BE 0 TO 9,999,999.99	
RELATIONAL EDITS	
1-395-01R	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

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

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

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

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.

