



**PGBA, LLC**

# TRICARE Companion Document



**837 Professional Health Care Claim – 004010X098A1**

*ANSI ASC X12N*

*Revised March 2011*



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## March 2011 Revisions

- New edit code DUP – Duplicate of a claim paid in last 60 days, see page 4 and 17.

## Introduction

**Note:** Production files of the HIPAA 837 Professional 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 X12 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 Professional 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 and Blue Cross Blue Shield of SC EDI Gateway documentation

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](http://www.access.gpo.gov). This final rule modifies a number of the electronic transactions and code sets adopted as national standards under HIPAA. 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](http://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](http://www.mytricare.com).

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Appropriate steps must be taken before submitting production ANSI ASC X12 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 toll-free at (800) 325-5920 (menu option 2).

**\*\*IMPORTANT BULLETIN\*\***

'DUP' effective for claims filed after April 1, 2011. – This claim is a duplicate submission of a claim that processed within the last 60 days. If changes need to be made to the previously processed claim, please resubmit as a corrected claim. If you are attempting to obtain claim status, submit a 276 Claim Status transaction. Claim status can also be verified at [www.myTRICARE.com](http://www.myTRICARE.com) .



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## **ANSI ASC X12N 837 Health Care Claim (004010X98A1) – 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 Professional 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 view of the transaction set is presented within this document.

- ✓ PGBA may edit data submitted beyond the requirement defined in the HIPAA Implementation Guide.
- ✓ PGBA may reject interchanges, functional groups or segments that do not follow all HIPAA Implementation Guide and PGBA Companion Document requirements
- ✓ PGBA 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**

- 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 REFERRING (situational)

NM108 = XX

NM109 = NPI

The referring physician secondary ID (REF segment) is not required. If referring NPI not known, send billing provider NPI.

2310B RENDERING (Individual NPI required if billing NPI is for a group or PA)

NM108 = XX

NM109 = NPI

The rendering secondary ID (REF segment) is not required.

2310C – 2310E/2420A – 2420F 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

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NM109 = EIN or SSN  
REF01 = '1H', 'EI', 'SY', 'G2' or 'LU'.  
REF02 = Tricare provider number

2310A REFERRING (situational)

NM108 = 24 or 34  
NM109 = EIN or SSN  
OR  
REF01 = '1H', 'EI', 'SY' or '1G'  
REF02 = Tricare provider number (If referring not known, send OTH000)

2310B RENDERING (required if billing provider is for a group or PA)

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/2420A-2420F, 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](http://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:

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### **Adjunctive Dental Claims**

Because of the type of Dental claims managed by PGBA, Adjunctive Dental claims, PGBA, LLC will not support the X12 837 Dental Claim format. These "Dental" claims will have to be submitted using the 837 Professional format or sent on Hard Copy as done today.



## Professional 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 (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**.

## Data Clarification Table Error Code Description

Note: Use to describe error code from first column of the Data Clarification Table.

Code	Error Description	Code	Error Description
CN1	CN104-127 REFERENCE ID REQUIRED	T12	PRINCIPAL QUALIFIER NOT 'BK'
OB1	CLM OR ENCOUNTER ID MUST BE CH - CHARGEABLE	T17	NM108 IDENTIFICATION CODE QUALIFIER NOT PI
OCC	TOTAL CLAIM CHARGES MUST BE < \$1,000,000.00	T18	PATIENT RELATIONSHIP INVALID
OC1	TOT CHARGE AT THE LINE MUST BE LESS THAN \$100,000	T19	SBR03 SUBSCRIBER IS EQUAL TO SELF (18)
OL2	LX01-554 ASSIGNED NUMBER < 1,000	T20	CLAIM OR ENCOUNTER ID NOT 'CH'
ON1	ENTITY TYPE QUAL FOR SUBSC NAME MUST = 1	T21	FOREIGN CURRENCY NOT = 'USD'
ON2	ID CODE QUALIFIER SUBSC NAME MUST = MI	T22	NM108 IDENTIFICATION QUAL NOT '24'   '34'
OP2	INDIVIDUAL RELSHP MUST BE VALID AND NOT = 41	T23	2010AA LOOP REQUIRED
OS5	ONLY 2 REPEATS OF OTHER SUBSC INFO ALLOWED	T24	REF IDENTIFICATION QUALIFIER NOT 1H, EI, SY, OR LU
T03	RENDERING PROV. 2ND-ID = ''   REF01 NOT SY, LU, 1G, OR OB	T25	BILLING PROVIDER 2ND-ID IS INVALID
T04	REFERRING PROVIDER 2ND-ID = ''   REF01 NOT LU	T26	NM109 SUBSCRIBER PRIMARY ID NOT NUMERIC
T05	CONTRACT INFO. NEEDED   CUR SEGMENT REQUIRED	T27	SBR SEGMENT REQUIRED
T06	CLAIM ORIGINAL REF NUMBER NOT F8	T29	PRODUCT   SERVICE ID QUALIFIER NOT HC OR ZZ
T07	2300-180-REF02-127 CLAIM NUMBER IS INVALID- MUST BE 13 CHARACTERS OF FORMAT 9999XXXX9999.	T31	MORE THAN 3 OCCURRENCES OF THE OTHER SUBSCRIBER COB INFO
T08	MONETARY AMT NOT PRESENT	60Y	FREQUENCY CODE IS INVALID
T09	2320-290-SBR05-1336 MUST NOT EQUAL MB  2320-AMT01-522-QUAL MUST = D		

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**Data Clarification Table for the Professional 837 (004010X098A1) Transaction Set**

Error Code	Loop	Seg Pos	Data Element	Req or Sit	Segment/Element	Instruction	Industry/Element Name	Attributes	IG Page No.
	N/A		353		BHT02	<b>All Files</b> – Any claims must indicate <b>00 (Original)</b> in this element. This element is the electronic transmission status, not the billing status. Original transmissions are claims/ encounters that have never been sent to the receiver.	Transaction Set Purpose Code	M ID 2/2	64
OB1	N/A		640		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.	Transaction Type Code	O ID 2/2	65
	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	69
	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	75
	1000B		67	R	NM109	PGBA, LLC requires this field to be <b>571132733</b>	Identification Code Receiver Primary Identifier	X AN 2/80	75
T21	2000A		100		CUR02	PGBA, LLC requires this data element if CUR segment is present in Loop 2000A, segment position 010. If present, report <b>USD (US Dollars)</b> is this element.			82
	2010AA		66	R	NM108	PGBA, LLC will only accept the following codes: <b>24 Employer's Identification Number</b> <b>34 Social Security Number</b> <b>XX National Provider ID</b> <b>Note:</b> if either NM108 or NM109 is present, then the other is required.	Identification Code Qualifier	X ID 1/2	86

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Error Code	Loop	Seg Pos	Data Element	Req or Sit	Segment/Element	Instruction	Industry/Element Name	Attributes	IG Page No.
T24	2010AA		128	R	REF01	Must have at least one of these qualifiers, for PGBA, LLC use: <b>1H TRICARE ID Number</b> <b>EI Employer's ID Number</b> <b>G2 Provider Commercial Number</b> <b>SY Social Security Number</b> <b>LU Location Number</b>	Reference Identification Qualifier	M ID 2/3	92
T25	2010AA		127	R	REF02	The Provider Secondary Identification (Billing Provider) must be greater than spaces and contain the TRICARE Provider Number and EIN or SSN.	Provider Additional Identifier Reference Identification	X AN 1/30	92
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	118
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	119
T26			67	S	NM109	If NM102 equals 1 (Person) then this field is required.  PGBA, LLC requires this field to be the <b>Subscribers Social Security Number (SSN)</b> .	Subscriber Primary Identifier Identification Code	X AN 2/80	119
T17	2010BB		66	R	NM108	Must equal: <b>PI Payor Identification</b>	Identification Code Qualifier	X ID 1/2	131
	2010BB		67	S	NM109	PGBA, LLC requires this field to equal <b>38520</b>	Payer Identifier Identification Code	X AN 2/80	131
OP2	2000C	007	1069	R	PAT01	If SBR02 in Loop 2000B, data element does not equal 18 (Self), then the relationship code located in the IG must be used.	Individual Relationship Code	O ID 2/2	154

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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: <b>1 Original (Admit thru Discharge Claim)</b> <b>7 Corrected (Adjustment of Prior Claim)</b> If a type 7 code is used, the original claim number (ICN/DCN) must be reported in the 2300 REF segment as indicated on page 229 of the IG Guide.	Claim Frequency Type Code	O ID 1/1	173 & 174
T05	2300		127	S	CN104	This field must be present when CN101 in Loop 2300, data element (Contract Type Code) equals <b>09 (Other)</b> . Reference ID = 'MTF/PPO ID'	Contract Code Reference Identification	O AN 1/30	218
T06	2300		128	R	REF01	If CLM05 – 3 in Loop 2300, data element 1325 (Claim Frequency Type Code) equals 7 (Corrected). This field must be present and must equal <b>F8 (Original Reference Number)</b> .	Reference Identification Qualifier	M ID 2/3	230
T07	2300		127	R	REF02	If CLM05 – 3 in Loop 2300, data element (Claim Frequency Type Code) equals 7 (Corrected), then the first 13 positions of this field must be greater than spaces.	Claim Original Reference Number (ICN/DCN) Reference Identification	X AN 1/30	230
T04	2310A		128	S		If 2310A loop is present and NM108/09 not used, then REF01/02 is required.	Reference Identification Qualifier	O ID 2/3	288
T03	2310B		128	R	REF01	Must be the ID of the physician that rendered services and must match an ID in the TRICARE provider files.	Reference Identification Qualifier	M ID 2/3	296 and 297
OS5	2320	290		S	SBR	This Loop is required if other payers could potentially be involved in payment of this claim.  <b>PGBA, LLC will use two repeats of this Loop.</b>	Other Subscriber Information		318

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Error Code	Loop	Seg Pos	Data Element	Req or Sit	Segment/Element	Instruction	Industry/Element Name	Attributes	IG Page No.
T27	2320	295		S	CAS	This segment should be used to report prior payer's claim level adjustments reason for zero payment.	Claim Level Adjustments Other Subscriber Information		326
	2320		522	R	AMT01	PGBA, LLC will only accept Qualifier Codes: <b>D (Payer Amount Paid)</b> <b>B6 (Allowed Amount)</b> The following conditions must be met prior to entering the qualifier code. The SBR segment must be present in Loop 2320. Loop 2000B, the SBR01 (Payer Responsibility Sequence Number Code) must not equal P (Primary).	Amount Qualifier Code	M ID 1/3	332
T08	2320		782	R	AMT02	The following conditions must be met prior to entering the amount. The SBR segment must be present in Loop 2320. Loop 2000B, the SBR01 (Payer Responsibility Sequence Number Code) must not equal P (Primary).	Payer Paid Amount Monetary Amount  Payer Allowed Amount Monetary Amount	M R 1/18	332  334
	2330B		67	R	NM109	If another payer is the Primary Payer, PGBA, LLC requires this field to be the <b>Other Payer's ID.</b>	Other Payer Primary Identifier	X AN 2/80	361

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Error Code	Loop	Seg Pos	Data Element	Req or Sit	Segment/Element	Instruction	Industry/Element Name	Attributes	IG Page No.
T29	2400		235	R	SV101 - 1	Used to identify claim service details and medical procedure(s) for a health care provider. All PGBA, LLC claims use the following qualifier: <b>HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes. The AMA's CPT codes are also level 1 HCPCS and should be reported under HC.</b>	Product/Service ID Qualifier	M ID 2/2	401
T03	2420A		128	R	REF01	Use this loop only if a line rendering provider is different from ID in 2310B.	Reference Identification Qualifier	M ID 2/3	507

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## Edit / Error Messages

A description of the edits performed on the 837 Professional claims. It lists 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
AAT	<b>MODIFIER INDICATING SERVICE PVDR/LEVEL REQ</b> Anesthesia procedure codes require a modifier indicating service provider level such as anesthesiologist or CRNA (2400/SV101-3).
AW1	<b>RENDERING PHYSICIAN EIN/SSN IS REQUIRED</b> If the Billing/Pay to Provider is a group, then the Rendering Provider Identifier (2310B   REF02) or (2420A / REF02) is required.
A71	<b>NON-PROFESSIONAL BASE PROVIDER</b> Provider (2010AA / REF02) not set up as Professional provider on PGBA file.
A72	<b>NON-PROFESSIONAL REFERRING PROVIDER</b> Referring Provider (2310A / REF02) not set up as Professional provider on PGBA file.
A73	<b>NON-PROFESSIONAL LINE (RENDERING) PROVIDER</b> Rendering Provider (2310B / REF02) not set up as Professional provider on PGBA file.
BG2	<b>INVALID PROVIDER/ASSIGNMENT INDICATOR</b> Medicare Assignment Code (2300   CLM07) must be 'A' or 'C'
BTD	<b>PROV HAS NO MTF AFFILIATION ON AFFILIATION FILE</b> If Contract Code (2300   CN101) = 09, Provider must have an MTF Affiliation on the Provider Master Database and MTF ID in CN104.
BT4	<b>PROC INVALID FOR DOS</b> Procedure invalid for date of service (2400   SV01-02)
BT9	<b>MTF PROVIDER MISSING OR INCORRECT</b> MTF Provider must be on Provider Master Database and 2300   CN104 must not be blank when CN101 = 09.
DUP	<b>Duplicate of a claim paid in last 60 days</b>
EB6	<b>S AND R CODE NOT COMPATIBLE W/ DIAGNOSIS CODE</b> Procedure code (2400   SV101-2) or Diagnosis code (2300   HI) is gender or age specific.
E10	<b>INVALID PROVIDER NUMBER</b> Billing Provider Identification Number (2010AA   NM109) or (2010AA   REF02) must be on the Provider Master Database.
E24	<b>INVALID DIAGNOSTIC CODE</b>
E51	<b>TOTAL CHARGES MUST BE NUMERIC</b> Total Claim Charge Amount (2300   CLM02) must be numeric

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Error Code	Edit Description
HAD	<b>DATES OF SERVICE SPAN BENEFIT PERIOD</b> If the Begin Service Date month (2400   DTP03) < 10, then the End Service Date month (2400   DTP03) must not be > 09)
HAI	<b>FROM DATE/DOB INCONSISTENT</b> The Begin Service Date (2400   DTP03) must not be less than the Patient Birth Date (2010CA   DMG02) or (2010BA / DMG02).
HAM	<b>ANESTHESIA MINUTES MUST BE GREATER THAN ZERO</b> If (2400   SV101-2) = 'Anesthesia', then the procedure minutes in (2400   SV104) must be greater than zero.
HAO	<b>DIAG/PL SVC/AGE INCONSISTENT</b> If the first 3 bytes of the Diagnosis code (2300   HI01-2, 2300   HI02-2, 2300   HI03-2, 2300   HI04-2, 2300   HI05-2, 2300   HI06-2, 2300   HI07-2, 2300   HI08-2) has a value of 'V30' and the Place of Service Code (2300   CLM05) = '12', '21' or '25', then the patient's age must not be greater than 1.
HA9	<b>INVALID REND PHYSICIAN ID NUMBER</b> A) The Rendering Provider Identifier (2310B   NM109 or REF02) must be on the Master Provider Database B) If the Provider (2010AA / REF02) is a group, the first nine bytes of the Rendering Provider Identifier (2310B   NM109 or REF02) must not be the same as the Provider Identifier
H09	<b>TOTAL CHARGE MUST BE GREATER THAN ZERO</b> Total Claim Charge Amount (2300   CLM02) must be greater than zero.
H10	<b>FROM DATE NOT ENTERED OR IS INVALID</b> Service Date (begin date)(2400   DTP03) can not be zero
H16	<b>CHARGE MUST BE GREATER THAN ZERO</b> Line Item Charge Amount (2400   SV102) must be greater than zero.
H21	<b>PAT PAY AMT CANNOT BE &gt; TOT CHG</b> Patient Paid Amount (2300   AMT02) cannot be greater than Total Claim Charge Amount (2300   CLM02).
H40	<b>AMOUNT PAID BY PATIENT INVALID OR NOT NUMERIC</b> The Patient Paid Amount (2300   AMT02) must be numeric
H62	<b>CITY INVALID OR NOT ENTERED</b> Patient City Name (2010CA   N401) must be greater than spaces.
H64	<b>STATE IS INVALID</b> A) If the Patient State Code (2010CA   N402) = spaces or low-values, then Patient Zip Code (2010CA   N403) must be alphabetic B) If the Patient State Code (2010CA   N402) greater than spaces or low-values and the first four characters of Patient City Name (2010CA   N401) equal ('APO ' OR 'FPO '), then the Patient State Code (2010CA   N402) must equal ('AA' OR 'AC' OR '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 Last Name (2010BA   NM103) must be greater than spaces or low values and alphabetic.
H76	<b>AMT PD BY OTHER CARRIER INVALID</b> (2320 / AMT02)

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Error Code	Edit Description
H81	<b>INVALID EMERGENCY/ACCIDENT INDICATOR</b> Emergency Indicator (2400   SV109) must = 'A', or 'E' or 'Y', or 'N'
N04	<b>DUT'S MUST EQUAL 1</b> If diagnosis 290-319 and (PROCEDURE CODE (2400   SV101-2) NOT = '90830 or '96100')) AND UNIT COUNT (2400   SV104) NOT EQUAL SPACES OR LOW VALUES, then UNIT COUNT (2400   SV104) MUST BE EQUAL +1
N10	<b>FROM DATE MUST EQUAL TO DATE</b> If diagnosis 290-319 and (PROCEDURE CODE (2400   SV101-2) NOT = '90830 or '96100')), then From-date (SERVICE DATE 2400   DTP03) must = TO-DATE (SERVICE DATE 2400   DTP03)
NP1	<b>Invalid Billing Provider NPI</b> - (2010AA/NM109). Billing NPI missing or invalid. NPI required for this loop.
NP4	<b>Invalid Referring Provider NPI</b> - (2310A/NM109). Referring NPI missing or invalid. NPI required when this loop is sent.
NP5	<b>Invalid Pay-to-Provider NPI</b> - (2010AB/NM109). Pay-to NPI missing or invalid. NPI required when this loop is sent.
NP6	<b>Invalid Rendering Physician NPI</b> - (2310B/NM109). Rendering NPI missing or invalid. NPI required when this loop is sent.
NP7	<b>Invalid Service Facility location NPI</b> - (2310D/NM109). Service Facility NPI missing or invalid. NPI required when this loop is sent.
OOJ	<b>OUT OF JURISDICTION, ZIP CODE NOT FOUND ON ZIP FILE</b> (2010BA   N403) or (2010CA   N403)
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>FIRST DIAGNOSIS IS NOT VALID</b> (2300   HI01-2) First occurrence of BF qualifier.
Q70	<b>SECOND DIAGNOSIS IS NOT VALID</b> (2300   HI02-2). BF qualifier.
Q71	<b>THIRD DIAGNOSIS IS NOT VALID</b> (2300   HI03-2). BF qualifier.
Q72	<b>FOURTH DIAGNOSIS IS NOT VALID</b> (2300   HI04-2). BF qualifier.
Q73	<b>FIFTH DIAGNOSIS IS NOT VALID</b> (2300   HI05-2). BF qualifier.
Q74	<b>SIXTH DIAGNOSIS IS NOT VALID</b> (2300   HI06-2). BF qualifier.
Q75	<b>SEVENTH DIAGNOSIS IS NOT VALID</b> (2300   HI07-2). BF qualifier.
Q76	<b>EIGHTH DIAGNOSIS IS NOT VALID</b> (2300   HI08-2). BF qualifier.
RPO	<b>NEED PROVIDER PHYSICAL ADDRESS</b> IN 2010AA OR 2310D. Excludes Place of Services 12, 14, 21, 22, 23, 24 and Puerto Rico.
TBS	<b>INSURED 1ST NAME MISSING OR 1ST POS BLANK</b> The Subscriber First Name (2010BA   NM104) must be alphabetic and greater than spaces or low-values.
358	<b>PATIENT BILL DOES NOT BALANCE</b> If Total Claim Charge Amount (2300   CLM02) numeric, then Total Claim Charge Amount (2300   CLM02) must equal the Total Line Item Charge Amounts (2400   SV102)

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Error Code	Edit Description
365	<b>MORE SPECIFIC DIAGNOSIS REQUIRED</b> The first 3 bytes of the Diagnosis code (2300   HI01-2, 2300   HI02-2, 2300   HI03-2, 2300   HI04-2, 2300   HI05-2, 2300   HI06-2, 2300   HI07-2, 2300   HI08-2) must be greater than spaces
555	<b>INVALID PATIENT FIRST NAME</b> The Patient first name (2010CA   NM104) or (2010BA   NM104) must be greater than spaces or low-values.
557	<b>INVALID PATIENT LAST NAME</b> The Patient last name (2010CA   NM103) or (2010BA   NM103) must be greater than spaces or low-values.

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## **EDIG 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.

### **CMS 1500**

The current industry standard format for professional claims submission and is not HIPAA compliant. This format is only used for paper claims.

### **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.

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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)

**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**

An acronym for Electronic Data Interchange.

**EDIG**

An acronym for Electronic Data Interchange Gateway.

**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.

**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.



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**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. 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.

**X12 Transaction Set**

A transactions set is considered one business document which is composed of a transactions et 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.