

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**

**1-202-02R** 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 MCS - TRICARE-TIDEWATER STANDARD PROGRAM

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

E	MCS - TRICARE-TIDEWATER PRIME
G	MCS - TRICARE-TIDEWATER EXTRA
R	TRICARE EXTRA - NORTH CAROLINA
T	MCS - STANDARD TRICARE PROGRAM
U	MCS - PRIME, CIVILIAN PCM
V	MCS - EXTRA
Y	CHCBP (CHCBP) STANDARD
Z	MCS - PRIME, MTF/PCM
AA	CHCBP EXTRA

**ELEMENT NAME: CLAIM FORM TYPE (1-204)**

**VALIDITY EDITS**

**1-204-01** VALUE MUST BE 'A' - 'J' IF FILING DATE ≥ 10/01/1993; 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**

**NO ERROR** IF OVERRIDE CODE = S ZIP CODE OVERRIDE TO BE USED WHEN A BENEFICIARY HAS MOVED OUT OF A REGION AND THE CONTRACTOR IS STILL RESPONSIBLE FOR THE CARE CLAIMED; OR IF A BENEFICIARY RESIDES IN A REGION DIFFERENT FROM THE REGION THEY ARE ENROLLED IN - **WITHIN THE SAME CONTRACT JURISDICTION** (I.E., 2/5, 3/4, 7/8 OR 9/10)

**THEN** BYPASS ALL PCM LOCATION DMIS-ID EDITING.**1-205-02R** IF DATE OF ADMISSION  $\geq$  10/01/1997**AND**IF ENROLLMENT STATUS  
CODE =

Z MCS - PRIME, MTF/CLINIC OR

BB TRICARE SENIOR PRIME

**THEN** PCM LOCATION DMIS-ID MUST BE A VALID MTF/CLINIC DMIS-ID<sup>1</sup>  
**AND CANNOT** = 6501, 6901 - 6915, 7901 - 7912, 7916, 8000 - 8099, OR BLANK**1-205-03R** IF DATE OF ADMISSION  $\geq$  10/01/1999**AND**IF ENROLLMENT STATUS  
CODE =

SR SHCP - REFERRED CARE

**THEN** PCM LOCATION DMIS-ID MUST BE A VALID MTF/CLINIC DMIS-ID<sup>1</sup>  
**AND CANNOT** = 6501, 6901 - 6915, 7901 - 7912, 7916, 8000 - 8099, OR BLANK**1-205-04R** IF DATE OF ADMISSION  $\geq$  10/01/1997 **AND**  $<$  10/01/1999**AND** ENROLLMENT STATUS  
CODE =

U MCS - 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  $\geq$  10/01/1997 **AND**  $<$  09/01/2002**AND** ENROLLMENT STATUS  
CODE =

U MCS - PRIME, CIVILIAN PCM

**AND** REGION CODE = 1 **THEN** DMIS-ID MUST BE 6901 OR 8000 - 8099**OR** REGION CODE = 2 **THEN** DMIS-ID MUST BE 6902 OR 8000 - 8099**OR** REGION CODE = 3 **THEN** DMIS-ID MUST BE 6903<sup>1</sup> A VALID MTF/CLINIC DMIS-ID MEANS ONE THAT MATCHES THE DOD DMIS-ID LISTING.

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

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

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

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 REGION CODE = 13 THEN DMIS-ID MUST BE 6913

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

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

**1-205-06R** IF DATE OF ADMISSION  $\geq$  10/01/1997 AND  $<$  10/01/1999

AND ENROLLMENT STATUS

CODE = W TPR **ADSM** - 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  $\geq$  10/01/1999 AND  $<$  09/01/2002

AND ENROLLMENT STATUS

CODE = W TPR **ADSM** - 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  $\geq$  10/01/1997

AND ENROLLMENT STATUS

CODE  $\neq$  SR SHCP - REFERRED CARE OR

<sup>1</sup> A VALID MTF/CLINIC DMIS-ID MEANS ONE THAT MATCHES THE DOD DMIS-ID LISTING.

**ELEMENT NAME: PCM LOCATION DMIS-ID (1-205) (CONTINUED)**U MCS - PRIME, CIVILIAN PCM **OR**W TPR **ADSM** - USA **OR**Z MCS - PRIME, MTF/CLINIC **OR**BB TRICARE SENIOR PRIME **OR**WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR  
ELIGIBLE ADSM**THEN PCM LOCATION DMIS-ID MUST = BLANK****1-205-09R** IF DATE OF ADMISSION ≥ 09/01/2002**AND ENROLLMENT STATUS  
CODE =**

U MCS - PRIME, CIVILIAN PCM

**AND REGION CODE = 1 THEN DMIS-ID MUST BE 6901****OR REGION CODE = 2 THEN DMIS-ID MUST BE 6902, 8007, OR 8009****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****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 <sup>2</sup>REGION CODE = 13 THEN DMIS-ID MUST BE 6913****OR <sup>2</sup>REGION CODE = 14 THEN DMIS-ID MUST BE 6914****OR <sup>2</sup>REGION CODE = 15 THEN DMIS-ID MUST BE 6915****1-205-10R** IF DATE OF ADMISSION ≥ 09/01/2002**AND ENROLLMENT STATUS  
CODE =**W TPR **ADSM** - USA **OR**WF TPR FOR ENROLLED ADFM RESIDING WITH A TPR  
ELIGIBLE ADSM**AND REGION CODE = 1 THEN DMIS-ID MUST BE 7901****OR REGION CODE = 2 THEN DMIS-ID MUST BE 7902****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 REGION CODE = 6 THEN DMIS-ID MUST BE 7906****OR REGION CODE = 7 THEN DMIS-ID MUST BE 7907****<sup>1</sup> A VALID MTF/CLINIC DMIS-ID MEANS ONE THAT MATCHES THE DOD DMIS-ID LISTING.**

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

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

<sup>1</sup> A VALID MTF/CLINIC DMIS-ID MEANS ONE THAT MATCHES THE DOD DMIS-ID LISTING.

**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 A VALID PROVIDER CONTRACT AFFILIATION CODE LOCATED IN CHAPTER 2, SECTION 7.

**RELATIONAL EDITS**

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

**EDITED ELEMENT RELATIONSHIP**

**1-209-02R** IF PROVIDER CONTRACT AFFILIATION CODE = 5 NON-CERTIFIED PROVIDERS (DOES NOT INCLUDE SANCTIONED/SUSPENDED PROVIDERS)

THEN OVERRIDE CODE MUST =

NC NON-CERTIFIED PROVIDERS (DOES NOT INCLUDE SANCTIONED/SUSPENDED PROVIDERS)

**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)
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PROVIDER STATE/COUNTRY CODE <sup>1</sup>	SEE BELOW	BEGIN DATE OF CARE, END DATE OF CARE, RECORD EFFECTIVE DATE <sup>1</sup> , PROVIDER TAXPAYER NUMBER <sup>1</sup> , ZIP CODE <sup>1</sup> , TYPE OF INSTITUTION <sup>1</sup>
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AMOUNT ALLOWED	SEE BELOW	
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**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 INSTITUTIONAL PROVIDER KEY: PROVIDER TAXPAYER NUMBER, ZIP CODE, AND TYPE OF INSTITUTION.

UNLESS AMOUNT ALLOWED ≤ ZERO

OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

FS TFL (SECOND PAYOR) OR

T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001

<sup>1</sup> PROVIDER FILE

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

THEN DO NOT CHECK FOR MATCH ON PROVIDER FILE.

<sup>1</sup> 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 <sup>1</sup>	SEE BELOW	PROVIDER ZIP CODE <sup>1</sup> , TYPE OF INSTITUTION <sup>1</sup>
<b>1-280-06R</b> BEGIN DATE OF CARE		RECORD EFFECTIVE DATE <sup>1</sup> , PROVIDER ACCEPTANCE DATE <sup>1</sup> , PROVIDER TERMINATION DATE <sup>1</sup> , AMOUNT ALLOWED
<b>1-285-06R</b> END DATE OF CARE		SAME AS ABOVE
INST/NON-INST INDICATOR <sup>1</sup>	SEE BELOW	RECORD TYPE

**EDITED ELEMENT RELATIONSHIP**

<b>NO ERROR</b> IF DENIAL REASON CODE =	M	PROVIDER IS NOT TRICARE CERTIFIED <b>OR</b>
	N	MULTIPLE DENIAL REASONS
<b>OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =</b>	FS	<b>TFL</b> (SECOND PAYOR) <b>OR</b>
	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001

THEN DO NOT CHECK FOR MATCH ON THE PROVIDER FILE.

<b>NO ERROR</b> IF DENIAL REASON CODE =	7	SUSPENSE LIMITATION EXCEEDE
TYPE OF SUBMISSION =	C	COMPLETE CANCELLATION OF PRIOR HCSR DATA <b>OR</b>
	D	COMPLETE CONTRACTOR DENIAL HCSR SUBMISSION <b>OR</b>
	E	COMPLETE CANCELLATION OF NON-HCSR DATA

THEN DO NOT CHECK PROVIDER FILE.

<sup>1</sup> PROVIDER FILE

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

**1-212-02R** IF ANY OCCURRENCE OF OVERRIDE CODE = NC (NON-CERTIFIED PROVIDER) 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 = ZEROS  
 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.

**1-212-04R** 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.)

<sup>1</sup> PROVIDER FILE

**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.

**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
PROVIDER ZIP CODE <sup>1</sup>	SEE BELOW	PROVIDER TAXPAYER NUMBER <sup>1</sup> , TYPE OF INSTITUTION <sup>1</sup>

<sup>1</sup> PROVIDER FILE

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

<b>1-280-06R</b>	BEGIN DATE OF CARE	RECORD EFFECTIVE DATE <sup>1</sup> , PROVIDER ACCEPTANCE DATE <sup>1</sup> , PROVIDER TERMINATION DATE <sup>1</sup> , AMOUNT ALLOWED
<b>1-285-06R</b>	END DATE OF CARE	SAME AS ABOVE

**EDITED ELEMENT RELATIONSHIP**

NONE

<sup>1</sup> PROVIDER FILE

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

**VALIDITY EDITS**

<b>1-225-01</b>	MUST BE ONE OF THE FOLLOWING VALUES	Y YES N NO
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**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 <sup>1</sup>	SEE BELOW	

**EDITED ELEMENT RELATIONSHIP**

<b>1-225-02R</b>	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'.

<sup>1</sup> 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.

<sup>1</sup> PROVIDER FILE

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

	<b>RELATED TO ELEMENT</b>	<b>EDITED ELEMENT RELATIONSHIP</b>	<b>ALSO RELATES TO ELEMENT(S)</b>
1-212-03R	PROVIDER MAJOR SPECIALTY OR TYPE OF INSTITUTION <sup>1</sup>		PROVIDER TAXPAYER NUMBER <sup>1</sup> , PROVIDER ZIP CODE <sup>1</sup>
1-280-06R	BEGIN DATE OF CARE		RECORD EFFECTIVE DATE <sup>1</sup> , PROVIDER ACCEPTANCE DATE <sup>1</sup> , PROVIDER TERMINATION DATE <sup>1</sup> , 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) <b>WHEN</b> 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

<sup>1</sup> PROVIDER FILE**ELEMENT NAME: ADMISSION DATE (1-235)****VALIDITY EDITS**

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

**RELATIONAL EDITS**

	<b>RELATED TO ELEMENT</b>	<b>EDITED ELEMENT RELATIONSHIP</b>	<b>ALSO RELATES TO ELEMENT(S)</b>
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
<sup>1</sup>	FILING DATE	≤	

<sup>1</sup> 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: ADMISSION DATE (1-235) (CONTINUED)**

**EDITED ELEMENT RELATIONSHIP**

**1-235-04R** ADMISSION DATE MUST BE < BEGIN DATE OF CARE

WHEN FREQUENCY CODE = 3 INTERIM-INTERIM OR

4 INTERIM-FINAL

ADMISSION DATE MUST = BEGIN DATE OF CARE

WHEN FREQUENCY CODE = 1 ADMIT THRU DISCHARGE OR

2 INTERIM-INITIAL

**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

<sup>1</sup> 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 = # HOSPICE

**ELEMENT NAME: FREQUENCY CODE (1-255)****VALIDITY EDITS****1-255-01** MUST BE WITHIN RANGE 1 - 4, 7, 8.**RELATIONAL EDITS**

<b>RELATED TO ELEMENT</b>	<b>EDITED ELEMENT RELATIONSHIP</b>	<b>ALSO RELATES TO ELEMENT(S)</b>
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**

<b>1-255-02R</b>	IF DISCHARGE STATUS =	30	STILL A PATIENT
	FREQUENCY CODE MUST BE =	2	INITIAL
		3	INTERIM
	IF DISCHARGE STATUS =	01	DISCHARGED <b>OR</b>
		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
<b>1-255-03R</b>	IF SPECIAL RATE CODE = 'H', 'J', 'N', <b>OR</b> 'Q'		
	FREQUENCY CODE MUST BE =	1	ADMIT THRU DISCHARGE
<b>1-255-05R</b>	IF SPECIAL PROCESSING CODE =	D	DRG QUALIFYING FOR INTERIM PAYMENT
	FREQUENCY CODE MUST BE =	2	INITIAL
		3	INTERIM
		4	FINAL
<b>1-255-06R</b>	IF SPECIAL RATE CODE = 'G', 'I', 'J', 'M', 'O' <b>OR</b> 'Q'		
	<b>AND</b> SPECIAL PROCESSING CODE ≠	D	DRG QUALIFYING FOR INTERIM PAYMENT
	FREQUENCY CODE MUST BE =	1	ADMIT THRU DISCHARGE
<b>1-255-07R</b>	IF SPECIAL PROCESSING CODE =	#	HOSPICE

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

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

**1-260-04R** IF TYPE OF ADMISSION = 4 NEWBORN

PRINCIPAL DIAGNOSIS MUST = 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	

**ELEMENT NAME: SOURCE OF ADMISSION (1-265) (CONTINUED)**

NAS EXCEPTION REASON	SEE BELOW
PRINCIPAL TREATMENT	SEE BELOW
EDITED ELEMENT RELATIONSHIP	
1-265-02R IF TYPE OF ADMISSION =	4 NEWBORN
<b>THEN</b> SOURCE OF ADMISSION <b>MUST</b> =	A NORMAL DELIVERY <b>OR</b>
	B PREMATURE DELIVERY <b>OR</b>
	C SICK BABY <b>OR</b>
	D EXTRAMURAL BIRTH
1-265-03R IF NAS EXCEPTION REASON =	2 EMERGENCY
<b>THEN</b> TYPE OF ADMISSION <b>MUST</b> =	1 EMERGENCY <b>OR</b>
	4 NEWBORN
1-265-04R IF SOURCE OF ADMISSION =	A NORMAL DELIVERY <b>OR</b>
	B PREMATURE DELIVERY <b>OR</b>
	C SICK BABY <b>OR</b>
	D EXTRAMURAL BIRTH
<b>THEN</b> PRINCIPAL DIAGNOSIS MUST BE =	NEWBORN
USE ICD-9-CM TAPE FOR TABLE OF DIAGNOSIS/AGE RELATIONSHIPS	

**ELEMENT NAME: DISCHARGE STATUS (1-275)**

VALIDITY EDITS		
1-275-01	VALUE MUST BE IN RANGE 01, 02, 03, 04, 05, 06, 07, 08, 20, 30, 40, 41, 42, 43, 50, 51, 61, 62, 63, 64, AND 65.	
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 <b>OR</b>	
	3 INTERIM	
<b>THEN</b> DISCHARGE STATUS <b>MUST</b> =	30 STILL A PATIENT	
IF FREQUENCY CODE =	1 ADMIT THRU DISCHARGE	
<b>THEN</b> DISCHARGE STATUS <b>MUST</b> =	01 DISCHARGED <b>OR</b>	

**ELEMENT NAME: DISCHARGE STATUS (1-275) (CONTINUED)**

02	TRANSFERRED <b>OR</b>
03	DISCHARGED/TRANSFERRED TO SKILLED NURSING FACILITY (SNF) <b>OR</b>
04	DISCHARGED/TRANSFERRED TO INTERMEDIATE CARE FACILITY (ICF) <b>OR</b>
05	DISCHARGED/TRANSFERRED TO ANOTHER TYPE OF INSTITUTION FOR INPATIENT CARE, OR REFERRED FOR OUTPATIENT CARE TO ANOTHER INSTITUTION <b>OR</b>
06	DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF ORGANIZED HOME HEALTH SERVICE ORGANIZATION <b>OR</b>
07	LEFT AGAINST MEDICAL ADVICE OR DISCONTINUED CARE <b>OR</b>
08	DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF A HOME IV PROVIDER <b>OR</b>
20	EXPIRED <b>OR</b>
40	DIED AT HOME <b>OR</b>
41	DIED IN MEDICAL FACILITY, SUCH AS HOSPITAL, SNF OR FREE-STANDING HOSPICE <b>OR</b>
42	PLACE OF DEATH UNKNOWN <b>OR</b>
43	DISCHARGED/TRANSFERRED TO A FEDERAL HOSPITAL <b>OR</b>
50	HOSPICE - HOME <b>OR</b>
51	HOSPICE - MEDICAL FACILITY <b>OR</b>
61	DISCHARGED/TRANSFERRED WITHIN THIS INSTITUTION TO A HOSPITAL-BASED MEDICARE APPROVED SWING BED <b>OR</b>
62	DISCHARGED/TRANSFERRED TO ANOTHER REHABILITATION FACILITY INCLUDING REHABILITATION DISTINCT PART UNITS OF A HOSPITAL <b>OR</b>
63	DISCHARGED/TRANSFERRED TO A LONG TERM CARE HOSPITAL <b>OR</b>
64	DISCHARGED/TRANSFERRED TO A NURSING FACILITY CERTIFIED UNDER MEDICAID BUT NOT CERTIFIED UNDER MEDICARE <b>OR</b>
65	DISCHARGED/TRANSFERRED TO PSYCHIATRIC HOSPITAL OR PSYCHIATRIC DISTINCT PART OF A HOSPITAL
1-275-03R	IF SPECIAL RATE CODE = 'H', 'J', 'N' <b>OR</b> 'Q' (TRICARE/CHAMPUS DRG) THEN DISCHARGE STATUS MUST ≠ 30 STILL A PATIENT

**ELEMENT NAME: DISCHARGE STATUS (1-275) (CONTINUED)**

	UNLESS SPECIAL PROCESSING CODE =	D	DRG QUALIFYING FOR INTERIM PAYMENT
<b>1-275-04R</b>	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
	UNLESS SPECIAL 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**

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

<sup>1</sup> PROVIDER FILE

<sup>2</sup> '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: BEGIN DATE OF CARE (1-280) (CONTINUED)**

<b>WHEN TYPE OF SUBMISSION =</b>	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

**1-280-06R** PROVIDER MUST BE 'AUTHORIZED'<sup>2</sup> ON PROVIDER FILE FOR THIS BEGIN DATE OF CARE, UNLESS AMOUNT ALLOWED ≤ ZERO

**OR OVERRIDE CODE = NC (NON-CERTIFIED PROVIDER)**

<b>OR IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =</b>	FS <b>TFL</b> (SECOND PAYOR) <b>OR</b>
	T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001

**THEN DO NOT CHECK FOR MATCH OF THE PROVIDER FILE**

<sup>1</sup> PROVIDER FILE

<sup>2</sup> '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 (1-285)**

**VALIDITY EDITS**

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

**RELATIONAL EDITS**

	<b>RELATED TO ELEMENT</b>	<b>EDITED ELEMENT RELATIONSHIP</b>	<b>ALSO RELATES TO ELEMENT(S)</b>
<b>1-235-03R</b>	ADMISSION DATE		
<b>1-280-02R</b>	BEGIN DATE OF CARE		
<sup>1</sup>	FILING DATE		
<b>1-285-04R</b>	DATE HCSR PROCESSED TO COMPLETION	≤	
<b>1-285-05R</b>	DATE ADJUSTMENT IDENTIFIED	SEE BELOW	TYPE OF SUBMISSION

<sup>1</sup> SEE 1-280-02R (BEGIN DATE OF CARE ≤ END DATE OF CARE) AND 1-280-03R (BEGIN DATE OF CARE ≤ FILING DATE).

<sup>2</sup> PROVIDER FILE

<sup>3</sup> '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 (1-285) (CONTINUED)**

<b>1-285-06R</b>	PROVIDER TAXPAYER NUMBER <sup>1</sup>	SEE BELOW	PROVIDER ZIP CODE <sup>2</sup> , TYPE OF INSTITUTION <sup>2</sup> , PROVIDER ACCEPTANCE & TERMINATION DATES <sup>2</sup> , PROVIDER RECORD EFFECTIVE DATE <sup>2</sup> , AMOUNT ALLOWED
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**EDITED ELEMENT RELATIONSHIP**

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

<b>WHEN TYPE OF SUBMISSION =</b>	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

**1-285-06R** PROVIDER MUST BE 'AUTHORIZED'<sup>3</sup> ON PROVIDER FILE FOR THIS END DATE OF CARE, UNLESS AMOUNT ALLOWED ≤ ZERO.

<b>OR IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =</b>	FS	TFL (SECOND PAYOR) OR
	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001

THEN DO NOT CHECK FOR MATCH OF THE PROVIDER FILE

<sup>1</sup> SEE 1-280-02R (BEGIN DATE OF CARE ≤ END DATE OF CARE) AND 1-280-03R (BEGIN DATE OF CARE ≤ FILING DATE).  
<sup>2</sup> PROVIDER FILE  
<sup>3</sup> '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: 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

<sup>1</sup> NETTED NUMBER OF BIRTHS CANNOT BE LESS THAN ONE.

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

PRINCIPAL AND SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE	SEE BELOW	TYPE OF SUBMISSION, FILING DATE
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**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 WITH 100% OHI/TPL
- 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
- R RESUBMISSION OF ERROR REJECT
- O ZERO PAYMENT WITH 100% OHI/TPL
- 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 HCSRs 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

**<sup>1</sup> NETTED NUMBER OF BIRTHS CANNOT BE LESS THAN ONE.**

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

	O	ZERO PAYMENT WITH 100% OHI/TPL
	F	ADJUSTMENT NEW SUFFIX
	G	ADDITIONAL DRG INTERIM BILLING WITH AMOUNT > 0
<b>OR TYPE OF SUBMISSION =</b>	A	ADJUSTMENT
	B	COMPLETE CANCELLATION
WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR <sub>s</sub> STORED ON THE DATABASE.		

<b>1-290-05R</b>	<b>IF</b>	TYPE OF SUBMISSION =	I	INITIAL SUBMISSION <b>OR</b>
			R	RESUBMISSION OF ERROR REJECT <b>OR</b>
			O	ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>
			F	ADJUSTMENT NEW SUFFIX <b>OR</b>
			G	ADDITIONAL DRG INTERIM BILLING WITH AMOUNT ALLOWED > 0

**AND** PRINCIPAL/SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE IS FOR OBSTETRICS-DELIVERY = 72.0 - 74.99 (EXCLUDING 73.3, 73.4, 74.3, 74.91, 73.21)<sup>1</sup>

**THEN** NUMBER OF BIRTHS MUST BE > ZERO

<b>IF</b>	TYPE OF SUBMISSION =	A	ADJUSTMENT <b>OR</b>
		C	COMPLETE CANCELLATION

**AND** PRINCIPAL/SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE IS FOR OBSTETRICS-DELIVERY = 72.0 - 74.99 (EXCLUDING 73.3, 73.4, 74.3, 74.91, 73.21)<sup>1</sup>

**THEN** NUMBER OF BIRTHS MUST BE ≤ ZERO

<sup>1</sup> NETTED NUMBER OF BIRTHS CANNOT BE LESS THAN ONE.

**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 ≠ 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 ≤ SUM OF UNITS OF SERVICE BY REVENUE CODE FOR REVENUE CODES WHICH INDICATE THAT A ROOM WAS USED (10X - 18X, 20X - 21X, 724, OR 762).
- 1-295-04R** TOTAL BED DAYS MUST BE ≥ GOVERNMENT AUTHORIZED BED DAYS
- 1-295-05R** TOTAL BED DAYS MUST BE > ZERO

WHEN TYPE OF SUBMISSION<sup>1</sup> =

- I INITIAL SUBMISSION
- R RESUBMISSION OF ERROR REJECT
- O ZERO PAYMENT WITH 100% OHI/TPL
- F ADJUSTMENT NEW SUFFIX
- D COMPLETE DENIAL
- G ADDITIONAL DRG INTERIM BILLING
- A ADJUSTMENT
- C COMPLETE CANCELLATION

<sup>1</sup> THIS TYPE OF SUBMISSION RELATIONSHIP APPLIES TO ALL EDITS ON THIS PAGE.

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

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WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR<sub>s</sub> STORED ON THE  
DATABASE

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NO OCCURRENCE OF OVERRIDE CODE = 'Y'

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NO OCCURRENCE OF SPECIAL PROCESSING CODE = '#'

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<sup>1</sup> THIS TYPE OF SUBMISSION RELATIONSHIP APPLIES TO ALL EDITS ON THIS PAGE.

