

INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS (1-300)	
VALIDITY EDITS	
1-300-01V	VALUE MUST BE A VALID DIAGNOSIS CODE.
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 (OP/NSP CODE 64.0)
	AND SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY (REFER TO FIGURE 2-E-10)
	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
	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, 74.4-74.99)
	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
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)

THEN PRINCIPAL TREATMENT DIAGNOSIS CODE MUST = 299-310

AND PATIENT AGE¹ MUST BE < 21

1-300-08R IF PRINCIPAL TREATMENT DIAGNOSIS = MATERNITY (630-676 OR V22-V24 OR V270-V289)

AND PERSON BIRTH CALENDAR DATE (PATIENT) INDICATES 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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ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS - 1-8 (1-305 THROUGH 1-340)

VALIDITY EDITS

1-XXX-01V¹ MUST BE A VALID DIAGNOSIS CODE IF PRESENT, **OR** BLANK FILLED. 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 (OP/NSP CODE 64.0)

AND SECONDARY TREATMENT DIAGNOSIS IS **NOT** FOR DELIVERY (REFER TO
[FIGURE 2-E-10](#))

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 [FIGURE 2-E-8](#)).

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 PERSON BIRTH CALENDAR DATE (PATIENT) INDICATES AGE² < 12

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

¹ XXX EQUALS ELN (305 THROUGH 340) 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: PRINCIPAL OPERATION/NON-SURGICAL PROCEDURE CODE (1-345)

VALIDITY EDITS

1-345-01V MUST BE A VALID OP/NSP CODE IF PRESENT, OR BLANK FILLED.

RELATIONAL EDITS

1-345-01R IF ANY OCCURRENCE OF REVENUE CODE = 36X OR 722

THEN OP/NSP IS REQUIRED.

UNLESS DRG NUMBER = BLANK

1-345-02R IF DIAGNOSIS IS FOR MATERNITY/OBSTETRICS (630-676)
EXCLUDING PRENATAL AND POSTPARTUM (REFER TO [FIGURE 2-E-11](#))

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

ELSE IF THE DIAGNOSIS CODE IS FOR DELIVERY (640-669)

THEN CIRCUMCISION (OP/NSP CODE 64.0) IS ALLOWED

1-345-03R 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

THEN PRINCIPAL OP/NSP CODE CANNOT = 37.5 (HEART TRANSPLANT) OR 50.51,
OR 50.59 (LIVER TRANSPLANT)

AND DATE OF ADMISSIONS < 10/01/1998

1-345-04R IF PERSON SEX (PATIENT) IS MALE

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

UNLESS ONE OCCURRENCE OF
OVERRIDE CODE =

H DIAGNOSIS/PROCEDURAL CODE FOR
MALE: SEX INDICATES FEMALE

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ELEMENT NAME: SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE 1-5 (1-350 THROUGH 1-370)

VALIDITY EDITS

1-XXX-01V¹ MUST BE A VALID OP/NSP CODE IF PRESENT, **OR** BLANK FILLED. MUST BE A VALID ICD-9-CM OP/NSP CODE IF PRESENT, **OR** BLANK FILLED. ALL OCCURRENCES OF SECONDARY OPERATIONAL/NON-SURGICAL PROCEDURE CODE FIELD MUST BE BLANK FILLED FOLLOWING THE FIRST OCCURRENCE OF A BLANK FILLED SECONDARY OPERATIONAL/NON-SURGICAL PROCEDURE 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

THEN SECONDARY OP/NSP CODE CANNOT = 37.5 (HEART TRANSPLANT) OR 50.59 (LIVER TRANSPLANT)

AND DATE OF ADMISSIONS < 10/01/1998

1-XXX-02R¹ IF PERSON SEX (PATIENT) IS MALE
THEN OP/NSP 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 OP/NSP 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 370) FOR EACH OCCURRENCE OF SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE.

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

VALIDITY EDITS

1-375-01V VALUE MUST BE IN RANGE 001-999.

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 OF 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 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 49X, 51X-54X, 630-635, 64X, 66X, 82X-85X AND 882.
1-385-02V	FIRST DETAILED LINE MUST CONTAIN REVENUE CODE 001.
RELATIONAL EDITS	
1-385-01R	ONLY ONE OCCURRENCE OF REVENUE CODE MUST = 001.
1-385-02R	AT LEAST ONE OCCURRENCE OF REVENUE CODE MUST = 02X, 10X-18X, 20X-21X OR 724 UNLESS ONE OCCURRENCE OF OVERRIDE CODE = Y NEWBORN IN MOTHER'S ROOM WITHOUT NURSERY CHARGES OR NO OCCURRENCE OF SPECIAL PROCESSING CODE = 11 HOSPICE OR DRG NUMBER ≠ 6 BLANK
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 THEN PROFESSIONAL SERVICE REVENUE CODES = 901, 914-918, OR 96X-98X AND ORGAN CODES (81X) MUST BE DENIED.
1-385-04R	IF ANY REVENUE CODE = 723 THEN PERSON SEX (PATIENT) MUST = MALE.
1-385-05R	IF ANY REVENUE CODE = 72X BUT NOT 723 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 = 022 SKILLED NURSING FACILITY CHARGE THEN ADMISSION DATE ≥ 09/01/2002 AND TYPE OF INSTITUTION MUST = 76 SKILLED NURSING FACILITY AND SNF HIPPS CODE ≠ BLANK UNLESS PATIENT AGE IS < 10 YEARS OF AGE ON DATE OF ADMISSION
1-385-08R	IF ANY REVENUE CODE = 655 INPATIENT RESPITE CARE OR 656 GENERAL INPATIENT CARE - NON-RESPITE THEN TYPE OF INSTITUTION MUST = 79 HOSPITAL BASED HOSPICE
1-385-09R	IF ANY REVENUE CODE = 650 GENERAL CLASSIFICATION OR

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ELEMENT NAME: REVENUE CODE (1-385) (CONTINUED)	
	651 ROUTINE HOME CARE OR
	652 CONTINUOUS HOME CARE OR
	657 PHYSICIAN SERVICES OR
	659 OTHER HOSPICE
	THEN TYPE OF INSTITUTION MUST =
	78 NON-HOSPITAL BASED HOSPICE
1-385-10R	IF ANY OCCURRENCE OF REVENUE CODE =
	023 HOME HEALTH AGENCY (HHA-PPS)
	THEN NO OTHER REVENUE CODES MAY BE PRESENT
	EXCEPT FOR REVENUE CODE 001
1-385-11R	IF REVENUE CODE =
	023 HOME HEALTH AGENCY (HHA-PPS)
	AND BEGIN DATE OF CARE ≥ MAY 15, 2003
	THEN TYPE OF INSTITUTION MUST =
	70 HOME HEALTH AGENCY

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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.
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 OCCURRENCE/LINE ITEMS EXCLUDING REVENUE CODE 001.
1-390-02R	IF UNITS OF SERVICE BY REVENUE CODE = 0
	THEN TOTAL CHARGE BY REVENUE CODE MUST ALSO = 0 (FOR THAT OCCURRENCE)
	EXCEPT FOR REVENUE CODE 001
1-390-03R	IF UNITS OF SERVICE BY REVENUE CODE > 0
	THEN TOTAL CHARGE BY REVENUE CODE MUST ALSO > 0 (FOR THAT OCCURRENCE)
1-390-04R	IF REVENUE CODE 001
	THEN UNITS OF SERVICE BY REVENUE CODE MUST BE ZERO.
1-390-05R	FOR REVENUE CODE 023 UNITS OF SERVICE BY REVENUE CODE MUST BE '1'

ELEMENT NAME: TOTAL CHARGE BY REVENUE CODE (1-395)	
VALIDITY EDITS	
1-395-01V	MUST BE 0 TO 999,999.99 UNLESS REVENUE CODE = 001 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 022)
1-395-02R	THE SUM OF ALL TOTAL CHARGE BY REVENUE CODE FOR REVENUE CODES OTHER THAN 001 MUST EQUAL THE TOTAL CHARGE BY REVENUE CODE FOR REVENUE CODE 001.

