

## Chapter 2

## Section 5.3

### Institutional Edit Requirements (ELN 200 - 299)

Revision: C-53, September 8, 2021

ELEMENT NAME: PROVIDER TAXPAYER NUMBER (1-200)			
VALIDITY EDITS			
1-200-01V	MUST BE NUMERIC		
	OR (FIRST THREE POSITIONS MUST BE A VALID STATE/COUNTRY CODE AND LAST SIX POSITIONS MUST BE NUMERIC)		
	OR (FIRST THREE POSITIONS MUST BE A VALID STATE/COUNTRY CODE AND FOURTH POSITION MUST BE = A AND LAST FIVE 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
1 ONLY THE FIRST FIVE DIGITS OF THE PROVIDER ZIP CODE ARE USED IN THE MATCH.			

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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<sup>1</sup>

**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<sup>1</sup>

**AND** PROVIDER SUB-IDENTIFIER

<sup>1</sup> ONLY THE FIRST FIVE DIGITS OF THE PROVIDER ZIP CODE ARE USED IN THE MATCH.

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

**VALIDITY EDITS**

**1-205-01V** MUST BE ALPHA **OR** NUMERIC--CANNOT BE BLANKS

**RELATIONAL EDITS**

NONE

**ELEMENT NAME: SCH DRG CALCULATION (1-208)**

**VALIDITY EDITS**

**1-208-01V** MUST BE NUMERIC AND MUST BE ≥ ZERO

**RELATIONAL EDITS**

**1-208-01R** IF SCH DRG NUMBER IS NOT BLANK

**THEN** SCH DRG CALCULATION MUST BE > ZERO

**ELEMENT NAME: PROVIDER ORGANIZATIONAL NPI NUMBER (TYPE 2) (1-215)**

**VALIDITY EDITS**

**1-215-01V** MUST BE ALL BLANKS **OR** 10 DIGITS (MUST NOT BE ALL ZEROES)

**1-215-02V** IF PROVIDER ORGANIZATIONAL NPI NUMBER IS ALL DIGITS

**THEN** THE CHECK DIGIT (POSITION 10 OF THE PROVIDER ORGANIZATIONAL NPI NUMBER) MUST EQUAL THE VALUE COMPUTED USING LUHN FORMULA FOR MODULES 10 "DOUBLE-ADD-DOUBLE" CHECK DIGIT ALGORITHM

**RELATIONAL EDITS**

NONE

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<b>ELEMENT NAME: PROVIDER ZIP CODE (1-220)</b>	
<b>VALIDITY EDITS</b>	
<b>1-220-01V</b>	MUST BE NINE DIGITS <b>OR</b> FIVE DIGITS WITH FOUR BLANKS
	MUST BE A VALID ZIP CODE (BASED ON ADMISSION DATE) IN THE GOVERNMENT PROVIDED ELECTRONIC ZIP CODE FILE <b>OR</b>
	MUST BE A THREE CHARACTER FOREIGN COUNTRY CODE (BASED ON THE COUNTRY CODES TABLE <sup>1</sup> ) FOLLOWED BY SIX BLANKS
<b>RELATIONAL EDITS</b>	
	NONE
<sup>1</sup> WHEN FOREIGN COUNTRY CODES ARE SUBMITTED, THE FIRST THREE CHARACTERS WILL BE EDITED AGAINST <a href="#">ADDENDUM A</a> .	

<b>ELEMENT NAME: PROVIDER PARTICIPATION INDICATOR (1-225)</b>	
<b>VALIDITY EDITS</b>	
<b>1-225-01V</b>	MUST BE A VALID PROVIDER PARTICIPATION INDICATOR.
<b>RELATIONAL EDITS</b>	
	NONE

<b>ELEMENT NAME: PROVIDER NETWORK STATUS INDICATOR (1-230)</b>	
<b>VALIDITY EDITS</b>	
<b>1-230-01V</b>	MUST BE ONE OF THE FOLLOWING VALUES
	1 NETWORK PROVIDER <b>OR</b>
	2 NON-NETWORK PROVIDER
<b>RELATIONAL EDITS</b>	
	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			
1-235-02R	IF PRICING RATE CODE =	K	HOSPITAL-SPECIFIC PSYCHIATRIC PER DIEM RATE <b>OR</b>
		L	REGION SPECIFIC PSYCHIATRIC PER DIEM RATE
	<b>THEN</b> TYPE OF INSTITUTION MUST =	22	PSYCHIATRIC HOSPITAL/UNIT <b>OR</b>
		52	CHILDREN'S PSYCHIATRIC HOSPITAL/UNIT
1-235-03R	IF TYPE OF INSTITUTION =	70	HHA
	<b>AND</b> BEGIN DATE OF CARE ≥ 06/01/2004		
	<b>THEN</b> ONE OCCURRENCE OF REVENUE CODE MUST =	0023	HHA PPS
	<b>UNLESS</b> AMOUNT ALLOWED (TOTAL) = ZERO		
1-235-04R	IF TYPE OF INSTITUTION =	91	SCH
	<b>AND</b> ADMISSION DATE ≥ 01/01/2014		
	<b>AND</b> AMOUNT ALLOWED (TOTAL) > 0		
	<b>THEN</b> PRICING RATE CODE MUST =	V	MEDICARE REIMBURSEMENT RATE <b>OR</b>
		CR	CCR

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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<b>ELEMENT NAME: FREQUENCY CODE (1-250)</b>		
<b>VALIDITY EDITS</b>		
<b>1-250-01V</b>	MUST BE A VALID FREQUENCY CODE	
<b>1-250-02V</b>	IF DRG NUMBER IS NOT BLANK	
<b>AND</b> TYPE OF SUBMISSION =	A	ADJUSTMENT TO TED RECORD DATA <b>OR</b>
	C	COMPLETE CANCELLATION TO TED RECORD DATA <b>OR</b>
	I	INITIAL TED RECORD SUBMISSION <b>OR</b>
	O	ZERO PAYMENT TED RECORD DUE TO 100% OHI <b>OR</b>
	R	RESUBMISSION OF AN INITIAL TED RECORD
<b>AND</b> FREQUENCY CODE =	2	INTERIM-INITIAL <b>OR</b>
	3	INTERIM-INTERIM <b>OR</b>
	4	INTERIM-FINAL
<b>THEN</b> THE FREQUENCY CODE SUBMISSION MUST FOLLOW THE DIRECTIONS IN THE TABLE BELOW		
	<b>FREQUENCY CODE</b>	<b>PREVIOUS TED RECORD FREQUENCY CODE</b>
	2	= 2 <b>OR</b> NO PREVIOUS TED RECORD
	3	= 2 <b>OR</b> 3 (PREVIOUS TED RECORD MUST EXIST)
	4	= 2, 3, <b>OR</b> 4 (PREVIOUS TED RECORD MUST EXIST)
<b>RELATIONAL EDITS</b>		
<b>1-250-01R</b>	IF PATIENT STATUS =	30 STILL A PATIENT
<b>AND</b> AMOUNT ALLOWED (TOTAL) ≠ ZERO		
<b>OR</b> OCCURRENCE OF SPECIAL PROCESSING CODE =		T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYER) <b>OR</b>
		FS TFL (SECOND PAYER)
<b>THEN</b> FREQUENCY CODE MUST =	2	INTERIM-INITIAL <b>OR</b>
	3	INTERIM-INTERIM
<b>UNLESS</b> TYPE OF INSTITUTION =	70	HHA
<b>THEN</b> FREQUENCY CODE MUST =	2	INTERIM-INITIAL <b>OR</b>
	3	INTERIM-INTERIM <b>OR</b>
	7	REPLACEMENT OF PRIOR CLAIM <b>OR</b>
	8	VOID/CANCEL OF PRIOR CLAIM <b>OR</b>
	9	FINAL CLAIM FOR HHA EPISODE
<b>1-250-02R</b>	IF PATIENT STATUS =	01 DISCHARGED <b>OR</b>
		02 TRANSFERRED <b>OR</b>
		20 EXPIRED
<b>THEN</b> FREQUENCY CODE MUST =	0	NON-PAYMENT/ZERO CLAIM <b>OR</b>
	1	ADMIT THROUGH DISCHARGE <b>OR</b>
	4	INTERIM-FINAL <b>OR</b>
	5	LATE CHARGE(S) <b>OR</b>
	7	REPLACEMENT OF PRIOR CLAIM <b>OR</b>
	8	VOID/CANCELLATION OF PRIOR CLAIM <b>OR</b>
	9	FINAL CLAIM FOR HHA PPS EPISODE

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<b>ELEMENT NAME: FREQUENCY CODE (1-250) (Continued)</b>			
<b>1-250-03R</b>	IF PRICING RATE CODE =	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER
	<b>THEN</b> FREQUENCY CODE MUST =	1	ADMIT THROUGH DISCHARGE
<b>1-250-05R</b>	IF FREQUENCY CODE =	5	LATE CHARGE(S)
	<b>THEN</b> AMOUNT ALLOWED (TOTAL) MUST = ZERO	<b>FOR ALL OCCURRENCE/LINE ITEMS</b>	

ELEMENT NAME: TYPE OF ADMISSION (1-255)			
VALIDITY EDITS			
1-255-01V	VALUE MUST BE A VALID TYPE OF ADMISSION CODE.		
	UNLESS REVENUE CODE ON ANY OF THE OCCURRENCES/LINE ITEMS =	0023	HHA
	OR TYPE OF INSTITUTION =	70	HHA
	OR AMOUNT ALLOWED (TOTAL) = ZERO		
	OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	11	HOSPICE
	THEN VALUE MUST BE BLANK OR A VALID TYPE OF ADMISSIONS CODE		
RELATIONAL EDITS			
1-255-03R	IF TYPE OF ADMISSION =	4	NEWBORN
	AND ICD VERSION =	9	ICD-9
	AND POINT OF ORIGIN =	1	NORMAL DELIVERY OR
		2	PREMATURE DELIVERY OR
		4	EXTRAMURAL BIRTH OR
		5	BORN INSIDE THIS HOSPITAL OR
		6	BORN OUTSIDE THIS HOSPITAL
	THEN PRINCIPAL DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) MUST BE BETWEEN V30.0 AND V39.2.		
1-255-04R	IF TYPE OF ADMISSION =	4	NEWBORN
	AND ICD VERSION =	0	ICD-10
	THEN POINT OF ORIGIN =	5	BORN INSIDE THIS HOSPITAL OR
		6	BORN OUTSIDE THIS HOSPITAL
	AND PRINCIPAL DIAGNOSIS/POA INDICATOR (POSITIONS 1-7) MUST BE BETWEEN Z38.00 AND Z38.8.		

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ELEMENT NAME: POINT OF ORIGIN (1-260)			
VALIDITY EDITS			
1-260-01V	VALUE MUST BE A VALID POINT OF ORIGIN.		
RELATIONAL EDITS			
1-260-01R	IF TYPE OF ADMISSION =	4	NEWBORN
	THEN POINT OF ORIGIN MUST =	1	NORMAL DELIVERY (DISCONTINUED 10/01/2007) OR
		2	PREMATURE DELIVERY (DISCONTINUED 10/01/2007) OR
		3	SICK BABY (DISCONTINUED 10/01/2007) OR
		4	EXTRAMURAL BIRTH OR
		5	BORN INSIDE THIS HOSPITAL OR
		6	BORN OUTSIDE THIS HOSPITAL

ELEMENT NAME: ADMISSION DATE (1-265)		
VALIDITY EDITS		
1-265-01V	MUST BE A VALID GREGORIAN DATE AND CANNOT BE > DHA CURRENT SYSTEM DATE.	
RELATIONAL EDITS		
1-265-01R	ADMISSION DATE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION (PTC)	
1-265-02R	ADMISSION DATE MUST BE ≤ END DATE OF CARE	
1-265-03R	IF FREQUENCY CODE =	1      ADMIT THROUGH DISCHARGE
	THEN ADMISSION DATE MUST BE ≥ BEGIN DATE OF CARE	
	ELSE IF FREQUENCY CODE =	2      INTERIM-INITIAL
	AND TYPE OF INSTITUTION ≠	70      HHA
	THEN ADMISSION DATE MUST BE ≥ BEGIN DATE OF CARE	
1-265-04R	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 ADMISSION DATE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED	

ELEMENT NAME: PATIENT STATUS (1-270)			
VALIDITY EDITS			
1-270-01V	VALUE MUST BE A VALID PATIENT STATUS CODE.		
RELATIONAL EDITS			
1-270-01R	IF FREQUENCY CODE =	2	INTERIM-INITIAL <b>OR</b>
		3	INTERIM-INTERIM
	<b>THEN</b> PATIENT STATUS MUST =	30	STILL A PATIENT
1-270-03R	IF PRICING RATE CODE =	H	TRICARE DRG REIMBURSEMENT WITH SHORT STAY OUTLIER <b>OR</b>
		J	TRICARE DRG REIMBURSEMENT WITH NO OUTLIER
	<b>THEN</b> PATIENT STATUS MUST ≠	30	STILL A PATIENT

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ELEMENT NAME: BEGIN DATE OF CARE (1-275)		
VALIDITY EDITS		
1-275-01V	MUST BE A VALID GREGORIAN DATE AND CANNOT BE > DHA CURRENT SYSTEM DATE.	
1-275-02V	BEGIN DATE OF CARE CANNOT BE < 01/01/1990.	
1-275-03V	BEGIN DATE OF CARE MUST BE ≤ END DATE OF CARE.	
RELATIONAL EDITS		
1-275-02R	BEGIN DATE OF CARE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION (PTC)	
1-275-03R	BEGIN DATE OF CARE MUST BE ≥ PERSON BIRTH CALENDAR DATE (PATIENT)	
1-275-05R	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 BEGIN DATE OF CARE MUST BE ≤ DATE ADJUSTMENT IDENTIFIED		
1-275-06R	PROVIDER MUST BE "AUTHORIZED" <sup>1</sup> ON PROVIDER FILE FOR THIS BEGIN DATE OF CARE	
UNLESS AMOUNT ALLOWED (TOTAL) ≤ ZERO		
	OR ADJUSTMENT/DENIAL REASON CODE =	38 SERVICES NOT PROVIDED <b>OR</b> AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS <b>OR</b>
		52 THE REFERRING/PRESCRIBING/RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE BILLED <b>OR</b>
		B7 THIS PROVIDER WAS NOT CERTIFIED ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE
	OR 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 INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER ZIP CODE, TYPE OF INSTITUTION, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (1-200-02R).		



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ELEMENT NAME: END DATE OF CARE (1-280)		
VALIDITY EDITS		
1-280-01V	MUST BE A VALID GREGORIAN DATE AND CANNOT BE > DHA CURRENT SYSTEM DATE.	
1-280-02V	END DATE OF CARE CANNOT BE < 01/01/1990.	
1-280-03V	END DATE OF CARE MUST BE ≥ BEGIN DATE OF CARE.	
RELATIONAL EDITS		
1-280-01R	END DATE OF CARE MUST BE ≤ DATE TED RECORD PROCESSED TO COMPLETION (PTC)	
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		
1-280-03R	PROVIDER MUST BE "AUTHORIZED" <sup>1</sup> ON PROVIDER FILE FOR THIS END DATE OF CARE	
UNLESS AMOUNT ALLOWED (TOTAL) ≤ ZERO		
	OR ADJUSTMENT/DENIAL REASON CODE =	38 SERVICES NOT PROVIDED <b>OR</b> AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS <b>OR</b>
		52 THE REFERRING/PRESCRIBING/RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE BILLED <b>OR</b>
		B7 THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE
	OR 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 INSTITUTIONAL PROVIDER TAXPAYER NUMBER, PROVIDER SUB-IDENTIFIER, PROVIDER ZIP CODE, TYPE OF INSTITUTION, AND PROVIDER ACCEPTANCE AND TERMINATION DATES. THIS IS ONLY DETERMINED ONCE A PROVIDER MATCH HAS BEEN OBTAINED (1-200-02R).		

ELEMENT NAME: ADMINISTRATIVE CLIN (1-283)	
VALIDITY EDITS	
<b>1-283-01V</b>	MUST BE BLANKS.
RELATIONAL EDITS	
REFER TO <a href="#">SECTION 8.1</a> .	

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ELEMENT NAME: COVERED DAYS (1-285)		
VALIDITY EDITS		
<b>1-285-01V</b>	MUST BE NUMERIC.	
<b>1-285-02V</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	
	11	HOSPICE
	<b>OR</b> TYPE OF SUBMISSION =	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA <b>OR</b>
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	<b>OR</b> TYPE OF INSTITUTION =	78 NON-HOSPITAL BASED HOSPICE <b>OR</b>
	79	HOSPITAL BASED HOSPICE
<b>THEN</b> BYPASS THIS EDIT		
<b>ELSE IF</b> AMOUNT ALLOWED (TOTAL) ≤ ZERO		
	<b>OR</b> TYPE OF INSTITUTION =	70 HHA
<b>OR</b> THE SUM OF UNITS OF SERVICE BY REVENUE CODE FOR REVENUE CODES THAT INDICATE THAT A ROOM WAS USED (010X-021X, <b>OR</b> 0724, <b>OR</b> 100X) = ZERO		
<b>THEN</b> COVERED DAYS MUST = ZERO		
	<b>ELSE IF</b> FREQUENCY CODE =	3 INTERIM - INTERIM TED RECORD
<b>OR</b> BEGIN DATE OF CARE = END DATE OF CARE		
<b>THEN</b> COVERDAYS MUST BE ≤ END DATE OF CARE - BEGIN DATE OF CARE + 1		
<b>ELSE IF</b> ADMISSION DATE = END DATE OF CARE		
<b>THEN</b> COVERED DAYS MUST BE ≤ 1		
	<b>ELSE IF</b> FREQUENCY CODE =	1 ADMIT THRU DISCHARGE
<b>THEN</b> COVERED DAYS MUST BE ≤ END DATE OF CARE - ADMISSION DATE		
	<b>ELSE IF</b> FREQUENCY CODE =	2 INTERIM - INITIAL TED RECORD
<b>THEN</b> COVERED DAYS MUST BE ≤ END DATE OF CARE - ADMISSION DATE + 1		
<b>ELSE</b> COVERED DAYS MUST BE ≤ END DATE OF CARE - BEGIN DATE OF CARE		
RELATIONAL EDITS		
NONE		

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ELEMENT NAME: DRG NUMBER (1-290)			
VALIDITY EDITS			
1-290-01V	MUST BE A VALID DRG NUMBER <b>OR</b> BLANK FILLED.		
RELATIONAL EDITS			
1-290-01R	IF PRICING RATE CODE =	<del>B</del>	NO SPECIAL RATE CODE <b>OR</b>
		K	HOSPITAL-SPECIFIC PSYCHIATRIC PER DIEM RATE <b>OR</b>
		L	REGIONAL-SPECIFIC PSYCHIATRIC PER DIEM RATE <b>OR</b>
		P	PER DIEM RATE AGREEMENT <b>OR</b>
		CA	CAH REIMBURSEMENT <b>OR</b>
		CI	CAH IRF REIMBURSEMENT <b>OR</b>
		CP	CAH PSYCHIATRIC HOSPITAL PER DIEM RATE <b>OR</b>
		LT	STANDARD LTCH REIMBURSEMENT <b>OR</b>
		RF	TRICARE IRF REIMBURSEMENT <b>OR</b>
		SN	SITE-NEUTRAL LTCH REIMBURSEMENT
THEN DRG NUMBER MUST = BLANK			
1-290-02R	IF ANY OCCURRENCE OF OVERRIDE CODE =	Y	NEWBORN IN MOTHER’S ROOM WITHOUT NURSERY CHARGES
THEN DRG NUMBER MUST = BLANK			
1-290-31R	IF PRICING RATE CODE =	H	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH SHORT STAY OUTLIER <b>OR</b>
		I	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH COST OUTLIER <b>OR</b>
		J	TRICARE/CHAMPUS DRG REIMBURSEMENT WITH NO OUTLIER <b>OR</b>
		S	HVBP ADJUSTMENT FACTOR <b>OR</b>
		CV	COVID-19 ADJUSTMENT FACTOR <b>OR</b>
		DD	DISCOUNTED DRG
THEN DRG MUST NOT BE BLANK			
AND IF END DATE OF CARE < 10/01/2014			
THEN DATE OF ADMISSION MUST BE ≥ THE DRG EFFECTIVE DATE AND ≤ THE DRG TERMINATION DATE			
ELSE END DATE OF CARE MUST BE ≥ THE DRG EFFECTIVE DATE AND ≤ THE DRG TERMINATION DATE			

ELEMENT NAME: HIPPS CODE (1-292)			
VALIDITY EDITS			
1-292-01V	MUST BE VALID HIPPS CODES REFER TO <a href="#">SECTION 2.5</a> <b>AND</b> REFER TO CMS WEBSITE AT <a href="https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PROSPMedicareFeeSvcPMTGEN/HIPPSCODES">HTTPS://WWW.CMS.GOV/MEDICARE/MEDICARE-FEE-FOR-SERVICE-PAYMENT/PROSPMEDICAREFEESVCPMTGEN/HIPPSCODES</a> .		
RELATIONAL EDITS			
1-292-01R	IF HIPPS CODE = BLANK		
	THEN NO OCCURRENCE OF REVENUE CODE CAN =	0022	SNF <b>OR</b>
		0023	HHA PPS

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ELEMENT NAME: ICD VERSION (1-293)		
VALIDITY EDITS		
1-293-01V	VALUE MUST BE A VALID ICD VERSION.	
RELATIONAL EDITS		
NO ERROR	IF AMOUNT ALLOWED (TOTAL) = ZERO	
1-293-02R	IF END DATE OF CARE ≥ 10/01/2015	
	THEN ICD VERSION MUST BE	0 ICD-10
1-293-04R	IF END DATE OF CARE < 10/01/2015	
	THEN ICD VERSION MUST BE	9 ICD-9

**TRICARE Systems Manual 7950.3-M, April 1, 2015**

Chapter 2, Section 5.3

Institutional Edit Requirements (ELN 200 - 299)

ELEMENT NAME: ADMISSION DIAGNOSIS (1-295)	
VALIDITY EDITS	
<b>1-295-01V</b>	<b>IF</b> FILING DATE IS PRIOR TO 10/01/2004
	<b>THEN</b> VALUE MUST BE VALID ICD DIAGNOSIS CODE, EXCLUDING E000.0-E999.1
	<b>UNLESS</b> REVENUE CODE ON ANY OF THE OCCURRENCES/LINE ITEMS = 0023 HHA
	<b>THEN</b> VALUE MUST BE BLANK <b>OR</b> A VALID ICD DIAGNOSIS CODE, EXCLUDING E000.0-E999.1
<b>1-295-02V</b>	<b>IF</b> FILING DATE ON <b>OR</b> AFTER 10/01/2004
	<b>THEN</b> VALUE MUST BE VALID ICD DIAGNOSIS CODE, EXCLUDING E000.0-E999.1 (ICD-9-CM) AND V00-Y99.9 (ICD-10-CM).
	<b>AND</b> BEGIN DATE OF CARE MUST BE ON <b>OR</b> AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD DIAGNOSIS REFERENCE TABLE
	<b>OR</b> END DATE OF CARE MUST BE ON <b>OR</b> AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD DIAGNOSIS REFERENCE TABLE
	<b>UNLESS</b> REVENUE CODE ON ANY OF THE OCCURRENCES/LINE ITEMS = 0023 HHA
	<b>OR</b> TYPE OF INSTITUTION = 70 HHA
	<b>OR</b> AMOUNT ALLOWED (TOTAL) = ZERO
	<b>OR</b> ANY OCCURRENCE OF SPECIAL PROCESSING CODE = 11 HOSPICE
	<b>THEN</b> VALUE MUST BE BLANK <b>OR</b> VALUE MUST BE A VALID ICD DIAGNOSIS CODE, EXCLUDING E000.0-E999.1 (ICD-9-CM) AND V00-Y99.9 (ICD-10-CM)
	<b>AND</b> BEGIN DATE OF CARE MUST BE ON <b>OR</b> AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD DIAGNOSIS REFERENCE TABLE
	<b>OR</b> END DATE OF CARE MUST BE ON <b>OR</b> AFTER THE DIAGNOSIS EFFECTIVE DATE AND NOT LATER THAN THE DIAGNOSIS TERMINATION DATE ON THE ICD DIAGNOSIS REFERENCE TABLE
RELATIONAL EDITS	
NONE	

- END -

