

Chapter 2

Section 5.4

Institutional Edit Requirements (ELN 300 - 399)

Revision: C-36, April 15, 2020

ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (1-300)			
VALIDITY EDITS			
1-300-01V	IF FILING DATE PRIOR TO 10/01/2004		
	THEN VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE, EXCLUDING E000.0-E999.1 (ICD-9-CM).		
1-300-02V	IF FILING DATE ON OR AFTER 10/01/2004		
	THEN VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE, EXCLUDING E000.0-E999.1 (ICD-9-CM) AND V00-Y99.9 (ICD-10-CM).		
	AND BEGIN DATE OF CARE MUST BE ON OR AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD 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 ICD DIAGNOSIS REFERENCE TABLE		
1-300-03V	POA INDICATOR (POSITION 8 OF THE PRINCIPAL DIAGNOSIS/POA INDICATOR) MUST BE A VALID VALUE.		
RELATIONAL EDITS			
1-300-01R	IF PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) =	799.9	ICD-9-CM OR
		R69	ICD-10-CM OR
		R99	ICD-10-CM
	THEN AMOUNT ALLOWED (TOTAL) MUST = ZERO		
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	1	MEDICAID
1-300-02R	IF PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) 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 PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) IS FOR MALE		
	AND PERSON SEX (PATIENT) = FEMALE		
	THEN AT LEAST ONE OVERRIDE CODE MUST =	H	DIAGNOSIS/PROCEDURE CODE FOR MALE: SEX INDICATES FEMALE
1-300-05R	IF OP/NSP CODE IS CESAREAN SECTION OR REMOVAL OF FETUS (74.0-74.2, 74.4-74.99, 10D00Z0, 10D00Z1, 10D00Z2, 10D07Z3, 10D07Z4, 10D07Z5, 10D07Z6, 10D07Z7, 10D07Z8, 10A00ZZ, 10A03ZZ, 10A04ZZ, 10A08ZZ, 10A07Z6, 10A07ZW, 10A07ZX, OR 10A07ZZ)		
1 PATIENT AGE IS CALCULATED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND DATE OF ADMISSION.			

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ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (1-300) (Continued)		
	THEN PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) MUST BE 640-676 OR O09.00-O77.9, O82, OR O85-O9A.53.	
1-300-06R	IF OP/NSP CODE IS ECTOPIC PREGNANCY (74.3, 10D27ZZ, 10D28ZZ, 10T20ZZ, 10T23ZZ, OR 10T24ZZ)	
	THEN PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) MUST BE 633.0-633.9 OR O00.0-O00.9.	
1-300-07R	IF TYPE OF INSTITUTION =	72 RTC
	AND AMOUNT ALLOWED (TOTAL) > 0	
	THEN PRINCIPAL TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) MUST =	290-316 (MENTAL HEALTH, ICD-9-CM) OR
		F01- F99 (MENTAL HEALTH, ICD-10-CM)
1-300-09R	IF TYPE OF INSTITUTION =	72 RTC
	AND AMOUNT ALLOWED (TOTAL) > 0	
	THEN PATIENT AGE ¹ MUST BE < 21	
	UNLESS ENROLLMENT/HEALTH PLAN CODE =	SR SHCP-MTF REFERRED CARE
¹ PATIENT AGE IS CALCULATED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND DATE OF ADMISSION.		

ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR OCCURRENCES 1-24 (1-305 THROUGH 1-328)		
VALIDITY EDITS		
1-XXX-01V ¹	IF FILING DATE PRIOR TO 10/01/2004	
	THEN VALUE IN POSITIONS 1-7 MUST BE A VALID ICD DIAGNOSIS CODE IF PRESENT OR BLANK FILLED	
1-XXX-0V ¹	IF FILLING DATE ON OR AFTER 10/01/2004	
	THEN VALUE IN POSITIONS 1-7 MUST BE A VALID ICD 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 ICD 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 ICD DIAGNOSIS REFERENCE TABLE	
1-XXX-03V ¹	ALL OCCURRENCES OF SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR.	
1-XXX-04V ¹	POA INDICATOR (POSITION 8 OF THE SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR) MUST BE A VALID VALUE.	
RELATIONAL EDITS		
1-XXX-01R ¹	IF ANY SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) 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 ¹	IF ANY SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) IS FOR MALE	
	AND PERSON SEX (PATIENT) = FEMALE	
¹ XXX EQUALS ELN (305 THROUGH 328) FOR EACH OCCURRENCE OF SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR.		

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ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR OCCURRENCES 1-24 (1-305 THROUGH 1-328) (Continued)

THEN AT LEAST ONE OVERRIDE CODE
MUST =

H DIAGNOSIS/PROCEDURE CODE FOR MALE: SEX
INDICATES FEMALE

¹ XXX EQUALS ELN (305 THROUGH 328) FOR EACH OCCURRENCE OF SECONDARY TREATMENT DIAGNOSIS/POA INDICATOR.

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

VALIDITY EDITS

1-345-01V IF FILING DATE IS PRIOR TO 10/01/2004

THEN VALUE MUST BE A VALID ICD OP/NSP CODE IF PRESENT **OR** BLANK FILLED

1-345-02V IF FILING DATE IS ON OR AFTER 10/01/2004

THEN VALUE MUST BE A VALID ICD OP/NSP CODE IF PRESENT **OR** BLANK FILLED

AND ADMISSION DATE MUST BE ON OR AFTER THE OP/NSP EFFECTIVE DATE AND NOT LATER THAN THE OP/NSP TERMINATION DATE ON THE ICD OP/NSP

OR 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 ICD 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 ICD OP/NSP REFERENCE TABLE

RELATIONAL EDITS

NONE

ELEMENT NAME: SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE OCCURRENCES 1-24 (1-350 THROUGH 1-373)

VALIDITY EDITS

1-XXX-01V¹ IF FILING DATE IS PRIOR TO 10/01/2004

THEN VALUE MUST BE A VALID ICD OP/NSP CODE IF PRESENT **OR** BLANK FILLED

1-XXX-02V¹ IF FILING DATE IS ON OR AFTER 10/01/2004

THEN VALUE MUST BE VALID ICD OP/NSP CODE IF PRESENT **OR** BLANK FILLED

AND ADMISSION DATE MUST BE ON OR AFTER THE OP/NSP EFFECTIVE DATE AND NOT LATER THAN THE OP/NSP TERMINATION DATE ON THE ICD OP/NSP

OR 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 ICD 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 ICD 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

NONE

¹ 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	
1-374-01V	VALUE MUST BE BLANK.
RELATIONAL EDITS	
NONE	

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 DHA DATABASE	
RELATIONAL EDITS	
NONE	

ELEMENT NAME: AMOUNT NETWORK PROVIDER DISCOUNT (1-377)	
VALIDITY EDITS	
1-377-01V	MUST BE NUMERIC AND \geq ZERO
RELATIONAL EDITS	
1-377-01R	IF TYPE OF SUBMISSION =
	B ADJUSTMENT TO NON-TED (HCSR) DATA OR
	C COMPLETE CANCELLATION OR
	D COMPLETE DENIAL OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA OR
	O ZERO GOVERNMENT TED RECORD DUE TO 100% OHI
THEN AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO	
1-377-02R	IF PROVIDER NETWORK STATUS INDICATOR = 2 NON-NETWORK PROVIDER
THEN AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO	
1-377-03R	IF REGION INDICATOR = B BLANK
THEN AMOUNT NETWORK PROVIDER DISCOUNT MUST = ZERO	

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ELEMENT NAME: ADJUSTMENT SEQUENCE NUMBER (1-378)			
VALIDITY EDITS			
1-378-01V	MUST BE NUMERIC		
RELATIONAL EDITS			
1-378-01R	IF TYPE OF SUBMISSION =	D	COMPLETE DENIAL OR
		I	INITIAL SUBMISSION OR
		O	ZERO PAYMENT WITH 100% OHI/TPL OR
		R	RESUBMISSION
THEN ADJUSTMENT SEQUENCE NUMBER MUST = 000 (ZEROES)			
1-378-02R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT OR
		C	COMPLETE CANCELLATION
THEN ADJUSTMENT SEQUENCE NUMBER MUST BE ONE GREATER THAN THE CURRENT VALUE IN THE TED DATABASE			
1-378-03R	IF TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
THEN ADJUSTMENT SEQUENCE NUMBER MUST = 000 (ZEROES)			

ELEMENT NAME: SCH DRG NUMBER (1-379)	
VALIDITY EDITS	
1-379-01V	MUST BE A VALID DRG NUMBER OR BLANK-FILLED.
RELATIONAL EDITS	
1-379-01R	IF SCH DRG CALCULATION > 0
THEN SCH DRG NUMBER MUST NOT BE BLANK	

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 G, FIGURE 2.G-1 OR FIGURE 2.G-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 OR 100X		
	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	HHA PPS
	OR AMOUNT ALLOWED (TOTAL) = ZERO		
1-385-03R	IF PRICING RATE CODE =	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
	THEN PROFESSIONAL SERVICE REVENUE CODES = 0901, 0914-0918, OR 096X-098X		
	AND AQUISITION OF BODY PARTS (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 DHA DATABASE.		
1-385-07R	IF REVENUE CODE =	0022	SNF CHARGE
	THEN ADMISSION DATE ≥ 08/01/2003		
	AND TYPE OF INSTITUTION MUST =	76	SNF
	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
		0652	CONTINUOUS HOME CARE OR

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ELEMENT NAME: REVENUE CODE (1-385) (Continued)		
	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	HHA PPS
AND BEGIN DATE OF CARE ≥ 06/01/2004		
THEN TYPE OF INSTIUTION MUST =	70	HHA

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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/LINE ITEM)	
	EXCEPT FOR REVENUE CODE 0001 OR 0022	
1-390-03R	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/LINE ITEM)	
	UNLESS REVENUE CODE =	0022 SNF PPS OR
		0023 HHA PPS OR
		0024 REHAB PPS OR
		0180 GENERAL CLASSIFICATION OR
		0182 PATIENT CONVENIENCE OR
		0183 THERAPEUTIC LEAVE OR
		0184 RESERVED (EFFECTIVE 04/01/2004) OR
		0185 HOSPITALIZATION OR
		0189 OTHER LEAVE OF ABSENCE
	OR THE OCCURRENCE/LINE ITEM CONTAINS AN ADJUSTMENT/DENIAL REASON CODE LISTED IN ADDENDUM G, FIGURE 2.G-1 OR FIGURE 2.G-2.	
1-390-04R	IF REVENUE CODE = 0001	
	THEN UNITS OF SERVICE BY REVENUE CODE MUST = ZERO.	

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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
THEN TOTAL CHARGE BY REVENUE CODE MUST BE > ZERO ON EACH OCCURRENCE/LINE ITEM (EXCLUDING REVENUE CODE 0001, 0022, 0023, 0024, 0180, 0182, 0183, 0184, 0185, AND 0189)		
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.	

- END -

