

INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: MAJOR DIAGNOSTIC CATEGORY (1-200)

VALIDITY EDITS

1-200-01 VALUE MUST = 1 - 25, 60, 90, **OR** BLANK.

RELATIONAL EDITS

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
NON-AVAILABILITY STATEMENT NUMBER	SEE BELOW	

EDITED ELEMENT RELATIONSHIP

1-200-02R IF NAS NUMBER IS NOT CODED THE MAJOR DIAGNOSTIC CATEGORY MUST NOT BE CODED.

ELEMENT NAME: REASON FOR ISSUANCE (1-202)

VALIDITY EDITS

1-202-01 VALUE MUST = 1 - 9, **OR** BLANK.

RELATIONAL EDITS

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
NON-AVAILABILITY STATEMENT NUMBER	SEE BELOW	
MAJOR DIAGNOSTIC CATEGORY	SEE BELOW	
ENROLLMENT CODE	SEE BELOW	

EDITED ELEMENT RELATIONSHIP

IF NAS NUMBER IS CODED THE NAS REASON FOR ISSUANCE MUST NOT BE BLANK

1-202-03R IF NAS NUMBER IS BLANK THE REASON FOR ISSUANCE MUST = BLANK.

1-202-04R IF MAJOR DIAGNOSTIC CATEGORY IS NOT CODED, REASON FOR ISSUANCE MUST = BLANK 7, 8 **OR** 9

1-202-05R IF REASON FOR ISSUANCE = 7, 8 **OR** 9

THEN

ENROLLMENT CODE = D MANAGED CARE SUPPORT TRICARE-TIDEWATER
 STANDARD PROGRAM

ELEMENT NAME: REASON FOR ISSUANCE (1-202) (CONTINUED)

E	MANAGED CARE SUPPORT TRICARE-TIDEWATER PRIME
G	MANAGED CARE SUPPORT TRICARE-TIDEWATER EXTRA
R	TRICARE EXTRA - NORTH CAROLINA
T	MANAGED CARE SUPPORT STANDARD TRICARE PROGRAM
U	MANAGED CARE SUPPORT PRIME, CIVILIAN PCM
V	MANAGED CARE SUPPORT EXTRA
Y	CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP) STANDARD
Z	MANAGED CARE SUPPORT PRIME, MTF/PCM
AA	CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP) EXTRA

ELEMENT NAME: CLAIM FORM TYPE (1-204)

VALIDITY EDITS

1-204-01 VALUE MUST BE 'A' - 'J' IF FILING DATE ≥ 10/01/93; OTHERWISE NO EDIT APPLIES.

RELATIONAL EDITS

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
NONE		

ELEMENT NAME: PCM LOCATION DMIS-ID (1-205)**VALIDITY EDITS****1-205-01** MUST BE VALID DMIS CODE.**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
REGION CODE	SEE BELOW	
ENROLLMENT CODE	SEE BELOW	

EDITED ELEMENT RELATIONSHIP

1-205-02R IF DATE OF ADMISSION \geq 10/01/97 **AND** $<$ 10/01/99

AND
IF ENROLLMENT STATUS
CODE =

Z **MANAGED CARE SUPPORT PRIME, MTF/CLINIC
OR**

BB **TRICARE SENIOR PRIME**

**THEN PCM LOCATION DMIS-ID MUST BE A VALID MTF/CLINIC DMIS-ID¹
AND CANNOT = 6501, 6901 - 6915, 7901 - 7912, 7916, 8000 - 8099, OR BLANK**

1-205-03R IF DATE OF ADMISSION \geq 10/01/99

AND
IF ENROLLMENT STATUS
CODE =

Z **MANAGED CARE SUPPORT PRIME, MTF/CLINIC
OR**

BB **TRICARE SENIOR PRIME OR**

SR **SUPPLEMENTAL HEALTH CARE PROGRAM -
REFERRED CARE**

**THEN PCM LOCATION DMIS-ID MUST BE A VALID MTF/CLINIC DMIS-ID¹
AND CANNOT = 6501, 6901 - 6915, 7901 - 7912, 7916, 8000 - 8099, OR BLANK**

1-205-04R IF DATE OF ADMISSION \geq 10/01/97 **AND** $<$ 10/01/99

AND ENROLLMENT STATUS
CODE =

U **MANAGED CARE SUPPORT PRIME, CIVILIAN PCM**

AND REGION CODE = 2 THEN DMIS-ID MUST BE 6501 OR 6902 OR 8000 - 8099

1-205-05R IF DATE OF ADMISSION \geq 10/01/97

AND ENROLLMENT STATUS
CODE =

U **MANAGED CARE SUPPORT PRIME, CIVILIAN PCM**

AND REGION CODE = 1 THEN DMIS-ID MUST BE 6901, 8000 - 8099

OR REGION CODE = 2 THEN DMIS-ID MUST BE 6902, 8000 - 8099

OR REGION CODE = 3 THEN DMIS-ID MUST BE 6903

OR REGION CODE = 4 THEN DMIS-ID MUST BE 6904

OR REGION CODE = 5 THEN DMIS-ID MUST BE 6905, 8000 - 8099

¹ A VALID MTF/CLINIC DMIS-ID MEANS ONE THAT MATCHES THE DOD DMIS-ID LISTING.
² THESE REGION CODES ARE RESERVED FOR FUTURE USE.

ELEMENT NAME: PCM LOCATION DMIS-ID (1-205) (CONTINUED)

OR REGION CODE = 6 **THEN** DMIS-ID MUST BE 6906

OR REGION CODE = 7 **THEN** DMIS-ID MUST BE 6907

OR REGION CODE = 8 **THEN** DMIS-ID MUST BE 6908

OR REGION CODE = 9 **THEN** DMIS-ID MUST BE 6909

OR REGION CODE = 10 **THEN** DMIS-ID MUST BE 6910

OR REGION CODE = 11 **THEN** DMIS-ID MUST BE 6911

OR REGION CODE = 12 **THEN** DMIS-ID MUST BE 6912

OR ²REGION CODE = 13 **THEN** DMIS-ID MUST BE 6913

OR ²REGION CODE = 14 **THEN** DMIS-ID MUST BE 6914

OR ²REGION CODE = 15 **THEN** DMIS-ID MUST BE 6915

1-205-06R IF DATE OF ADMISSION ≥ 10/01/97 **AND** < 10/01/99

AND ENROLLMENT STATUS

CODE = W TPR ACTIVE DUTY CLAIMS - USA

AND REGION CODE = 1 **THEN** DMIS-ID MUST BE BLANK **OR** 7901 **OR** 8000 - 8099

OR REGION CODE = 2 **THEN** DMIS-ID MUST BE BLANK **OR** 7902 **OR** 8000 - 8099

OR REGION CODE = 5 **THEN** DMIS-ID MUST BE BLANK **OR** 7905 **OR** 8000 - 8099

OR REGION CODE = 11 **THEN** DMIS-ID MUST BE BLANK **OR** 6911

1-205-07R IF DATE OF ADMISSION ≥ 10/01/99 **AND** < 08/01/00

AND ENROLLMENT STATUS

CODE = W TPR ACTIVE DUTY CLAIMS - USA

AND REGION CODE = 1 **THEN** DMIS-ID MUST BE 7901 **OR** 8000 - 8099

OR REGION CODE = 2 **THEN** DMIS-ID MUST BE 7902 **OR** 8000 - 8099

OR REGION CODE = 3 **THEN** DMIS-ID MUST BE 7903

OR REGION CODE = 4 **THEN** DMIS-ID MUST BE 7904

OR REGION CODE = 5 **THEN** DMIS-ID MUST BE 7905 **OR** 8000 - 8099

OR REGION CODE = 6 **THEN** DMIS-ID MUST BE 7906

OR REGION CODE = 7 **THEN** DMIS-ID MUST BE 7907

OR REGION CODE = 8 **THEN** DMIS-ID MUST BE 7908

OR REGION CODE = 9 **THEN** DMIS-ID MUST BE 7909

OR REGION CODE = 10 **THEN** DMIS-ID MUST BE 7910

OR REGION CODE = 11 **THEN** DMIS-ID MUST BE 7911

OR REGION CODE = 12 **THEN** DMIS-ID MUST BE 7912 **OR** 7916

1-205-08R IF DATE OF ADMISSION ≥ 10/01/97

AND ENROLLMENT STATUS

CODE ≠ SR SUPPLEMENTAL HEALTH CARE PROGRAM - REFERRED CARE **OR**

¹ A VALID MTF/CLINIC DMIS-ID MEANS ONE THAT MATCHES THE DOD DMIS-ID LISTING.
² THESE REGION CODES ARE RESERVED FOR FUTURE USE.

ELEMENT NAME: PCM LOCATION DMIS-ID (1-205) (CONTINUED)

U	MANAGED CARE SUPPORT PRIME, CIVILIAN PCM OR
W	TPR ACTIVE DUTY CLAIMS - USA OR
Z	MANAGED CARE SUPPORT PRIME, MTF/CLINIC OR
BB	TRICARE SENIOR PRIME

THEN PCM LOCATION DMIS-ID MUST = BLANK

**¹ A VALID MTF/CLINIC DMIS-ID MEANS ONE THAT MATCHES THE DOD DMIS-ID LISTING.
² THESE REGION CODES ARE RESERVED FOR FUTURE USE.**

ELEMENT NAME: NUMBER OF PAYMENT REDUCTION DAYS/SERVICES (1-207)

VALIDITY EDITS

1-207-01 MUST BE NUMERIC

RELATIONAL EDITS

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
REASON FOR PAYMENT REDUCTION	SEE BELOW	AMOUNT PAYMENT REDUCTION ENROLLMENT STATUS
NUMBER OF PAYMENT REDUCTION DAYS/SERVICES	SEE BELOW	

EDITED ELEMENT RELATIONSHIP

1-207-02R IF REASON FOR PAYMENT REDUCTION IS NOT EQUAL TO BLANK
 NUMBER OF PAYMENT REDUCTION DAYS/SERVICES MUST NOT BE ZERO.

ELEMENT NAME: PROVIDER CONTRACT AFFILIATION CODE (1-209)

VALIDITY EDITS

1-209-01 MUST BE AN ALPHANUMERIC VALUE OF '0' (NOT APPLICABLE), **OR** '1' (CONTRACTED),
OR '2' (NOT CONTRACTED), **OR** '3' (CONTRACTED/NOT CONTRACTED), **OR** '4' (ACTIVE
 DUTY - TPR).

RELATIONAL EDITS

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
NONE		

ELEMENT NAME: PROVIDER STATE OR COUNTRY CODE (1-210)

VALIDITY EDITS

1-210-01 MUST APPEAR IN A FIGURE OF VALID STATE OR COUNTRY CODES.

RELATIONAL EDITS

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
PROVIDER STATE/COUNTRY CODE ¹	SEE BELOW	BEGIN DATE OF CARE, END DATE OF CARE, RECORD EFFECTIVE DATE ¹ , PROVIDER TAXPAYER NUMBER ¹ , ZIP CODE ¹ , TYPE OF INSTITUTION ¹
AMOUNT ALLOWED	SEE BELOW	

EDITED ELEMENT RELATIONSHIP

1-210-02R MUST MATCH THE PROVIDER STATE/COUNTRY CODE ON THE CORRESPONDING RECORD IN THE PROVIDER FILE. THE 'CORRESPONDING' RECORD IS BASED ON CARE DATES, AND INSTITUTIONAL PROVIDER KEY: PROVIDER TAXPAYER NUMBER, ZIP CODE, AND TYPE OF INSTITUTION.

IF AMOUNT ALLOWED ≤ ZERO

DO NOT CHECK FOR MATCH ON PROVIDER FILE.

¹ PROVIDER FILE

ELEMENT NAME: PROVIDER TAXPAYER NUMBER (1-212)

VALIDITY EDITS

1-212-01 MUST BE NUMERIC, OR FIRST 2 CHARACTERS MUST BE A VALID STATE/COUNTRY CODE AND LAST 7 CHARACTERS MUST BE NUMERIC, OR FIRST 2 CHARACTERS MUST BE A VALID STATE/COUNTRY CODE AND THIRD CHARACTER MUST BE = 'A' AND LAST 6 CHARACTERS MUST BE NUMERIC.

RELATIONAL EDITS

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
PROVIDER TAXPAYER NUMBER ¹	SEE BELOW	PROVIDER ZIP CODE ¹ , TYPE OF INSTITUTION ¹
1-280-06R BEGIN DATE OF CARE		RECORD EFFECTIVE DATE ¹ , PROVIDER ACCEPTANCE DATE ¹ , PROVIDER TERMINATION DATE ¹ , AMOUNT ALLOWED
1-285-06R END DATE OF CARE		SAME AS ABOVE
INST/NON-INST INDICATOR ¹	SEE BELOW	RECORD TYPE

¹ PROVIDER FILE

² USE 1-212-04R ONLY WHEN PROVIDER HISTORY DOES NOT MATCH. IF CURRENT PROVIDER INFORMATION DOES NOT MATCH, CONTINUE TO USE 1-212-03R.

ELEMENT NAME: PROVIDER TAXPAYER NUMBER (1-212) (CONTINUED)

EDITED ELEMENT RELATIONSHIP

NO ERROR IF DENIAL REASON CODE = 'M' (PROVIDER IS NOT TRICARE CERTIFIED) OR 'N' (MULTIPLE DENIAL REASONS)

DO NOT CHECK PROVIDER FILE.

NO ERROR IF DENIAL REASON CODE = '7' (SUSPENSE LIMITATION EXCEEDED)

TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION OF PRIOR HCSR DATA OR
	D	COMPLETE CONTRACTOR DENIAL HCSR SUBMISSION OR
	E	COMPLETE CANCELLATION OF NON-HCSR DATA

THEN DO NOT CHECK PROVIDER FILE.

1-212-02R MUST MATCH AN INSTITUTIONAL PROVIDER TAXPAYER NUMBER ON THE PROVIDER FILE **OR** TYPE OF INSTITUTION AND/OR ZIP CODE ON THE CLAIM MUST MATCH THE TYPE OF INSTITUTION AND/OR ZIP CODE ON THE PROVIDER FILE FOR THE PROVIDER TAXPAYER NUMBER **UNLESS** PROVIDER IS NOT CERTIFIED TO PROVIDE SERVICES ON THE CLAIM DATE(S) OF CARE (DENIAL REASON CODES 'M' **OR** 'N').

1-212-04R² **WHEN AN AUTHORIZED PROVIDER IS FOUND ON THE DATABASE, THE INST/NON-INST INDICATOR MUST AGREE WITH THE HCSR RECORD TYPE. (IF HCSR IS INSTITUTIONAL AND PROVIDER IS NON-INSTITUTIONAL, THE PROVIDER DATABASE WILL NOT CONTAIN THE NECESSARY INSTITUTIONAL DATA.)**

¹ **PROVIDER FILE**
² **USE 1-212-04R ONLY WHEN PROVIDER HISTORY DOES NOT MATCH. IF CURRENT PROVIDER INFORMATION DOES NOT MATCH, CONTINUE TO USE 1-212-03R.**

ELEMENT NAME: PROVIDER SUB-IDENTIFIER (1-215)

VALIDITY EDITS

1-215-01 MUST BE ALPHA **OR** NUMERIC. NO BLANKS.

RELATIONAL EDITS

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
NONE		

ELEMENT NAME: PROVIDER ZIP CODES (1-220)

VALIDITY EDITS

1-220-01 MUST BE NINE CHARACTERS; EITHER 9 DIGITS, **OR** 5 DIGITS (NOT 5 ZEROES **OR** 5 NINES) FOLLOWED BY 4 BLANKS, **OR** 2 CHARACTERS FOLLOWED BY 7 BLANKS, **OR** ALL BLANKS.

¹ **PROVIDER FILE**

ELEMENT NAME: PROVIDER ZIP CODES (1-220) (CONTINUED)

1-220-03 THE FIRST 5 DIGITS MUST MATCH CORRESPONDING RECORD ON THE PROVIDER FILE, BASED ON INSTITUTIONAL PROVIDER KEY PROVIDER TAXPAYER NUMBER, ZIP CODE, AND TYPE OF INSTITUTION.

RELATIONAL EDITS

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
PROVIDER ZIP CODE ¹	SEE BELOW	PROVIDER TAXPAYER NUMBER ¹ , TYPE OF INSTITUTION ¹
1-280-06R BEGIN DATE OF CARE		RECORD EFFECTIVE DATE ¹ , PROVIDER ACCEPTANCE DATE ¹ , PROVIDER TERMINATION DATE ¹ , AMOUNT ALLOWED
1-285-06R END DATE OF CARE		SAME AS ABOVE

EDITED ELEMENT RELATIONSHIP

NO ERROR IF DENIAL REASON CODE =	M	PROVIDER IS NOT TRICARE CERTIFIED
DO NOT CHECK PROVIDER FILE		
NO ERROR IF DENIAL REASON CODE =	7	SUSPENSE LIMITATION EXCEEDED
TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION OF PRIOR HCSR DATA
	D	COMPLETE CONTRACTOR DENIAL HCSR SUBMISSION
	E	COMPLETE CANCELLATION OF NON-HCSR DATA
DO NOT CHECK PROVIDER FILE.		

¹ PROVIDER FILE

ELEMENT NAME: PROVIDER PARTICIPATION INDICATOR (1-225)

VALIDITY EDITS

1-225-01 MUST BE ONE OF THE FOLLOWING VALUES	Y	YES
	N	NO

RELATIONAL EDITS

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
SPECIAL PROCESSING CODE	SEE BELOW	
SPECIAL RATE CODE	SEE BELOW	
MEDICARE NUMBER ¹	SEE BELOW	

¹ PROVIDER FILE

ELEMENT NAME: PROVIDER PARTICIPATION INDICATOR (1-225) (CONTINUED)**EDITED ELEMENT RELATIONSHIP**

1-225-02R IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = B PARTNERSHIP PROGRAM, EXTERNAL WITH SIGNED AGREEMENTS

E HHC/CM

PROVIDER PARTICIPATION INDICATOR MUST = 'Y'

1-225-03R MUST BE 'Y' (YES) WHEN SPECIAL RATE CODE = 'G', 'H', 'I', 'J', 'M', 'N', 'O', OR 'Q'.

1-225-04R 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 HCSR MUST BE 'Y'. IF AMOUNT ALLOWED ≤ ZERO, DO NOT CHECK AGAINST PROVIDER FILE.

¹ PROVIDER FILE**ELEMENT NAME: TYPE OF INSTITUTION (1-230)****VALIDITY EDITS**

1-230-01 MUST BE A VALID TYPE OF INSTITUTION (SEE [CHAPTER 2, ADDENDUM D](#)). MUST NOT BE BLANK.

RELATIONAL EDITS

	RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
1-212-03R	PROVIDER MAJOR SPECIALTY OR TYPE OF INSTITUTION ¹		PROVIDER TAXPAYER NUMBER ¹ , PROVIDER ZIP CODE ¹
1-280-06R	BEGIN DATE OF CARE		RECORD EFFECTIVE DATE ¹ , PROVIDER ACCEPTANCE DATE ¹ , PROVIDER TERMINATION DATE ¹ , AMOUNT ALLOWED
1-285-06R	END DATE OF CARE		SAME AS ABOVE
	NAS EXCEPTION REASON	SEE BELOW	
	SPECIAL RATE CODE	SEE BELOW	

EDITED ELEMENT RELATIONSHIP

1-230-02R TYPE OF INSTITUTION MUST BE '72' (RTC) WHEN NAS EXCEPTION REASON IS '5' (RTC).

1-230-03R IF SPECIAL RATE CODE = K HOSPITAL-SPECIFIC PSYCHIATRIC PER DIEM RATE
L REGION SPECIFIC PSYCHIATRIC PER DIEM RATE

TYPE OF INSTITUTION MUST BE = 22 PSYCHIATRIC HOSPITAL/UNIT

52 CHILDREN'S PSYCHIATRIC HOSPITAL/UNIT

NO ERROR IF DENIAL REASON CODE = M PROVIDER IS NOT TRICARE CERTIFIED

¹ PROVIDER FILE

ELEMENT NAME: TYPE OF INSTITUTION (1-230) (CONTINUED)

DO NOT CHECK PROVIDER FILE

NO ERROR IF DENIAL REASON CODE =	7	SUSPENSE LIMITATION EXCEEDED
TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION OF PRIOR HCSR DATA
	D	COMPLETE CONTRACTOR DENIAL HCSR SUBMISSION
	E	COMPLETE CANCELLATION OF NON-HCSR DATA

DO NOT CHECK PROVIDER FILE.

¹ PROVIDER FILE

ELEMENT NAME: ADMISSION DATE (1-235)

VALIDITY EDITS

1-235-01 MUST BE A VALID GREGORIAN DATE.

RELATIONAL EDITS

	RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
1-085-06R	PATIENT DATE OF BIRTH		
1-235-02R	DATE HCSR PROCESSED TO COMPLETION	≤	
1-235-03R	END DATE OF CARE	≤	
	BEGIN DATE OF CARE	SEE BELOW	FREQUENCY CODE
	DATE ADJUSTMENT IDENTIFIED	SEE BELOW	TYPE OF SUBMISSION
¹	FILING DATE	≤	

EDITED ELEMENT RELATIONSHIP

1-235-04R ADMISSION DATE MUST BE < BEGIN DATE OF CARE **WHEN** FREQUENCY CODE IS INTERIM-INTERIM (3) **OR** INTERIM-FINAL (4).
 ADMISSION DATE MUST = BEGIN DATE OF CARE **WHEN** FREQUENCY CODE IS ADMIT THRU DISCHARGE (1) **OR** INTERIM-INITIAL (2).

1-235-05R ADMISSION DATE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED **WHEN**:

TYPE OF SUBMISSION =	A	ADJUSTMENT
	C	COMPLETE CANCELLATION
	B	ADJUSTMENT OF NON-HCSR DATA
	E	CANCELLATION OF NON-HCSR DATA
	F	ADJUSTMENT HCSR NEW SUFFIX
	G	ADDITIONAL DRG INTERIM BILLING

¹ SEE 1-235-03R (ADMISSION DATE ≤ END DATE OF CARE) AND/OR 1-280-03R (BEGIN DATE OF CARE ≤ FILING DATE) AND/OR 1-280-02R (BEGIN DATE OF CARE ≤ END DATE OF CARE).

ELEMENT NAME: BILL CLASSIFICATION CODE (1-250)**VALIDITY EDITS****1-250-01** VALUE MUST BE '1' OR '2'**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
SPECIAL PROCESSING CODE	SEE BELOW	

EDITED ELEMENT RELATIONSHIP**1-250-02R** IF BILL CLASSIFICATION CODE = '2' (HOSPITAL BASED HOSPICE) THEN SPECIAL PROCESSING CODE MUST EQUAL '#' (HOSPICE)**ELEMENT NAME: FREQUENCY CODE (1-255)****VALIDITY EDITS****1-255-01** MUST BE WITHIN RANGE 1 - 4, 7, 8.**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
DISCHARGE STATUS	SEE BELOW	
SPECIAL RATE CODE	SEE BELOW	SPECIAL PROCESSING CODE
DRG NUMBER	SEE BELOW	
FREQUENCY CODE	SEE BELOW	
SPECIAL PROCESSING CODE	SEE BELOW	

EDITED ELEMENT RELATIONSHIP**1-255-02R** IF DISCHARGE STATUS = '30' (STILL A PATIENT)FREQUENCY CODE MUST
BE =

2 INITIAL

3 INTERIM

IF DISCHARGE STATUS = '01' (DISCHARGED) OR '20' (EXPIRED)

FREQUENCY CODE MUST
BE =

1 ADMIT THRU DISCHARGE

4 FINAL

IF DISCHARGE STATUS = '02' (TRANSFERRED)

FREQUENCY CODE MUST
BE =

1 ADMIT THRU DISCHARGE

4 FINAL

1-255-03R IF SPECIAL RATE CODE = 'H', 'J', 'N', OR 'Q'

ELEMENT NAME: FREQUENCY CODE (1-255) (CONTINUED)

	FREQUENCY CODE MUST BE =	1	ADMIT THRU DISCHARGE
1-255-05R	IF SPECIAL PROCESSING CODE = 'D' (DRG QUALIFYING FOR INTERIM PAYMENT)		
	FREQUENCY CODE MUST BE =	2	INITIAL.
		3	INTERIM
		4	FINAL
1-255-06R	IF SPECIAL RATE CODE = 'G', 'T', 'J', 'M', 'O' OR 'Q' AND SPECIAL PROCESSING CODE ≠	D	DRG QUALIFYING FOR INTERIM PAYMENT
	FREQUENCY CODE MUST BE =	1	ADMIT THRU DISCHARGE
1-255-07R	IF SPECIAL PROCESSING CODE = #	#	HOSPICE
	FREQUENCY CODE MUST BE =	1	ADMIT THRU DISCHARGE
		2	INITIAL
		3	INTERIM
		4	FINAL
		7	REPLACEMENT OF PRIOR CLAIM
		8	VOID/CANCEL OF A PRIOR CLAIM

ELEMENT NAME: TYPE OF ADMISSION (1-260)

VALIDITY EDITS

1-260-01 VALUE MUST BE IN RANGE 1 - 4.

RELATIONAL EDITS

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
SOURCE OF ADMISSION	SEE BELOW	
NAS EXCEPTION REASON	SEE BELOW	
PRINCIPAL TREATMENT DIAGNOSIS	SEE BELOW	

EDITED ELEMENT RELATIONSHIP

1-260-02R	IF SOURCE OF ADMISSION = 'A' THRU 'D' (NEWBORN)		
	TYPE OF ADMISSION MUST BE =	4	NEWBORN
1-260-03R	IF NAS EXCEPTION REASON =	2	EMERGENCY
	TYPE OF ADMISSION MUST BE =	1	EMERGENCY
		4	NEWBORN

ELEMENT NAME: TYPE OF ADMISSION (1-260) (CONTINUED)**1-260-04R** IF TYPE OF ADMISSION = 4 NEWBORN

PRINCIPAL DIAGNOSIS MUST

= 4 NEWBORN

USE ICD-9-CM TAPE FOR TABLE OF NEWBORN DIAGNOSIS CODES.

ELEMENT NAME: SOURCE OF ADMISSION (1-265)**VALIDITY EDITS****1-265-01** VALUE MUST BE IN RANGES 1 - 9; A - D.**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
TYPE OF ADMISSION	SEE BELOW	
NAS EXCEPTION REASON	SEE BELOW	
PRINCIPAL TREATMENT	SEE BELOW	

EDITED ELEMENT RELATIONSHIP**1-265-02R** IF TYPE OF ADMISSION = 4 NEWBORNSOURCE OF ADMISSION
MUST BE =

A NORMAL DELIVERY

B PREMATURE DELIVERY

C SICK BABY

D EXTRAMURAL BIRTH

1-235-03R IF NAS EXCEPTION REASON = 2 EMERGENCY

TYPE OF ADMISSION MUST BE = 1 EMERGENCY

4 NEWBORN

1-265-04R IF SOURCE OF ADMISSION = A NORMAL DELIVERY

B PREMATURE DELIVERY

C SICK BABY

D EXTRAMURAL BIRTH

PRINCIPAL DIAGNOSIS MUST
BE =

NEWBORN

USE ICD-9-CM TAPE FOR TABLE OF DIAGNOSIS/AGE RELATIONSHIPS

ELEMENT NAME: DISCHARGE STATUE (1-275)

VALIDITY EDITS

1-275-01 VALUE MUST BE IN RANGE 01, 02, 03, 04, 05, 06, 07, 08, 20, 30, 40, 41, AND 42.

RELATIONAL EDITS

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
FREQUENCY CODE	SEE BELOW	
SPECIAL RATE CODE	SEE BELOW	SPECIAL PROCESSING CODE

EDITED ELEMENT RELATIONSHIP

1-275-02R IF FREQUENCY CODE =	2	INITIAL
	3	INTERIM
DISCHARGE STATUS MUST BE =	30	STILL A PATIENT
IF FREQUENCY CODE =	1	ADMIT THRU DISCHARGE
DISCHARGE STATUS MUST BE =	01	DISCHARGED
	02	TRANSFERRED
	03	DISCHARGED/TRANSFERRED TO SKILLED NURSING FACILITY (SNF)
	04	DISCHARGED/TRANSFERRED TO INTERMEDIATE CARE FACILITY (ICF)
	05	DISCHARGED/TRANSFERRED TO ANOTHER TYPE OF INSTITUTION FOR INPATIENT CARE, OR REFERRED FOR OUTPATIENT CARE TO ANOTHER INSTITUTION
	06	DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF ORGANIZED HOME HEALTH SERVICE ORGANIZATION
	07	LEFT AGAINST MEDICAL ADVICE OR DISCONTINUED CARE
	08	DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF A HOME IV PROVIDER
	20	EXPIRED
	40	DIED AT HOME
	41	DIED IN MEDICAL FACILITY, SUCH AS HOSPITAL, SNF OR FREE-STANDING HOSPICE
	42	PLACE OF DEATH UNKNOWN

1-275-03R IF SPECIAL RATE CODE = 'H', 'J', 'N' OR 'Q' (TRICARE/CHAMPUS DRG)

THEN
 DISCHARGE STATUS
 MUST ≠ 30 STILL A PATIENT

ELEMENT NAME: DISCHARGE STATUE (1-275) (CONTINUED)**UNLESS**SPECIAL PROCESSING
CODE =

D DRG QUALIFYING FOR INTERIM PAYMENT

1-275-04R IF SPECIAL RATE CODE = 'G', 'I', 'M' OR 'O' (TRICARE/CHAMPUS DRG, WITH LONG STAY OR COST OUTLIER)

DISCHARGE STATUS MUST ≠ 30 STILL A PATIENT

UNLESSSPECIAL PROCESSING
CODE =

D DRG QUALIFYING FOR INTERIM PAYMENT

ELEMENT NAME: BEGIN DATE OF CARE (1-280)**VALIDITY EDITS****1-280-01** MUST BE A VALID GREGORIAN DATE.**RELATIONAL EDITS**

	RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
1-280-02R	END DATE OF CARE	≤	
1-280-03R	FILING DATE	SEE BELOW	SPECIAL PROCESSING CODE, FREQUENCY CODE
1-280-04R	DATE HCSR PROCESSED TO COMPLETION	≤	
1-280-05R	DATE ADJUSTMENT IDENTIFIED	SEE BELOW	TYPE OF SUBMISSION
1-280-06R	PROVIDER TAXPAYER NUMBER ¹	SEE BELOW	PROVIDER ZIP CODE ¹ , TYPE OF INSTITUTION ¹ , PROVIDER ACCEPTANCE & TERMINATION DATES ¹ , PROVIDER RECORD EFFECTIVE DATE ¹ , AMOUNT ALLOWED
1-280-07R	PATIENT DATE OF BIRTH	≥	
1-280-08R	ADMISSION DATE	≥	
1-295-02R	TOTAL BED DAYS		END DATE OF CARE

EDITED ELEMENT RELATIONSHIP**1-280-03R** BEGIN DATE OF CARE MUST BE ≤ FILING DATE.**UNLESS**SPECIAL PROCESSING
CODE =

D DRG QUALIFYING FOR INTERIM PAYMENT

FREQUENCY CODE =

3 INTERIM

4 FINAL

1-280-05R BEGIN DATE OF CARE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED **WHEN:**

TYPE OF SUBMISSION =

A ADJUSTMENT

¹ PROVIDER FILE

ELEMENT NAME: BEGIN DATE OF CARE (1-280) (CONTINUED)

	C	COMPLETE CANCELLATION
	B	ADJUSTMENT TO NON-HCSR DATA
	E	CANCELLATION OF NON-HCSR DATA
	F	ADJUSTMENT HCSR NEW SUFFIX
	G	ADDITIONAL DRG INTERIM BILLING
1-280-06R		PROVIDER MUST BE 'AUTHORIZED' ON PROVIDER FILE FOR THIS BEGIN DATE OF CARE, UNLESS AMOUNT ALLOWED ≤ ZERO. '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.

¹ PROVIDER FILE

ELEMENT NAME: END DATE OF CARE (1-285)

VALIDITY EDITS

1-285-01 MUST BE A VALID GREGORIAN DATE.

RELATIONAL EDITS

	RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
1-235-03R	ADMISSION DATE		
1-280-02R	BEGIN DATE OF CARE		
¹	FILING DATE		
1-285-04R	DATE HCSR PROCESSED TO COMPLETION	≤	
1-285-05R	DATE ADJUSTMENT IDENTIFIED	SEE BELOW	TYPE OF SUBMISSION
1-285-06R	PROVIDER TAXPAYER NUMBER ¹	SEE BELOW	PROVIDER ZIP CODE ² , TYPE OF INSTITUTION ² , PROVIDER ACCEPTANCE & TERMINATION DATES ² , PROVIDER RECORD EFFECTIVE DATE ² , AMOUNT ALLOWED

EDITED ELEMENT RELATIONSHIP

1-285-05R END DATE OF CARE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED **WHEN:**

TYPE OF SUBMISSION =	A	ADJUSTMENT
	C	COMPLETE CANCELLATION
	B	ADJUSTMENT TO NON-HCSR DATA
	E	CANCELLATION OF NON-HCSR DATA
	F	ADJUSTMENT HCSR NEW SUFFIX
	G	ADDITIONAL DRG INTERIM BILLING

ELEMENT NAME: END DATE OF CARE (1-285) (CONTINUED)

1-285-06R PROVIDER MUST BE 'AUTHORIZED' ON PROVIDER FILE FOR THIS END DATE OF CARE, UNLESS AMOUNT ALLOWED ≤ ZERO. '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.

- ¹ SEE 1-280-02R (BEGIN DATE OF CARE ≤ END DATE OF CARE) AND
1-280-03R (BEGIN DATE OF CARE ≤ FILING DATE).
² PROVIDER FILE

ELEMENT NAME: NUMBER OF BIRTHS (1-290)**VALIDITY EDITS**

1-290-01 VALUE MUST BE NUMERIC.

RELATIONAL EDITS

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
PRINCIPAL TREATMENT	SEE BELOW	TYPE OF SUBMISSION, FILING DATE, SECONDARY TREATMENT DIAGNOSIS
PRINCIPAL AND SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE	SEE BELOW	TYPE OF SUBMISSION, FILING DATE

EDITED ELEMENT RELATIONSHIP

1-290-02R IF PRINCIPAL TREATMENT DIAGNOSIS IS FOR PREGNANCY-DELIVERY (640 - 669.9, INCLUSIVE, WITH FIFTH POSITION = 1 OR 2, OR 650) NUMBER OF BIRTHS MUST BE > ZERO

WHEN

TYPE OF SUBMISSION =	I INITIAL SUBMISSION
	R RESUBMISSION OF ERROR REJECT
	O ZERO PAYMENT
	F ADJUSTMENT NEW SUFFIX
	G ADDITIONAL DRG INTERIM BILLING WITH AMOUNT ALLOWED > 0

OR

TYPE OF SUBMISSION =	A ADJUSTMENT
	C COMPLETE CANCELLATION

WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRS STORED ON THE DATABASE.

1-290-03R IN ADDITION, IF DIAGNOSIS IS FOR MULTIPLE GESTATION (651 - 651.9, INCLUSIVE, WITH FIFTH POSITION = 1 OR 2), NUMBER OF BIRTHS MUST BE CONSISTENT WITH PRINCIPAL TREATMENT DIAGNOSIS.

FOR EXAMPLE, IF PRINCIPAL TREATMENT DIAGNOSIS IS 651.01 (TWIN PREGNANCY), NUMBER OF BIRTHS MUST BE = 2

WHEN

TYPE OF SUBMISSION =	I INITIAL SUBMISSION
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ELEMENT NAME: NUMBER OF BIRTHS (1-290) (CONTINUED)

R RESUBMISSION OF ERROR REJECT

O ZERO PAYMENT

F ADJUSTMENT NEW SUFFIX

G ADDITIONAL DRG INTERIM BILLING WITH AMOUNT ALLOWED > 0

0 AMOUNT ALLOWED > 0

OR

TYPE OF SUBMISSION =

A ADJUSTMENT

C COMPLETE CANCELLATION

WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR_s STORED ON THE DATABASE.

1-290-04R IF PRINCIPAL TREATMENT DIAGNOSIS IS FOR PREGNANCY-DELIVERY (640 - 669.9, INCLUSIVE, WITH FIFTH POSITION = 1 **OR** 2, **OR** 650), AT LEAST ONE SECONDARY TREATMENT DIAGNOSIS MUST BE FOR OUTCOME OF DELIVERY (V27.X), AND NUMBER OF BIRTHS MUST ALSO BE CONSISTENT WITH V-CODE. FOR EXAMPLE, IF SECONDARY TREATMENT DIAGNOSIS IS V27.3 (TWINS, ONE LIVEBORN AND ONE STILLBORN), NUMBER OF BIRTHS MUST BE = 2

WHEN

TYPE OF SUBMISSION =

I INITIAL SUBMISSION

R RESUBMISSION OF ERROR REJECT

O ZERO PAYMENT

F ADJUSTMENT NEW SUFFIX

G ADDITIONAL DRG INTERIM BILLING WITH AMOUNT > 0

OR

TYPE OF SUBMISSION =

A ADJUSTMENT

B COMPLETE CANCELLATION

WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR_s STORED ON THE DATABASE.

1-290-05R IF PRINCIPAL/SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE IS FOR OBSTETRICS-DELIVERY (72.0 - 74.99, INCLUSIVE), NUMBER OF BIRTHS MUST BE > ZERO

WHEN

TYPE OF SUBMISSION =

I INITIAL SUBMISSION

R RESUBMISSION OF ERROR REJECT

O ZERO PAYMENT

F ADJUSTMENT NEW SUFFIX

G ADDITIONAL DRG INTERIM BILLING WITH AMOUNT ALLOWED > 0

OR

A ADJUSTMENT

C COMPLETE CANCELLATION

WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR_s STORED ON THE DATABASE.

ELEMENT NAME: TOTAL BED DAYS (1-295)**VALIDITY EDITS****1-295-01** VALUE MUST BE NUMERIC.**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
BEGIN DATE OF CARE AND END DATE OF CARE	SEE BELOW	FREQUENCY CODE, TYPE OF SUBMISSION, FILING DATE, OVERRIDE CODE
UNITS OF SERVICE BY REVENUE CODE	SEE BELOW	REVENUE CODE, TYPE OF SUBMISSION, FILING DATE
GOVERNMENT AUTHORIZED BED DAYS	SEE BELOW	TYPE OF SUBMISSION, FILING DATE
TYPE OF SUBMISSION	SEE BELOW	FILING DATE, OVERRIDE CODE

EDITED ELEMENT RELATIONSHIP

1-295-02R IF FREQUENCY CODE = '1' (ADMIT THRU DISCHARGE HCSR) **OR** '4' (FINAL HCSR) AND BEGIN DATE OF CARE \neq END DATE OF CARE, TOTAL BED DAYS = (END DATE OF CARE - BEGIN DATE OF CARE), **UNLESS** ONE OCCURRENCE OF OVERRIDE CODE = 'Y' **OR** ANY OCCURRENCE OF SPECIAL PROCESSING CODE '#' (HOSPICE **OR** ANY OCCURRENCE OF SPECIAL PROCESSING CODE = '8' (CONTRACTED PROVIDER ARRANGEMENT)).

IF FREQUENCY CODE = '2' (INITIAL HCSR) **OR** '3' (INTERIM HCSR) **OR** BEGIN DATE OF CARE = END DATE OF CARE, TOTAL BED DAYS = (END DATE OF CARE - BEGIN DATE OF CARE) + 1, **UNLESS** ONE OCCURRENCE OF OVERRIDE CODE = 'Y' **OR** ANY OCCURRENCE OF SPECIAL PROCESSING CODE '#' (HOSPICE **OR** ANY OCCURRENCE OF SPECIAL PROCESSING CODE = '8' (CONTRACTED PROVIDER ARRANGEMENT)).

1-295-03R TOTAL BED DAYS MUST BE \leq SUM OF UNITS OF SERVICE BY REVENUE CODE FOR REVENUE CODES WHICH INDICATE THAT A ROOM WAS USED (10X - 18X, 20X - 21X, **OR** 724).

1-295-04R TOTAL BED DAYS MUST BE \geq GOVERNMENT AUTHORIZED BED DAYS

1-295-05R TOTAL BED DAYS MUST BE $>$ ZERO **WHEN**

TYPE OF SUBMISSION ¹ =	I	INITIAL SUBMISSION
	R	RESUBMISSION OF ERROR REJECT
	O	ZERO PAYMENT
	F	ADJUSTMENT NEW SUFFIX
	D	COMPLETE DENIAL
	G	ADDITIONAL DRG INTERIM BILLING

OR

TYPE OF SUBMISSION =	A	ADJUSTMENT
	C	COMPLETE CANCELLATION

WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE;

¹ THIS TYPE OF SUBMISSION RELATIONSHIP APPLIES TO ALL EDITS ON THIS PAGE.

ELEMENT NAME: TOTAL BED DAYS (1-295) (CONTINUED)

NO OCCURRENCE OF OVERRIDE CODE = 'Y'

NO OCCURRENCE OF SPECIAL PROCESSING CODE = '#'

¹ THIS TYPE OF SUBMISSION RELATIONSHIP APPLIES TO ALL EDITS ON THIS PAGE.

