CHAPTER 2
SECTION 5.4

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, EXCLUDING E800.0-E999.1.		
	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 (V50.2)		
	AND SECONDARY TREATMENT DIAGNOSIS IS **NOT** FOR DELIVERY (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-9)		
	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, 74.0-74.99)		
	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.

ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS (1-300) (CONTINUED)			
	THEN PRINCIPAL TREATMENT DIAGNOSIS CODE MUST = 290-316		
	AND PATIENT AGE[1] MUST BE < 21		
1-300-08R	IF PRINCIPAL TREATMENT DIAGNOSIS = MATERNITY (630-676 **OR** V22-V24 **OR** V270-V289)		
	AND PATIENT AGE[1] < 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.**

ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS - 1-11 (1-305 THROUGH 1-342)			
VALIDITY EDITS			
1-XXX-01V[1]	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-01R[1]	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-02R[1]	IF ANY SECONDARY TREATMENT DIAGNOSIS CODE IS FOR MALE		
	AND NOT FOR CIRCUMCISION (V50.2)		
	AND SECONDARY TREATMENT DIAGNOSIS IS **NOT** FOR DELIVERY (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-9)		
	AND PERSON SEX (PATIENT) = FEMALE		
	THEN AT LEAST ONE OVERRIDE CODE MUST =	H	DIAGNOSIS/PROCEDURE CODE FOR MALE: SEX INDICATES FEMALE
1-XXX-03R[1]	IF SECONDARY TREATMENT DIAGNOSIS CODE HAS AN AGE PARAMETER RESTRICTION		
	THEN PATIENT'S AGE MUST BE CONSISTENT WITH RESTRICTIONS (i.e., NEWBORN) (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-7).		
	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-04R[1]	IF SECONDARY TREATMENT DIAGNOSIS = MATERNITY (630-676 **OR** V22-V24 **OR** V270-V289)		
	AND PATIENT AGE[2] < 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 342) FOR EACH OCCURRENCE OF SECONDARY TREATMENT DIAGNOSIS.
[2] PATIENT AGE IS CALCULATED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.

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 = 036*X* **OR** 0722		
	THEN PRINCIPAL OP/NSP PROCEDURE CODE IS REQUIRED.		
	UNLESS DRG NUMBER = BLANK		
1-345-02R	IF DIAGNOSIS CODE FOR MATERNITY/OBSTETRICS (630-676) **EXCLUDING** PRENATAL **AND** POSTPARTUM (REFER TO CHAPTER 2, ADDENDUM E, FIGURE 2-E-10)		
	THEN PRINCIPAL OP/NSP PROCEDURE 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 PROCEDURE CODE **CANNOT** =	37.5	HEART TRANSPLANT **OR**
		50.51	LIVER TRANSPLANT **OR**
		50.59	LIVER TRANSPLANT
	AND DATE OF ADMISSIONS < 10/01/1998		
1-345-04R	IF PERSON SEX (PATIENT) IS MALE		
	THEN PRINCIPAL OP/NSP PROCEDURE CODE **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 PRINCIPAL OP/NSP PROCEDURE CODE **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

ELEMENT NAME:	SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODE 1-11 (1-350 THROUGH 1-373)		
	VALIDITY EDITS		
1-XXX-01V[1]	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-01R[1]	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 PROCEDURE CODE **CANNOT** =	37.5	HEART TRANSPLANT **OR**
		50.59	LIVER TRANSPLANT
	AND DATE OF ADMISSIONS < 10/01/1998		
1-XXX-02R[1]	IF PERSON SEX (PATIENT) IS MALE		
	THEN SECONDARY OP/NSP PROCEDURE CODE **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-03R[1]	IF PERSON SEX (PATIENT) IS FEMALE		
	THEN SECONDARY OP/NSP PROCEDURE CODE **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 373) FOR EACH OCCURRENCE OF SECONDARY OPERATION/ NON-SURGICAL PROCEDURE CODE.**

ELEMENT NAME: TED RECORD CORRECTION INDICATOR (1-374)			
VALIDITY EDITS			
1-374-01V	VALUE MUST BE A VALID TED RECORD CORRECTION INDICATOR		
1-374-02V	IF TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) **SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR**
		2	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT CLAIM PROCESSING ERRORS OR TO UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION. (**NOT TO BE USED TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD**) **OR**
		3	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT **BOTH** CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD
	THEN TYPE OF SUBMISSION MUST =	A	ADJUSTMENT **OR**
		B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA **OR**
		C	COMPLETE CANCELLATION OF TED RECORD DATA **OR**
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
1-374-03V	IF TED RECORD CORRECTION INDICATOR =	1	ADJUSTMENT/CANCELLATION (TYPE OR SUBMISSION A, B, C, OR E) **SOLELY TO CORRECT A PROVISIONALLY ACCEPTED TED RECORD OR**
		3	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) TO CORRECT **BOTH** CLAIM PROCESSING ERRORS AND EDIT ERRORS ON A PROVISIONALLY ACCEPTED TED RECORD
	THEN A MATCH TO A PROVISIONALLY ACCEPTED TED RECORD **MUST** BE PRESENT ON THE TMA DATABASE.		
1-374-04V	IF TED RECORD CORRECTION INDICATOR =	2	ADJUSTMENT/CANCELLATION (TYPE OF SUBMISSION A, B, C, OR E) SOLELY TO CORRECT CLAIM PROCESSING ERRORS OR TO UPDATE PRIOR DATA WITH MORE CURRENT/ACCURATE INFORMATION
	THEN A CORRESPONDING PROVISIONALLY ACCEPTED TED RECORD **MUST NOT** BE PRESENT ON THE TMA DATABASE.		
RELATIONAL EDITS			
	NONE		

ELEMENT NAME:	TOTAL OCCURRENCE/LINE ITEM COUNT (1-375)		
	VALIDITY EDITS		
1-375-01V	VALUE MUST BE IN RANGE 001-450.		
	AND MUST EQUAL THE PHYSICAL COUNT OF THE DETAIL LINE ITEMS ON THE TED RECORD		
1-375-02V	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		C	COMPLETE CANCELLATION
	THEN TOTAL OCCURRENCE/LINE ITEM COUNT MUST BE ≥ 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

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 CHAPTER 2, ADDENDUM H, 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 049X, 051X-054X, 0630-0635, 064X, 0661, 0662, 082X-085X, 0882, **AND** 310X.		
1-385-02V	FIRST DETAILED LINE MUST CONTAIN REVENUE CODE 0001.		
	RELATIONAL EDITS		
1-385-01R	ONLY ONE OCCURRENCE OF REVENUE CODE MUST = 0001.		
1-385-02R	AT LEAST ONE OCCURRENCE OF REVENUE CODE FOR ROOM ACCOMMODATION CHARGES MUST = 010X-021X **OR** 0724		
	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 ≠	~~b~~	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 = 0901, 0914-0918, **OR** 096X-098X		
	AND ORGAN CODES (081X) MUST BE DENIED.		
1-385-04R	IF ANY REVENUE CODE = 0723		
	THEN PERSON SEX (PATIENT) MUST = MALE.		
1-385-05R	IF ANY REVENUE CODE = 072X BUT **NOT** 0723		
	THEN PERSON SEX (PATIENT) MUST = FEMALE		
1-385-06R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		C	COMPLETE CANCELLATION
	THEN REVENUE CODES MUST OCCUR IN THE SAME ORDER		
	AND ON THE SAME OCCURRENCE/LINE ITEM NUMBER AS TMA DATABASE.		
1-385-07R	IF REVENUE CODE =	0022	SKILLED NURSING FACILITY CHARGE
	THEN ADMISSION DATE ≥ 08/01/2003		
	AND TYPE OF INSTITUTION MUST =	76	SKILLED NURSING FACILITY
	AND HIPPS CODE ≠ BLANK		
	UNLESS PATIENT AGE IS < 10 YEARS OF AGE ON DATE OF ADMISSION		
1-385-08R	IF ANY REVENUE CODE =	0655	INPATIENT RESPITE CARE **OR**
		0656	GENERAL INPATIENT CARE - NON-RESPITE
	THEN TYPE OF INSTITUTION MUST =	79	HOSPITAL BASED HOSPICE

ELEMENT NAME: REVENUE CODE (1-385) (CONTINUED)			
1-385-09R	IF ANY REVENUE CODE =	0650	GENERAL CLASSIFICATION **OR**
		0651	ROUTINE HOME CARE **OR**
		0652	CONTINUOUS HOME CARE **OR**
		0657	PHYSICIAN SERVICES **OR**
		0659	OTHER HOSPICE
	THEN TYPE OF INSTITUTION MUST =	78	NON-HOSPITAL BASED HOSPICE
1-385-11R	IF REVENUE CODE =	0023	HOME HEALTH AGENCY (HHA-PPS)
	AND BEGIN DATE OF CARE ≥ 06/01/2004		
	THEN TYPE OF INSTIUTION MUST =	70	HOME HEALTH AGENCY

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 0001.		
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 0001 **OR** 0022		
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 0001		
	THEN UNITS OF SERVICE BY REVENUE CODE MUST = ZERO.		
1-390-05R	IF REVENUE CODE =	0023	HOME HEALTH AGENCY (HHA-PPS)
	THEN UNITS OF SERVICE BY REVENUE CODE MUST = 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 = 0001.		
	THEN MUST BE 0 TO 9,999,999.99		
RELATIONAL EDITS			
1-395-01R	IF TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		C	COMPLETE CANCELLATION **OR**
		D	COMPLETE DENIAL **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION
	THEN TOTAL CHARGE BY REVENUE CODE MUST BE > ZERO ON EACH OCCURRENCE/LINE ITEM (EXCLUDING REVENUE CODE 0022)		
1-395-02R	THE SUM OF ALL TOTAL CHARGE BY REVENUE CODE FOR REVENUE CODES OTHER THAN 0001 MUST EQUAL THE TOTAL CHARGE BY REVENUE CODE FOR REVENUE CODE 0001.		