



**PGBA, LLC**

# TRICARE Companion Document



**837 Institutional Health Care Claim – 005010X223A2**

*ANSI ASC X12N*

*Revised: August 2011*



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## **Introduction**

*Note: Production files of the HIPAA implementation standard 837 Institutional transactions will not be accepted prior to January 01, 2011.*

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

This document provides information related to specific elements with the ANSI ASC X12N 837 institutional 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. 75, No. 197, October 13, 2010).

This document is intended solely for use as a companion to the Health Insurance Portability and Accountability Act (HIPAA) mandated ANSI ASC X12N 837 institutional 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.

The Final Rule adopting updated versions of the standards for electronic transactions was published in the Federal Register on October 13, 2010. The URL Link to the Federal Register is: <http://www.access.gpo.gov>. This final rule also adopts a transaction standard for Medicaid pharmacy subrogation. In addition, this final rule adopts two standards for billing retail pharmacy supplies and professional services, and clarifies who the “senders” and “receivers” are in the descriptions of certain transactions. The updated versions are available and can be downloaded through the Washington Publishing Company website at <http://www.wpc-edi.com>.

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 on the TRICARE web site: [www.myTRICARE.com](http://www.myTRICARE.com).

Appropriate steps must be taken before submitting production ANSI ASC X12N transactions, such as testing, completion of an EDIG 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 EDI Help Desk at 1-800-325-5920 (Menu Option 2).

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## **ANSI ASC X12N 837 Institutional Health Care Claim (005010X223A2) – 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 in 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.

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.

## **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. Do not send leading zeroes, for example, 0.05 should be .05.
- 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.
- Present on admission (POA indicator) HI01-9 should not be sent when the diagnosis code is exempt from POA reporting.

## **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. Refer to implementation guide for a complete list.

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

### 2010AA BILLING

NM108 = XX

NM109 = NPI

OR

2010BB

REF01 = 'G2'

REF02 = TRICARE Provider Number

**Billing provider must provide an NPI number if eligible for an NPI. Must be a healthcare or healthcare service provider.**

### 2310A ATTENDING (required on outpatient ER and all inpatient)

NM108 = XX NPI is required if provider is eligible for an NPI

NM109 = NPI

OR

REF01 = 'G2'

REF02 = TRICARE Provider Number

### 2310B – 2310E OTHER PROVIDER LOOPS (situational)

NM108 = XX If loop is sent, NPI is required if provider is eligible for an NPI

NM109 = NPI

OR

REF01 = 'G2'

REF02 = TRICARE Provider Number

Note: See Data Clarification Table

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## 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 Acknowledgment (999) 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**.

### Data Clarification Table Error Code Description

Code	Error Description	Code	Error Description
CN1	CN104-127 REFERENCE ID REQUIRED		
OB1	CLM OR ENCOUNTER ID MUST BE CH - CHARGEABLE	T19	SBR03 SUBSCRIBER IS EQUAL TO SELF (18)
OCC	TOTAL CLAIM CHARGES MUST BE < \$10,000,000.00	T20	CLAIM OR ENCOUNTER ID NOT 'CH'
OC1	TOT CHARG AT THE LINE MUST BE LESS THAN \$100,000	T21	FOREIGN CURRENCY NOT = 'USD'
OL2	LX01-554 ASSIGNED NUMBER < 1,000	T22	NM108 IDENTIFICATION QUAL INCORRECT
ON1	ENTITY TYPE QUAL FOR SUBSC NAME MUST = 1	T25	BILLING PROVIDER 2ND-ID IS INVALID
ON2	ID CODE QUALIFIER SUBSC NAME MUST = MI	T26	NM109 SUBSCRIBER PRIMARY ID NOT NUMERIC
OP2	INDIVIDUAL RELSHP MUST BE VALID	T27	SBR SEGMENT REQUIRED
OS5	ONLY 2 REPEATS OF OTHER SUBSC INFO ALLOWED	T29	PRODUCT   SERVICE ID QUALIFIER NOT HC OR HP
T05	CONTRACT INFO. NEEDED   CUR SEGMENT REQUIRED	T30	ADMITTING CODE NOT 'BJ'
T06	CLAIM ORIGINAL REF NUMBER NOT F8	T31	MORE THAN 3 OCCURRENCES OF THE OTHER SUBSCRIBER COB INFO
T07	2300-180-REF02-127 CLAIM NUMBER IS INVALID - MUST BE 13 CHARACTERS OF FORMAT 9999XXXXX9999	T32	2310B REF01 MUST EQUAL G2
T08	MONETARY AMT NOT PRESENT	T33	2320/SBR09 MUST NOT EQUAL MB, 2320/AMT01 MUST EQUAL D
T12	PRINCIPAL QUALIFIER NOT 'BK'	T34	PRODUCT   SERVICE ID QUALIFIER NOT HC
T13	PRINCIPAL QUALIFIER NOT 'BR'	60Y	FREQUENCY CODE IS INVALID
T15	REF-ID-QUAL NOT   ATTEND-PHYS-2ND-ID = ''		
T17	NM108 IDENTIFICATION CODE QUALIFIER NOT PI		

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**Data Clarification Table for the Institutional 837 (005010X223) Transaction Set**

Error Code	Loop	Seg Pos	Data Element	Req or Sit	Segment/Element				
T20	N/A		640	R	BHT06	<b>All Files</b> – Must equal <b>CH (Chargeable)</b> . 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 <b>Trading Partner Identification Number</b>	Identification Code Submitter Identifier	X AN 2/80	63
	1000B		1035	R	NM103	PGBA, LLC requires this field to be <b>TRICARE</b>	Receiver Name Name Last or Organization Name	O AN 1/35	68
	1000B		67	R	NM109	PGBA, LLC requires this field to be <b>571132733</b>	Identification Code Receiver Primary Identifier	X AN 2/80	68
T21	2000A		100	R	CUR02	Do not send.	Currency Code	M ID 3/3	74
T25	2010BB		127	S	REF02	<b>Required when NM109 in Loop 2010AA is not used.</b>  Use 'G2' in REF01 and REF02 is the 'TRICARE provider number'.	Billing Provider Secondary Identification	X AN 1/30	129
ON1	2010BA		1065	R	NM102	Code qualifying the type of entity. All payers must use: <b>1 Person</b>	Entity Type Qualifier	M ID 1/1	113
ON2	2010BA		66	S	NM108	This field is required if NM102 equals 1 (Person). Must use: <b>MI Member Identification Number</b> This is the subscriber's identification number.	Identification Code Qualifier	X ID 1/2	113-114

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Error Code	Loop	Seg Pos	Data Element	Req or Sit	Segment/Element				
T26	2010BA		67	S	NM109	If NM102 equals 1 (Person) then this field is required. PGBA, LLC requires this field to be the <b>Subscriber's 9 digit Social Security Number (SSN) or 11 digit DOD Benefits Number (DBN).</b>	Subscriber Primary Identifier Identification Code	X AN 2/80	114
T17	2010BB		66	R	NM108	Must equal: <b>PI Payor Identification</b>	Identification Code Qualifier	X ID 1/2	100
	2010BB		67	S	NM109	PGBA, LLC this field should be <b>38520.</b>	Payer Identifier Identification Code	X AN 2/80	100
OCC	2300		782	R	CLM02	Must not be greater than 9,999,999.99.	Total Claim Charge Amount	O R 1/10	145
60Y	2300		1325	R	CLM05 - 3	PGBA, LLC will recognize the following Frequency Types:  <b>Valid HIPAA codes between 0 - 9, G, I, J, and M.</b>  <i>Note: Facility code and frequency must be consistent.</i>	Claim Frequency Type Code	O ID 1/1	145
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	159
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).	Payer Claim Control Number	X AN 1/30	166
T13	2300		1270	R	HI01 - 1	Must equal <b>BR (International Classification of Diseases Clinical Modification).</b>	Code List Qualifier Code	M ID 1/3	240

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Error Code	Loop	Seg Pos	Data Element	Req or Sit	Segment/Element				
	2320	295		S	AMT 01  AMT 02	<p>Must equal <b>D</b>  <b>Required:</b> This segment must be present if in Loop 2000B, SBR01 (Payer Responsibility Sequence Number Code) does not equal P (Primary). COB Primary Payer is identified in Loop 2330B.                      Primary Payer amount paid.  <b>Not Present:</b> This segment must not be present if in Loop 2000B, SBR01 (Payer Responsibility Sequence Number Code) equals P (Primary).</p>	Qualifier  COB Primary payer paid amount.	364	
	2330B		67	R	NM109	<p>If another payer is the Primary Payer, PGBA, LLC requires this field to be the <b>Other Payer's ID</b>.</p>	Other Payer Primary Identifier	X AN 2/80	385
T29	2400		235	R	SV202 - 1	<p>All PGBA, LLC claims use the following qualifiers:</p> <p><b>HC</b> 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.</p> <p><b>HP</b> Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code</p>	Product/Service ID Qualifier	M ID 2/2	425

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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.

AAF	<b>CHAMPUS-PATIENT STATUS REQ ON OUTPAT AMBULANCE</b> 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 <b>not</b> be spaces or low values.
AR0	<b>OTHER PHYS REQ WHEN SURG PROC CODE ENTERED</b> Other Physician ID (2310B/NM109) required when surgical procedure code (2300/HI01) entered.
ATT	<b>2310A REFO1 MUST EQUAL G2</b>
A52	<b>MULTIPLE BIRTHING CENTER REV CODES NOT ALLOWED</b> The claim must <b>not</b> have multiple lines with Service Line Revenue Code (2400   SV201)=724
A53	<b>BIRTHING CENTER REV CODE-MUST BE OUTPATIENT</b> If the Service Line Revenue code (2400   SV201) is '724' then the second digit of the Facility Type Code (2300   CLM05-1) <b>must</b> not be '1'.
BC3	<b>REVENUE CODE - INVALID FOR BILL CLASS</b> 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) <b>must not</b> 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	<b>ADMISS TYPE/DIAGNOSIS/REV CODE INCONSISTENT</b> 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	<b>BILL CLASS AND FREQUENCY INCONSISTENT</b> 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	<b>INVALID PROVIDER/ASSIGNMENT INDICATOR</b> Assignment Indicator (2300/CLM08) must be valid.
BH9	<b>ADMITTING DIAGNOSIS INVALID OR NOT ENTERED</b> The admitting diagnosis (2300   HIO1-2) is invalid.
BTD	<b>PROV HAS NO MTF AFFILIATION ON AFFILIATION FILE</b> Provider must have an MTF Affiliation and must not be affiliated with more than one MTF provider (2300 / CN104)

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B0A	<b>INVALID ADMISSION TYPE CODE</b>
B01	<b>INVALID TYPE FACILITY OF TYPE BILL</b> The first digit of the Facility Type Code (2300   CLM05-1) must equal '1', '2', '7', or '8'.
B02	<b>INVALID BILL CLASS - OF TYPE BILL</b> The second digit of the Facility Type Code (2300   CLM05-1) must equal '1', '2', '3', '4', '5', '6', '7', or '8'.
B03	<b>INVALID FREQUENCY - OF TYPE BILL</b> The Claim Frequency Code (2300 / CLM05-3) must equal '0'-'9', 'G', 'I', 'J', or 'M'.
B05	<b>INVALID TYPE ADMISSION</b> 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	<b>INVALID SOURCE OF ADMISSION</b> Source of admission code (2300   CL102) must be valid.
B07	<b>INVALID COVERAGE FROM DATE</b> Coverage from date (2300   DTP03) invalid.
B08	<b>INVALID COVERAGE THROUGH DATE</b> Coverage through date (2300   DTP03) invalid.
B13	<b>INVALID OCCUR SPAN CODE</b> Occurrence Span Code (2300   HI01-02) must be valid.
B14	<b>INVALID OCCURRENCE SPAN FROM DATE</b> Occurrence span from date (2300   HI01-3) not valid.
B15	<b>INVALID OCCURRENCE SPAN TO DATE</b> Occurrence span to date (2300   HI01-3) not valid.
B20	<b>REVENUE CODE ----- INVALID</b> Revenue code (2400   SV201) not valid.
B21	<b>REVENUE CODE ----- UNITS INVALID</b> The Service Line Units (2400   SV204) must be a numeric and greater than zero.
B22	<b>REVENUE CODE ----- TOTAL CHARGE INVALID</b> The Service Line Charge Amount (2400   SV203) must be a numeric and greater than zero.
B23	<b>REVENUE CODE ----- NON-COV CHG INVALID</b> The Service Line Non-Covered Charge Amount (2400   SV207) must be a numeric and greater than zero.
B27	<b>MED REC OR PAT CONTROL NBR MUST BE ENTERED</b> 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'.

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B28	<p><b>SURG/OCCUR CODES MUST BE ENTERED CONTIGUOUSLY</b></p> <p>A) The Principal Procedure Code (2300   HI01-2) and Procedure Code (2300   HI01-2, 2300   HI02-2, 2300   HI03-2, 2300   HI04-2, 2300   HI05-2) must be entered contiguously.</p> <p>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.</p>
B31	<p><b>SPAN TO DATE IS LESS THAN THE SPAN FROM DATE</b></p> <p>The Occurrence Span Code Associated (2300   HI01-4) to date must be greater than from date.</p>
B32	<p><b>FACILITY OF TYPE BILL-BILL CLASS INCONSISTENT</b></p> <p>Facility type code (2300   CLM05-1) and Frequency Code (2300   CLM05-2) must be consistent.</p>
B33	<p><b>ADMISS SOURCE - TYPE OF ADMISS INCONSISTENT</b></p> <p>If the Type of Admission (2300   CL101) is '4', then the Admission source (2300   CL102) must be '5' or '6'.</p>
B34	<p><b>PAT STATUS - FREQ OF TYPE BILL INCONSISTENT</b></p> <p>A) If the Claim frequency type code (2300   CLM05-3) is 1, 4, 7 or 9, then the Patient Status Code must be valid excluding 30 (2300   CL103).                  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).</p>
B35	<p><b>PATIENT STATUS NOT CONSISTENT WITH BILL CLASS</b></p> <p>If the Patient status code (2300   CL103) is spaces, then the second byte of facility type code (2300   CLM0502) must not be '1'.</p>
B37	<p><b>SURGERY PROC REQD WITH SURGERY REVENUE CODE</b></p> <p>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.</p>
B38	<p><b>BLOOD FURN AND REPLACED INVALID OR NOT ENTERED</b></p> <p>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.</p>
B39	<p><b>COND CODES MUST BE ENTERED CONTIGUOUSLY</b></p> <p>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.</p>
B40	<p><b>DIAG. CODES MUST BE ENTERED CONTIGUOUSLY</b></p> <p>The Industry Code (2300   HI01-1, 2300   HI02-2, 2300   HI03-2, 2300   HI04-2, 2300   HI05-2, 2300   HI06-2, 2300   HI07-2, 2300   HI08-2, 2300   HI09-2,) must be entered contiguously.</p>
B54	<p><b>AMBULANCE ORIGIN/DEST CODE IS INVALID</b></p> <p>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'</p>

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B59	<b>IMBEDDED BLANKS IN SPONSOR NAME</b> Spaces/blanks in Sponsor's Last Name (2010BA   NM103) or Sponsor's First Name (2010BA   NM104)
B67	<b>COND CODE-OCC CODE INCONSISTENT - EMP RELATED</b> If occurrence code (2300   HI01-2) = '04', then condition code (2300   HI01-2) must be '02'
B70	<b>1ST SURGICAL DATE INVALID</b> (2300   HI01-4)
B71	<b>2ND SURGICAL DATE INVALID</b> (2300   HI02-4)
B73	<b>3RD SURGICAL DATE INVALID</b> (2300   HI03-4)
B74	<b>1ST OCC CODE ----- NOT VALID</b> (2300   HI01-2)
B75	<b>2ND OCC CODE ----- NOT VALID</b> (2300   HI02-2)
B76	<b>3RD OCC CODE ----- NOT VALID</b> (2300   HI03-2)
B77	<b>4TH OCC CODE ----- NOT VALID</b> (2300   HI04-2)
B78	<b>5TH OCC CODE ----- NOT VALID</b> (2300   HI05-2)
B79	<b>1ST OCC CODE ----- DATE NOT VALID</b> (2300   HI01-4)
B80	<b>2ND OCC CODE ----- DATE NOT VALID</b> (2300   HI02-4)
B81	<b>3RD OCC CODE ----- DATE NOT VALID</b> (2300   HI03-4)
B82	<b>4TH OCC CODE ----- DATE NOT VALID</b> (2300   HI04-4)
B83	<b>5TH OCC CODE ----- DATE NOT VALID</b> (2300   HI05-4)
B84	<b>1ST COND CDE ----- NOT VALID</b> (2300   HI01-2)
B85	<b>2ND COND CDE ----- NOT VALID</b> (2300   HI02-2)
B86	<b>3RD COND CDE ----- NOT VALID</b> (2300   HI03-2)
B87	<b>4TH COND CDE ----- NOT VALID</b> (2300   HI04-2)
B88	<b>5TH COND CDE ----- NOT VALID</b> (2300   HI05-2)
CTP	<b>DRUG QUANTITY REQUIRED</b> 2410 CTP segment required when NDC sent and place of service is the home (12).
DGQ	<b>NDC# MUST BE 11 DIGITS</b> 2410 LIN03 must be 11 digits when LIN02 = N4.
DUP	<b>DUP - Duplicate of a claim paid in last 60 days</b>
EB6	<b>S AND R CODE NOT COMPATIBLE W/DIAGNOSIS CODE</b> 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	<b>PROVIDER NUMBER NOT ON INSTITUTIONAL PROV FILE 2010BB / REF 02)</b>

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E04	<b>INVALID S/R</b> Sex code (2010BA   DMG03 or 2010CA   DMG03) and relationship code (2000B   SBR02 OR 2000C   PAT01) must be valid.
E07	<b>INVALID ADMISSION DATE</b> Zeroes not allowed in Admission Date (2300   DTP03)
E10	<b>INVALID PROVIDER NUMBER</b> Invalid Provider Identification ( <b>2010BB</b>   REF02)
E24	<b>INVALID DIAGNOSTIC CODE</b>
H29	<b>IMBEDDED BLANKS IN PATIENT NAME</b> Spaces/blanks in Patient's Last Name (2010BA   NM103) or Patient's First Name (2010BA   NM104)
H64	<b>STATE IS INVALID</b> 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	<b>INVALID SPONSOR ID</b> The Subscriber's Primary Identifier (2010BA/NM09) must be numeric and less than 12 bytes.
H68	<b>SUBS/SPON LAST/FIRST NAME MISSING OR INVALID</b> Subscriber Name (2010BA   NM103   NM104) must be alphabetic.
H83	<b>STATE AND ZIP CODE INCONSISTENT</b> State (2010AA, 2010BA / N402) and Zip Code (2010AA, 2010BA / N403) must be consistent.
H96	<b>ADMIT/DISCH/COVERAGE DATES INCONSISTENT</b> 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	<b>DIAG AND SURGERY CODES ARE INCONSISTENT</b> (2300 / HI)
H98	<b>ROOM DAYS AND/OR CHARGES REQUIRED ON INPT</b> 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	<b>INVALID HIPPS CODE</b> (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	<b>INVALID HCPCS CODE</b> (2400 / SV202)

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HRC	<b>MULTIPLE 0023 REVENUE CODES NOT ALLOWED</b> (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	<b>INVALID TREATMENT AUTHORIZATION CODE</b> (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	<b>BLOOD DEDUCT PINTS INVALID</b> 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	<b>BABY DIAG ON CHILD, NEED TOA=4 &amp; SOA= 5 OR 6</b> 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   C1101) is '4' then the Admission source code (2300   C1102) value must be '5' or '6'.
NP1	<b>INVALID BILLING PROVIDER NPI</b> - (2010AA/NM109). Billing NPI missing or invalid. NPI required for this loop and must pass Luhn-10. Must provide NPI if eligible; otherwise submit TRICARE provider number.
NP2	<b>INVALID ATTENDING PROVIDER ID NPI</b> - (2310A/NM109). Attending NPI missing or invalid. NPI required when this loop is sent and must pass Luhn-10. Must provide NPI if eligible; otherwise submit TRICARE provider number.
NP3	<b>INVALID OPERATING PROVIDER ID NPI</b> - (2310B/NM109). Operating NPI missing or invalid. NPI required when this loop is sent and must pass Luhn-10. Must provide NPI if eligible; otherwise submit TRICARE provider number.
NP5	<b>INVALID PAY-TO PROVIDER ID NPI</b> - (2010AB/NM109). Pay-to NPI missing or invalid. NPI required when this loop is sent and must pass Luhn-10. Must provide NPI if eligible; otherwise submit TRICARE provider number.
NP7	<b>INVALID SERVICE FACILITY LOCATION ID NPI</b> - (2310E/NM109). Service facility NPI missing or invalid. NPI required when this loop is sent and must pass Luhn-10.
N04	<b>DUT'S MUST EQUAL 1</b> Units must be at least 1 (2400 / SV205)
OOJ	<b>OUT OF JURISDICTION, ZIP NOT FOUND ON ZIP FILE</b> Patient zip code (2010BA   N403 or 2010CA   N403) must be in region processed by PGBA, LLC.
OPE	<b>2310B REF01 MUST EQUAL G2</b>
OPN	<b>2420A REF01 MUST EQUAL G2</b>

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OTH	<b>2310C REF01 MUST EQUAL G2</b>
PST	<b>2000B/2320 SBR MUST BE P, S OR T</b>
PTD	<b>DATE OF SERVICE REQUIRED ON ALL LINES</b> For outpatient claims, the Service line date (2400  DTP03) must be valid.
QSE	<b>PRINCIPAL DIAGNOSIS IS NOT VALID</b> (2300  HI01-2) BK qualifier.
QSF	<b>PRINCIPAL DIAGNOSIS CANNOT CONTAIN AN E-CODE</b> (2300  HI01-2) BK qualifier
Q69	<b>1ST DIAGNOSIS IS NOT VALID</b> (2300  HI01-2), first occurrence of BF qualifier.
Q70	<b>2ND DIAGNOSIS IS NOT VALID</b> (2300  HI02-2), BF qualifier.
Q71	<b>3RD DIAGNOSIS IS NOT VALID</b> (2300  HI03-2), BF qualifier.
Q72	<b>4TH DIAGNOSIS IS NOT VALID</b> (2300  HI04-2), BF qualifier.
Q73	<b>5TH DIAGNOSIS IS NOT VALID</b> (2300  HI05-2). BF qualifier.
Q74	<b>6TH DIAGNOSIS IS NOT VALID</b> (2300  HI06-2), BF qualifier.
Q75	<b>7TH DIAGNOSIS IS NOT VALID</b> (2300  HI07-2), BF qualifier.
Q76	<b>8TH DIAGNOSIS IS NOT VALID</b> (2300  HI08-2), BF qualifier.
QD9	<b>9TH DIAGNOSIS IS NOT VALID</b> (2300  HI09-2), BF qualifier.
QDA	<b>10TH DIAGNOSIS IS NOT VALID</b> (2300  HI10-2, BF qualifier.
QDB	<b>11TH DIAGNOSIS IS NOT VALID</b> (2300  HI11-2), BF qualifier.
QDC	<b>12TH DIAGNOSIS IS NOT VALID</b> (2300  HI12-2), BF qualifier.
QDD	<b>13TH DIAGNOSIS IS NOT VALID</b> (2300  HI13-2), BF qualifier.
QDE	<b>14TH DIAGNOSIS IS NOT VALID</b> (2300  HI14-2), BF qualifier.
QDF	<b>15TH DIAGNOSIS IS NOT VALID</b> (2300  HI15-2), BF qualifier.
QDG	<b>16TH DIAGNOSIS IS NOT VALID</b> (2300  HI16-2), BF qualifier.
QDH	<b>17TH DIAGNOSIS IS NOT VALID</b> (2300  HI17-2), BF qualifier.
QDI	<b>18TH DIAGNOSIS IS NOT VALID</b> (2300  HI18-2), BF qualifier.
QDJ	<b>19TH DIAGNOSIS IS NOT VALID</b> (2300  HI19-2), BF qualifier.
QDK	<b>20TH DIAGNOSIS IS NOT VALID</b> (2300  HI20-2), BF qualifier.
QDL	<b>21ST DIAGNOSIS IS NOT VALID</b> (2300  HI21-2), BF qualifier.
QDM	<b>22ND DIAGNOSIS IS NOT VALID</b> (2300  HI22-2), BF qualifier.
QDN	<b>23RD DIAGNOSIS IS NOT VALID</b> (2300  HI23-2), BF qualifier.
QDO	<b>24TH DIAGNOSIS IS NOT VALID</b> (2300  HI24-2), BF qualifier.
QSD	<b>PRINCIPAL SURGICAL CODE INVALID</b> (2300  HI01-1), BR qualifier.

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Q78	<b>1ST PROCEDURE CODE IS INVALID</b> (2300   HI01-2), first occurrence of BQ qualifier.
Q79	<b>2ND PROCEDURE CODE IS INVALID</b> (2300   HI02-2), BQ qualifier.
Q80	<b>3RD PROCEDURE CODE IS INVALID</b> (2300   HI03-2), BQ qualifier.
Q81	<b>4TH PROCEDURE CODE IS INVALID</b> (2300   HI04-2), BQ qualifier.
Q82	<b>5TH PROCEDURE CODE IS INVALID</b> (2300   HI05-2), BQ qualifier.
Q83	<b>6TH PROCEDURE CODE IS INVALID</b> (2300   HI06-2), BQ qualifier.
REP	<b>2310D REFO1 MUST EQUAL G2</b>
RPN	<b>2310F REFO1 MUST EQUAL G2</b>
RPO	<b>NEED PROVIDER PHYSICAL ADDRESS IN 2010AA OR 2310E.</b>
RX0	<b>DUPLICATE DIAGNOSIS CODE</b> 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.
SG2	<b>2310E REFO1 MUST EQUAL G2</b>
008	<b>INVALID BLOOD PINTS REPLACED</b> 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	<b>MORE SPECIFIC DIAGNOSIS REQUIRED</b> (2300 / HI)
394	<b>SURGERY DATE INVALID OR NOT IN PERIOD OF STAY</b>
395	<b>INCOMPATIBLE SEX &amp; SURGICAL PROCEDURE CODE</b> 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 5010**

HIPAA standardized ANSI X12 transaction format approved on January 2009. The 837 transactions are for the claims submission data. All lines of business will use this transaction with the exception of retail pharmacy.

### **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](http://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.

### **Translation Software**

Commercial computer software that with input instructions converts a standard format to an application format and vice-versa.

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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.