

INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: PROVIDER TAXPAYER NUMBER (1-200)	
VALIDITY EDITS	
1-200-01V	MUST BE NUMERIC
	OR (FIRST 3 POSITIONS MUST BE A VALID STATE/COUNTRY CODE AND LAST 6 POSITIONS MUST BE NUMERIC)
	OR (FIRST 3 POSITIONS MUST BE A VALID STATE/COUNTRY CODE AND FOURTH POSITION MUST BE = 'A' AND LAST 5 POSITIONS MUST BE NUMERIC)
RELATIONAL EDITS	
NO ERROR	IF ADJUSTMENT/DENIAL REASON CODE =
	38 SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS OR
	52 THE REFERRING/PRESCRIBING/ RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE BILLED OR
	B7 THIS PROVIDER WAS NOT CERTIFIED/ ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE
	THEN DO NOT CHECK PROVIDER FILE
NO ERROR	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR
	FG TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) OR
	FS TFL (SECOND PAYOR) OR
	RS MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) AND BEGIN DATE OF CARE ≥ 10/01/2001
	THEN DO NOT CHECK PROVIDER FILE
NO ERROR	IF AMOUNT ALLOWED (TOTAL) ≤ ZERO
	THEN DO NOT CHECK PROVIDER FILE
1-200-02R	IF ANY OCCURRENCE OF OVERRIDE CODE =
	NC NON-CERTIFIED PROVIDER

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**ELEMENT NAME: PROVIDER TAXPAYER NUMBER (1-200) (CONTINUED)**

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 = ZEROES

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.

**ELEMENT NAME: PROVIDER SUB-IDENTIFIER (1-205)**

**VALIDITY EDITS**

1-205-01V MUST BE ALPHA OR NUMERIC--NO BLANKS

**RELATIONAL EDITS**

NONE

**ELEMENT NAME: PROVIDER INDIVIDUAL NPI NUMBER (RESERVED) (1-210)**

**VALIDITY EDITS**

1-210-01V MUST BE BLANK FILLED.

**RELATIONAL EDITS**

NONE

**ELEMENT NAME: PROVIDER GROUP NPI NUMBER (RESERVED) (1-215)**

**VALIDITY EDITS**

1-215-01V MUST BE BLANK FILLED.

**RELATIONAL EDITS**

NONE

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**ELEMENT NAME: PROVIDER ZIP CODE (1-220)**

**VALIDITY EDITS**

**1-220-01V** MUST BE 9 DIGITS OR 5 DIGITS WITH 4 BLANKS

MUST BE A VALID ZIP CODE (BASED ON ADMISSION DATE) IN THE GOVERNMENT PROVIDED ELECTRONIC ZIP CODE FILE OR

MUST BE A 3 CHARACTER FOREIGN COUNTRY CODE (BASED ON THE COUNTRY CODES TABLE<sup>1</sup>) FOLLOWED BY 6 BLANKS

**RELATIONAL EDITS**

NONE

<sup>1</sup> WHEN FOREIGN COUNTRY CODES ARE SUBMITTED, THE FIRST 3 CHARACTERS WILL BE EDITED AGAINST CHAPTER 2, ADDENDUM A.

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

**VALIDITY EDITS**

**1-225-01V** MUST BE A VALID PROVIDER PARTICIPATION INDICATOR.

**RELATIONAL EDITS**

<b>1-225-01R</b>	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 PROVIDER PARTICIPATION INDICATOR MUST = Y YES

**1-225-02R** 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 TED MUST = Y YES

**ELEMENT NAME: PROVIDER NETWORK STATUS INDICATOR (1-230)**

**VALIDITY EDITS**

<b>1-230-01V</b>	MUST BE ONE OF THE FOLLOWING VALUES	1	NETWORK PROVIDER OR
		2	NON-NETWORK PROVIDER

**RELATIONAL EDITS**

NONE

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**ELEMENT NAME: TYPE OF INSTITUTION (1-235)**

**VALIDITY EDITS**

**1-235-01V** VALUE MUST BE A VALID TYPE OF INSTITUTION CODE.

**RELATIONAL EDITS**

**1-235-01R** IF TYPE OF INSTITUTION = 72 RTC  
AND PATIENT ZIP CODE IS IN AN MTF CATCHMENT AREA

THEN CA/NAS  
EXCEPTION REASON  
MUST = 5 RTC

**1-235-02R** IF PRICING RATE CODE = K HOSPITAL-SPECIFIC PSYCHIATRIC PER  
DIEM RATE OR  
L REGION SPECIFIC PSYCHIATRIC PER DIEM  
RATE

THEN TYPE OF INSTITUTION  
MUST = 22 PSYCHIATRIC HOSPITAL/UNIT OR  
52 CHILDREN'S PSYCHIATRIC HOSPITAL/  
UNIT

**1-235-03R** IF TYPE OF INSTITUTION = 70 HOME HEALTH AGENCY

AND BEGIN DATE OF CARE ≥ 06/01/2004

THEN ONE OCCURRENCE  
OF REVENUE CODE  
MUST = 0023 HOME HEALTH AGENCY (HHA-PPS)

**ELEMENT NAME: CLAIM FORM TYPE/EMC INDICATOR (1-240)**

**VALIDITY EDITS**

**1-240-01V** VALUE MUST BE A VALID CLAIM FORM TYPE/EMC INDICATOR.

**RELATIONAL EDITS**

NONE

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**ELEMENT NAME: FREQUENCY CODE (1-250)**

**VALIDITY EDITS**

**1-250-01V** MUST BE A VALID FREQUENCY CODE AND MUST = THE VALUES IN THE FOLLOWING TABLE:

FREQUENCY CODE	PREVIOUS TED RECORD FREQUENCY CODE	BEGIN DATE OF CARE
1	= 1 OR NO PREVIOUS TED RECORD	N/A
2	= 2 OR NO PREVIOUS TED RECORD	N/A
3	= 2 OR 3	PLUS 1 DAY OF ENDING DATE OF CARE ON EXISTING PREVIOUS TED NET RECORD
4	= 2 OR 3	PLUS 1 DAY OF ENDING DATE OF CARE ON EXISTING PREVIOUS TED NET RECORD

**RELATIONAL EDITS**

<b>1-250-01R</b>	IF PATIENT STATUS =	30	STILL A PATIENT
	THEN FREQUENCY CODE MUST =	2	INTERIM-INITIAL OR
		3	INTERIM-INTERIM
	UNLESS TYPE OF INSTITUTION =	70	HOME HEALTH AGENCY
	THEN FREQUENCY CODE MUST =	2	INTERIM-INITIAL OR
		3	INTERIM-INTERIM OR
		7	REPLACEMENT OF PRIOR CLAIM OR
		8	VOID/CANCEL OF PRIOR CLAIM OR
		9	FINAL CLAIM FOR HOME HEALTH AGENCY EPISODE
<b>1-250-02R</b>	IF PATIENT STATUS =	01	DISCHARGED OR
		02	TRANSFERRED OR
		20	EXPIRED
	THEN FREQUENCY CODE MUST =	1	ADMIT THRU DISCHARGE OR
		4	INTERIM-FINAL
<b>1-250-03R</b>	IF PRICING RATE CODE =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER
	THEN FREQUENCY CODE MUST =	1	ADMIT THRU DISCHARGE
<b>1-250-04R</b>	IF FREQUENCY CODE =	3	INTERIM-INTERIM OR
		4	INTERIM-FINAL
	THEN TYPE OF SUBMISSION MUST ≠	I	INITIAL SUBMISSION OR
		R	RESUBMISSION
<b>1-250-05R</b>	IF FREQUENCY CODE =	0	NON-PAYMENT/ZERO CLAIM

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ELEMENT NAME: FREQUENCY CODE (1-250) (CONTINUED)

THEN TYPE OF INSTITUTION  
MUST =

70 HOME HEALTH AGENCY OR

76 SKILLED NURSING FACILITY

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**ELEMENT NAME: TYPE OF ADMISSION (1-255)**

**VALIDITY EDITS**

**1-255-01V** VALUE MUST BE A VALID TYPE OF ADMISSIONS CODE.

**RELATIONAL EDITS**

**1-255-02R** IF CA/NAS EXCEPTION REASON = 2 EMERGENCY

THEN TYPE OF ADMISSION  
MUST = 1 EMERGENCY **OR**

4 NEWBORN

**1-255-03R** IF TYPE OF ADMISSION = 4 NEWBORN

THEN PRINCIPAL DIAGNOSIS MUST BE A NEWBORN DIAGNOSIS (REFER TO  
CHAPTER 2, ADDENDUM E, FIGURE 2-E-8).

**ELEMENT NAME: SOURCE OF ADMISSION (1-260)**

**VALIDITY EDITS**

**1-260-01V** VALUE MUST BE A VALID SOURCE OF ADMISSION.

**RELATIONAL EDITS**

**1-260-01R** IF TYPE OF ADMISSION = 4 NEWBORN

THEN SOURCE OF ADMISSION  
MUST = 1 NORMAL DELIVERY **OR**

2 PREMATURE DELIVERY **OR**

3 SICK BABY **OR**

4 EXTRAMURAL BIRTH

**AND** PRINCIPAL DIAGNOSIS MUST BE A NEWBORN DIAGNOSIS (REFER TO  
CHAPTER 2, ADDENDUM E, FIGURE 2-E-8).

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

<b>ELEMENT NAME: ADMISSION DATE (1-265)</b>	
<b>VALIDITY EDITS</b>	
<b>1-265-01V</b>	MUST BE A VALID GREGORIAN DATE.
<b>RELATIONAL EDITS</b>	
<b>1-265-01R</b>	ADMISSION DATE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION
<b>1-265-02R</b>	ADMISSION DATE MUST BE ≤ END DATE OF CARE
<b>1-265-03R</b>	IF FREQUENCY CODE =
	1 ADMIN THRU DISCHARGE <b>OR</b>
	2 INTERIM-INITIAL
	<b>THEN</b> ADMISSION DATE MUST = BEGIN DATE OF CARE
<b>1-265-04R</b>	IF TYPE OF SUBMISSION =
	A ADJUSTMENT <b>OR</b>
	B ADJUSTMENT OF NON-TED RECORD (HCSR) DATA <b>OR</b>
	C COMPLETE CANCELLATION <b>OR</b>
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	<b>THEN</b> ADMISSION DATE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED
	<b>UNLESS</b> TED RECORD CORRECTION INDICATOR =
	1 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) <b>SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD</b>
	<b>AND</b> DATE ADJUSTMENT IDENTIFIED ON TMA DATABASE = ZEROES.

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**ELEMENT NAME: PATIENT STATUS (1-270)**

**VALIDITY EDITS**

**1-270-01V** VALUE MUST BE A VALID PATIENT STATUS CODE.

**RELATIONAL EDITS**

<b>1-270-01R</b>	IF FREQUENCY CODE =	2	<b>INTERIM-INITIAL OR</b>
		3	<b>INTERIM-INTERIM</b>
	<b>THEN PATIENT STATUS MUST =</b>	30	<b>STILL A PATIENT</b>
<b>1-270-02R</b>	IF FREQUENCY CODE =	1	<b>ADMIT THRU DISCHARGE</b>
	<b>THEN PATIENT STATUS MUST =</b>	01	<b>DISCHARGED OR</b>
		02	<b>TRANSFERRED OR</b>
		03	<b>DISCHARGED/TRANSFERRED TO SKILLED NURSING FACILITY (SNF) OR</b>
		04	<b>DISCHARGED/TRANSFERRED TO INTERMEDIATE CARE FACILITY (ICF) OR</b>
		05	<b>DISCHARGED/TRANSFERRED TO ANOTHER TYPE OF INSTITUTION FOR INPATIENT CARE, OR REFERRED FOR OUTPATIENT CARE TO ANOTHER INSTITUTION OR</b>
		06	<b>DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF ORGANIZED HOME HEALTH SERVICE ORGANIZATION OR</b>
		07	<b>LEFT AGAINST MEDICAL ADVICE OR DISCONTINUED CARE OR</b>
		08	<b>DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF A HOME IV PROVIDER OR</b>
		20	<b>EXPIRED OR</b>
		40	<b>DIED AT HOME OR</b>
		41	<b>DIED IN MEDICAL FACILITY, SUCH AS HOSPITAL, SNF OR FREE-STANDING HOSPICE OR</b>
		42	<b>PLACE OF DEATH UNKNOWN OR</b>
		43	<b>DISCHARGED/TRANSFERRED TO A FEDERAL HOSPITAL OR</b>
		50	<b>HOSPICE-HOME OR</b>
		51	<b>HOSPICE-MEDICAL FACILITY OR</b>
		61	<b>DISCHARGED/TRANSFERRED WITHIN THIS INSTITUTION TO A HOSPITAL-BASED MEDICARE APPROVED SWING BED OR</b>
		62	<b>DISCHARGED/TRANSFERRED TO ANOTHER REHABILITATION FACILITY INCLUDING REHABILITATION DISTINCT PART UNITS OF A HOSPITAL OR</b>
		63	<b>DISCHARGED/TRANSFERRED TO A LONG TERM CARE HOSPITAL OR</b>

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<b>ELEMENT NAME:</b>		<b>PATIENT STATUS (1-270) (CONTINUED)</b>	
		64	DISCHARGED/TRANSFERRED TO A NURSING FACILITY CERTIFIED UNDER MEDICAID BUT NOT CERTIFIED UNDER MEDICARE <b>OR</b>
		65	DISCHARGED/TRANSFERRED TO A PSYCHIATRIC HOSPITAL OR PSYCHIATRIC DISTINCT PART OF A HOSPITAL
<b>1-270-03R</b>	IF PRICING RATE CODE =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER <b>OR</b>
		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER
	<b>THEN PATIENT STATUS MUST ≠</b>	30	STILL A PATIENT

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

<b>ELEMENT NAME: BEGIN DATE OF CARE (1-275)</b>	
<b>VALIDITY EDITS</b>	
<b>1-275-01V</b>	MUST BE A VALID GREGORIAN DATE.
<b>RELATIONAL EDITS</b>	
<b>1-275-01R</b>	BEGIN DATE OF CARE MUST BE ≤ END DATE OF CARE
<b>1-275-02R</b>	BEGIN DATE OF CARE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION
<b>1-275-03R</b>	BEGIN DATE OF CARE MUST BE ≥ PERSON BIRTH CALENDAR DATE (PATIENT)
<b>1-275-04R</b>	BEGIN DATE OF CARE MUST BE ≥ ADMISSION DATE
<b>1-275-05R</b>	IF TYPE OF SUBMISSION =
	A ADJUSTMENT <b>OR</b>
	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>
	C COMPLETE CANCELLATION <b>OR</b>
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	<b>THEN BEGIN DATE OF CARE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED</b>
	<b>UNLESS TED RECORD CORRECTION INDICATOR =</b>
	1 ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) <b>SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD</b>
	<b>AND DATE ADJUSTMENT IDENTIFIED ON TMA DATABASE = ZEROES.</b>
<b>1-275-06R</b>	PROVIDER MUST BE "AUTHORIZED" <sup>1</sup> ON PROVIDER FILE FOR THIS BEGIN DATE OF CARE
	<b>UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =</b>
	T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) <b>AND BEGIN DATE OF CARE ≥ 10/01/2001 OR</b>
	FG TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b>
	FS TFL (SECOND PAYOR) <b>OR</b>
	RS MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) <b>AND BEGIN DATE OF CARE ≥ 10/01/2001</b>
	<b>THEN DO NOT CHECK PROVIDER FILE</b>
<sup>1</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.	

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

**ELEMENT NAME: END DATE OF CARE (1-280)**

**VALIDITY EDITS**

**1-280-01V** MUST BE A VALID GREGORIAN DATE.

**RELATIONAL EDITS**

**1-280-01R** END DATE OF CARE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION

**1-280-02R** IF TYPE OF SUBMISSION =

A	ADJUSTMENT <b>OR</b>
B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>
C	COMPLETE CANCELLATION <b>OR</b>
E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA

**THEN** END DATE OF CARE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED

**UNLESS** TED RECORD CORRECTION INDICATOR =

1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) <b>SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD</b>
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**AND** DATE ADJUSTMENT IDENTIFIED ON TMA DATABASE = ZEROES.

**1-280-03R** PROVIDER MUST BE "AUTHORIZED"<sup>1</sup> ON PROVIDER FILE FOR THIS END DATE OF CARE

**UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =**

T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b>
FG	TFL (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICAL BENEFITS HAVE BEEN EXHAUSTED) <b>OR</b>
FS	TFL (SECOND PAYOR) <b>OR</b>
RS	MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) <b>AND</b> BEGIN DATE OF CARE ≥ 10/01/2001

**THEN DO NOT CHECK PROVIDER FILE**

<sup>1</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.

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**ELEMENT NAME: ADMINISTRATIVE CLIN (1-283)**

**VALIDITY EDITS**

**1-283-01V** MUST BE ALPHANUMERIC OR BLANKS

**1-283-02V** IF TYPE OF SUBMISSION = A ADJUSTMENT OR  
C COMPLETE CANCELLATION

AND ADMINISTRATIVE  
CLAIM COUNT CODE (TMA  
DERIVED FIELD) ON TMA  
FILE =

1 CLAIM RATE HAS BEEN PAID

THEN ADMINISTRATIVE CLIN ON THE ADJUSTMENT MUST = ADMINISTRATIVE  
CLIN ON TMA DATABASE<sup>1</sup>

**RELATIONAL EDITS**

REFER TO [CHAPTER 2, SECTION 8.1](#).

<sup>1</sup> THIS EDIT IS CHECKED DURING THE MATCH AND MARRY PROCESS.

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**ELEMENT NAME: COVERED DAYS (1-285)**

**VALIDITY EDITS**

**1-285-01V** MUST BE NUMERIC.

**RELATIONAL EDITS**

**NO ERROR** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = 11 HOSPICE

**THEN BYPASS ALL COVERED DAYS**

**1-285-01R** IF TYPE OF SUBMISSION = A ADJUSTMENT OR  
 I INITIAL SUBMISSION OR  
 O ZERO PAYMENT WITH 100% OHI/TPL OR  
 R RESUBMISSION

**AND TYPE OF INSTITUTION ≠ 70 HOME HEALTH AGENCY**

**THEN COVERED DAYS MUST BE > ZERO**

**1-285-02R** IF TYPE OF SUBMISSION = C COMPLETE CANCELLATION OR  
 D COMPLETE DENIAL

**THEN COVERED DAYS MUST = ZERO**

**1-285-03R** IF TYPE OF SUBMISSION = A ADJUSTMENT OR  
 I INITIAL SUBMISSION OR  
 O ZERO PAYMENT WITH 100% OHI/TPL OR  
 R RESUBMISSION

**THEN COVERED DAYS MUST BE ≤ SUM OF UNITS OF SERVICE BY REVENUE CODE FOR REVENUE CODES THAT INDICATE THAT A ROOM WAS USED (010X-018X, 020X-021X, 0724, OR 0762)**

**1-285-04R** IF TYPE OF INSTITUTION = 70 HOME HEALTH AGENCY  
**AND TYPE OF SUBMISSION =** I INITIAL SUBMISSION OR  
 O ZERO PAYMENT TED RECORD DUE 100% OHI OR  
 R RESUBMISSION OF ERROR REJECT

**THEN COVERED DAYS MUST = ZERO**

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<b>ELEMENT NAME: DRG NUMBER (1-290)</b>			
<b>VALIDITY EDITS</b>			
<b>1-290-01V</b>	MUST BE A VALID DRG NUMBER OR BLANK FILLED.		
<b>RELATIONAL EDITS</b>			
<b>1-290-01R</b>	IF PRICING RATE CODE =	<del>B</del>	NO SPECIAL RATE CODE OR
		K	HOSPITAL SPECIFIC PSYCHIATRIC PER DIEM RATE OR
		L	REGIONAL-SPECIFIC PSYCHIATRIC PER DIEM RATE OR
		P	PER DIEM RATE AGREEMENT
	<b>THEN DRG NUMBER MUST = BLANK</b>		
<b>1-290-02R</b>	IF ANY OCCURRENCE OF OVERRIDE CODE =	Y	NEWBORN IN MOTHER'S ROOM WITHOUT NURSERY CHARGES
	<b>THEN DRG NUMBER MUST = BLANK.</b>		
<b>1-290-08R</b>	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
	<b>AND DATE OF ADMISSION ≥ 10/01/1996 AND &lt; 10/01/1997</b>		
	<b>THEN DRG NUMBER MUST = 001-102, 104-108, 110-384, 391-434, 436-437, 439-473, 475-479, 481-495, 600-619, 621-624, 626-628, 630-636, OR 900-901.</b>		
<b>1-290-09R</b>	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
	<b>AND DATE OF ADMISSION ≥ 10/01/1997 AND &lt; 10/01/1998</b>		
	<b>THEN DRG NUMBER MUST = 001-102, 104-108, 110-213, 216-220, 223-384, 391-434, 436-437, 439-473, 475-479, 481-503, 600-619, 621-624, 626-628, 630-636, OR 900-901.</b>		
<b>1-290-10R</b>	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
	<b>AND DATE OF ADMISSION ≥ 10/01/1998 AND &lt; 10/01/1999</b>		
	<b>THEN DRG NUMBER MUST = 001-213, 216-220, 223-384, 391-437, 439-455, 461-471, 473, 475-511, 600-619, 621-624, 626-628, 630-636, OR 900-901.</b>		
<b>1-290-21R</b>	IF PRICING RATE CODE =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER OR

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

**ELEMENT NAME: DRG NUMBER (1-290) (CONTINUED)**

		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER
AND DATE OF ADMISSION ≥ 10/01/1999 AND < 10/01/2000			
THEN DRG NUMBER MUST = 001-213, 216-220, 223-384, 391-437, 439-455, 461-473, 475-511, 600-619, 621-624, 626-628, 630-636, OR 900-901.			
<b>1-290-23R</b>	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 ADMISSION ≥ 10/01/2000 AND < 10/01/2001			
THEN DRG NUMBER MUST = 001-213, 216-220, 223-384, 391-437, 439-455, 461-471, 473, 475-511, 600-619, 621-624, 626-628, 630-636, 900-901			
<b>1-290-24R</b>	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 ADMISSION ≥ 10/01/2001 AND ≤ 09/30/2002			
THEN DRG NUMBER MUST = 001-111, 113-213, 216-220, 223-384, 391-433, 439-455, 461-471, 473, 475-523, 600-619, 621-624, 626-628, 630-636, 900-901			
<b>1-290-25R</b>	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 ADMISSION ≥ 10/01/2002 AND ≤ 09/30/2003			
THEN DRG NUMBER MUST = 001-111, 113-213, 216-220, 223-384, 391-433, 439-455, 461-471, 473, 475-527, 600-619, 621-624, 626-628, 630-636, 900-901			
<b>1-290-26R</b>	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 ADMISSION ≥ 10/01/2003			
THEN DRG NUMBER MUST = 001-003, 006-111, 113-213, 216-220, 223-230, 232-384, 391-399, 401-433, 439-455, 461-471, 473, 475-513, 515-540, 600-619, 621-624, 626-628, 630-636, 900-901.			
<b>1-290-27R</b>	IF PRICING RATE CODE =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER OR
		I	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER OR

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INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

**ELEMENT NAME: DRG NUMBER (1-290) (CONTINUED)**

J TRICARE/CHAMPUS DRG REIMBURSEMENT  
WITH NO OUTLIER

AND DATE OF ADMISSION ≥ 10/01/2004

THEN DRG NUMBER MUST = 001-111, 113-213, 216-220, 223-384, 391-433, 439-455, 461-471, 473, 475-482, 484-513, 515-543, 600-619, 621-624, 626-628, 630-636, 900-901.

**ELEMENT NAME: HIPPS CODE (1-292)**

**VALIDITY EDITS**

1-292-01V MUST BE VALID HIPPS CODES REFER TO [CHAPTER 2, SECTION 2.8](#)

**RELATIONAL EDITS**

1-292-01R IF HIPPS CODE = BLANK

THEN NO OCCURRENCE OF  
REVENUE CODE CAN =

0022 SKILLED NURSING FACILITY OR

0023 HOME HEALTH AGENCY

**ELEMENT NAME: ADMISSION DIAGNOSIS (1-295)**

**VALIDITY EDITS**

1-295-01V VALUE MUST BE VALID DIAGNOSIS CODE, EXCLUDING E800.0-E999.1.

**RELATIONAL EDITS**

NONE

