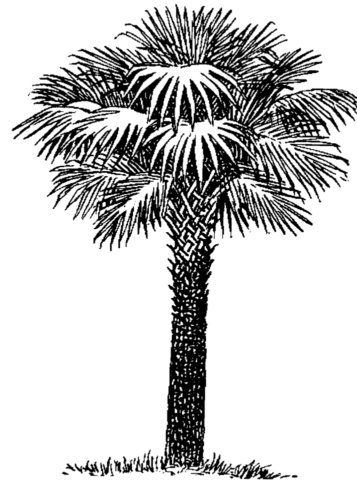
PGBA, LLC

TRICARE Companion Document



837 Institutional Health Care Claim - 004010X096A1

ANSI ASC X12N

Revised: December 2009

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December 2009 Revisions

- Updated edits BF8, B33 and NB1 for source of admission codes '5' and '6' when admission type is '4' for newborn.

Introduction

***Note**: Production files of the HIPAA implementation standard 837 Institutional transactions will not be accepted prior to October 16, 2003.*

This document is the property of PGBA, LLC and is for the use solely in your capacity as Trading Partner health care transactions with PGBA, LLC.

This document provides information related to specific elements with the ANSI ASC X12N 837 transaction. It does not change the definition, data conditions, or use of the data elements or segments in a standard. Nor does it add data elements or segments to the maximum defined data set. It will not use any code or data elements that are marked "not used" in the standard's implementation specifications or are not in the standard's implementation specification(s), or change the meaning or intent of the HIPAA standards implementation specifications. (Refer to Standards for Electronic Transactions, *Federal Register, Vol. 65, No. 160, August 17, 2000 page 50368.*)

This document is intended solely for use as a companion to the Health Insurance Portability and Accountability Act (HIPAA) mandated ANSI ASC X12 Institutional 837 transaction set Implementation Guides (IG). Specific payer instructions contained in this document are provided for clarification purposes only. This document should be used in conjunction with the applicable HIPAA Implementation Guides published by Washington Publishing Company, companion documents, physician's manuals, and/or other billing guidelines published by our clearinghouse payers, including Companion Technologies.

The Final Rule adopting changes to the HIPAA Electronic Transactions and Code Set Standards was published in the Federal Register on February 20, 2003. The URL Link to the Federal Register is: www.access.gpo.gov. This final rule modifies a number of the electronic transactions and code sets adopted as national standards under HIPAA, and eliminates the NDC code set as the standard for all providers except retail pharmacies. It does not adopt a standard reporting drugs and biologics on non-retail pharmacy transactions. The modifications are published as Addenda to the ASC X12 Implementation Guides and are available and can be downloaded through the Washington Publishing Company Web site at www.wpc-edi.com. The X12N Addenda to the Implementation Guides are not independent documents and must be used in concert with the May 2000 Implementation Guides.

This document is incorporated by reference in the Trading Partner Agreement. All instructions were written as known at the time of publication and are subject to change. Changes will be communicated in future letters and on the PGBA, LLC Web site: www.mytricare.com.

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Appropriate steps must be taken before submitting production ANSI ASC X12N transactions, such as testing, completion of a Trading Partner Agreement validation and demographic confirmation with our customer support staff. To begin the process, receive more information or ask questions, please contact the TRICARE EDI Help Desk at (800) 325-5920 (menu option 2).

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ANSI ASC X12N 837 Institutional Health Care Claim (004010X96A1) – Reporting Instruction Clarifications

Overview

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance payers in the United States comply with the EDI technology standards for health care as established by the Secretary of Health and Human Services for Administrative Simplification. The use of standard transactions and code sets will improve Federal and Private health care programs, and the effectiveness and efficiency of the health care industry. The ANSI ASC X12 837 transaction set has been selected as the format to meet HIPAA requirements for the electronic submission of Institutional health care claims.

There are two formats, or views that are used to present the transaction sets in the National Electronic Data Interchange Implementation Guide edits. They are the implementation view and the standard view. The intent of the implementation view is to clarify the segments' purpose and use by restricting the view to display only those segments used with their assigned health care names. For this reason the implementation and view of the transaction set is presented within this document.

- ✓ PGBA, LLC may edit data submitted beyond the requirement defined in the HIPAA Implementation Guide.
- ✓ PGBA, LLC may reject interchanges, functional groups or segments that do not follow all HIPAA Implementation Guide and PGBA, LLC Companion Document requirements
- ✓ PGBA, LLC may reject an interchange that is submitted with a submitter identification number that is not authorized for electronic submission.

Trading partners should note that if the information associated with any of the claims on the 837 ST-SE envelope is not correctly formatted from a syntactical perspective, that all claims between the ST-SE envelope would be rejected. Providers and submitters should consider this possible response when determining the size of their transactions.

Hierarchical Structure

The 837 format incorporates a hierarchical structure to make the submission of healthcare claims as efficient as possible. This structure can differentiate relationships between the provider, subscriber, and patient and aides in the elimination of repetitious reporting of data. An example of this is the ability to report claims for both the subscriber and dependents without repeating the subscriber information.

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A subordinate dependent hierarchical level should not be included when the subscriber is also the patient and no additional claims are being sent for the subscriber's dependents. When the dependent is the patient or when there is a combination of claims for the subscriber and their dependents the additional patient information should be reported at the dependent level. If only dependent claims are reported for a subscriber, address and demographic segments are required for the patient/dependent.

The dependent hierarchical level should be used when there are only claims for dependents or claims for both the subscriber and dependents.

Maximums/Limitations

- Report a maximum of 999 service lines per claim.
- Submit a maximum of 5,000 claims per transaction set.

Claim Reporting Clarifications

- When reporting zero dollar amounts, report that amount (do not leave blank) in the transaction. Amount elements that are required and left blank will cause the claim to be rejected.
- When reporting percentages in amount elements, be certain to indicate the percentage as a decimal. For example, 50% would be .5, 25% would be .25.
- Segments submitted at the claim level apply to the entire claim unless overridden by information provided at the service level.

Character Set Requirement

The following character set guidelines must be followed to avoid file rejections. Only characters identified below can be reported within any data field.

A…Z	0…9	!	"	&	,	(	)	+	'	-	/	;	?	?	=	@	Space

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Monetary Amounts

For implementation of this guide under the rules promulgated under the Health Insurance Portability and Accountability Act (HIPAA), decimal data elements in Data Element 782 (Monetary Amount) will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). However, PGBA, LLC currently only accepts 8 characters.

Provider Identifiers

NPI

2010AA BILLING (required)
NM108 = XX
NM109 = NPI
REF01 = 'EI' or 'SY'
REF02 = EIN or SSN

2310A ATTENDING (required on outpatient ER and all inpatient)
NM108 = XX
NM109 = NPI
NPI required if loop is sent. Secondary ID (REF segment) is not required.

2310B – 2310E OTHER PROVIDER LOOPS (situational)
NM108 = XX
NM109 = NPI
NPI required if loop is sent. Secondary ID (REF segment) is not required.

ATYPICAL

2010AA BILLING (required)
NM108 = 24 or 34
NM109 = EIN or SSN
REF01 = '1H', 'EI' , 'SY', 'G2' or 'LU'.
REF02 = Tricare provider number

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2310A ATTENDING (required on outpatient ER and all inpatient)
NM108 = 24 or 34
NM109 = EIN or SSN
REF01 = '1H', 'EI' , 'SY' or '1G'
REF02 = Tricare provider number

2310B – 2310E OTHER PROVIDER LOOPS (situational)
NM108 = 24 or 34
NM109 = EIN or SSN
REF01 = '1H', 'EI' , 'SY' or '1G'
REF02 = Tricare provider number

Note: See Data Clarification Table

National Provider Identifiers (NPI)

National provider identifiers were implemented on May 23, 2008 and are required for reporting provider IDs, except for atypical providers. Billing (2010AA) NPI is required and must be sent with a REF segment with an EI or SY qualifier. Provider loops 2310A-2310E, when sent, require an NPI, but do not require a secondary (legacy) ID. Please note and adhere to the instructions for provider identifiers above and any elements within the 837 Implementation Guides that apply. Additional address information may also be required on claims when legacy number use is discontinued. See bulletin below:

****IMPORTANT NPI BULLETIN****

There may be gaps between your enumeration strategy compared to PGBA's internal legacy identifiers. To ensure correct one (NPI) to many (legacy ID) crosswalks, verify the addresses that PGBA, LLC has on file for each location and specialty (taxonomy) by becoming a member of www.myTricare.com, or contacting customer service. Once you have verified that the service address you will submit on a claim matches an address on PGBA's provider files, follow guidelines below:

For UB04, only send post office boxes in FL2 (2010AB). FL1 should be used for physical address where services were rendered and map to the 2010AA loop in the HIPAA EMC format. Loop 2310E can be used to send a physical address only when physical address not provided in 2010AA. When loop 2310E is sent, an NPI is required in NM109.

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Resource Sharing Identifiers

If you are filing a Resource Sharing claim, the Contract Type Code must equal '09'. The Reference Identification must contain the MTF ID.

In Loop: 2300, the CN1 Segment needs to be present.
2300-CN101 (**Contract Type Code)** = '09'
2300-CN104 (**Reference Identification)** = 'MTF ID'

Note: ** Use CN1 segment only if provider has a contract with a Military Treatment Facility. Any other use will result in CN1 edit.* *See page 8.*

Secondary Claims Filing

If there is another health insurance primary to TRICARE, then loop 2300 and 2320 are used to provide the following other health insurance payment information:

In Loop: 2300 HI01-1 = BE
HI01-2 = 44
HI01-5 = Amount allowed by primary insurance
OR HI01-2 = Value code or occurrence code with reason for nonpayment by primary insurance (use only if AMT02 equals zero)
In Loop: 2320 AMT01 = C4
AMT02 = Primary payer paid amount

Note: See Data Clarification Table
If PGBA, LLC receives next payer information, they will accept it, but will not forward the information to the next payer.

Institutional 837 Interchange Envelope and Functional Group Structure

Trading partners should follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B. Trading Partners should also follow the basic character set guidelines as set forth in the implementation guide. The interchange cannot contain non-HIPAA version functional groups. For unique instructions for transmitting to PGBA, LLC, please refer to the ***GPNet Technical Communications User's Manual.***

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Data Clarification Table Error Code Description

Code	Error Description
CN1	CN104-127 REFERENCE ID REQUIRED
OB1	CLM OR ENCOUNTER ID MUST BE CH - CHARGEABLE
OCC	TOTAL CLAIM CHARGES MUST BE < $10,000,000.00
OC1	TOT CHARG AT THE LINE MUST BE LESS THAN $100,000
OL2	LX01-554 ASSIGNED NUMBER < 1,000
ON1	ENTITY TYPE QUAL FOR SUBSC NAME MUST = 1
ON2	ID CODE QUALIFIER SUBSC NAME MUST = MI
OP2	INDIVIDUAL RELSHP MUST BE VALID AND NOT = 41
OS5	ONLY 2 REPEATS OF OTHER SUBSC INFO ALLOWED
T05	CONTRACT INFO. NEEDED | CUR SEGMENT REQUIRED
T06	CLAIM ORIGINAL REF NUMBER NOT F8
T07	2300-180-REF02-127 CLAIM NUMBER IS INVALID – MUST BE 13 CHARACTERS OF FORMAT 9999XXXXX9999
T08	MONETARY AMT NOT PRESENT
T09	2320-290-SBR05-1336 MUST NOT EQUAL MB|2320-AMT-522-QUAL MUST = D. POSSIBLE TRICARE FOR LIFE.
T12	PRINCIPAL QUALIFIER NOT 'BK'
T13	PRINCIPAL QUALIFIER NOT 'BR'

Code	Error Description
T15	REF-ID-QUAL NOT 1H OR LU | ATTEND-PHYS-2ND-ID = ' '
T17	NM108 IDENTIFICATION CODE QUALIFIER NOT PI
T18	PATIENT RELATIONSHIP INVALID
T19	SBR03 SUBSCRIBER IS EQUAL TO SELF (18)
T20	CLAIM OR ENCOUNTER ID NOT 'CH'
T21	FOREIGN CURRENCY NOT = 'USD'
T22	NM108 IDENTIFICATION QUAL NOT '24' | '34'
T23	2010AA LOOP REQUIRED
T24	REF IDENTIFICATION QUALIFIER NOT 1H, EI, SY, OR LU
T25	BILLING PROVIDER 2ND-ID IS INVALID
T26	NM109 SUBSCRIBER PRIMARY ID NOT NUMERIC
T27	SBR SEGMENT REQUIRED
T29	PRODUCT | SERVICE ID QUALIFIER NOT HC OR ZZ
T30	ADMITTING CODE NOT 'BJ'
T31	MORE THAN 3 OCCURRENCES OF THE OTHER SUBSRIBER COB INFO
60Y	FREQUENCY CODE IS INVALID

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Data Clarification Table for the Institutional 837 (004010X096A1) Transaction Set

Error Code	Loop	Seg Pos	Data Element	Req or Sit	Segment/ Element	Instruction	Industry/Element Name	Attributes	IG Page No.
T20	N/A		640	R	BHT06	**All Files** – Must equal **CH (Chargeable).** The claim or encounter identifier code specifies the type of transaction. It is used to indicate the type of billed service.	Claim or Encounter Identifier Transaction Type Code	O ID 2/2	59
	1000A		67	R	NM109	PGBA, LLC requires this field to be your **Trading Partner Identification Number**	Identification Code Submitter Identifier	X AN 2/80	63
	1000B		1035	R	NM103	PGBA, LLC requires this field to be **TRICARE**	Receiver Name Name Last or Organization Name	O AN 1/35	68
	1000B		67	R	NM109	PGBA, LLC requires this field to be **571132733**	Identification Code Receiver Primary Identifier	X AN 2/80	68
	2000A	010		S	CUR	This segment optional and is used to specify the currency (dollars, pounds, francs, etc.) used in the transaction.	Foreign Currency Information		73
T21	2000A		100	R	CUR02	PGBA, LLC requires this data element if CUR segment is present in Loop 2000A, segment position 010. If present, report USD (US Dollars) is this element.	Currency Code	M ID 3/3	74
T23	2010AA	035		S	REF	PGBA, LLC requires this Loop. At least one repeat of this Loop must have the data element REF01, position 128 present.	Billing Provider Secondary Identification Reference Identification Qualifier		82
T24	2010AA		128	R	REF01	Must have these qualifiers, for PGBA, LLC use: **1H CHAMPUS ID Number** (Atypical only) **EI Employers Identification Number**	Reference Identification Qualifier	M ID 2/3	83

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Error Code	Loop	Seg Pos	Data Element	Req or Sit	Segment/ Element	Instruction	Industry/Element Name	Attributes	IG Page No.
T25	2010AA		127	R	REF02	The Provider Secondary Identification (Billing Provider) must be greater than spaces and contain the 'TRICARE Provider Number' or EIN/SSN.	Provider Additional Identifier Reference Identification	X AN 1/30	83
ON1	2010BA		1065	R	NM102	Code qualifying the type of entity. All payers must use: **1 Person**	Entity Type Qualifier	M ID 1/1	109
ON2	2010BA		66	S	NM108	This field is required if NM102 equals 1 (Person). Must use: **MI Member Identification Number** This is the subscriber's identification number.	Identification Code Qualifier	X ID 1/2	110
T26	2010BA		67	S	NM109	If NM102 equals 1 (Person) then this field is required. PGBA, LLC requires this field to be the **Subscribers Social Security Number (SSN).**	Subscriber Primary Identifier Identification Code	X AN 2/80	110
T17	2010BC		66	R	NM108	Must equal: **PI Payor Identification**	Identification Code Qualifier	X ID 1/2	127
	2010BC		67	S	NM109	PGBA, LLC requires this field to be **38520.**	Payer Identifier Identification Code	X AN 2/80	127
T18	2000C		1069	R	PAT01	If SBR03 in Loop 2000B, data element 1069 does not equal 18 (Self) then the relationship code located in the IG must be used.	Individual Relationship Code	O ID 2/2	142 & 143
OCC	2300		782	R	CLM02	Must not be greater than 9,999,999.99.	Total Claim Charge Amount	O R 1/10	159

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Error Code	Loop	Seg Pos	Data Element	Req or Sit	Segment/ Element	Instruction	Industry/Element Name	Attributes	IG Page No.
60Y	2300		1325	R	CLM05 - 3	PGBA, LLC will recognize the following Frequency Types: **1 - Original (Admit thru Discharge Claim)** **2 - Interim – first claim** **3 - Interim – continuing claim** **4 - Interim – last claim** **7 - Corrected (Adjustment of prior claim).** **9 – Final claim for a Home Health PPS episode.**	Claim Frequency Type Code	O ID 1/1	159
CN1	2300		127	S	CN104	This field must be present when CN101 in Loop 2300, data element 1166 (Contract Type Code) equals 09 (Other). Reference ID = MTF ID	Contract Code Reference Identification	O AN 1/30	177
T06/ T07	2300		127	R	REF02	This field will be the Original Claim Number (13 characters) if CLM05 – 3 in Loop 2300, data element 1325 (Claim Frequency Type Code) equals 7 (Corrected).	Claim Original Reference Number (ICN/DCN) Reference Identification	X AN 1/30	192
T13	2300		1270	R	HI01 - 1	Must equal **BR (International Classification of Diseases Clinical Modification)**.	Code List Qualifier Code	M ID 1/3	242
	2300				HI01 – 1 HI01 – 2 HI01 – 5 HI01 – 2	Must equal 'BE' Must equal '44' Allowed amount Value code or occurrence code with reason for non payment by primary insurance	Qualifier Value Code Amount Allowed by Primary payer		

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Error Code	Loop	Seg Pos	Data Element	Req or Sit	Segment/ Element	Instruction	Industry/Element Name	Attributes	IG Page No.
	2320	295		S	AMT 01 AMT 02	Must equal C4. **Required:** This segment must be present if in Loop 2000B, SBR01 (Payer Responsibility Sequence Number Code) does not equal P (Primary). Primary Payer amount paid. **Not Present:** This segment must not be present if in Loop 2000B, SBR01 (Payer Responsibility Sequence Number Code) equals P (Primary).	Qualifier Primary payer amount paid.		365
	2330B		67	R	NM109	If another payer is the Primary Payer, PGBA, LLC requires this field to be the **Other Payer's ID.**	Other Payer Primary Identifier	X AN 2/80	411
T29	2400		235	R	SV202 - 1	All PGBA, LLC claims use the following qualifiers: **HC** Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes. AMA's CPT codes are also level 1 HCPCS and should be reported under HC. **ZZ** Mutually Defined Use code ZZ to convey the Health Insurance Prospective Payment System (HIPPS) skilled Nursing Facility Rate Code.	Product/Service ID Qualifier	M ID 2/2	446

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Edit / Error Messages

A description of the edits performed on the 837 Institutional claims. This is a list of error codes, their associated error message, and the type of edit performed. It cross-references the Data Element Name, the Loop, and the Reference Description with the error codes in which they are referenced.

Error Code	Edit Description
AAF	**CHAMPUS-PATIENT STATUS REQ ON OUTPAT AMBULANCE** If the Service Line Revenue code (2400 | SV201) is from 540 thru 549 (ambulatory charges) and the type of bill (2300 | CLM05-1, 2300 | CLM05-3) = 131, the patient status code (2300 | CL103) must **not** be spaces or low values.
AR0	**OTHER PHYS REQ WHEN SURG PROC CODE ENTERED** Other Physician ID (2310B/NM109) required when surgical procedure code (2300/HI01) entered.
A52	**MULTIPLE BIRTHING CENTER REV CODES NOT ALLOWED** The claim must **not** have multiple lines with Service Line Revenue Code (2400 | SV201)=724
A53	**BIRTHING CENTER REV CODE-MUST BE OUTPATIENT** If the Service Line Revenue code (2400 | SV201) is '724' then the second digit of the Facility Type Code (2300 | CLM05-1) **must** not be '1'.
BC3	**REVENUE CODE - INVALID FOR BILL CLASS** A) If the type of claim is for outpatient treatment or home treatment, then the revenue code should not be for any room and board charges. B) If the type of claim is for outpatient treatment or home treatment, then the Service Line Revenue code (2400 | SV201) **must not** be one of the following: '100', 101', '110-159', '160', '164', '167', '169', '170-175', '179', '180-185', '189', '190-194', '199', '200-204', '206-209', '219'.
BF8	**ADMISS TYPE/DIAGNOSIS/REV CODE INCONSISTENT** A) If the second digit of the Facility Type Code (2300 | CLM05-1) = '1' and the Industry Code (2300 | HI01-2) is a maternity diagnosis, the Admission Type Code (2300 |CL101) must be '1', '2', or '3'. B) If the Service Line Revenue code (2400 | SV201) = '170', '171', '172', '173', '174', '175', or '179', the Admission Type Code (2300 |CL101) must be '4'. C) If the Service Line Revenue code (2400 | SV201) = '170', '171', '172', '173', '174', '175', or '179', the Admission Source (2300 |CL102) must be '5' or '6'.
BF9	**BILL CLASS AND FREQUENCY INCONSISTENT** If the second digit of the Facility Type Code (2300 | CLM05-1) = '2', '3', or '4', the Claim Frequency Code must equal '1' or '7'.
BG2	**INVALID PROVIDER/ASSIGNMENT INDICATOR** Assignment Indicator (2300/CLM08) must be valid.
BH9	**ADMITTING DIAGNOSIS INVALID OR NOT ENTERED** The admitting diagnosis (2300 | HI02-2) is invalid.
BTD	**PROV HAS NO MTF AFFILIATION ON AFFILIATION FLE** Provider must have an MTF Affiliation and must not be affiliated with more than one MTF provider (2300 / CN104)

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Error Code	Edit Description
B01	**INVALID TYPE FACILITY OF TYPE BILL** The first digit of the Facility Type Code (2300 | CLM05-1) must equal '1', '2', '7', or '8'.
B02	**INVALID BILL CLASS - OF TYPE BILL** The second digit of the Facility Type Code (2300 | CLM05-1) must equal '1', '2', '3', '4', '5', '6', '7', or '8'.
B03	**INVALID FREQUENCY - OF TYPE BILL** The Claim Frequency Code (2300 / CLM05-3) must equal '1', '2', '3', '4', 7 or '9'.
B05	**INVALID TYPE ADMISSION** If the second digit of the Facility Type Code (2300 | CLM05-1) = '1', the Admission Type Code (2300 |CL101) must not equal '9'. Excluding claims with the first digit of the Facility Type Code (2300 | CLM05-1) = '2'.
B06	**INVALID SOURCE OF ADMISSION** If the second digit of the Facility Type Code (2300 | CLM05-1) = '1', the Admission Source Code (2300 | CL102) must equal '1', 2', '3', '4', '5', '6', '7', '8', or '9'. Excluding claims with the first digit of the Facility Type Code (2300 | CLM05-1) = '2'.
B07	**INVALID COVERAGE FROM DATE** Coverage from date (2300 | DTP03) invalid.
B08	**INVALID COVERAGE THROUGH DATE** Coverage through date (2300 | DTP03) invalid.
B09	**INVALID COVERED DAYS** The Claim Days Count (2300 | QTY02) must be numeric and greater than zero.
B10	**INVALID NON-COVERED DAYS** The Claim Days Count (2300 | QTY02) must be numeric.
B13	**INVALID OCCUR SPAN CODE** Occurrence Span Code (2300 | HI01-02) must be valid.
B14	**INVALID OCCURRENCE SPAN FROM DATE** Occurrence span from date (2300 | HI01-3) not valid.
B15	**INVALID OCCURRENCE SPAN TO DATE** Occurrence span to date (2300 | HI01-3) not valid.
B20	**REVENUE CODE ------- INVALID** Revenue code (2400 | SV201) not valid.
B21	**REVENUE CODE ------- UNITS INVALID** The Service Line Units (2400 | SV204) must be a numeric and greater than zero.
B22	**REVENUE CODE ------- TOTAL CHARGE INVALID** The Service Line Charge Amount (2400 | SV203) must be a numeric and greater than zero.

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Error Code	Edit Description
B23	**REVENUE CODE ------- NON-COV CHG INVALID** The Service Line Non-Covered Charge Amount (2400 | SV207) must be a numeric and greater than zero.
B27	**MED REC OR PAT CONTROL NBR MUST BE ENTERED** If the Medical record number (2300 | REF02) is spaces or less than spaces, the Patient Control Number (2300 | CLM01) is spaces or less than spaces, then the first digit of the Facility Type Code (2300 | CLM05-1) must be 2' or' 7'.
B28	**SURG/OCCUR CODES MUST BE ENTERED CONTIGUOUSLY** A) The Principal Procedure Code (2300 | H101-2) and Procedure Code (2300 | H101-2, 2300 | H102-2, 2300 | H103-2, 2300 | H104-2, 2300 | H105-2) must be entered contiguously. B) The Occurrence Code (2300 | HI01-2, 2300 | HI02-2, 2300 | HI03-2, 2300 | HI04-2, 2300 | HI05-2, 2300 | HI06-2, 2300 | HI07-2) and the Occurrence Code Ass. Date (2300 | HI01-4, 2300 | HI02-4, 2300 | HI03-4, 2300 | HI04-4, 2300 | HI05-4, 2300 | HI06-4, 2300 | HI07-4) must be entered contiguously.
B31	**SPAN TO DATE IS LESS THAN THE SPAN FROM DATE** The Occurrence Span Code Associated (2300 | H101-4) to date must be greater than from date.
B32	**FACILITY OF TYPE BILL-BILL CLASS INCONSISTENT** Facility type code (2300 |CLM05-1) and Frequency Code (2300 |CLM05-2) must be consistent.
B33	**ADMISS SOURCE - TYPE OF ADMISS INCONSISTENT** If the Type of Admission (2300 |Cl101) is '4', then the Admission source (2300 |CL102) must be '5' or '6'.
B34	**PAT STATUS - FREQ OF TYPE BILL INCONSISTENT** A) If the Claim frequency type code (2300 |CLM05-3) is 1, 4, 7 or 9, then the Patient Status Code (2300 |CL103) must be one of the following. (01, 02, 03, 04, 05, 06, 07, 08, 20, 30, 40, 41, 42, 43, 50, 51, 61, 62, 63, 64, or 65). B) If the Patient status code (2300 |CL103) is '30', then the claim frequency type code (2300 |CLM05-3) must be one of the following. (2,3).
B35	**PATIENT STATUS NOT CONSISTENT WITH BILL CLASS** If the Patient status code (2300 |CL103) is spaces, then the second byte of facility type code (2300 |CLM0502) must not be '1'.
B37	**SURGERY PROC REQD WITH SURGERY REVENUE CODE** If the service line revenue code range is '360' thru '369', then the Principal Procedure Code (2300 | HI01-2, 2300 | HI02-2, 2300 | HI03-2, 2300 | HI04-2, 2300 | HI05-2) must be valid code. Only applies to inpatient claims with accommodations revenue code.
B38	**BLOOD FURN AND REPLACED INVALID OR NOT ENTERED** A) If the value code (2300 | HI01-2, thru 2300 | HI12-2) is '37', then the Value Amount Associated Code (2300 | HI01-5 thru 2300 | HI12-5) must be a numeric. B) If the service line revenue code range is '380' thru '399', the value code (2300 | HI01-2, thru 2300 | HI12-2) is '37', then the Value Amount Associated Code (2300 | HI01-5 thru 2300 | HI12-5) must be a numeric and greater than .99 cents.
B39	**COND CODES MUST BE ENTERED CONTIGUOUSLY** The Condition Codes (2300 | HI01-2, 2300 | HI02-2, 2300 | HI03-2, 2300 | HI04-2, 2300 | HI05-2, 2300 | HI06-2, 2300 | HI07-2, 2300 | HI08-2, 2300 | HI09-2, 2300 | HI10-2) must be entered contiguously.

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<table>
<tr><th>Error Code</th><th>Edit Description</th></tr>
<tr><td>B40</td><td>DIAG. CODES MUST BE ENTERED CONTIGUOUSLY
The Industry Code (2300 |H101-1, 2300 |H102-2, 2300 |H103-2, 2300 |H104-2, 2300 |H105-2, 2300 |H106-2, 2300 |H107-2, 2300 |H108-2, 2300 |H109-2,) must be entered contiguously.</td></tr>
<tr><td>B54</td><td>AMBULANCE ORIGIN/DEST CODE IS INVALID
Ambulance/destination code must be valid. Patient status (2300 | CL103) and modifier (2400 | SV202-3 or 4) must be valid.
Valid modifiers are: 'HH', 'HE', 'EE', 'EH', 'HT', 'AR', 'AS', 'EP', 'ER', 'HR', 'PH', 'RA', 'RE', 'RH', 'SH', 'UC'</td></tr>
<tr><td>B59</td><td>IMBEDDED BLANKS IN SPONSOR NAME
Spaces/blanks in Sponsor's Last Name (2010BA | NM103) or Sponsor's First Name (2010BA | NM104)</td></tr>
<tr><td>B67</td><td>COND CODE-OCC CODE INCONSISTENT - EMP RELATED
If occurrence code (2300 | HI01-2) = '04', then condition code (2300 | HI01-2) must be '02'</td></tr>
<tr><td>B70</td><td>1ST SURGICAL DATE INVALID (2300 | HI01-4)</td></tr>
<tr><td>B71</td><td>2ND SURGICAL DATE INVALID (2300 | HI02-4)</td></tr>
<tr><td>B73</td><td>3RD SURGICAL DATE INVALID (2300 | HI03-4)</td></tr>
<tr><td>B74</td><td>1ST OCC CODE ----- NOT VALID (2300 | HI01-2)</td></tr>
<tr><td>B75</td><td>2ND OCC CODE ----- NOT VALID (2300 | HI02-2)</td></tr>
<tr><td>B76</td><td>3RD OCC CODE ----- NOT VALID (2300 | HI03-2)</td></tr>
<tr><td>B77</td><td>4TH OCC CODE ----- NOT VALID (2300 | HI04-2)</td></tr>
<tr><td>B78</td><td>5TH OCC CODE ----- NOT VALID (2300 | HI05-2)</td></tr>
<tr><td>B79</td><td>1ST OCC CODE ----- DATE NOT VALID (2300 | HI01-4)</td></tr>
<tr><td>B80</td><td>2ND OCC CODE ----- DATE NOT VALID (2300 | HI02-4)</td></tr>
<tr><td>B81</td><td>3RD OCC CODE ----- DATE NOT VALID (2300 | HI03-4)</td></tr>
<tr><td>B82</td><td>4TH OCC CODE ----- DATE NOT VALID (2300 | HI04-4)</td></tr>
<tr><td>B83</td><td>5TH OCC CODE ----- DATE NOT VALID (2300 | HI05-4)</td></tr>
<tr><td>B84</td><td>1ST COND CDE ----- NOT VALID (2300 | HI01-2)</td></tr>
<tr><td>B85</td><td>2ND COND CDE ----- NOT VALID (2300 | HI02-2)</td></tr>
<tr><td>B86</td><td>3RD COND CDE ----- NOT VALID (2300 | HI03-2)</td></tr>
<tr><td>B87</td><td>4TH COND CDE ----- NOT VALID (2300 | HI04-2)</td></tr>
<tr><td>B88</td><td>5TH COND CDE ----- NOT VALID (2300 | HI05-2)</td></tr>
<tr><td>CPT</td><td>CPT4 CODE MUST BE ENTERED
A) Service Line Revenue Code (2400 | SV201) and HCPCS/CPT Procedure Code (2400 | SV202-2) must be compatible
B) HCPCS/CPT code blank or invalid.
C) HCPCS/CPT code cannot have embedded spaces.</td></tr>
</table>

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Error Code	Edit Description
EB6	**S AND R CODE NOT COMPATIBLE W/DIAGNOSIS CODE** Sex code (2010BA | DMG03 or 2010CA | DMG03) or relationship code (2000B | SBR02 OR 2000C | PAT01) are not compatible with gender or age specific diagnosis (2300 | HI).
EIP	**PROVIDER NUMBER NOT ON INSTITUTIONAL PROV FILE** (2010AA / REF 02)
E04	**INVALID S/R** Sex code (2010BA | DMG03 or 2010CA | DMG03) and relationship code (2000B | SBR02 OR 2000C | PAT01) must be valid.
E07	**INVALID ADMISSION DATE** Zeroes not allowed in Admission Date (2300 | DTP03)
E10	**INVALID PROVIDER NUMBER** Invalid Provider Identification (2010AA | REF02)
E24	**INVALID DIAGNOSTIC CODE**
H21	**PAT PAY AMT CANNOT BE > TOT CHG** Patient paid amount (2300 |AMT02) must be less than Total Claim Charges (2300 |CLM02).
H29	**IMBEDDED BLANKS IN PATIENT NAME** Spaces/blanks in Patient's Last Name (2010BA | NM103) or Patient's First Name (2010BA | NM104)
H64	**STATE IS INVALID** A) The Subscriber's State (2010BA/N402) or Patient's state (2010CA/N402) must be a valid state. B) If the Patient or Subscriber's (2010BA/N401, 2010CA/N401) city name is (first four bytes) 'APO' or 'FPO', then state must be one of the following 'AA', 'AC','AE' or 'AP'.
H65	**INVALID SPONSOR ID** The Subscriber's Primary Identifier (2010BA/NM09) must be numeric and less than 12 bytes.
H68	**SUBS/SPON LAST/FIRST NAME MISSING OR INVALID** Subscriber Name (2010BA | NM103 | NM104) must be alphabetic.
H83	**STATE AND ZIP CODE INCONSISTENT** State (2010AA, 2010BA / N402) and Zip Code (2010AA, 2010BA / N403) must be consistent.
H96	**ADMIT/DISCH/COVERAGE DATES INCONSISTENT** A) Facility type code (2300 |CLM05-1), second byte must not be equal to ''2','3'. B) The Occurrence Span code Associated Date (2300 |HI01-4, HI02-4, HI03-4, HI04-4, HI05-4, HI06-4, HI07-4, HI08-4, HI09-4, HI10-4, HI11-4, HI12-4) must be equal to statement TO date (2300 |DTP03). C) The Admission date (2300 |DPT03) must be less than or equal to the Occurrence Span code Associated Date (2300 |HI01-4, HI02-4, HI03-4, HI04-4, HI05-4, HI06-4, HI07-4, HI08-4, HI09-4, HI10-4, HI11-4, HI12-4). D) The Admission date (2300 |DPT03) must be less than or equal to the statement FROM date (2300 |DTP03).
H97	**DIAG AND SURGERY CODES ARE INCONSISTENT** (2300 / HI)

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Error Code	Edit Description
H98	**ROOM DAYS AND/OR CHARGES REQUIRED ON INPT** If the type of bill (2300 |CLM05-1) is inpatient, then Service line revenue code (2400 |SV201) must be equal to '100','101','160','164','167','169','170', 171','172','173','174','175','179','189','199','219',"110' THRU '159', '180' THRU '185', '190' THRU '194', '200' THRU '204', '206' THRU '209', '210' THRU '214'.
HIP	**INVALID HIPPS CODE** (2400/SV202-2) For bill types equal to 322, 332, 327, 337, 328, 338, 329 or 339 and the effective From Date of Service of the episode is on or after 01/01/08, HHA EMC claims with 'H' in the first position of the HIPPS code will reject,
HP3	**INVALID HCPCS CODE** (2400 / SV202)
HRC	**MULTIPLE 0023 REVENUE CODES NOT ALLOWED** (2400/SV201) For bill types equal to 327, 337, 329, 339 and the effective From Date of Service of the episode is on or after 01/01/08, HHA EMC claims with multiple revenue code 0023 lines will reject.
HTC	**INVALID TREATMENT AUTHORIZATION CODE** (2300/REF02 WITH G1 QUALIFIER) For bill types equal to 322,332,327,337,328,329 or 339 that do not have condition code 21, are not for maternity or children under age 18, and the effective From Date of Service of the episode is on or after 01/01/08, the treatment authorization code must have the following format: Positions 1, 2, 5, 6 and 9 must be numeric. Positions 3, 4, 7 and 8 must be alphabetic. position 10 must contain 1 or 2. Positions 11-18 must be alphabetic.
J63	**BLOOD DEDUCT PINTS INVALID** If the Value code (2300 |HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2, HI09-2, HI10-2, HI11-2, HI12-2) is '38' then the Value code associated amount (HI01-5, HI02-5, HI03-5, HI04-5, HI05-5, HI06-5, HI07-5, HI08-5, HI09-5, HI10-5, HI11-5, HI12-5) must be a numeric value.
NB1	**BABY DIAG ON CHILD, NEED TOA=4 & SOA=1 2 3 OR 4** If the Diagnosis code "Industry code" (2300 |HI01-2, HI02-2) or other diagnosis code (2300 | HI01-2, HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2, HI10-2, HI11-2, HI12-2) is 'V300' thru 'V399', '7600' thru 7799' and the Admission type code (2300 |Cl101) is '4' then the Admission source code (2300 |Cl102) value must be '5' or '6'.
NP1	**INVALID BILLING PROVIDER NPI** - (2010AA/NM109). Billing NPI missing or invalid. NPI required for this loop and must pass Luhn-10.
NP2	**INVALID ATTENDING PROVIDER NPI** – (2310A/NM109). Attending NPI missing or invalid. NPI required when this loop is sent and must pass Luhn-10.
NP3	**INVALID OPERATING PROVIDER NPI** – (2310B/NM109). Operating NPI missing or invalid. NPI required when this loop is sent and must pass Luhn-10
NP5	**INVALID PAY-TO PROVIDER NPI** - (2010AB/NM109). Pay-to NPI missing or invalid. NPI required when this loop is sent and must pass Luhn-10
NP7	**INVALID SERVICE FACILITY LOCATION NPI** - (2310E/NM109). Service facility NPI missing or invalid. NPI required when this loop is sent and must pass Luhn-10.
N04	**DUT'S MUST EQUAL 1** Units must be at least 1 (2400 / SV205)
OOJ	**OUT OF JURISDICTION, ZIP NOT FOUND ON ZIP FILE** Patient zip code (2010BA | N403 or 2010CA | N403) must be in region processed by PGBA, LLC.

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Error Code	Edit Description
PTD	**DATE OF SERVICE REQUIRED ON ALL LINES** For outpatient claims, the Service line date (2400 |DTP03) must be valid.
QSE	**PRINCIPAL DIAGNOSIS IS NOT VALID** (2300 |HI01-2) BK qualifier.
QSF	**PRINCIPAL DIAGNOSIS CANNOT CONTAIN AN E-CODE** (2300 |HI01-2) BK qualifier
Q69	**FIRST DIAGNOSIS IS NOT VALID** (2300 |HI01-2) First occurrence of BF qualifier.
Q70	**SECOND DIAGNOSIS IS NOT VALID** (2300 | HI02-2). BF qualifier.
Q71	**THIRD DIAGNOSIS IS NOT VALID** (2300 | HI03-2). BF qualifier.
Q72	**FOURTH DIAGNOSIS IS NOT VALID** (2300 | HI04-2). BF qualifier.
Q73	**FIFTH DIAGNOSIS IS NOT VALID** (2300 | HI05-2). BF qualifier.
Q74	**SIXTH DIAGNOSIS IS NOT VALID** (2300 | HI06-2). BF qualifier.
Q75	**SEVENTH DIAGNOSIS IS NOT VALID** (2300 | HI07-2). BF qualifier.
Q76	**EIGHTH DIAGNOSIS IS NOT VALID** (2300 | HI08-2). BF qualifier.
QSD	**PRINCIPAL SURGICAL CODE INVALID.** (2300 | HI01-1). BR qualifier.
Q78	**FIRST PROCEDURE CODE IS INVALID** (2300 | HI01-2). BQ qualifier.
Q79	**SECOND PROCEDURE CODE IS INVALID** (2300 | HI02-2). BQ qualifier.
Q80	**THIRD PROCEDURE CODE IS INVALID** (2300 | HI03-2). BQ qualifier.
Q81	**FOURTH PROCEDURE CODE IS INVALID** (2300 | HI04-2). BQ qualifier.
Q82	**FIFTH PROCEDURE CODE IS INVALID** (2300 | HI05-2). BQ qualifier.
Q83	**SIXTH PROCEDURE CODE IS INVALID** (2300 | HI06-2). BQ qualifier.
RPO	**NEED PROVIDER PHYSICAL ADDRESS IN 2010AA OR 2310E.** Excluding Puerto Rico.
RX0	**DUPLICATE DIAGNOSIS CODE** The Diagnosis code "Industry code" (2300 |HI01-2, HI02-2) or other diagnosis codes (2300 | HI01-2, HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2, HI10-2, HI11-2, HI12-2) must not be duplicates.
008	**INVALID BLOOD PINTS REPLACED** If the Value code (2300 |HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2, HI09-2, HI10-2, HI11-2, HI12-2) is '39', the Value code associated amount (2300 |HI01-5, HI02-5, HI03-5, HI04-5, HI05-5, HI06-5, HI07-5, HI08-5, HI09-5, HI10-5, HI11-5, HI12-5) must be numeric.
365	**MORE SPECIFIC DIAGNOSIS REQUIRED** (2300 / HI)
394	**SURGERY DATE INVALID OR NOT IN PERIOD OF STAY**

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Error Code	Edit Description
395	**INCOMPATIBLE SEX & SURGICAL PROCEDURE CODE** A) If the Patient sex in (2010BA | DMG03 or 2010CA | DMG03) = Male, the Principal procedure code (2300 |HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2, HI09-2, HI10-2, HI11-2, HI12-2) must not be equal to '650' through '759'. B) If the Patient sex in (2010BA | DMG03 or 2010CA | DMG03) = Female, the Principal procedure code (2300 |HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2, HI09-2, HI10-2, HI11-2, HI12-2) must not be equal to '600' through '649'.

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Glossary of Terms

ANSI X12 837 V4010A1
HIPAA standardized ANSI X12 transaction format that includes the Addenda approved on October 10, 2002. The 837 transactions are for the claims submission data. All lines of business will use this transaction with the exception of retail pharmacy.

ANSI X12 837 V4010
Original HIPAA standardized ANSI X12 transaction format that was published in May 2000 for the claims submission data.

CMS
An acronym for the Centers for Medicare & Medicaid Services.

Data Segment
Corresponds to a record in data processing terminology and consist of logically related fields (data elements). These records and elements are structured in a defined sequence (defined by X12). Each segment begins with a segment identifier and one or more related data elements that are preceded by a data element separator and ends with a segment terminator.

Data Element
Relates to a field in data processing terminology and are assigned an individual reference number. Each element has a name, description, type, minimum length and maximum length. The length of an element is the number of character positions used, except as noted for numeric, decimal and binary elements. Data Element types are:

Nn	Numeric	Implied number of decimal positions and for this representation Nn; the N indicates numeric and n is the number of decimal positions to the right of the implied decimal point. Used when the position of the decimal within the data is permanently fixed and will not be transmitted with the data
R	Decimal Real Number	Used for numeric values that have a varying number of decimal positions. For negative values, the leading (-) minus sign is used. Absence of a sign indicates a positive value. The (+) plus sign should not be transmitted.
ID	Identifier	Always contains a value from a predefined list of codes.
AN	Alphanumeric string	Sequence of any characters from a basic or extended character set.
DT	Date	States the standard date in either YYMMDD or CCYYMMDD. CC (first two digits of calendar year), YY (last two digits of calendar year), MM (month 01 – 12), DD (day in the month 01 – 31)
TM	Time	The ISO standard time HHMMSSd, 24-hour clock. HH (Hour 00 - 23), MM (minute 00 – 59), SS (second 00 – 59), d (decimal seconds)

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Delimiter
A character used to separate two data elements (or sub-elements) or to end a segment. They are specified in the interchange header segment (ISA). Once specified in the ISA, they should not be used in the data elsewhere other than as a separator or terminator.

EDI – Electronic Data Interchange
The application-to-application transfer of key business information transacted in a standard format using a computer-to-computer communications link. There are typically 6 components used in order to do EDI. They are: an EDI file, a trading partner agreement, an application file/form, translator (mapper), communications and value-added service provider.

EDIG
An acronym for Electronic Data Interchange Gateway.

HCFA
An acronym for Health Care Finance Administration, renamed to CMS (Centers for Medicare & Medicaid Services) in 2001.

Implementation Guides
Documents that provide standardized data requirements and content permitting the specification of consistent implementation of a standard transaction set. HIPAA implementation guides are published by the Washington Publishing Company on their Web site: www.wpc-edi.com.

Interface
The connection point that two systems pass data.

Loops
Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

Routing
Separation of data based on specific criteria for subsequent transfer to an internal or external system.

Trading Partners
Entities that exchange electronic data files. Agreements are sometimes made between the partners to define the parameters of the data exchange and simplify the implementation process.

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Translation Software
Commercial computer software that with input instructions converts a standard format to an application format and vise-versa. Most translation software products also compliance check standard format files and automatically create interchange/functional acknowledgements to identify receipt of translation status of a file. Some products also offer translation capability from any format to any format.

UB04
The current industry standard format for institutional claims submission and is not HIPAA compliant.

X12 Transaction Set
A transactions set is considered one business document which is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. For example, one 837- transaction set is equivalent to one claim file.

X12N
An Accredited Standards Committee (ASC) commissioned by the American National Standards Institute (ANSI) to develop standard for Electronic Data Interchange (EDI). While X12 indicates EDI, the N identifies the Insurance Subcommittee that is responsible for developing EDIO standards for the insurance industry. There is a special health care task group within this subcommittee responsible for the development of health care insurance transactions.

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