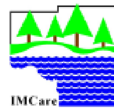

IMCare Errors and Descriptions

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00001	P	I	D	A6	135	562		85	If National Provider Identifier (NPI) is not applicable for billing provider, then Unique Minnesota Provider Identifier (UMPI) must be present in "Billing Provider Secondary ID" and be 10 digits long.	2010AA.NM108 must be present unless 2010BB REF01 = "G2."
PW00002	P	I	D	A7	128			85	Billing provider tax ID must be nine digits with no punctuation.	2010AA.REF02 must be nine digits with no punctuation.
PW00003	P	I	N/A	A6	21	564			when the claim includes services with the Healthcare Common Procedure Coding System (HCPCS) code S0302, the provider must submit the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) referral information with the condition Indicator having one of the following values: "AV," "NU," "S2," or "ST."	2300 - CRC EPSDT Referral Segment must include CRC03 when HCPCS code S0302 is included on the claim. The Condition Indicator CRC03 must be one of the following values: "AV," "NU," "S2," or "ST."
PW00004	P	I	D	A6	505			IL	Subscriber first name must contain at least one alpha character.	2010BA.NM104 must be present and contain at least one alpha character and no numeric characters.
PW00006	P	I	D	A7	510	158		IL	Subscriber date of birth cannot be a future date.	2010BA.DMG02 must not be a future date.
PW00007	P	I	D	A7	693	178			Submitted claim charge amount must be greater than or equal to zero.	2300.CLM02 must be greater than or equal to zero.
PW00008	P	I	D	A7	400	178			Total claim amount must equal the sum of all service line charges.	2300.CLM02 must equal the sum of all 2400.SV102 amounts.
PW00009	P	I	D	A7	400	672			Total claim amount must equal the sum of the prior payer paid amounts and adjustments from both the claim and service levels.	CLM02 must equal the sum of all 2320 and 2430 CAS amounts and the 2320 AMT02 (AMT01 = D). Per payer.
PW00010	P	N/A	D	A7	249				Place of service (POS) code must be valid.	2300.CLM05-1 must be a valid POS code.
PW00011	P	I	N/A	A6	189				Admission date must be present for all inpatient claims.	Inpatient Institutional (837I) and Professional (837P) claims must include the admission date. When the Institutional claim (837I) facility type code (CLM05-1) = 21, 11, 18, 28, 32, 41, or 86, the admission date (DTP03) must be present, where date qualifier (DTP01) = 435 or the claim will be rejected. When Professional claim (837P) facility code value (CLM05-1) = 21, 51, or 61, or if service line (2400) facility code value (SV105) = 21, 51, or 61, the admission date (DTP03) must be present, where the date qualifier (DTP01) = 435 or the claim will be rejected.
PW00012	P	N/A	D	A7	693	183		QC	Patient paid amount must be greater than or equal to zero.	If AMT01 = "F5," AMT02 must be greater than or equal to zero.
PW00013	P	N/A	N/A	A7	337				POS must equal a 41, 42, or 99 when ambulance transport information is present.	If 2300.CR1 is present, 2300.CLM05-1 must be "41," "42," or "99."
PW00014	P	N/A	N/A	A7	337				POS must equal a 41, 42, or 99 when ambulance certification information is present.	If 2300.CRC .07 is present, 2300.CLM05-1 must be "41," "42," or "99."
PW00015	N/A	I	N/A	A7	254				Principal diagnosis code must be a valid ICD-9-CM or ICD-10-CM diagnosis code for the qualifier submitted. Use the statement "from" dates for all types of bill (TOBs) except for TOBs 11x, 18x, 21x, and 32x. For these TOBs, use the statement "to" date to match the Centers for Medicare & Medicaid Services (CMS).	If 2300.HI01-1 is "BK" or "ABK," then 2300.HI01-2 must be a valid ICD-9-CM or ICD-10-CM principal diagnosis code (using the "from" or "through" statement date based on TOB).

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PW00016	P	I	N/A	A7	460				Must be a valid condition code.	2300.HI01-2 through HI12-2must be a valid condition code.
PW00017	P	I	D	A7	562			DN	Referring provider's NPI must be 10 digits and start with a "1."	2310A.NM109 must be 10 digits long and start with a "1."
PW00018	P	I	D	A6	286				When submitted payer is not the primary payer, the prior payer information must be included.	If 2000B.SBR01 = "S," 2320.SBR01 = "P" must be present.
PW00019	P	I	D	A6	286				When the submitted payer is not the primary payer, the COB prior payer paid amount or COB total non-covered amount must be present.	If 2000B.SBR01 = "S," then Loop 2320 must contain an AMT segment with AMT01 = "D" or "A8" present.
PW00021	P	I	D	A7	507	187	188		The HCPCS code must be valid. The edit will validate the claim's "Service To Date" for the 837P and 837I. If the 837I does not include a service date, the "Statement To Date" at the claim level will be used. For the 837D, the service date will be checked at the service level, if not available, the service date at the claim level will be used.	When 2400.SV101-1 = "HC," 2400.SV101-2 must be a valid HCPCS code on the date in 2400.DTP03 when DTP01 = "472." The HCPCS code (Loop 2400_SV101-1 = "HC," SV101-2) must be valid. The edit will validate the claim's "Service To Date" (2400.DTP03 when DTP01 = "472") for the 837P and 837I. If the 837I does not include a service date, the "Statement To Date" (2400.DTP03 when DTP01 = "434") at the claim level will be used. For the 837D, the service date will be checked at the service level" (2400.DTP03 when DTP01 = "472"); if not available, the service date" (2300.DTP03 when DTP01 = "472") at the claim level will be used.
PW00022	P	I	D	A7	453				Procedure code modifier invalid.	Procedure code modifier must be valid Loop 2400:SV101-3_SV101-6(837P), SV202-3_SV202-6(837I), SV301-3_SV301-6(837D).
PW00023	P	N/A	N/A	A6	306				Procedure code T1013 is included on the claim. Claim must include the oral Interpreter's name in the Procedure Code Description Field.	When 2400 SV101-2 = "T1013," then SV101-7 must include the name of the oral Interpreter.
PW00024	P	I	D	A7	693	583			Service line charge amount must be greater than or equal to zero.	2400.SV102 must be greater than or equal to zero.
PW00025	P	I	D	A7	400	583	643		Service line charge amount must equal the sum of all payer amounts paid plus the sum of all line adjustment amounts.	SV102 must equal the sum of all payer amounts paid found in 2430 SVD02 and the sum of all line adjustments found in 2430 CAS Adjustment Amounts per subscriber.
PW00026	P	N/A	N/A	A7	659				If procedure code modifier contains an anesthesia modifier (AA, QK, QS, QX, QY, or QZ), service unit qualifier must be MJ.	2400.SV103 must be MJ when SV101-3, SV101-4, SV101-5, or SV101-6 is an anesthesia modifier (AA, QK, QS, QX, QY, or QZ). Otherwise, must be UN.
PW00027	P	N/A	N/A	A7	476				Missing or invalid units/minutes, Service unit count must be greater than 0 and less than 10,000.	If 2400.SV103 = "UN" or "MJ," 2400.SV104 must be > 0 and <= 9,999.9.
PW00028	P	N/A	N/A	A7	477				There must be a corresponding diagnosis code at the claim level for the pointer value entered at the service line level.	There must be a corresponding diagnosis code in 2300.HI where HI01-1 is "ABK" or "BK" for the pointer value entered. Example 1: if 2400.SV107-1 = 3, when 2300.HI01-1 with "BK" or "ABK," 2300.HI03-2 must be populated. Example 2: if 2400.SV107-1 = 5, when 2300.HI05-1 with "BK" or "ABK," 2300.HI05-2 must be populated.
PW00029	P	I	D	A7	187				The "From Service Date" cannot be greater than the "To Service Date."	If 2400.DTP02 is RD8, the first date listed in 2400.DTP03 must be a date prior or equal to the second date listed in 2400.DTP03.

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PW00030	P	N/A	N/A	A7	187				Claim is rejected because the "from" and "through" service dates are equal, the procedure modifier is RR, and the quantity is not equal to 1.	Reject the claim if 2400.DTP02 = D8 or 2400.DTP02 = RD8 and the CCYYMM portion of the first date and the CCYYMM portion of the second date are equal and 2400.SV101-3, SV101-4, SV101-5 or SV101-6 = "RR" and 2400.SV104 is not = "1."
PW00031	P	N/A	D	A7	584				Line item control number must be unique within a patient control number.	2400.REF02 must be unique within a single iteration of 2300.CLM01.
PW00032	P	I	D	A7	562			85	Billing provider's NPI must be valid on the National Plan and Provider Enumeration System (NPPES) Registry.	Billing provider's NPI (Loop 2010AA-NM109 where Entity Identifier Code = 85) must be valid on the NPPES Registry or the claim will be rejected.
PW00033	P	N/A	N/A	A7	562				Care Plan Oversight Number - REF. Valid NPIs must be 10 digits and start with a "1."	2300.REF02 must be 10 digits long and start with a "1."
PW00034	P	I	D	A7	562	741		82	Rendering provider's NPI must be valid on the NPPES Registry for all claim types (837I, 837P, and 837D). For the 837I claim format, the EDI entity type qualifier and the NPI type in the NPPES Registry must be a person.	Rendering provider's NPI (Service/Claim Loop-NM109 where Entity Identifier Code = 82) must be valid on the NPPES Registry for all claim types (837I, 837P, and 837D). For the 837I claim format, the EDI entity type qualifier must = 1 (Loop 2300/2400 - NM102 where NM101 = 82) and the NPI type in the NPPES Registry must be a person or the claim will be rejected.
PW00035	P	I	D	A7	562			77	Service facility's NPI must be valid on the NPPES Registry.	Service facility's NPI (Service/Claim Loop-NM109 where Entity Identifier Code = 77)must be valid on the NPPES Registry or the claim will be rejected.
PW00036	P	N/A	D	A7	562	741		DQ	Supervising provider's NPI must be valid on the NPPES Registry. The EDI entity type qualifier and the NPI type in the NPPES Registry must be a person.	Supervising provider's NPI (Service/Claim Loop-NM109) must be valid on the NPPES Registry. The EDI entity type qualifier (NM102) and the NPI type in the NPPES Registry must be a person "1" where Entity Identifier Code (NM101) = DQ or the claim will be rejected.
PW00037	P	N/A	N/A	A7	562	741		DK	Ordering provider's NPI must be valid on the NPPES Registry. The EDI entity type qualifier and the NPI type in the NPPES Registry must be a person.	Ordering provider's NPI (Loop 2420E-NM109 where Entity Identifier Cod e= DK) must be valid on the NPPES Registry or the claim will be rejected. The EDI entity type qualifier (NM102) and the NPI type in the NPPES Registry must be a person "1" where Entity Identifier Code (NM101) = DK or the claim will be rejected.
PW00039	P	N/A	N/A	A7	562			QB	Purchased service provider's NPI must be valid on the NPPES Registry.	Purchased service provider's NPI (Loop2420B-NM109 where Entity Identifier Code = QB) must be valid on the NPPES Registry or the claim will be rejected.
PW00042	P	I	D	A7	562	741		DN	Referring provider's NPI must be valid on the NPPES Registry. The EDI entity type qualifier and the NPI type in the NPPES Registry must be a person.	Referring provider's NPI (Service/Claim Loop-NM109) must be valid on the NPPES Registry. The EDI entity type qualifier (NM102) and the NPI type in the NPPES Registry must be a person "1" where Entity Identifier Code (NM101) = DN or the claim will be rejected.
PW00043	P	I	N/A	A7	254				Principal diagnosis code must be "BK" or "ABK" and be present.	2300.HI01-1 must be "BK" or "ABK."
PW00044	P	I	D	A6	478				Submitter entity type qualifier must be "85."	2010AA.NM101 must be "85."
PW00045	P	N/A	N/A	A6	516				Remittance date is required when claim has been previously adjudicated.	If 2430.SVD is present, 2430.DTP = 573 must be present.
PW00046	p	N/A	D	A7	510	516			Invalid remittance date. Date reported cannot be greater than current date.	If 2430 DTP = 573 is present, 2430.DTP03 cannot be a future date.

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PW00047	N/A	I	N/A	A7	562	741		72	Operating provider's NPI must be valid on the NPPES Registry. The EDI entity type qualifier and the NPI type in the NPPES Registry must be a person.	Operating provider's NPI (Loop2420A/2310B-NM109) must be valid on the NPPES Registry. The EDI entity type qualifier (NM102) and the NPI type in the NPPES Registry must be a person "1" where Entity Identifier Code(NM101) = 72 or the claim will be rejected.
PW00048	N/A	I	N/A	A7	562	741		ZZ	Other operating provider's NPI must be valid on the NPPES Registry. The EDI entity type qualifier and the NPI type in the NPPES Registry must be a person.	Other operating provider's NPI (Loop2420B/2310C-NM109) must be valid on the NPPES Registry. The EDI entity type qualifier(NM102) and the NPI type in the NPPES Registry must be a person "1" where Entity Identifier Code (NM101) = ZZ or the claim will be rejected.
PW00050	N/A	I	N/A	A7	231				Admission type code must be valid.	2300.CL101 must be a valid admission type code.
PW00051	N/A	I	N/A	A7	229				Source of admission code must be valid. If patient is newborn (admit type = 4), valid newborn admission source codes must be present.	2300.CL102 must be a valid admission source code.
PW00052	N/A	I	N/A	A7	234				Patient status code must be valid.	2300.CL103 must be a valid patient status code.
PW00053	N/A	I	N/A	A7	255				Other diagnosis code must be a valid ICD-9-CM or ICD-10-CM diagnosis code. Use the statement "from" date for all TOBs except for TOBs 11x, 18x, 21x, and 32x. For these TOBs, use the statement "to" date to match CMS.	If 2300.HI01-1 is "BF" or "ABF," then 2300.HI01-2 must be a valid ICD-9-CM or ICD-10-CM diagnosis code (using the "from" or "through" statement date based on TOB).
PW00054	N/A	I	N/A	A7	232				Admitting diagnosis code must be a valid ICD-9-CM or ICD-10-CM diagnosis code for qualifier submitted. Use the statement "from" date for all TOBs except for TOBs 11x, 18x, 21x, and 32x. For these TOBs, use the statement "to" date to match CMS.	If 2300.HI01-1 is "BJ" or "ABJ," then 2300.HI01-2 must be a valid ICD-9-CM or ICD-10-CM admitting diagnosis code (using the "from" or "through" statement date based on TOB).
PW00055	N/A	I	N/A	A7	673				Patient reason for visit code must be a valid ICD-9-CM or ICD-10-CM diagnosis. Use the statement "from" date for all TOBs except for TOBs 11x, 18x, 21x, and 32x. For these TOBs, use the statement "to" date to match CMS.	If 2300.HI01-1 is "PR" or "APR," then 2300.HI01-2 must be a valid ICD-9-CM or ICD-10-CM patient reason for visit code (using the "from" or "through" statement date based on TOB).
PW00056	N/A	I	N/A	A7	509				E-code must be a valid ICD-9-CM or ICD-10-CM diagnosis code. Use the statement "from" date for all TOBs except for TOBs 11x, 18x, 21x, and 32x. For these TOBs, use the statement "to" date to match CMS.	If 2300.HI01-1 is "BN" or "ABN," then 2300.HI01-2 must be a valid ICD-9-CM or ICD-10-CM external cause of injury code (using the "from" or "through" statement date based on TOB). Code will need to be validated to the payer system DIAGDETAIL table. Obsolete_diag is also checked, and if the statement "to" date is after effective date, the claim will be rejected.
PW00057	N/A	I	N/A	A7	256				Diagnosis-related group (DRG) code must be valid (based on statement date).	2300.HI01-2 must be a valid DRG code if HI01-1 is a "DR." Validate DRG code to the Amisys DRG_M table.
PW00058	N/A	I	N/A	A7	465				Principal procedure code must be a valid ICD-9-PCS or ICD-10-PCS procedure code. Use the statement "from" date for all TOBs except for TOBs 11x, 18x, 21x, and 32x. For these TOBs, use the statement "to" date to match CMS.	If 2300.HI01-1 is "BR" or "BBR," then 2300.HI01-2 must be a valid ICD-9-PCS or ICD-10-PCS principal procedure code (using the "from" or "through" statement date based on TOB).

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PW00059	N/A	I	N/A	A7	490				Procedure code must be a valid ICD-9-PCS or ICD-10-PCS procedure code. Use the statement "from" date for all TOBs except for TOBs 11x, 18x, 21x, and 32x. For these TOBs, use the statement "to" date to match CMS.	If 2300.HI01-1 is "BQ" or "BBQ", then 2300.HI01-2 must be a valid ICD-9-PCS or ICD-10-PCS other procedure code (using the "from" or "through" statement date based on TOB).
PW00060	N/A	I	N/A	A7	721				Occurrence span code must be a valid code.	If 2300.HI01-1 is "BI," then 2300.HI01-2 must be a valid occurrence span code.
PW00061	N/A	I	N/A	A7	719				Occurrence code must be a valid code.	If 2300.HI01-1 is "BH," then 2300.HI01-2 must be a valid occurrence code.
PW00062	N/A	I	N/A	A7	725				Value code must be a valid code.	If 2300.HI01-1 is "BE," then 2300.HI01-2 must be a valid value code.
PW00063	N/A	I	N/A	A7	562	741		71	Attending provider's NPI must be valid on the NPPES Registry. The EDI entity type qualifier and the NPI type in the NPPES Registry must be a person.	Attending provider's NPI (Loop 2310A-NM109) must be valid on the NPPES Registry. The EDI entity type qualifier (NM102) and the NPI type in the NPPES Registry must be a person "1" where Entity Identifier Code (NM101) = 71 or the claim will be rejected.
PW00066	N/A	I	N/A	A7	455				Revenue code must be valid.	2400.SV201 must be a valid revenue code.
PW00067	N/A	I	N/A	A7	513				Health Insurance Prospective Payment System (HIPPS) code must be valid for service date.	When 2400.SV202-1 = "HP," 2400.SV202-2 must be a valid HIPPS Skilled Nursing Facility rate code.
PW00068	N/A	I	N/A	A7	402	476			Missing or invalid units/days; service unit count must be greater than zero.	2400.SV205 must be greater than zero.
PW00069	N/A	I	N/A	A7	693	596			Negative amounts are not valid.	2400.SV207 must be greater than or equal to zero.
PW00070	N/A	I	N/A	A7	228				Bill type must be valid.	2300.CLM05-1 must be the 1st and 2nd positions of a valid uniform bill type code.
PW00071	P	N/A	D	A7	254				Principal diagnosis code must be a valid ICD-9-CM or ICD-10-CM diagnosis code (based on "service from" date).	If HI01-1 through HI12-1 is "BK" or "ABK," then 2300.HI01-2 must be a valid ICD-9-CM or ICD-10-CM diagnosis code.
PW00072	P	N/A	D	A7	255				Diagnosis code must be a valid ICD-9-CM or ICD-10-CM diagnosis code (based on "service from" date).	If HI02-1 - HI12-1 is "BF" or "ABF," then 2300.HI01-2-HI12-2 must be a valid ICD-9-CM or ICD-10-CM diagnosis code.
PW00073	N/A	N/A	D	A7	245				If oral cavity code is sent, the code must be a equal to "00," "01," "02," "10," "20," "30," or "40."	If oral cavity designation is sent, the code must be a numeric code (00, 01, 02, 10, 20, 30, 40).
PW00074	N/A	N/A	D	A7	242				Tooth code must be a valid Universal National Tooth Code.	If 2400.TOO02 is sent, it must be a valid Universal National Tooth Code.
PW00075	N/A	N/A	D	A7	562			DD	Assistant Surgeon Provider's NPI must be 10 digits and start with a "1."	2420B.NM109 must be 10 digits long and start with a "1."
PW00076	N/A	N/A	D	A7	240				Tooth surface must be one of these values: B, D, F, I, L, M, or O.	If 2400.TOO03.1-5 is sent, it must be one of the following values: B, D, F, I, L, M, or O.
PW00078	N/A	N/A	D	A7	737				Current Dental Terminology (CDT) codes must be valid for service date.	When 2400.SV301-1 = "AD," 2400.SV301-2 must be a valid CDT code on the date in 2400.DTP03 when DTP01 = "472."
PW00079	N/A	N/A	N/A	A3	493				Claim version submitted to payer must be "005010X222A1," "005010X223A2," or "005010X224A2."	837 Version (GS08) submitted to payer must be "005010X222A1," "005010X223A2," or "005010X224A2."
PW00080	N/A	N/A	D	A6	242				CDT code requires a mouth location or tooth.	When Loop 2400 SV301-1 = "AD" and SV301-2 includes a CDT code that requires a mouth location (SV304) or tooth information (TOO02).
PW00081	P	I	D	A7	242				Payer is unable to process claims from another provider in another country.	When 2010AA N404 is not blank or not US, The claim will be rejected.

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PW00082	P	I	D	A6	306				Detail service description is required for non-specific procedure codes, unless an NDC is present. Please review Payer Billing Guidelines for non-specific procedure codes.	When Loop 2400 element SV101-2 (Professional), SV202-2 (Institutional), or SV301-2 (Dental) contains a non-specific procedure code, the element SV101-7, SV202-7, or SV301-7 must be present, unless the NDC is entered in the LIN segment. If a dental claim (837D), description may be located in the Claim NTE.
PW00083	P	I	N/A	A6	453				If ambulance HCPCS codes are present, at least one modifier per ambulance HCPCS code is required on the claim.	When 2400 SV101-2 (Professional) or SV202-2 (Institutional) contains an ambulance HCPCS code at least one procedure modifier in element SV101-3 or SV202-3 must be present.
PW00084	P	I	D	A7	728				If accident state is present in claim transaction, the state code must be valid or claim will be rejected.	When 2300 CLM11-4 (Professional **or** Dental) is present or REF01 = LU (Institutional), the accident state code must be valid.
PW00085	N/A	I	N/A	A6	562	560		71	If attending provider is present in the claim transaction, at the claim or service Line, the attending provider must include the NPI or UMPI. If not present, claim will be rejected.	When Attending Provider 2310A loop is present in the 837I, then the NPI (NM109) or UMPI (REF02 when REF01 = "G2") must be present for that loop.
PW00086	P	I	D	A6	562	560		82	If rendering provider is present in the claim transaction, at the claim or service Line, the rendering provider must include the NPI or UMPI. If not present, claim will be rejected.	When Professional or Dental 2310B/2420A or Institutional 2310D/2420C loop is present, then an NPI (NM109) or UMPI (REF02 when REF01 = "G2") must be present for that loop.
PW00087	P	I	D	A6	562	560		DN	If referring provider is present in the claim transaction, at the claim or service line, the referring provider must include the NPI or UMPI. If not present, claim will be rejected.	When Referring Provider Professional 2310A or 2420F, Institutional 2310F or 2420D, or Dental 2310A loop is present, then an NPI (NM109) or UMPI (REF02 when REF01 = "G2") must be present for that loop.
PW00088	N/A	I	N/A	A6	673	560			Due to state reporting requirements, payer requires the patient's reason for visit on all unscheduled outpatient visits.	When facility code (CLM05-1) is 13 or 85 and admission type code (CL101) is 1, 2, or 5 and any service line revenue code (SV201) of 045x, 0516, or 0762 is present, the patient reason for visit (HI01-2 with HI01-1 equal to "PR" or "APR") is required. If not found, claim will be rejected.
PW00091	N/A	I	N/A	A6	562	560		71	If ambulance HCPCS code A0426 or A0428 is present (non-emergency ambulance trips), the NPI in the Attending Physician field is required. See bulletin M7557.	When 2400 SV202-2 (Institutional) contains an ambulance HCPCS code A0426 or A0428, the attending provider (2310A) NPI must be present on the claim. The claim will be rejected if claim does not include the NPI.
PW00092	N/A	I	N/A	A7	187	188			If the Service Date is outside the Statement from and Statement through date, claim will be rejected, unless the Revenue Code is equal to 0022 or Bill Type is 21x.	If the Service Date(Loop 2400 DTP03, DTP01=472) is outside the Statement from and Statement through date(Loop 2300 DTP03, DTP01=434), claim will be rejected, unless the Revenue Code is equal to 0022 or Bill Type is 21x.
PW00093	P	I	N/A	A6	306				Detail service description is required for non-specific procedure codes on high-dollar claims. Please review Payer Billing Guidelines for non-specific code description requirement.	When 2400 SV101-2 (Professional) or SV202-2 (Institutional) contains a non-specific procedure codes and the charge amount is greater than $100. The edit is determined by a "D100" in the LOS_GROUP field of the PROC_DETAIL table, the element SV101-7 or SV202-7 must be present. The claim will be rejected back if there is no detailed description of the service.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00094	P	I	D	N/A	N/A				Claim loaded in error. File was sent multiple times or there was a payer processing issue. Claims passed were deleted before loading to Amisys.	Claim loaded In error. File was sent multiple times or payer processing issue.
PW00095	N/A	I	N/A	A6	719	159		IL	Subscriber/patient: If discharge status/patient status code = 20, 40, 41, or 42, occurrence code 55 is required with date of death.	When Loop 2300, Segment CL1, Element 03 Patient Status Code = 20, 40, 41, or 42, the Element HI01-1 must include a BH qualifier code with the occurrence code of 55 in the HI01-2 and the date of death in HI-01-4.
PW00096	N/A	I	N/A	A7	507	228			If claim includes HCPCS code G0257, the claim must be submitted with the appropriate TOB (i.e., TOB 13x or 85x).	If HCPCS code G0257 is present on a claim, the claim must be submitted with the appropriate TOB (i.e., TOB 13x or 85x). If bill type is not equal to 13x or 85x, the claim will be rejected.
PW00097	P	I	N/A	A6	216	659			When a National Drug Code (NDC) is submitted, drug unit of measure and quantity are required.	If LIN segment is present, the CTP segment must be present and requires the CTP04 and CTP05 (unit of measure and quantity required).
PW00098	N/A	I	N/A	A6	231				Minnesota Health Care Programs (MHCP) requires hospitals to enter an admission type on all institutional claims per the Minnesota Department of Human Services' (DHS) website.	Admission type code (CL101) for Institutional claims is required by MHCP.
PW00099	P	N/A	N/A	A6	244	245			Oral cavity designation or tooth number is required for CPT codes 41820, 41828, 41872, and 41874 and is missing.	K3 segment missing in loop 2400 for oral cavity designation or tooth number that is required for CPT codes 41820, 41828, 41872, and 41874.
PW00100	P	N/A	N/A	A7	244	245			Oral cavity designations or tooth numbers that were submitted are invalid.	K3 fixed file format oral cavity designations or tooth numbers in loop 2400 that were submitted are invalid. Ex (K3*JP12 14~)
PW00101	N/A	I	N/A	A6	234				Patient status code is required on Institutional claims.	Patient status code (CL103) is required on Institutional claims.
PW00103	P	I	D	A7	503			85	Billing provider address 1 and/or address 2 must be a street address, not a post office box or lock box.	Billing provider address N301 and N302 must not contain the following exact phrases (not case sensitive): "Post Office Box," "P.O. Box", "P O Box," "PO Box," "Lock Box," or "Lock Bin."
PW00104	P	I	D	A7	503			77	Service facility address 1 must be a street address, not a post office box or lock box.	Service facility address N301 must not contain the following exact phrases (not case sensitive): "Post Office Box," "P.O. Box," "P O Box," "PO Box," "Lock Box," or "Lock Bin."
PW00105	P	I	D	A7	562	135	128	85	The combination of the billing provider's Tax Identification Number (TIN) and NPI/UMPIs does not exist in the payer's system.	The combination of the billing provider Tax ID (2010AA REF02) and the NPI (2010AA NM109) or UMPI (2010BB REF02) does not exist in the payer's system.
PW00106	N/A	I	N/A	A7	234				If the bill type ends in a "1" or "4" (excluding 861 and 891), the patient status can not be "30" or the claim will be rejected.	If the claim frequency code (CLM05-3) ends in a "1" or "4," excluding 861 and 891 (CLM05-1/CLM05-3), and the patient status code (CL103) is equal to "30," the claim will be rejected.
PW00109	P	N/A	N/A	A6	562			DK	If ordering provider name is present in the 837P claim transaction, the ordering provider must include the NPI.	If ordering provider name is present in the Service Loop 2420E of the 837P claim transaction, the ordering provider must include the 10-digit NPI. If NPI is not present, claim will be rejected.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00110	N/A	I	N/A	A6	562			72	If operating provider name is present in the 837I claim transaction, the operating provider must include the NPI.	If operating provider name is present in the Claim or Service Loop 2310B/2420A of the 837I claim transaction, the operating provider must include the 10-digit NPI. If NPI is not present, claim will be rejected.
PW00111	N/A	I	N/A	A6	562			ZZ	If other operating provider name is present in the 837I claim transaction, the other operating provider must include the NPI.	If other operating provider name is present in the Claim or Service Loop 2310C/2420B of the 837I claim transaction, the other operating provider must include the 10-digit NPI. If NPI is not present, claim will be rejected.
PW00112	N/A	I	N/A	A7	560			71	If attending provider is present in the 837I claim transaction and the NPI is blank, the UMPI must be 10 digits in length and start with an "A" or "M."	When attending provider 2310A loop is present in the 837I and the NPI (NM109) is blank, the UMPI (REF02 when REF01 = "G2") must be 10 digits in length and start with an "A" or "M."
PW00113	P	I	D	A7	560			82	If rendering provider is present in the 837P, 837D, or 837I claim transaction and the NPI is blank, the UMPI must be 10 digits in length and start with an "A" or "M."	When the rendering provider is present in the Professional or Dental 2310B/2420A or Institutional 2310D/2420C loop and the NPI (NM109) is blank, the UMPI (REF02 when REF01 = "G2") must be 10 digits in length and start with an "A" or "M."
PW00114	P	I	D	A7	560			DN	If referring provider is present in the 837P, 837D, or 837I claim transaction and the NPI is blank, the UMPI must be 10 digits in length and start with an "A" or "M."	When the referring provider is present in the Professional 2310A or 2420F, Institutional 2310F or 2420D, Dental 2310A loop and the NPI (NM109) is blank, the UMPI (REF02 when REF01 = "G2") must be 10 digits in length and start with an "A" or "M."
PW00116	N/A	I	N/A	A7	228				When the 837I claim transaction claim frequency (last digit) of the TOB = "5," the claim will be rejected. All late charge billings should be submitted with the claim frequency of "7" and should be submitted as a part of a replacement claim per Administrative Uniformity Committee (AUC) Guidelines.	When the 837I claim transaction Loop 2300 CLM05-3 = "5," the claim will be rejected. All late charge billings should be submitted with the CLM05-3 = "7" and should be submitted as a part of a replacement claim per AUC Guidelines.
PW00117	N/A	N/A	D	A6	216				If the CDT codes "D9610," "D9612," or "D9630" are present in the 837D claim file, the claim "NTE" segment is required and should include the NDC, drug name, and dosage.	If the CDT codes (SV301-2) contains "D9610," "D9612," or "D9630" in the 837D claim file, the front end edit will validate that there is information in the claim "NTE" segment. The information that needs to be sent in the NTE segment is the NDC, drug name, and dosage. The edit is only checking to be sure that the segment is there. The edit is unable to determine if the correct information is being sent.
PW00118	P	I	N/A	A6	306				Detail service description is required for non-specific procedure code "E1399," unless the modifier QH or 52 is included in the electronic data interchange (EDI) data.	When 2400 SV101-2 (Professional) or SV202-2 (Institutional) contains the non-specific procedure code "E1399," the element SV101-7 or SV202-7 must be present unless the modifier QH or 52 are included in the (837P) SV101-3, 4, 5, or 6 or the (837I) SV202-3, 4, 5, or 6. If one of the two modifiers are not included "QH" or "52," the service description is required. If no service description is on the claim, the claim will be rejected.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00119	P	I	N/A	A6	306				Detail service description is required for procedure code "A7520," "A7521," or "B4088" when the modifier U3 is included in the EDI data.	When 2400 SV101-2 (Professional) or SV202-2 (Institutional) contains the procedure code "A7520," "A7521," or "B4088" with the modifier U3 in the (837P) SV101-3, 4, 5, or 6 or the (837I) SV202-3, 4, 5, or 6, the element SV101-7 or SV202-7 must be present. If no service description on the claim, the claim will be rejected.
PW00120	N/A	I	N/A	A7	228				Payer will no longer accept Institutional claims submitted with TOB 033X after October 1, 2013. If the "Statement From" date is equal to or after October 1, 2013, the claim will be rejected.	TOB - 033x will be invalid on October 1, 2013. Loop 2300 segment/elements CLM05-1 and CLM05-3. When an Institutional claim is submitted after October 1, 2013, and the statement "from" date (Loop 2300 DTP) is equal to or after October 1, 2013, and the TOB = 033x, the claim will be rejected.
PW00121	P	I	N/A	A7	476				Institutional/Professional claim is missing or has invalid units of service. Units of service must be > 0 and <= 9,999.9 for Professional claims. Units of service must be > 0 and <= 9,999,999.9 for Institutional claims.	Institutional/Professional service line, Loop 2400 SV104 (Professional) or SV205 (Institutional) is missing or has invalid units of service - SV104 (837P) must be > 0 and <= 9,999.9 and the SV205 (837I) must be > 0 and <= 999,999.9.
PW00124	P	I	N/A	A7	187	158		IL	Service "From Date" must be greater than or equal to patient's date of birth.	837P and 837I_2400 - DTP01 = 4 72, then DTP03 ("Service From" date) must be greater than 2010BA subscriber demographic date of birth DMG02.
PW00125	P	N/A	N/A	A7	189	187			All 837 Professional claims, except ambulance services, will be rejected when the admit date submitted is greater than the first date of service.	All 837P claims, except ambulance services, will be rejected when the admit date (Loop 2300 DTP01 = 435, DTP03) submitted is greater than the first date of service (Loop 2400 DTP01 = 472, DTP03). Providers should only submit an admit date on ambulance claims when patients are known to be admitted or on inpatient medical visits. All other services billed should not include an admit date.
PW00126	P	N/A	N/A	A6	763	740			All 837 Professional ambulance claims require a pickup and drop-off location zip code.	All 837 Professional claims that include one of the following procedure codes: A0021, A0422, A0426, A0427, A0428, A0429, A0430, A0431, A0433, or A0434 requires a pickup location zip code (2310E/2420G, element N403) and drop-off location zip code (2310F/2420H, element N403). Must be 5 or 9 characters long.
PW00127	N/A	I	N/A	A6	763	725			All 837 Institutional ambulance claims require a pickup location zip code in the value amount field with a value code of "A0."	All 837 Institutional claims that include one of the following procedure codes: A0021, A0422, A0426, A0427, A0428, A0429, A0430, A0431, A0433, or A0434 requires a pickup location zip code, using the National Uniform Billing Committee (NUBC) value code "A0" with the zip code located in the value amount field. Must be 3, 4, 5, 7, 8, or 9 characters in length.
PW00128	P	N/A	N/A	A7	477				Primary diagnosis code pointer cannot point to an external cause of injury code.	Per the AUC version 6.0 Minnesota Uniform Companion Guide, the 837P claim transaction segment SV107-1 primary diagnosis code pointer cannot point to an external cause of injury code.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00129	P	I	N/A	A6	218				NDC code is required for specified service line HCPCS codes, unless a "UD" modifier is submitted for the HCPCS code. Medicare and/or Medicaid require NDC codes for specific service line HCPCS codes.	Specific identified HCPCS codes (SV101-2 and SV202-2) require NDC codes in the LIN segment for the service line for HCPCS codes that require NDC codes.
PW00130	P	I	N/A	A7	254				Manifestation codes are not allowed to be entered into the "Principal Diagnosis Code" field in the 837 EDI file.	Manifestation codes are not allowed in the "Principal Diagnosis Code" field (HI01-2) of the 837 EDI data where the qualifier is (HI01-1 = BK or ABK).
PW00131	N/A	I	N/A	A7	189	188			When the admission date that is submitted on the 837I claim is greater than the "Statement To" date, the claim will be rejected.	When the admission date (Loop 2300 DTP0 1= 435, DTP03) that is submitted on the 837I claim is greater than the "Statement To" date (Loop 2300 DTP01 = 434, DTP03), the claim will be rejected.
PW00133	N/A	I	N/A	A7	228	455			Claims for Medicare members will be rejected if the claim contains an outpatient TOB and one or more of the following revenue codes: 0500, 0509, 0583 ,0660-0663, 0669, 0905-0907, 0931, or 0932.	Claims for Medicare members will be rejected if the claim contains an outpatient TOB CLM05-1 and CLM05-3 and one or more of the following revenue codes: 0500, 0509, 0583, 0660-0663, 0669, 0905 - 0907, 0931, or 0932. These revenue codes are not recognized by Medicare if billed on outpatient claims.
PW00134	N/A	I	N/A	A6	460				Claims submitted with TOB 11X and a patient status code of 02, 03, 05, 50, 51, 61, 62, 63, 65, 66, 70, 82, 83, 85, 89, 90, 91, 93, 94, or 95 with an admission date equal to the "Statement Through" date must contain condition code 40; same day transfer.	Claims submitted with TOB 11x (CLM05-1) and a patient status code (CL103) of 02, 03, 05, 50, 51, 61, 62, 63, 65, 66, 70, 82, 83, 85, 89, 90, 91, 93, 94, or 95; and the admission date (DTP01 = 435; DTP03) is equal to the "Statement Through" date (DTP01 = 434; DTP03) the claim must contain condition code 40 in one of the following 12 HI composites (HI01-1 = BG; HI01-2 (HI02-1 = BG; HI02-2, etc.).
PW00135	P	I	D	A6	286				When sending line adjudication Information for other payers, the other payer claim information must have a payment amount.	When sending line adjudication information for the other payers, the identifier sent in SVD01 (Payer Identifier) of Loop ID-2430 (Line Adjudication Information) must match the Claim Level Other Payer Identifier in loop 2330B and there must be a AMT03 payment amount.
PW00136	N/A	I	N/A	A6	719				If claims submitted with revenue code 0022 do not include a HIPPS code containing "AAAxx," occurrence code "50" is required on the claim.	Claims submitted with revenue code (SV201) equal to 0022 that do not include the HIPPS code containing "AAAxx" (SV202-2) where (SV202-1) = "HP," the EDI claim data must contain occurrence code "50" in HI0X-02.
PW00138	N/A	I	N/A	A6	254	255	228		When the Institutional claim TOB = "41x," the claim must include the ICD-9 principal diagnosis 799.9 and ICD-9 other diagnosis V62.6. After the ICD-10 implementation, the 837I claim transaction must include the ICD-10 principal diagnosis "R69" and ICD-10 other diagnosis "Z53.1."	When the 837I claim transaction facility type code = "41x," the claim must include the ICD-9 (HI01-1 = BK) principal diagnosis (HI01-2) 799.9 and ICD-9 (HI01:HI12-1 = BF) other diagnosis (HI01:HI12-2) V62.6. After the ICD-10 implementation, the 837I claim transaction must include the ICD-10 (HI01-1 = ABK) principal diagnosis (HI01-2) "R69" and ICD-10 (HI01:HI12-1 = ABF) other diagnosis (HI01:HI12-2) "Z53.1."

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00139	N/A	I	N/A	A7	510	188			Claims with future dates are not accepted. When the claim statement date includes a date that is after the payer received date and the claim didn't contain one of the following HCPCS codes: B4161-B5200, B9000-B9999, S0012-S9999, E0776-E0791, B4034-B4162, A4244-A4290, E0910-E0948, the claim will be rejected.	Claims with future dates are not accepted. When the claim statement date (Loop 2300, DTP03 where DTP01 = 434) includes a date that is after the payer received date and the claim didn't contain one of the following HCPCS codes: B4161-B5200, B9000-B9999, S0012-S9999, E0776-E0791, B4034-B4162, A4244-A4290, E0910-E0948, the claim will be rejected.
PW00140	P	I	D	A7	510	187			Claims with future dates are not accepted. When the service date on the claim includes a date that is after the payer received date and the claim didn't contain one of the following HCPCS codes: B4161-B5200, B9000-B9999, S0012-S9999, E0776-E0791, B4034-B4162, A4244-A4290, E0910-E0948, the claim will be rejected.	Claims with future dates are not accepted. When the service date (Loop 2400, DTP03 where DTP01 = 472) includes a date that is after the payer received date and the claim didn't contain one of the following HCPCS codes: B4161-B5200, B9000-B9999, S0012-S9999, E0776-E0791, B4034-B4162, A4244-A4290, E0910-E0948, the claim will be rejected.
PW00141	N/A	I	N/A	A6	233				Discharge hour is required on 837I Inpatient claims.	837I Inpatient claims that include the first two digits of facility type code (CLM05-1) = 11, 18, 86, 28, 41, 65, or 66 and frequency code (CLM05-3) = 1, 4, or 7, along with discharge status of 01 - 20 or 81 - 86 require the discharge hour (DTP03) where date qualifier (DTP01) = 96 or the claim will be rejected.
PW00142	N/A	I	N/A	A7	21	481		82	When the 837I claim level rendering provider NPI matches the claim level attending provider NPI, the claim will be rejected.	When the 837I claim level rendering provider NPI (2310D) matches the claim level attending provider NPI (2310A), the claim will be rejected.
PW00143	P	I	D	A7	21	247		82	When claims have one charge line or multiple charge lines and the rendering provider's NPI at the service line level are all different than the rendering provider's NPI at the claim level, the claim will be rejected.	When claims have one charge line or multiple charge lines and the rendering provider's NPI at the service line level (2420A for 837P and 837D or 2420C for 837I) are all different than the rendering provider's NPI at the claim level (2310B for 837P and 837D or 2310D for 837I), the claim will be rejected.
PW00144	P	N/A	N/A	A7	258	453			When a claim contains transportation codes A0130, T2001, T2003, and/or T2005; the units are greater than two; and modifier "UC" is not present, the claim will be rejected. If two units are billed with the above codes, two or more modifiers are required. If the claim contains A0100 and units are greater than two, the claim will be rejected.	When a claim contains A0130, T2001, T2003, and/or T2005 (SV101-2); units are greater than two (SV104); and modifier "UC" (SV101-3:SV101-6) is not present, the claim will be rejected. If two (SV104) units are billed with the above codes, two or more modifiers (SV101-3:SV101-6) are required. If the claim contains A0100 (SV101-2) and units are greater than two (SV104), the claim will be rejected.
PW00145	P	I	D	A7	145			85	When the 837P, 837I, and 837D billing provider taxonomy code is present, the taxonomy code must be valid based on the National Uniform Claim Committee (NUCC) Provider Taxonomy Code Set.	When the 837P, 837I, and 837D Loop 2000A, billing provider taxonomy code (PRV03) is present, the taxonomy code must be valid based on the NUCC Provider Taxonomy Code Set.
PW00146	N/A	I	N/A	A7	145			71	When the 837I attending provider taxonomy code is present, the taxonomy code must be valid based on the NUCC Provider Taxonomy Code Set.	When the 837I Loop 2310A, attending provider taxonomy code (PRV03) is present, the taxonomy code must be valid based on the NUCC Provider Taxonomy Code Set.
PW00147	N/A	N/A	D	A7	145			DN	When the 837D referring provider taxonomy code is present, the taxonomy code must be valid based on the NUCC Provider Taxonomy Code Set.	When the 837D 2310A referring provider taxonomy code (PRV03) is present, the taxonomy code must be valid based on the NUCC Provider Taxonomy Code Set.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00148	P	N/A	D	A7	145			82	When the 837P and 837D rendering provider taxonomy code is present, the taxonomy code must be valid based on the NUCC Provider Taxonomy Code Set.	When the 837P and 837D Loop 2310B and 2420A rendering provider taxonomy code (PRV03) is present, the taxonomy code must be valid based on the NUCC Provider Taxonomy Code Set.
PW00149	N/A	N/A	D	A7	145			AS	When the 837D assistant surgeon taxonomy code is present, the taxonomy code must be valid based on the NUCC Provider Taxonomy Code Set.	When the 837D Loop 2310D and 2420B assistant surgeon taxonomy code (PRV03) is present, the taxonomy code must be valid based on the NUCC Provider Taxonomy Code Set.
PW00150	P	I	N/A	A7	218				NDC must be 11 numerical digits long. If the NDC contains an alpha character, has all the same digits, has 5 leading zeros, has or combinations of "05555xxxxxx" or "5555xxxxxxx," the claim will be rejected.	NDC (Loop 2410-LIN03) must be 11 numerical digits long. If the NDC contains an alpha character, has all the same digits, has 5 leading zeros, or has combinations of "05555xxxxxx" or "5555xxxxxxx," the claim will be rejected.
PW00151	N/A	N/A	D	A6	306				Detail service description or a claim note is required for the non-specific procedure code "D9920" when the member is age 21 or over and not pregnant. Please review Payer Billing Guidelines for non-specific procedure codes.	When 2400 SV301-2 (dental) contains the non-specific procedure code "D9920," and the member is age 21 or over and not pregnant, the 2300 claim "NTE" segment or the element SV301-7 must be present.
PW00152	N/A	I	N/A	A7	228				When a critical access hospital (CAH) submits an 837I claim and the claim contains the TOB 13x or 83x, the claim will be rejected back to the provider.	When a CAH submits an 837I claim and the claim contains the TOB 13x or 83x, the claim will be rejected back to the provider. (The edit will determine the facility type by matching the group practice TIN/NPI, to the proper affiliation record in Amisys. The Type [PR] field needs to have an "HP" for Hospital and the Spec [SP] field will have a "CH" for Critical Access Hospital.)
PW00154	P	I	D	A8	164			IL	No subscriber match in the payer system. The subscriber ID does not exist	Subscriber (Loop2010BA, NM109) must be a valid payer member ID (PMI).
PW00155	P	I	D	A7	158			IL	The subscriber's date of birth does not exist or does not match the member's date of birth from the DHS enrollment file.	The subscriber's date of birth (Loop 2010BA, DMG02) does not exist or does not match the member's date of birth from the DHS enrollment file.
PW00157	P	I	D	A7	88			IL	The member was not eligible for services based on the service date on the claim.	The member was not eligible for services on the from/to statement (Loop 2300, DTP03) or service dates (Loop 2400, DTP03) for the claim.
PW00158	P	I	N/A	A6	489	252		PR	Unlisted or non-specified laboratory/pathology, radiology, or diagnostic services was submitted on the claim. You must attach documentation or an authorization number to the claim to justify the use of the unlisted procedure code and to describe the procedure or service rendered.	Unlisted or non-specified laboratory/pathology, radiology, or diagnostic services (SV101-2 and SV202-2) were submitted on the claim. The PWK segment or REF prior authorization number is required and must include the attachment control number to link the claim and the attachment.
PW00159	P	N/A	D	A6	464				When replacement or void claims for a non-Medicare member are from a Federally Qualified Health Center/Rural Health Clinic (FQHC/RHC) provider, the payer claim control number must contain the DHS claim control number (TCN). The only exception to this is for the BB01 carve out. Those claims will be paid by the managed care organization (MCO) as of July 1, 2015.	The payer claim control number (REF02, REF01 = F8) is required where the claim frequency = 7 or 8 (CLM05-3). If the non-Medicare claim is received from a FQHC/RHC provider, the payer claim control number (REF02, REF01 = F8) must contain the DHS claim control number (TCN). The only exception to this is for the BB01 carve out. Members that have a status of M5, M6, or M7 will be paid by the MCO as of July 1, 2015, so they would not have a DHS claim control number (TCN).

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00160	P	N/A	D	A7	464				When replacement or void claims for a non-Medicare member are from a FQHC/RHC provider, the payer claim control number must be 17 characters long, start with a 5, and the second and third digit together must not be greater than the current year. The only exception to this is for the BB01 carve out. Those claims will be paid by the MCO as of July 1, 2015.	The replacement or void claim (frequency = 7 or 8 [CLM05-3]) contains an invalid payer claim control number. If the non-Medicare claim is from a FQHC/RHC provider, the payer claim control number (REF02, REF01 = F8) must be 17 characters long, start with a 5, and the second and third digit together must not be greater than the current year. The only exception to this is for the BB01 carve out. Members who have a status of M5, M6, or M7 will be paid by the MCO as of July 1, 2015, so they would not have a DHS claim control number (TCN).
PW00161	P	I	N/A	A7	512	216			The drug quantity field cannot exceed an 11-character maximum (7.3) and the quantity submitted cannot be < 0.001 (or equal to zero).	When the drug quantity field (Loop 2410 Segment CPT04) is submitted, a maximum of 11 characters can be submitted (7 digits, decimals, 3 digits) and the quantity submitted cannot be < 0.001 (or equal to zero).
PW00162	N/A	I	N/A	A7	481				Payers are required to forward FQHC/RHC claims for non-Medicare members to DHS (MHCP) for payment; unless the prior payer is Medicare Part A or Medicare Part B and the claim contains the Other Subscriber Payer Amount or Non-covered amount. MHCP does not accept the 837I claim format for FQHC/RHC providers.	Payers are required to forward FQHC/RHCs (service facility [2310E]/billing provider (2010AA) [NPI]) claims for non-Medicare members to DHS (MHCP) for payment; unless the Other Subscriber Loop 2320, SBR09 = MA or MB and the claim contains the Other Subscriber Payer Amount AMT = D or the Other Subscriber Non-covered charge amount AMT = A8. MHCP does not accept the 837I claim format (GS08 = 005010X223A2) for FQHC/RHC facilities/providers.
PW00163	p	N/A	D	A7	743	562		82	When the payer receives a FQHC/RHC non-Medicare claim (837P or 837D), the rendering providers have to be registered with Minnesota Information Transfer System (MN-ITS) or the claim will be rejected, unless the prior payer is Medicare Part A or Medicare Part B and the claim contains the Other Subscriber Payer Amount or Non-covered amount. The only other exception to this is for the BB01 carve out. Those claims will be paid by the MCO as of July 1, 2015.	When the payer receives an FQHC/RHC non-Medicare claim (837P or 837D), the rendering providers (2310B/2420A) have to be registered with MN-ITS or the claim will be rejected, unless the Other Subscriber Loop 2320, SBR09 = MA or MB and the claim contains the Other Subscriber Payer Amount AMT = D or the Other Subscriber Non-covered charge amount AMT = A8. The only other exception to this is for the BB01 carve out. Members that have a status of M5, M6, or M7 will need to be paid by the MCO as of July 1, 2015.
PW00164	P	I	N/A	A7	88	229	234	IL	Member was not eligible for services while incarcerated. Institutional claim source of admission = 8 and discharge status was 21 or 87. Professional claim includes POS = "09."	Member was not eligible for services while incarcerated. Institutional claim lists source of admission (CL102) = 8 and discharge status (CL103) was 21 or 87. Professional claim includes POS (CLM05-1 or SV105) = "09."
PW00166	N/A	I	N/A	A7	228	507			Claims will reject when the claim contains HCPCS G0473 and the facility type code does not = "13" or "85."	Claims will reject when the claim contains HCPCS (SV202-2) G0473 and the Facility Type Code (CLM05-1) does not = "13" or "85."
PW00168	P	I	D	A7	745	560		85	Invalid qualifier located in the billing provider secondary identifier.	Invalid qualifier located in the billing provider Loop 2010AA - REF segment (REF01) secondary identifier. Must be EI, SY, 0B, or 1G.
PW00169	P	N/A	N/A	A7	187				PCA services (T1019) or Comprehensive Community Support Services (H2015) may not be billed with a span of dates; each date of service must be billed separately.	If 2400 SV101-2 contains the procedure code T1019 or H2015 and the DTP02 is RD8, the "from" service date (DTP03) listed must be equal the to service date (DTP03) or the claim will be rejected.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00170	P	I	N/A	A6	453				When Member's age is < 19 and CPT Code requires the "SL" modifier, the claim will be rejected, unless the Other Payer has adjudicated the claim.	When the CPT code(SV101-2,SV202-2) is included in the EDI Edit Code Table with Edit Code Type "MNVFC" and the member's age < 19 (2010BA-DMG02, 2400-DTP03 [Service Date]), the modifier (SV101-3,SV202-3) "SL" is required, unless the Other Payer (Loop 2330B) has adjudicated the claim (Loop 2320-segment AMT01=D).
PW00171	P	I	D	A3	746				Trading partner cannot submit the same interchange control number (ISA13) that was submitted in a previous 837 file received from the same trading partner.	Trading partner cannot submit a duplicate 837 submission file.
PW00172	N/A	I	D	A7	476				Institutional/dental service line has invalid units of service. If billing for dental procedure only a unit count of 1 is allowed per service line, except for CDT D9223 and D9243.	837I/837D: If Loop 2400 SV306 (837D) has units > 1 or SV205 (837I) has units > 1 and the procedure code qualifier (SV202-1) = "HC" and procedure code (SV202-2) starts with "D," the claim will be rejected, except for CDT D9223 and D9243.
PW00173	P	I	D	A6	464				The payer claim control number is required for replacement or void claims.	The payer claim control number (REF02, REF01 = F8) is required where the claim frequency = 7 or 8 (CLM05-3). This edit does not include COBA and FQHC/RHC claims. The BB01 carve out for FQHC/RHC is included in the edit.
PW00174	P	I	D	A7	464				The replacement or void claim contains an invalid payer claim control number.	The replacement or void claim (frequency = 7 or 8 [CLM05-3]) contains an invalid payer claim control number. The payer claim control number (REF02, REF01 = F8) must be 12 characters long. This edit does not include COBA and FQHC/RHC claims. The BB01 carve out for FQHC/RHC is included in the edit.
PW00175	N/A	I	N/A	A7	234				Valid discharge status must be "01, 02, 04, 06, 07, 09, 20, 43, 50, 51, 62, 63, 64, 65, 66, or 70" when TOB is 131 or 134 and a service line has a revenue code of 0944, 0945, or 0953 and a HCPCS code of H0020, H0047, or H2035.	Claim must have a valid discharge status (CL103) of "01, 02, 04, 06, 07, 09, 20, 43, 50, 51, 62, 63, 64, 65, 66, or 70" when facility codes/frequency code (CLM05) is 131 or 134 and a service line has a revenue code (SV201) of 0944, 0945, or 0953 and HCPCS codes (SV203) of H0020, H0047, or H2035 or claim will be rejected.
PW00176	N/A	I	N/A	A7	234				Patient status must be "30" when TOB is xx2 or xx3.	If patient status code (CL103) is NOT equal to "30" and the facility codes/frequency code (CLM05) is (xx2 or xx3), then reject.
PW00177	N/A	I	N/A	A6	719				Claims submitted with TOB 211, 212, 213, 214, 217 or 18x, and Revenue Code 0022 must include the occurrence span code "70" or the claim will be rejected.	Claims submitted with Facility Type Code and Claim Frequency combinations (CLM05-1, CLM05-3) of 211, 212, 213, 214, 217, or 18x and Revenue Code (SV201) equal to 0022 claim must include the Occurrence Span Code 70 (HI0x-2, when HI0x-1 = BI) or the claim will be rejected.
PW00178	P	N/A	N/A	A7	453				Providers will no longer be reimbursed for lab tests they did not complete. Tests submitted on 837P with modifier "90" will be rejected, except for 837P claims that include POS 22, POS 19, or procedure code 88321.	Providers will no longer be reimbursed for lab tests (SV101-2) they did not complete. Tests submitted on 837P with modifier "90" (SV101-3,SV101-4, SV101-5, SV101-6) will be rejected, except for 837P claims that include POS 22 or POS 19 at the claim level (CLM05-1) or at the service level (SV105) or that include procedure code 88321 (SV101-2).

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00179	P	N/A	N/A	A6	453				Hearing aid claims require modifier "NU" or "RB" based on specific procedure codes. If one of the modifiers is not present, the claim will be rejected.	When the procedure code (SV101-2) is included in the EDI Edit Code Table with Edit Code Type "Hearing_Aid_Modifier," the modifier (SV101-3,SV101-4, SV101-5, SV101-6) "NU" or "RB" is required. If modifier is not present, the claim will be rejected.
PW00180	P	N/A	N/A	A7	453				Hearing aid claims cannot include modifier "RA" or "RP" based on specific procedure codes. If one of the invalid modifiers is present, the claim will be rejected.	When the procedure code (SV101-2) is included in the EDI Edit Code Table with Edit Code Type "Hearing_Aid_Modifier," the modifier (SV101-3,SV101-4, SV101-5, SV101-6) "RA" or "RP" is invalid. If modifier is present, the claim will be rejected.
PW00181	N/A	I	N/A	A6	725				Medicaid claims submitted with statement through date after 10/01/2015 and TOB equal to 11x, must include the NUBC value code "80" or the claim will be rejected.	Medicaid claims submitted with statement through date after 10/01/2015 (DTP03 where DTP01 = 434) and facility type code equal to 11x (CLM05-1), claim must include the value code 80 (HI0x-2, when HI0x-1 = BE) or the claim will be rejected.
PW00182	N/A	I	N/A	A6	725				Medicaid claims submitted for members who are < 29 days old as of the admit date with TOB 11x and a discharge date on or after 10/1/2015 are required to be submitted with the member's weight, using value code 54 and value amount equal to the member's weight in grams.	Medicaid claims submitted for members that are < 29 days (DMG02 compared to admit date DTP03 when DTP0 1= 435) with facility type code equal to 11x (CLM05-1) and statement through date on or after 10/01/2015 (DTP03 where DTP01 = 434) are required to submit the member's weight, using value code 54 (HI0x-2, when HI0x-1 = BE) and value amount (HI0x-5, when HI0x-1 = BE) equal to the member's weight in grams.
PW00183	N/A	I	N/A	A7	700	255	726		Medicaid claims submitted for members that are < 29 days old as of the admit date with TOB 11x and a discharge date on or after 10/1/2015 are required to be submitted with the member's weight. If the ICD-10 diagnosis code indicating birth weight is reported on the claim, the birth weight must correlate to the weight reported with value code 54 in the Value Code Amount.	Medicaid claims submitted for members that are < 29 days (DMG02 compared to admit date DTP03 when DTP01 = 435) with facility type code equal to 11x (CLM05-1) and statement through date on or after 10/01/2015 (DTP03 where DTP01 = 434) are required to submit the member's weight. If the ICD-10 diagnosis code (HI0x-2, when HI0x-1 = ABK or ABF) indicating birth weight is reported on the claim, the birth weight must correlate to the weight reported with value code 54, value amount (HI0x-5, when HI0x-1 = BE) .
PW00184	N/A	I	N/A	A7	725				For Medicaid claims submitted with a "statement through" date on or after 10/01/2015, TOB equal to 11x, and NUBC Value Code "80" and "81" (if present), the value amount must match the days/units, excluding revenue codes 1000, 1001, 1002, 1003, 1004, and 1005 or the claim will be rejected.	Medicaid claims submitted with "statement through" date after 10/01/2015 (DTP03 where DTP01=434), facility type code equal to 11x (CLM05-1), and the claim includes the value code 80 and 81 (if present) (HI0x-2, when HI0x-1=BE), the value amount (HI0x-5, when HI0x-1=BE) must match the room and board (SV201) excluding revenue codes 1000, 1001, 1002, 1003, 1004, and 1005) units (SV204) or the claim will be rejected.
PW00185	P	I	N/A	A7	476				Medicare claims can only contain a decimal in the service line quantity for the following procedures: A0425, A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, A0434, A0435, or A0436 or revenue code 054x; all other claims will be rejected.	Medicare claims can only contain a decimal in the service line quantity, Loop 2400 SV104 (Professional) or SV205 (Institutional) for the following procedures (SV101-2 and SV202-2) A0425, A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, A0434, A0435, A0436 or revenue code (SV201) 054x. All other claims will be rejected.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00186	P	I	N/A	A6	507	453			DME claims, where the DHS DME fee schedule procedure codes include modifiers NU, RR, UE, U3, RB, RA or RP, will require procedure code to include one of the following modifiers: NU, RR, UE, U3, RB, RA, RP, or MS or the claim will be rejected.	DME claims, where the DHS DME fee schedule procedure codes include modifiers NU, RR, UE, U3, RB, RA, or RP, will require those procedure codes (SV101-2 [Professional] or SV202-2 [Institutional]) to include one of the following modifiers: NU, RR, UE, U3, RB, RA, RP, or MS (SV101-3-SV101-6 [Professional]) or (SV202-3 - SV202-6 [Institutional]) or the claim will be rejected.
PW00188	P	I	D	A7	228				Non-RHC providers can not submit claims with TOB 71x, the only exception is TOB 718. All other claims will be rejected back to the Non-RHC providers.	Non-RHC providers (Service Facility NPI-NM109/Billing Provider NPI-NM109) cannot submit claims with TOB 71x. The only exception is TOB 718. All other claims will be rejected back to the non-RHC providers.
PW00189	P	I	D	A3	718				Claims with dates of service <= 12/31/2014 are being rejected for timely filing.	Claims with dates of service <= 12/31/2014 are being rejected for timely filing. When the Claim Statement Date (Loop 2300, DTP03 where DTP01=434) and/or Service Date(Loop 2400, DTP03 where DTP01=472) includes a date <= 12/31/2014, the claim will be rejected.
PW00190	P	I	N/A	A6	507				When a claim is billing for vaccinations, the claim must include the vaccine code and administration code on the same claim or the claim will be rejected.	When a claim is billing for vaccinations (Loop 2400 SV101-2 (Professional) or Loop 2400 SV202-2 (Institutional), the claim must include the administration code (Loop 2400 SV101-2 [Professional] or Loop 2400 SV202-2 [Institutional]) or the claim will be rejected. Vaccine codes and administration codes are updated annually in the EDI Edit Code table.
PW00191	P	I	N/A	A6	453	158			When member's age is < 18 and claim includes procedure code H0035 or H0040, the "HA" modifier is required. If the modifier is missing, the claim will be rejected.	When the procedure code (SV101-2; SV202-2) H0035 or H0040 is included on the claim and the member's age < 18 (2010BA-DMG02, 2400-DTP03 [Service Date]), the modifier (SV101-3, 4, 5, 6; SV202-3, 4, 5, 6) "HA" is required. If no modifier is included, the claim will be rejected.
PW00192	P	I	N/A	A7	254	255	509		When the claim includes duplicate codes for the principal diagnosis, other diagnosis code, or external cause code fields, the claim will be rejected for incorrect coding.	When the claim includes duplicate codes for the principal diagnosis (HI01-1 = ABK) (HI01-2), other diagnosis code fields (HI01-1 = ABF) (HI01:HI12-2), or external cause code (HI01-1 = ABN) (HI01:HI12-2), the claim will be rejected for incorrect coding.
PW00195	P	N/A	N/A	A6	453				If HCPCS procedure code "T2029" is present, at least one of the following modifiers: "NU," "UE," "RB," or "RR" are required on the claim.	When the 837P claim Loop 2400 SV101-2 contains the HCPCS procedure code "T2029," at least one of the following procedure modifiers "NU," "UE," "RB," or "RR" must be present in element SV101-3, 4, 5 or 6, or the claim will reject.
PW00196	P	N/A	N/A	A6	562	453		77	Medicare reference lab or Medicare anti-markup claims submitted need to include the NPI of the service facility.	Medicare reference lab (SV101-3, 4, 5, or 6 = "90") or anti-markup (Loop 2400, segment PS1) claims submitted will need to include the NPI (Loop 2310C/2420C where NM101 = 77, Element NM109) of the service facility.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00197	P	N/A	N/A	A7	562			77	Medicare Reference Lab or Medicare Anti-Markup claims must include a Service Facility NPI that is different than the Billing Provider NPI.	Medicare reference lab (SV101-3, 4, 5, or 6 = "90") or Medicare anti-markup (Loop 2400, segment PS1) claims must include a service facility NPI (Loop 2310C/2420C, Element NM109) that is different than the billing provider NPI (Loop 2010AA, Element NM109) or the claims will be rejected.
PW00198	N/A	I	N/A	A7	228	454			Claims with service date on or after 7/1/2015 cannot contain the TOB 72x and procedure code J0888, J0883, or Q5106 or the claim will be rejected, unless the service date is after 10/2/2017 and the condition code 84 is present on the claim.	Claims with service date (Loop 2400, DTP03 where DTP01 = 472) on or after 7/1/2015 cannot contain the TOB 72x (Loop 2300 CLM05-1) and procedure code J0888, J0883, or Q5106 (Loop 2400 SV202-2 [Institutional]) or the claim will be rejected, unless the service date is after 10/2/2017 and the condition code 84 (HI0x-2, when HI0x-1 = BG) is present on the claim.
PW00199	P	N/A	N/A	A7	659				When the service unit qualifier is MJ, the procedure code must contain one of the following anesthesia modifiers (AA, QK, QS, QX, QY, or QZ) or the claim will be rejected.	When the service unit qualifier (Loop2400.SV103) is MJ, the procedure code must contain one of the following anesthesia modifiers (AA, QK, QS, QX, QY, or QZ) SV101-3, SV101-4, SV101-5, or SV101-6 or the claim will be rejected.
PW00200	P	N/A	N/A	A7	275	247	562	82	The rendering provider at the claim or line level cannot be a doula provider's NPI or the claim will be rejected.	The rendering provider at the claim (2310B) or line (2420B) level can not be a doula provider (Amisys provider specialty = "DL") NPI (NM109) or the claim will be rejected.
PW00201	P	N/A	N/A	A6	275	247	562	82	When claims are being billed by a doula provider where Amisys Provider Specialty = "DL," the rendering provider at the claim or line level is required and must include the doula's supervising provider's NPI or the claim will be rejected.	When claims are being billed by a doula provider (Loop 2010AA) where Amisys Provider Specialty = "DL," the rendering provider at the claim level (2310B) or line level (2420B) is required and must include the doula's supervising provider's NPI (NM109) or the claim will be rejected.
PW00202	N/A	I	N/A	A7	481				Reject claim if procedure code T1019 is billed on the 837I claim format.	Reject claim if procedure code T1019 (SV202-2) is billed on the 837I claim format (GS08 = 005010X223A2).
PW00203	P	N/A	N/A	A7	453				Reject claim if procedure code T1019 is billed with procedure modifier U1 or UD.	Reject claim if procedure code T1019 (SV101-2) is billed with procedure modifier U1 or UD (SV101-3 through SV101-6).
PW00204	P	N/A	N/A	A7	453				When claim includes procedure code T1019 and procedure modifier UA, all T1019 procedure codes on the claim must include-and only include-the modifier UA or the claim will be rejected.	When claim includes procedure code T1019 (SV101-2) and procedure modifier UA (SV101-3 through SV101-6), all T1019 (SV101-2) procedure codes on the claim must include-and only include-the modifier UA (SV101-3 through SV101-6) or the claim will be rejected.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00205	P	I	N/A	A7	562	453		82	When the claim includes procedure code T1019 and procedure modifier UA, the rendering provider and provider type (in Amisys) cannot equal a physician ("PY") or the claim will be rejected. If the procedure code T1019 does not include procedure modifier UA, the rendering provider and provider type (in Amisys) must be a physician ("PY") or the claim will be rejected.	When claim includes procedure code T1019 (SV101-2) and procedure modifier UA (SV101-3 through SV101-6), the rendering provider (2420A/2310B/2010AA) and provider type (in Amisys) cannot equal a physician ("PY") or the claim will be rejected. If the procedure code T1019 (SV101-2) does not equal a procedure modifier UA (SV101-3 through SV101-6), the rendering provider (2420A/2310B/2010AA) and provider type (in Amisys) must equal a physician ("PY") or the claim will be rejected.
PW00206	N/A	I	N/A	A7	228	455	507		For Medicare claims with the TOB = "77x" where the claim does not have at least one of the following revenue code/procedure code combinations of 052x or 0519 and G0466, G0467, G0468 or revenue code/procedure code combinations of 0900 or 0519 and G0469 or G0470, the claim will be rejected.	For Medicare claims with the facility type code (CLM05-1) = "77" where the claim does not have at least one of the following revenue code/procedure code combinations of 052x or 0519 (SV201) and G0466, G0467 or G0468 (SV202-2) or revenue code/procedure code combinations of 0900 or 0519 (SV201) and procedure code G0469 or G0470 (SV202-2), the claim will be rejected.
PW00207	N/A	I	N/A	A7	228	455	507		For Medicare claims with the TOB = "77x" where the claim service line contains revenue code 029x, 030x, 031x (excluding procedure code 36415), 054x or procedure codes 99217-99239, 99281-99292, 99460-99480, 97804, G0271, or 99441-99444, the claim will be rejected.	For Medicare claims with the facility type code (CLM05-1) = "77" where the claim service line contains revenue code (SV201) 029x, 030x, 031x (excluding procedure code [SV202-2] 36415), 054x or procedure codes (SV202-2) 99217-99239, 99281-99292, 99460-99480, 97804, G0271, or 99441-99444, the claim will be rejected.
PW00208	P	I	N/A	A7	453	454	490		Reject claim if procedure code H0046 is billed with procedure modifier UB and is the only procedure code on the claim.	Reject claim if procedure code H0046 (SV101-2) is billed with procedure modifier UB (SV101-3 through SV101-6) and is the only procedure code (SV101-2) on the claim.
PW00209	N/A	N/A	D	A7	21	625			When a Predetermination of Dental Benefits claim is received, the claim will be rejected, except for the exception codes D8000-D8999.	When a Predetermination of Dental Benefits claim (CLM19 = PB) is received, the claim will be rejected, except for the exception codes D8000-D8999(SV301-2).
PW00211	P	N/A	N/A	A6	562	560		DN	When rehab services are billed on a professional claim and contain modifier GO, GN, or GP and the procedure code for modifiers GN or GP doesn't start with an "A," "S," or "T," the claim must include the referring or ordering provider NPI/UMPI.	When rehab services are billed on a professional claim and contain modifier GO, GN, or GP (SV101-3 – SV101-6) and the procedure code (SV101-2) for modifiers GN or GP (SV101-3 – SV101-6) doesn't start with an "A," "S," or "T," the claim must include the referring or ordering provider NPI/UMPI.
PW00212	P	N/A	N/A	A6	562	560		DK	When rehab service are billed on a professional claim and contain modifier GO, GN, or GP and the procedure code for modifiers GN or GP doesn't start with an "A," "S," or "T," the claim must include the referring or ordering provider NPI/UMPI.	When rehab services are billed on a professional claim and contain modifier GO, GN, or GP (SV101-3 – SV101-6) and the procedure code (SV101-2) for modifiers GN or GP (SV101-3 – SV101-6) doesn't start with an "A," "S," or "T," the claim must include the referring or ordering provider NPI/UMPI.
PW00213	P	I	N/A	A6	453	507			Substance use disorder requires HCPCS code H0047 to be submitted with modifier U9 or UB and HCPCS code H2036 to be submitted with at least one of the following modifiers: TG, TF, UD, HA or HK. If modifier is missing, the claim will be rejected.	Substance use disorder requires HCPCS code H0047 (SV202-2 [837I] or SV101-2 [837P]) to be submitted with modifier U9 or UB (SV202-3_SV202-6 [837I] or SV101-3_SV101-6 [837P]) and HCPCS code H2036 (SV202-2 [837I] or SV101-2 [837P]) to be submitted with at least one of the following modifiers: TG, TF, UD, HA or HK (SV202-3_SV202-6 [837I] or SV101-3_SV101-6 [837P]). If the modifier is missing, the claim will be rejected.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00214	P	I	D	A7	743			85	The Amisys provider review "PV" record contains a "GW" for this billing provider's NPI or UMPI because the billing provider is on the DHS withhold list.	The Amisys provider review "PV" record contains a "GW" for this billing provider's NPI (2010AA NM109) or UMPI (2010BB REF02) because the billing provider is on the DHS withhold list.
PW00215	P	I	D	A7	743			82	The Amisys provider review "PV" record contains a "GW" for this rendering provider's NPI or UMPI because the rendering provider is on the DHS withhold list.	The Amisys provider review "PV" record contains a "GW" for this rendering provider's NPI (2310B/2310D-2420A/2420C NM109) or UMPI (2310B/2310D-2420A/2420C REF02) because the rendering provider is on the DHS withhold list.
PW00216	N/A	N/A	D	A6	562	560		82	When a dental claim is received (excluding the predetermination claims) and the billing provider is an organization, the rendering provider's NPI or UMPI is required or the claim will be rejected.	When a dental claim is received (excluding predetermination claims [CLM19 = PB]) and the billing provider (2010AA NM102 = 2) is an organization, the rendering provider's (2310B/2420A) NPI (NM109) or UMPI (REF02 when REF01 = "G2") is required or the claim will be rejected.
PW00217	N/A	N/A	D	A7	562	560		82	When a dental claim is received (excluding the predetermination claims), the rendering provider cannot be an organization or the claim will be rejected.	When a dental claim is received (excluding predetermination claims [CLM19 = PB]), the rendering provider (2310B/2420A NM102 = 2) cannot be an organization or the claim will be rejected.
PW00218	N/A	I	N/A	A7	460				If the TOB is not equal to 323, 324, or 329, and the condition code = 54, the claim will be rejected.	If the TOB is not equal to 323, 324, or 329 (CLM05-1 + CLM05-3) and the condition code = 54 in one of the following 12 HI composites: HI01-1=BG, HI01-2; HI02-1=BG, HI02-2; etc., the claim will be rejected.
PW00219	N/A	I	N/A	A7	460	455	188		Claims submitted with TOB 329 where the statement from date is not equal to the admission date, and revenue code 042x, 043x, 044x, or 055x is not present on the claim, and the condition code is not equal to 20, 21, or 54, will be rejected.	Claims submitted with TOB 329 (CLM05-1 + CLM05-3) where the statement from date (DTP01 = 434; DTP03) is not equal to the admission date (DTP01 = 435; DTP03), and revenue code 042x, 043x, 044x, or 055x is not present on the claim, and condition code is not equal to 20, 21, or 54 in one of the following 12 HI composites: HI01-1=BG, HI01-2; HI02-1=BG, HI02-2; etc., will be rejected.
PW00220	P	I	D	A7	476				Medicaid claims can only contain a decimal in the service line quantity for HCPCS procedure codes where the treatment type in Amisys = CH, CS, DP, IF, or IN or the claims will be rejected. Dental claims cannot contain a decimal or they will be rejected.	Medicaid 837I or 837P claims can only contain a decimal in the service line quantity, Loop 2400 SV104 (Professional) or SV205 (Institutional) for HCPC procedure codes (SV101-2 and SV202-2) where the treatment type (PROCDETAIL) in Amisys = CH, CS, DP, IF, or IN, or the claims will be rejected. 837D claims cannot contain a decimal or they will be rejected.
PW00221	P	I	D	A7	157			IL	If the subscriber's gender does not exist or does not match the gender from the DHS enrollment file for the member, the claim will be rejected unless the condition code 45 is on the Institutional claim or the KX modifier is on one of the Professional/Dental claim service lines.	If the subscriber's gender (Loop 2010BA, DMG03) does not exist or does not match the gender from the DHS enrollment file for the member, the claim will be rejected unless the condition code 45 is in one of the following 12 HI composites: HI01-1=BG, HI01-2; HI02-1=BG, HI02-2; etc. on the 837I or the KX modifier (Loop 2400: SV101-3_SV101-6 (837P), SV301-3_SV301-6 (837D) is on one of the service lines.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00222	P	N/A	N/A	A7	741			82	When specific CPT codes are billed on a Professional claim, the rendering provider must be an individual or the claim will be rejected.	When specific CPT codes (Loop 2400 SV101-2) are billed on the 837P claim format, the rendering provider (Loop 2420A/2310B) must be an individual (NM102 = 1) or the claim will be rejected.
PW00223	P	N/A	N/A	A7	741			85	When specific CPT codes are billed on a Professional claim and there is no rendering provider at the service or claim level, the billing provider must be an individual or the claim will be rejected.	When specific CPT codes (Loop 2400 SV101-2) are billed on the 837P claim format and there is no rendering provider at the service line or claim level (Loop 2420A/2310B), the billing provider (Loop 2010AA) must be an individual (NM102 = 1) or the claim will be rejected.
PW00229	P	N/A	N/A	A6	504			DQ	When specific Early Intensive Developmental and Behavioral Intervention (EIDBI) or counseling service CPT codes are billed on a Professional claim, the supervising provider must be included on the claim or the claim will be rejected.	When specific EIDBI or counseling service CPT Codes (Loop 2400 SV101-2) are billed on the 837P claim format, the supervising provider (Loop 2420D/2310D NM101 = DQ) must be present or the claim will be rejected.
PW00230	N/A	I	D	A8	507				When a claim is billed with D9410, the code D9410 cannot be billed alone or the claim will be rejected.	When a claim is billed with D9410, Loop 2400 SV202-2 (Institutional), Loop 2400 SV301-2 (Dental), the code D9410 cannot be billed alone or the claim will be rejected.
PW00231	N/A	I	D	A6	507				When a claim is billed with D5992 and the claim doesn't include the code D9410, the claim will be rejected.	When a claim is billed with D5992 Loop 2400 SV202-2 (Institutional), Loop 2400 SV301-2 (Dental) and the claim doesn't include the code D9410, Loop 2400 SV202-2 (Institutional), Loop 2400 SV301-2 (Dental), the claim will be rejected.
PW00232	P	I	N/A	A7	453	507			The SL modifier can only be included with vaccine codes that are available through the MnVFC program. When a CPT code that is not on the MnVFC list and CPT code includes the SL modifier, the claim will be rejected, unless the other payer has adjudicated the claim.	The SL modifier (SV101-3_SV101-6, SV202-3_SV202-6) can only be included with vaccine codes that are available through the MnVFC program, which are kept current in the EDI Edit Code Table with Edit Code Type "MNVFC." When a CPT code (SV101-2, SV202-2) that is not on the list and CPT code includes the SL modifier, the claim will be rejected, unless the other payer (Loop 2330B) has adjudicated the claim (Loop 2320-segment AMT01 = D).
PW00233	P	I	N/A	A7	453	507			The KU modifier is only allowed on claims for HCPCS codes that are included on the DME1 or DME2 schedules or the claim will be rejected.	The KU modifier (SV101-3_SV101-6, SV202-3_SV202-6) is only allowed on claims for HCPCS codes (SV101-2, SV202-2) that are included on the DME1 or DME2 schedules or the claim will be rejected.
PW00234	P	I	N/A	A7	453				The KU and KE modifiers are not allowed on the same service line or the claim will be rejected.	The KU and KE modifiers (SV101-3 – SV101-6, SV202-3 – SV202-6) are not allowed on the same service line or the claim will be rejected.
PW00235	P	N/A	N/A	A7	507	187	453		Professional case management claims will be rejected as a duplicate when billing T1016 and more than 1 service line contains the same service date and modifier. If using the span date qualifier for the service date, the date of service can only span one day.	837 Professional case management claims will be rejected as a duplicate when billing HCPCS code T1016 (SV101-2), and more than 1 service line contains the same service date (DTP03) and modifier (SV101-3 – SV101-6). If using the RD8 qualifier in DTP02, the date of service can only span one day.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00236	N/A	I	N/A	A7	507	228			Home Health Claims that bill for HCPCS 97607 or 97608 require the claim to include TOB 34x or the claim will be rejected.	Home Health Claims that bill for HCPCS (SV202-2) 97607 or 97608 require the claim to include the facility type code (CLM05-1) 34x or the claim will be rejected.
PW00237	N/A	I	N/A	A7	507	455			Home Health Claims that bill for HCPCS 97607 or 97608 require the claim to include revenue codes 42x, 43x, or 559 or the claim will be rejected.	Home Health Claims that bill for HCPCS (SV202-2) 97607 or 97608 require the claim to include revenue codes (SV201) 42x, 43x, or 559 or the claim will be rejected.
PW00238	P	N/A	N/A	A6	453	507			When billing CTSS services using HCPCS code H0031, H0032, H2012, or H2019 for a member who is under age 18, you are required to include modifier "UA" or "UB" or the claim will be rejected.	When billing CTSS services using HCPCS code H0031, H0032, H2012, or H2019 (SV101-2) for a member who is under age 18 (Loop 2010CA or 2010BA DMG02), you are required to include modifier "UA" or "UB" (SV101-3 – SV101-6) or the claim will be rejected.
PW00239	P	N/A	N/A	A6	453	507			Capped rental codes submitted with the RR modifier must also include one of the following modifiers: KH, KI, or KJ. Claims that do not include one of these modifiers or that include more than one will be rejected.	Capped rental codes (SV101-2) included on the DME2 or DMCR fee schedule and that include the RR modifier (SV101-3 – SV101-6) must also include one of the following modifiers: KH, KI, or KJ (SV101-3 – SV101-6). Claims that do not include one of these modifiers or that include more than one will be rejected.
PW00240	P	N/A	N/A	A7	453	507			Capped rental codes can not be submitted with both the RR and UE modifiers or the claim will be rejected.	Capped rental codes (SV101-2) included on the DME2 or DMCR fee schedule cannot include both the RR and UE modifier (SV101-3 – SV101-6) or the claim will be rejected.
PW00241	P	I	N/A	A7	453				Claims will be rejected when service lines are billed with the following invalid modifier combinations: RB and KY, RB and KE, or RB and RR.	Claims will be rejected when service lines are billed with the following invalid modifier combinations: RB and KY, RB and KE, or RB and RR (SV101-3 – SV101-6, SV202-3 – SV202-6).
PW00242	P	N/A	N/A	A7	258	476			When a claim contains select DME codes found in the EDI Edit Codes table and the service units are greater than 1, the service date span must be greater than 1 or the claim will be rejected.	When a claim contains select DME codes (SV101-2) found in the EDI Edit Codes table and the service units (SV104) are greater than 1, the service date span (DTP03 where DTP01 = 472) must be greater than 1 or the claim will be rejected.
PW00243	P	N/A	D	A7	187	507			Claims that include service dates where they bill across multiple months will be rejected unless Medicare is the primary payer and has paid, the MCO is the Medicare payer or the claim includes one of the following HCPCS codes: B9000-B9999, S0012-S0208, S0210-S0214, S0216-S5099, S5200-S9122, S9124-S9999, E0776-E0791, B4034-B5200, A4244-A4290, E0910-E0948.	Claims that include service dates (Loop 2400, DTP03 where DTP01 = 472) that bill across multiple months will be rejected unless Medicare is the primary payer and has paid, the MCO is the Medicare payer or the claim includes one of the following HCPCS codes (SV101-2, SV301-2): B9000-B9999, S0012-S0208, S0210-S0214, S0216-S5099, S5200-S9122, S9124-S9999, E0776-E0791, B4034-B5200, A4244-A4290, E0910-E0948.
PW00244	P	I	N/A	A7	453				When claims are billed with the SL modifier and the member is >= 19, the claim will be rejected.	When claims are billed with the SL modifier (SV101-3 – SV101-6, SV202-3 – SV202-6) and the member's age (2010BA.DMG02) is >= 19, the claim will be rejected.
PW00245	N/A	I	N/A	A7	460				Claims with service dates prior to July 1, 2017 that include condition code 87 will be rejected.	Claims with service dates (Loop 2400, DTP03 where DTP01 = 472) prior to July 1, 2017 that include condition code 87 (Loop 2300-HI01-2 – HI12-2 where HI01-1 – HI12-1 = BG) will be rejected.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00246	N/A	I	N/A	A7	460	228			When a claim includes condition code 87, the claim can not include additional condition codes of 71, 72, 73, 74, or 76 or the claim will be rejected.	When a claim includes condition code (Loop 2300-HI01-2 – HI12-2 where HI01-1 – HI12-1 = BG) 87, the claim cannot include additional condition codes (Loop 2300-HI01-2 – HI12-2 where HI01-1 – HI12-1 = BG) of 71, 72, 73, 74, or 76 or the claim will be rejected.
PW00247	P	N/A	N/A	A7	507	562		82	When a claim contains select Home Health HCPC codes found in the EDI Edit Codes table and the rendering provider NPI or UMPI does not match the billing provider NPI or UMPI, the claim will be rejected.	When a claim contains select Home Health HCPC codes (SV101-2) found in the EDI Edit Codes table and the rendering provider NPI (Loop2400/2300-NM109 where NM101 = 82) or UMPI (REF02 when REF01 = G2) does not match the billing provider NPI (Loop2010AA-NM109) or UMPI (REF02 when REF01 = G2), the claim will be rejected.
PW00248	P	N/A	D	A7	562	741		P3	Primary care provider's NPI must be valid on the NPPES Registry. The EDI entity type qualifier and the NPI type in the NPPES Registry must be a person.	Primary care provider's NPI (Service/Claim Loops-NM109) must be valid on the NPPES Registry. The EDI entity type qualifier (NM102) and the NPI type in the NPPES Registry must be a person "1" where Entity Identifier Code (NM101) = P3 or the claim will be rejected.
PW00249	N/A	N/A	D	A7	562	741		DD	Assistant surgeon provider's NPI must be valid on the NPPES Registry. The EDI entity type qualifier and the NPI type in the NPPES Registry must be a person.	Assistant surgeon provider's NPI (2420B/2310D Loop-NM109) must be valid on the NPPES Registry. The EDI entity type qualifier (NM102) and the NPI type in the NPPES Registry must be a person "1" where Entity Identifier Code (NM101) = DD or the claim will be rejected.
PW00250	N/A	I	N/A	A6	725	507			All claims billing for the administration of an ESA on an institutional claim with HCPCS codes J0881, J0882, J0885, J0886, J0890, or Q4081 must report the most recent hematocrit or hemoglobin reading available. You must submit value codes 48 or 49 or the claim will be rejected, unless, after 10/2/2017, the condition code 84 is present on the claim.	All claims billing for the administration of an ESA on an institutional claim with HCPCS codes (SV101-2) J0881, J0882, J0885, J0886, J0890, or Q4081 must report the most recent hematocrit or hemoglobin reading available. You must submit value codes (HI01-2 – HI12-2 where HI01-1 – HI12-1 = BE) 48 or 49 or the claim will be rejected, unless, after 10/2/2017, the condition code 84 (HI0x-2, when HI0x-1 = BG) is present on the claim.
PW00251	P	N/A	N/A	A6	731	507			All claims billing for the administration of an ESA on a professional claim with HCPCS codes J0881, J0882, J0885, J0886, J0890, or Q4081 must report the most recent hematocrit or hemoglobin reading available. There must be a MEA-Test result included in the claim. If test results are not present, the claim will be rejected, unless, after 10/2/2017, the condition code 84 is present on the claim.	All claims billing for the administration of an ESA on a professional claim with HCPCS codes J0881, J0882, J0885, J0886, J0890, or Q4081 must report the most recent hematocrit or hemoglobin reading available. There must be a test result (Loop 2400 MEA01=TR) included in the claim with either the MEA02 = R1 (for hemoglobin) or R2 (for hematocrit), and MEA03 = the test results. If test results are not present, the claim will be rejected, unless, after 10/2/2017, the condition code 84 (HI0x-2, when HI0x-1 = BG) is present on the claim.
PW00252	P	I	N/A	A6	453	507			All claims billed with HCPC code T2023 are required to include a modifier. If the modifier is missing, the claim will be rejected.	All claims billed with HCPC code (SV101-2, SV202-2) T2023 are required to include a modifier (SV101-3, 4, 5, 6; SV202-3, 4, 5, 6). If no modifier is included, the claim will be rejected.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00254	P	N/A	N/A	A7	453	249			When professional telehealth claims/charges are received with modifier "GQ," the POS should be "02" or the claim will be rejected.	When 837P telehealth claims/charges are received with a modifier (SV101-3, 4, 5, 6) "GQ," the POS (CLM05-1) should be "02" or the claim will be rejected
PW00255	P	N/A	N/A	A7	249	507			When professional telehealth claims/charges are received with POS "02" and HCPCS code Q3014, the claim will be rejected.	When 837P telehealth claims/charges are received with POS (CLM05-1) "0"2 and HCPCS code (SV101-2) Q3014, the claim will be rejected.
PW00256	P	N/A	N/A	A7	507	453			When professional telehealth claims are received with HCPC code Q3014 and modifier "GQ," the claim will be rejected.	When 837P telehealth claims are received with HCPC code (SV101-2) Q3014 and modifier (SV101-3, 4, 5, 6) "GQ," the claim will be rejected.
PW00257	P	N/A	N/A	A7	507				When a member is enrolled in the Essential Community Services, there are select HCPC codes that need to be billed to the State. If the HCPC code is found in the EDI Edit Codes table, the claim will be rejected.	When a member is enrolled in the Essential Community Services (RISKPOP(RP) = YY), there are select HCPC codes (SV101-2) that need to be billed to the State. If the HCPC code (SV101-2) is found in the EDI Edit Codes table, the claim will be rejected.
PW00258	N/A	I	N/A	A6	725	228	507		Dual member hospice claims with TOB 81x or 82x that include HCPCS codes that are entered in the EDI Edit Codes table require value code 76 or the claim will be rejected.	Dual member hospice claims with facility type code 81x or 82x (CLM05-1) that include HCPCS codes (SV201-2) entered in the EDI Edit Codes table require value code 76 (HI0x-2, when HI0x-1 = BE) or the claim will be rejected.
PW00259	N/A	I	N/A	A7	460	228			When the condition code "85" is present on a claim, TOB must be 81x or 82x or the claim will be rejected.	When the condition code "85" (HI0x-2, when HI0x-1 = BG) is present on a claim, the facility type code (CLM05-1) must be 81x or 82x or the claim will be rejected.
PW00260	N/A	I	N/A	A7	720	722	460		When the occurrence code 27 date on a hospice claim falls within the occurrence span code 77 from/through dates and the condition code "85" is present on a claim, the claim will be rejected.	When the occurrence code 27 date (HI0x-2, HI0x-4, when HI0x-1 = BH) on a hospice claim falls within the occurrence span code 77 from/through dates (HI0x-2, HI0x-4, when HI0x-1 = BI) and the condition code "85" (HI0x-2, when HI0x-1 = BG) is present on a claim, the claim will be rejected.
PW00261	P	N/A	N/A	A6	562			DQ	When a claim is submitted with the rendering provider as a community health worker, the supervising provider must be present on the claim or the claim will be rejected.	When a claim is submitted with the rendering provider (Loop 2420A/2310B NM109 when NM108 = XX or else REF02 when REF01 = G2) as a community health worker (use NPI or UMPI to search MN-ITS PECD for provider type 55), the supervising provider (Loop 2420D/2310D NM109) must be present on the claim or the claim will be rejected.
PW00262	P	N/A	N/A	A7	507	560		82	When a claim is submitted with the rendering provider as a community health worker, the HCPC codes must be 98960, 98961, or 98962 or the claim will be rejected.	When a claim is submitted with the rendering provider (Loop 2420A/2310B NM109 when NM108 = XX or else REF02 when REF01 = G2) as a community health worker (use NPI or UMPI to search MN-ITS PECD for provider type 55), the HCPC codes must be 98960, 98961, or 98962 or the claim will be rejected.
PW00263	P	I	D	A7	775			85	Billing provider's EDI entity type qualifier and the NPI type in the NPPES Registry must match or the claim will be rejected, unless the TOB or POS = 86x or 89x.	Billing provider's EDI entity type qualifier (NM102 where Entity Identifier Code NM101 = 85) and the NPI type in the NPPES Registry must match or the claim will be rejected, unless the facility type code (CLM05-1) = 86 or 89.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00264	P	N/A	D	A7	775			82	Rendering provider's EDI entity type qualifier and the NPI type in the NPPES Registry must match or the claim will be rejected, unless the POS = 86x or 89x.	Rendering provider's EDI entity type qualifier (NM102 where Entity Identifier Code NM101 = 82) and the NPI type in the NPPES Registry must match or the claim will be rejected, unless the facility type code (CLM05-1) = 86 or 89.
PW00266	P	N/A	N/A	A7	775			QB	Purchase Service provider's EDI entity type qualifier and the NPI type in the NPPES Registry must match or the claim will be rejected, unless the POS = 86x or 89x.	Purchase Service provider's EDI entity type qualifier (NM102 where Entity Identifier Code NM101 = QB) and the NPI type in the NPPES Registry must match or the claim will be rejected, unless the facility type code (CLM05-1) = 86 or 89.
PW00267	N/A	I	N/A	A6	562	560		71	When rehab services are billed on an Institutional claim and contain modifier GO, GN, or GP and the procedure code for modifiers GN or GP don't start with an "A," "S," or "T," the claim must include the attending provider NPI/UMPI.	When rehab services are billed on an Institutional claim and contain modifier GO, GN, or GP (SV202-3 – SV202-6) and the procedure code (SV202-2) for modifiers GN or GP (SV202-3 – SV202-6) don't start with an "A," "S," or "T," the claim must include the attending provider NPI/UMPI.
PW00268	N/A	I	N/A	A7	453	228			When billing modifier 25 or modifier 59 on a Rural Health Claim (71x), you should not report modifier CG on the same service line or the claim will be rejected.	When billing modifier 25 or modifier 59 (SV202-3_SV202-6)on a Rural Health Claim 71x (CLM05-1), you should not report modifier CG (SV202-3_SV202-6) on the same service line or the claim will be rejected.
PW00269	P	I	D	A7	743			DN	The payer system's provider review PV record contains a GW for this referring provider's NPI or UMPI because the referring provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.	The payer system's provider review PV record contains a GW for this referring provider's NPI (2310A/2310F 2420F/2420D NM109) or UMPI (2310A/2310F 2420F/2420D REF02) because the referring provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.
PW00270	P	N/A	N/A	A7	743			DK	The payer system's provider review PV record contains a GW for this ordering provider's NPI or UMPI because the ordering provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.	The payer system's provider review PV record contains a GW for this ordering provider's NPI (2420E NM109) or UMPI (2420E REF02) because the ordering provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.
PW00271	N/A	I	N/A	A7	743			71	The payer system's provider review PV record contains a GW for this attending provider's NPI or UMPI because the attending provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.	The payer system's provider review PV record contains a GW for this attending provider's NPI (2310A NM109) or UMPI (2310A REF02) because the attending provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.
PW00272	N/A	I	N/A	A7	743			72	The payer system's provider review PV record contains a GW for this operating provider's NPI or UMPI because the operating provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.	The payer system's provider review PV record contains a GW for this operating provider's NPI (2310B/2420A NM109) or UMPI (2310B/2420A REF02) because the operating provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.
PW00273	N/A	I	N/A	A7	743			ZZ	The payer system's provider review PV record contains a GW for this other operating provider's NPI or UMPI because the other operating provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.	The payer system's provider review PV record contains a GW for this other operating provider's NPI (2310C/2420B NM109) or UMPI (2310C/2420B REF02) because the other operating provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00274	P	N/A	D	A7	743			DQ	The payer system's provider review PV record contains a GW for this supervising provider's NPI or UMPI because the supervising provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.	The payer system's provider review PV record contains a GW for this supervising provider's NPI (2310D/2310E 2420D/2420C NM109) or UMPI (2310D/2310E 2420D/2420C REF02) because the supervising provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.
PW00275	P	N/A	N/A	A7	743			QB	The payer system's provider review PV record contains a GW for this purchased service provider's NPI or UMPI because the purchased service provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.	The payer system's provider review PV record contains a GW for this purchased service provider's NPI (2420B NM109) or UMPI (2420B REF02) because the purchased service provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.
PW00276	P	N/A	D	A7	743			P3	The payer system's provider review PV record contains a GW for this primary care provider's NPI or UMPI because the primary care provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.	The payer system's provider review PV record contains a GW for this primary care provider's NPI (2310A/2420F NM109) or UMPI (2310A/2420F REF02) because the primary care provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.
PW00277	N/A	N/A	D	A7	743			DD	The payer system's provider review PV record contains a GW for this assistant surgeon provider's NPI or UMPI because the assistant surgeon provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.	The payer system's provider review PV record contains a GW for this assistant surgeon provider's NPI (2310D/2420B NM109) or UMPI (2310D/2420B REF02) because the assistant surgeon provider is on the DHS, OIG, EPLS, or CMS withhold or ineligible list.
PW00278	N/A	I	N/A	A7	258	228	455		Home health therapy claims with TOB 32x, revenue code 0023, and another service line with revenue codes 042x, 043x, 044x, 055x, 056x, or 057x that report over 96 service units on a single date of service will be rejected.	Home health therapy claims with facility type code (CLM05-1) 32x and revenue code (SV201) 0023 and service lines with revenue codes (SV201) 042x, 043x, 044x, 055x, 056x, 057x that report over 96 service units (SV205) on a single date of service will be rejected.
PW00279	N/A	I	N/A	A7	453	455			Reject claim if revenue code 0450 is billed with modifier PO or PN.	Reject claim if revenue code (SV201) 0450 is billed with modifier (SV202-3 - SV202-6) PO or PN.
PW00280	N/A	I	N/A	A7	228				When a Federally Qualified Health Center (FQHC) submits an outpatient 837I claim and the claim contains TOB 73x, the claim will be rejected.	When a Federally Qualified Health Center (FQHC) submits an outpatient 837I claim and the claim contains the facility type code (CLM05-1) = 73, the claim will be rejected.
PW00281	P	I	N/A	A7	507	453	187		When a claim is received with stationary oxygen equipment codes (E0424, E0439, E1390, or E1391) and includes the QG or QR modifier and the same beneficiary also has a claim with portable oxygen equipment codes (E0431, E0433, E0434, E1392, or K0738), whether on the same claim or an overlapping claim with same DOS or within the past 30 days from the DOS, the claim will be rejected.	When a claim is received with stationary oxygen equipment codes (E0424, E0439, E1390, or E1391) (SV202-2 or SV101-2) and includes the QG or QR modifier (SV202-3_SV202-6 or SV101-3_ SV101-6) and the same beneficiary also has a claim with portable oxygen equipment codes (E0431, E0433, E0434, E1392, or K0738)(SV202-2 or SV101-2), whether on the same claim or an overlapping claim with same DOS or within the past 30 days from the DOS (Loop 2400 DTP03 where DTP01 = 472), the claim will be rejected.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00282	P	I	N/A	A7	507	453	187		When a claim is received with portable oxygen equipment codes (E0431, E0433, E0434, E1392, or K0738) and the same beneficiary also has a claim with stationary oxygen equipment codes (E0424, E0439, E1390, or E1391) with the QG or QR modifier and same DOS or within the past 30 days from the DOS, the claim will be rejected.	When a claim is received with portable oxygen equipment codes (E0431, E0433, E0434, E1392, or K0738) (SV202-2 or SV101-2) and the same beneficiary also has a claim with stationary oxygen equipment codes (E0424, E0439, E1390, or E1391) (SV202-2 or SV101-2) with the QG or QR modifier (SV202-3_SV202-6 or SV101-3_ SV101-6) and same DOS or within the past 30 days from the DOS (Loop 2400 DTP03 where DTP01 = 472), the claim will be rejected.
PW00283	P	I	N/A	A7	507	453	187		When a claim is received with stationary oxygen equipment codes (E0424, E0439, E1390, or E1391) and includes the QF modifier and the same beneficiary also has a claim with portable oxygen equipment codes (E0431, E0433, E0434, E1392, or K0738) without the QF or QB modifier, whether on the same claim or an overlapping claim with same DOS or within the past 30 days from the DOS, the claim will be rejected.	When a claim is received with stationary oxygen equipment codes (E0424, E0439, E1390, or E1391) (SV202-2 or SV101-2) and includes the QF modifier (SV202-3_SV202-6 or SV101-3_ SV101-6) and the same beneficiary also has a claim with portable oxygen equipment codes (E0431, E0433, E0434, E1392, or K0738) (SV202-2 or SV101-2) without the QF or QB modifier (SV202-3_SV202-6 or SV101-3_ SV101-6), whether on the same claim or an overlapping claim with the same DOS or within the past 30 days from the DOS (Loop 2400 DTP03 where DTP01 = 472), the claim will be rejected.
PW00284	P	I	N/A	A7	507	453	187		When a claim is received with portable oxygen equipment codes (E0431, E0433, E0434, E1392, or K0738) and includes the QF modifier and the same beneficiary also has a claim with stationary oxygen equipment codes (E0424, E0439, E1390, or E1391) without the QF or QB modifier, whether on the same claim or an overlapping claim with same DOS or within the past 30 days from the DOS, the claim will be rejected.	When a claim is received with portable oxygen equipment codes (E0431, E0433, E0434, E1392, or K0738) (SV202-2 or SV101-2) and includes the QF modifier (SV202-3_SV202-6 or SV101-3_ SV101-6) and the same beneficiary also has a claim with stationary oxygen equipment codes (E0424, E0439, E1390, or E1391) (SV202-2 or SV101-2) without the QF or QB modifier (SV202-3_SV202-6 or SV101-3_ SV101-6), whether on the same claim or an overlapping claim with same DOS or within the past 30 days from the DOS (Loop 2400 DTP03 where DTP01 = 472), the claim will be rejected.
PW00285	N/A	I	N/A	A7	188				When a claim is received with the statement "from" and "through" dates spanning over multiple months, the claim will be rejected, unless the TOB = 11x, 12x, 18x, 86x, or 33x, or the claim includes at least one revenue code 762 or 450, or the claim has a TOB 32x with either HIPPS 0023 or Gcode, or TOB = 211, 214, or 217 and discharge status = 01 or 20, or TOB = 34x and discharge status = 01.	When a claim is received with the statement "from" and "through" dates spanning over multiple months (DTP03 when DTP01 = 434) the claim will be rejected, except when the facility type code (CLM05-1) = 11x, 12x, 18x, 86x, or 33x, or the claim includes at least one revenue code (SV201) = 762 or 450, or claim has a facility type code (CLM05-1) = 32x with either HIPPS (SV202 - 2) = 0023 or Gcode (SV202 - 2), or facility type code (CLM05-1) = 211, 214, or 217 and patient status (CL103) = 01 or 20, or facility type code (CLM05-1) = 34x and patient status (CL103) = 01.
PW00286	P	N/A	N/A	A7	507	453			When a claim contains HCPCS code S0215, S0209, or T2049 and claim does not contain HCPCS code T2003, T2005, A0100, or A0130, the claim will be rejected unless the HCPCS code S0215, S0209, or T2049 includes the UC modifier on the claim.	When a claim contains HCPCS code S0215, S0209, or T2049 (SV101-2) and claim does not contain HCPCS T2003, T2005, A0100, or A0130 (SV101-2), the claim will be rejected unless the HCPCS code S0215, S0209, or T2049 (SV101-2) includes the UC modifier on the claim (SV101-3_ SV101-6).

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00287	N/A	I	N/A	A7	688				When a claim includes the present on admission indicator, the TOB must include 11x, 18x, 21x or 41x, or the claim will be rejected.	When a claim includes "Yes/No Condition or Response Code" (HI01-9 [present on admission indicator]), the facility type code (CLM05-1) must be 11, 18, 21, or 41, or the claim will be rejected.
PW00288	P	I	N/A	A7	116	507	453		When a claim is received with a HCPCS code or HCPCS/modifier that is not covered by payer, the claim will be rejected because DHS needs to be billed for the code.	When a claim is received with a HCPCS code or HCPCS/modifier that is not covered by payer (Loop 2400 SV202-2 [Institutional] or Loop 2400 SV101-2 [Professional]), the claim will be rejected because DHS needs to be billed for the code.
PW00289	N/A	I	N/A	A6	460	228	725		When the condition code 26 is present on a claim and the TOB is 11x, 18x, 21x, 41x or 51x, the claim must include the value code 42 or the claim will be rejected.	When the condition code 26 (HI0x-2, when HI0x-1 = BG) is present on a claim and the facility type code (CLM05-1) is 11x, 18x, 21x, 41x or 51x, the claim must include the value code 42 (HI0x-2, when HI0x-1 = BE) or the claim will be rejected.
PW00290	N/A	I	N/A	A6	725	228	460		When the value code 42 is present on a claim and the TOB is 11x, 18x, 21x, 41x or 51x, the claim must include the condition code 26 or the claim will be rejected.	When the value code 42 (HI0x-2, when HI0x-1 = BE) is present on a claim and the facility type code (CLM05-1) is 11x, 18x, 21x, 41x or 51x, the claim must include the condition code 26 (HI0x-2, when HI0x-1 = BG) or the claim will be rejected.
PW00291	P	N/A	N/A	A7	507	562		82	When a claim contains select mental health or substance use disorder HCPCS codes found in the EDI Edit Codes table for this edit and the rendering provider is an individual, the claim will be rejected, unless the claim is submitted with an UMPI as their billing provider.	When a claim contains select mental health or substance use disorder HCPCS codes (SV101-2) found in the EDI Edit Codes table for this edit and the Rendering Provider Entity Type Qualifier (Loop2400/2300-NM102) is a 1 for person, the claim will be rejected. If there is no rendering provider (Loop 2400 or 2300), the Billing Provider Entity Type Qualifier (Loop2010AA-NM102) will be checked. If the claim is submitted with an UMPI as the billing provider, the claim is excluded from this edit.
PW00293	P	I	D	A7	743			85	When the billing provider is on the OIG, EPLS, CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system will include a provider review ("PV") indicator of "NE" with an effective date. If the service/statement date of the claim is on or after the effective date in the table, the claim will be rejected.	When the billing provider (2010AA NM109 /2010BB REF02) is on the OIG, EPLS, CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system will include a provider review ("PV") indicator of "NE" with an effective date. If the service/statement (837I) Admission(837P) date (Loop 2400 DTP03, DTP01=472/Loop 2300 DTP03, DTP01=434 (837I) or Loop 2300 DTP03, DTP01=435 (837P) of the claim is on or after the effective date in the table, the claim will be rejected.
PW00294	P	I	D	A7	743			82	When the rendering provider is on the OIG, EPLS, CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system will include a provider review ("PV") indicator of "NE" with an effective date. If the service/statement date of the claim is on or after the effective date in the table, the claim will be rejected.	When the rendering provider (2310B/2310D-2420A/2420C NM109) or UMPI (2310B/2310D-2420A/2420C REF02) is on the OIG, EPLS, CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system includes a provider review ("PV") indicator of "NE" with an effective date. If the service/statement date (Loop 2400 DTP03, DTP01=472/Loop 2300 DTP03, DTP01=434 (837I) or Loop 2300 DTP03, DTP01=435 (837P) of the claim is on or after the effective date in the table, the claim will be rejected.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00295	N/A	I	N/A	A7	507	453	455		ESRD claims (TOB 72x), excluding acute kidney injury (AKI) patients (condition code 84), will need to include modifier "AX" when billing HCPCS code J0604 or J0606. Or, if claim includes modifier "AX," the HCPCS code J0604 or J0606 must be present. The revenue code 0636 must be included with the HCPCS code or the claim will be rejected.	ESRD claims (TOB 72x[Loop 2300 CLM05-1]), excluding AKI claims with condition code 84 (HI0x-2, when HI0x-1 = BG), will need to include modifier "AX" (Loop 2400 SV202-3_SV202-6 [Institutional]) when billing HCPCS code J0604 or J0606 (Loop 2400 SV202-2 [Institutional]). Or, if the claim includes modifier "AX" (Loop 2400 SV202-3_SV202-6 [Institutional]) then the HCPCS code J0604 or J0606 (Loop 2400 SV202-2 [Institutional]) must be present. The revenue code 0636 (SV201) must be included with the HCPCS code or the claim will be rejected.
PW00296	N/A	I	N/A	A7	507	460			ESRD claims (TOB 72x) with acute kidney injury (AKI) patients (condition code 84) and service dates on or after 04/01/2018 will be returned to the provider when billing HCPCS code J0604 or J0606.	ESRD claims (TOB 72x[Loop 2300 CLM05-1]) with AKI patients (condition code 84 [HI0x-2, when HI0x-1 = BG]) and service dates on or after 04/01/2018 (Loop 2400 DTP03 when DTP01=472) will be returned to the provider when billing HCPCS code J0604 or J0606 (Loop 2400 SV202-2).
PW00297	N/A	I	N/A	A7	507	453	460		ESRD claims (TOB 72x) with acute kidney injury(AKI) patients (condition code 84) and service dates on or after 04/01/2018 will be returned to the provider when billing CPT code G0491, modifier "AX," and one of the following ICD-10 diagnosis codes: N17.0, N17.1, N17.2, N17.8, N17.9, T79.5XXA, T79.5XXD, T79.5XXS, or N99.0.	ESRD claims (TOB 72x[Loop 2300 CLM05-1]) with AKI patients (condition code 84[HI0x-2, when HI0x-1 = BG]) and service dates on or after 04/01/2018 (Loop 2400 DTP03 when DTP01=472) will be returned to the provider when billing CPT code G0491(Loop 2400 SV202-2), modifier "AX" (Loop 2400 SV202-3_SV202-6), and one of the following ICD-10 diagnosis codes: N17.0, N17.1, N17.2, N17.8, N17.9, T79.5XXA, T79.5XXD, T79.5XXS, or N99.0 (HI01:HI12-2 where HI01-1 = ABK or HI01:HI12-1 = ABF).
PW00298	P	I	D	A7	743			DN	When the referring provider is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system will include a provider review ("PV") indicator of "NE" with an effective date. If the service/statement date of the claim is on or after the effective date in the table, the claim will be rejected.	When the referring provider (2310A/2310F 2420F/2420D NM109) or UMPI (2310A/2310F 2420F/2420D REF02) is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system includes a provider review ("PV") indicator of "NE" with an effective date. If the service/statement date (Loop 2400 DTP03, DTP01=472/Loop 2300 DTP03, DTP01=434 [837I] or Loop 2400 DTP03, DTP01=472 [837P/837]) of the claim is on or after the effective date in the table, the claim will be rejected.
PW00299	P	N/A	N/A	A7	743			DK	When the ordering provider is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system will include a provider review ("PV") indicator of "NE" with an effective date. If the service date of the claim is on or after the effective date in the table, the claim will be rejected.	When the ordering provider (2420E NM109) or UMPI (2420E REF02) is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system includes a provider review ("PV") indicator of "NE" with an effective date. If the service date (Loop 2400 DTP03, DTP01=472[837P]) of the claim is on or after the effective date in the table, the claim will be rejected.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00300	N/A	I	N/A	A7	743			71	When the attending provider is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system will include a provider review ("PV") indicator of "NE" with an effective date. If the service/statement date of the claim is on or after the effective date in the table, the claim will be rejected.	When the attending provider (2310A NM109) or UMPI (2310A REF02) is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system includes a provider review("PV") indicator of "NE" with an effective date. If the service/statement date (Loop 2400 DTP03, DTP01=472/Loop 2300 DTP03, DTP01=434(837I) or Loop 2300 DTP03, DTP01=435(837P)) of the claim is on or after the effective date in the table, the claim will be rejected.
PW00301	N/A	I	N/A	A7	743			72	When the operating provider is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system will include a provider review ("PV") indicator of "NE" with an effective date. If the service/statement date of the claim is on or after the effective date in the table, the claim will be rejected.	When the operating provider (2310B/2420A NM109) or UMPI (2310B/2420A REF02) is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system includes a provider review ("PV") indicator of "NE" with an effective date. If the service/statement date (Loop 2400 DTP03, DTP01=472/Loop 2300 DTP03, DTP01=434 (837I)) of the claim is on or after the effective date in the table, the claim will be rejected.
PW00302	N/A	I	N/A	A7	743			ZZ	When the other operating provider is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system will include a provider review ("PV") indicator of "NE" with an effective date. If the service/statement date of the claim is on or after the effective date in the table, the claim will be rejected.	When the other operating provider (2310C/2420B NM109) or UMPI (2310C/2420B REF02) is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system includes a provider review ("PV") indicator of "NE" with an effective date. If the service/statement date (Loop 2400 DTP03, DTP01=472/Loop 2300 DTP03, DTP01=434 (837I)) of the claim is on or after the effective date in the table, the claim will be rejected.
PW00303	P	N/A	D	A7	743			DQ	When the supervising provider is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system will include a provider review ("PV") indicator of "NE" with an effective date. If the service date of the claim is on or after the effective date in the table, the claim will be rejected.	When the supervising provider (2310D/2310E 2420D/2420C NM109) or UMPI (2310D/2310E 2420D/2420C REF02) is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system includes a provider review ("PV") indicator of "NE" with an effective date. If the service date (Loop 2400 DTP03, DTP01=472) of the claim is on or after the effective date in the table, the claim will be rejected.
PW00304	P	N/A	N/A	A7	743			QB	When the purchased service provider is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system will include a provider review ("PV") indicator of "NE" with an effective date. If the service date of the claim is on or after the effective date in the table, the claim will be rejected.	When the purchased service provider (2420B NM109) or UMPI (2420B REF02) is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system includes a provider review ("PV") indicator of "NE" with an effective date. If the service date (Loop 2400 DTP03, DTP01=472) of the claim is on or after the effective date in the table, the claim will be rejected.

Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	HealthCare Claim Status Category Code	HealthCare Claim Status Code 1	HealthCare Claim Status Code 2	HealthCare Claim Status Code 3	Entity Identifier Code	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00305	P	N/A	D	A7	743			P3	When the primary care provider is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system will include a provider review ("PV") indicator of "NE" with an effective date. If the service date of the claim is on or after the effective date in the table, the claim will be rejected.	When the primary care provider (2310A/2420F NM109) or UMPI (2310A/2420F REF02) is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system includes a provider review ("PV") indicator of "NE" with an effective date. If the service date (Loop 2400 DTP03, DTP01=472) of the claim is on or after the effective date in the table, the claim will be rejected.
PW00306	N/A	N/A	D	A7	743			DD	When the assistant surgeon provider is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system will include a provider review ("PV") indicator of "NE" with an effective date. If the service date of the claim is on or after the effective date in the table, the claim will be rejected.	When the assistant surgeon provider (2310D/2420B NM109) or UMPI (2310D/2420B REF02) is on the OIG, EPLS, or CMS withhold list or is not eligible due to license suspension or revocation or is not licensed, the payer system includes a provider review ("PV") indicator of "NE" with an effective date. If the service date (Loop 2400 DTP03, DTP01=472) of the claim is on or after the effective date in the table, the claim will be rejected.
PW00307	P	I	N/A	A6	556				When the 837P or 837I claim contains modifier Q0 and/or Q1, the claim must include the Demonstration Project ID, referencing the National Clinical Trial ID number.	When the 837P or 837I claim contains procedure modifier Q0 and/or Q1, (Loop 2400-SV101-3:SV101-6/SV202-3:SV202-6), the claim must include the Demonstration Project ID (Loop2300-REF02 when REF01=P4), referencing the National Clinical Trial ID number.
PW00308	P	I	N/A	A6	254	255	460		When the 837P or 837I claim for MSHO and SNBC members contains modifier Q0 and/or Q1, with the Demonstration Project ID referencing the National Clinical Trial ID number, the claim must also include the principal or other diagnosis Z00.6. An 837I claim must also include Condition Code 30.	When the 837P or 837I claim for MSHO and SNBC members contains modifier Q0 and/or Q1 (Loop 2400-SV101-3:SV101-6/SV202-3:SV202-6), with the Demonstration Project ID (Loop2300-REF02 when REF01=P4) referencing the National Clinical Trial ID number, the claim must also include the principal or other diagnosis Z00.6 (Loop 2300-HI0x-2 when HI0x-1=ABK or HI0x-2 when HI0x-1=ABF). An 837I claim must also include Condition Code 30 (Loop 2300-HI0x-2, when HI0x-1 = BG).
PW00310	P	I	N/A	A7	116				When abortion diagnosis codes O04.xxx or Z33.2 or abortion CPT codes 59840, 59841, 59850-59852, or 59855 - 59857 are submitted on the 837 Professional or Institutional claims, the claim will be rejected. The claims need to be submitted to MHCP.	When abortion diagnosis codes O04.xxx or Z33.2 (Loop 2300 - HI01-2:HIxx-2, when HI01-1:HIxx-1 = ABK or ABF) or abortion CPT codes 59840, 59841, 59850-59852, or 59855 - 59857 Loop 2400 SV202-2 (Institutional) or Loop 2400 SV101-2 (Professional), are submitted on the 837 Professional or Institutional claims, the claim will be rejected. The claims need to be submitted to MHCP.
PW00311	N/A	I	N/A	A6	453	455	454		CAH CRNA non-exempt facilities (TOB 85x), will need to include one of the modifiers AA, AD, QA, QK, QX, QY, or QZ when billing procedure codes 00100 - 01999 and revenue code 0964 or the claim will be rejected.	CAH CRNA non-exempt facilities (TOB 85x[Loop 2300 CLM05-1]), will need to include one of the modifiers AA, AD, QA, QK, QX, QY, or QZ (Loop 2400 SV202-3_SV202-6 [Institutional]) when billing procedure codes 00100 - 01999 (Loop 2400 SV202-2 [Institutional]) and revenue code 0964 (SV201) or the claim will be rejected.

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PW00312	P	N/A	N/A	A7	562	135		82	When DME or lab providers submit claims that contain a rendering provider, the NPI/UMPI must match the billing provider NPI/UMPI or the claims will be rejected.	When DME or lab providers submit claims that contain a rendering provider (Loop 2310B), the NPI (NM109) or UMPI (REF02 when REF01=G2) must match the billing provider (Loop 2010AA) NPI (NM109) or UMPI (REF02 when REF01=G2) or the claims will be rejected.
PW00313	P	N/A	N/A	A7	249	507			When a member is in an institution, the provider is unable to bill any DME or oxygen furnished to the member on a professional claim with a POS of 12.	When a member is in an institution (the payer's member span HS codes = 41, 42, or DD) the provider is unable to bill any DME or oxygen (Payer treatment types = D1, D2, AD, DS, EN, SR) furnished to the member on a professional claim with a POS of 12 (CLM-05-1).
PW00314	P	N/A	N/A	A7	481	249	507		Providers designated as Rural Health Clinics must send claims in the 837I format for dual eligible (Medicare/Medicaid) members, unless one of the following is true: •POS is 20, 21, 22, or 23 •The claim is for the administration of pneumococcal vaccine code G0009 with vaccine code 90670 or 90732 •The claim is for the administration of influenza vaccine code G0008 with vaccine code 90630, 90653, 90656, 90662, 90673-74, 90682, 90685-88, 90756, Q2035, Q2037, or Q2039 •The claim is for a Health Care Home and includes procedure code S0280 and S0281	Providers that are designated as Rural Health Clinics (Payer System-Billing Facility = R5) must send claims in the 837I format (GS08 = 005010X223A2) for dual eligible Medicare/Medicaid members (payer system-division type = MP), unless one of the following is true: • The facility type code (CLM05-1) is equal to 20, 21, 22, or 23 •The claim is for the administration of pneumococcal vaccine code (Loop 2400 SV101-2) G0009 with vaccine code 90670, 90732 •The claim is for the administration of influenza vaccine code (Loop 2400 SV101-2) G0008 with vaccine code 90630, 90653, 90656, 90662, 90673-74, 90682, 90685-88, 90756, Q2035, Q2037, or Q2039 •The claim is for a Health Care Home (Loop 2400 SV101-2) and includes S0280 and S0281
PW00315	P	I	D	A6	286	643			When 837 Professional, 837 Dental, or 837 OP Institutional claims (excluding nonpayment and voids) are submitted from a provider, if there is prior payment information, it must be reported at the line level or the claim will be rejected.	When 837P, 837D, or 837I OP claims (CLM05-1(Facility Type Code) = 13, 83, 71, 72, 22, and 85) excluding nonpayment and voids (CLM05-2 [Frequency Type Code]=xxx0 or xxx8) are submitted from a provider, if there is prior payment information (Loop 2320 AMT02, AMT01=D), it must be reported at the line level (Loop 2430) or the claim will be rejected.
PW00317	P	N/A	N/A	A7	453				Anesthesia informational modifier QS, G8, G9, GC, or 23 cannot be placed in the first modifier position or the claim will be rejected.	Anesthesia informational modifier QS, G8, G9, GC, or 23 (Loop 2400 SV101-3) cannot be placed in the first modifier position or the claim will be rejected.
PW00318	P	I	N/A	A7	454				When claims are received for MSHO or SNBCDI members billing for the procedure code G9878 or G9879 for Medicare Diabetes Prevention Program (MDPP), the claim must also contain G9880 or G9881 or the claim will be rejected. Also, when billing procedure code G9880 or G9881, the claim cannot contain procedure code G9876 or G9877 or the claim will be rejected.	When claims are received for MSHO or SNBCDI members billing for the procedure code G9878 or G9879 (Loop 2400 SV101-2 or SV202-2) for Medicare Diabetes Prevention Program (MDPP), the claim must also contain procedure code (Loop 2400 SV101-2 or SV202-2) G9880 or G9881 or the claim will be rejected. Also, when billing procedure code (Loop 2400 SV101-2 or SV202-2) G9880 or G9881, the claim cannot contain procedure code (Loop 2400 SV101-2 or SV202-2) G9876 or G9877 or the claim will be rejected.

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PW00319	P	I	N/A	A7	453				When claims are received for MSHO or SNBCDI members billing for the Medicare Diabetes Prevention Program (MDPP), the procedure code G9873, G9880, or G9881 cannot be billed with the modifier VM or the claim will be rejected.	When claims are received for MSHO or SNBCDI members billing for the Medicare Diabetes Prevention Program (MDPP), the procedure code (Loop 2400 SV101-2 or SV202-2) G9873, G9880, or G9881 cannot be billed with the modifier (Loop 2400 SV101-3:SV101-6 or SV202-3:SV202-6) VM or the claim will be rejected.
PW00320	P	I	N/A	A6	453				When outpatient rehabilitation therapy services are billed on a claim, there are specific code lists based on Medicaid, Medicare, or Medicare and provider specialty (Physical, Occupational, Speech Therapist) that require a modifier of GO, GN, or GP or the claim will be rejected.	When outpatient rehabilitation therapy (SV101-2 or SV202-2) services are billed on a claim, there are specific code lists based on Medicaid, Medicare (SNBC or MSHO), or Medicare (SNBC or MSHO) and provider specialty (Physical, Occupational, Speech Therapist)that require a modifier of GO, GN, or GP (SV101-3: SV101-6 or SV202-3:SV202-6) or the claim will be rejected.
PW00321	P	N/A	N/A	A7	453				When a claim is billing procedure code T1016 and the member is under age 64, the procedure code can only include a modifier of U4, TF, 52, U3, U6, U2, or U5. If the member is over age 64, the procedure code can only include a modifier of U4, TF, 52 U3, U6, U2, U5, or UC. If other modifiers are included with procedure code T1016, the claim will be rejected.	When a claim is billing procedure code T1016 (SV101-2) and the member is under age 64, the procedure code can only include a modifier of U4, TF, 52, U3, U6, U2, or U5 (SV101-3 through SV101-6). If the member is over age 64, the procedure code T1016 (SV101-2) can only include a modifier of U4, TF, 52 U3, U6, U2, U5, or UC (SV101-3 through SV101-6). If other modifiers are included with procedure code T1016, the claim will be rejected.
PW00323	P	N/A	N/A	A7	453	507			When billing HCPCS V5014 for hearing aid repairs of the battery door, re-casing, or shell modifications, the modifier RB cannot be in any of the modifier positions, or the claim will be rejected.	When billing HCPCS V5014 (SV202-2) for hearing aid repairs of the battery door, re-casing, or shell modifications, the modifier RB (SV202-3_SV202-6) cannot be in any of the modifier positions, or the claim will be rejected.
PW00325	P	I	N/A	A7	556	116			When the 837P or 837I claim contains the Demonstration Project ID "85," Comprehensive ESRD Care (CEC), the claim will be rejected and will need to be forwarded to the correct payer.	When the 837P or 837I claim contains the Demonstration Project ID "85" (REF02), Comprehensive ESRD Care (CEC), where the Project Code (REF01) = "P4," the claim will be rejected and will need to be forwarded to the correct payer.
PW00326	N/A	I	N/A	A6	465	455			Institutional IP claims with TOB 11x, 18x, or 21x containing revenue code 036x require a principle procedure code. If the principle procedure code is not available, the claim must include one of the following ICD-10 diagnosis codes: Z5301, Z5309, Z531, Z5320, Z5321, Z5329, Z538, Z539, Z9911, Z9981, or Z993 or the claim will be rejected.	Institutional IP claims with facility type code (CLM05-1) 11, 18, or 21 containing revenue code (SV201) 036x require a principle procedure code (Loop2300 HI01-2 where HI01-1 = BBR). If the principle procedure code (Loop2300 HI01-2 where HI01-1=BBR) is not available, the claim must include one of the following ICD-10 diagnosis codes (Loop2300 HI01-2 where HI01-1= ABK or ABJ or ABF) = Z5301, Z5309, Z531, Z5320, Z5321, Z5329, Z538, Z539, Z9911, Z9981, or Z993 or the claim will be rejected.
PW00327	P	N/A	N/A	A7	142	507	453	82	When a professional claim is received with HCPCS code T1019 and modifier "TG," the PECD file for the Rendering Provider must include a P2 indicating they are approved to be paid at this higher PCA rate or the claim will be rejected.	When a professional claim (837P) is received with HCPCS code T1019 (SV101-2) and modifier "TG" (SV101-3 through SV101-6), the PECD file for the Rendering Provider (Loop 2400/2300 NM109 where NM 1= 82, or REF02 where REF01 = G2) must include a P2 indicating they are approved to be paid at this higher PCA rate or the claim will be rejected.

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PW00328	N/A	I	N/A	A7	228	116			When an institutional claim contains TOB "65x" or "66x," the claim will be rejected and will need to be forwarded to the correct payer.	When the 837I claim contains the TOB "65x" or "66x"(CLM05-1), the claim will be rejected and will need to be forwarded to the correct payer.
PW00329	P	I	D	A7	453	228	455		When a telehealth claim is received with a "GT" modifier, the claim will be rejected, unless the claim is for Method II CAH (TOB 85x) and the claim includes revenue code 96x, 97x, or 98x.	When a telehealth claim is received with a "GT" modifier (SV202-3, 4, 5, 6), the claim will be rejected, unless the claim is for Method II CAH (TOB 85x) and the claim includes revenue code (SV201) 96x, 97x, or 98x.
PW00332	N/A	I	N/A	A7	234				Institutional claims with an Inpatient TOB or 11x, 18x, 21x, 28x, 329, 41x, 65x, or 66x cannot use the discharge status "09" or the claim will be rejected.	Institutional claims with an Inpatient Facility Type Code (CLM05-1) 11x, 18x, 21x, 28x, 329, 41x, 65x, or 66x cannot use the dicharge status (CL103) "09"' or the claim will be rejected.
PW00333	N/A	I	N/A	A6	507	228	455		Institutional OP claims with TOB 13x, 22x, 23x, 83x, or 85x that include ambulance revenue code 054x, require one of the following HCPCS codes: A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 and mileage HCPCS code or A0425, A0435, or A0436 or the claim will be rejected.	Institutional OP claims with Facility Type Code (CLM05-1) 13, 22, 23, 83, or 85 and that include ambulance revenue code (SV201) 054x, require one of the following HCPCS codes (SV101-2): A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 and mileage HCPCS code A0425, A0435, or A0436 or the claim will be rejected.
PW00337	N/A	I	N/A	A6	721	455			When claims contain TOB 21x, revenue code 022, and revenue code 180, 183, or 185, the claim must include the occurrence span code "74," or the claim will be rejected.	When claims contain TOB 21x (Loop 2300 CLM05-1), revenue code 022 (SV201), and revenue code 180, 183, or 185 (SV201), the claim must include the occurrence span code "74" (HI01:HI12-2 when HI01:HI12-1 = BI), or the claim will be rejected.
PW00340	N/A	I	N/A	A7	228	145	455	85	Billing providers for acute, rehab, or long-term care facilities with stays longer than 30 days cannot use the TOB 113 or 114 or the claim will be rejected, unless the revenue code 1000, 1001, 1002, 1003, 1004, 1005, or 0101 is on the claim.	Billing providers for acute, rehab, or long-term care facilities with stays longer than 30 days cannot use the Facility Type Code "11" (CLM05-1) and Claim Frequency Type Code "3" or "4" (CLM05-3) or the claim will be rejected, unless the revenue code (SV201) 1000, 1001, 1002, 1003, 1004, 1005, or 0101 is on the claim.
PW00341	N/A	I	N/A	A7	562	228		85	Billing provider's NPI is not valid with TOB 71x submitted.	Billing provider's NPI (Loop 2010AA-NM109 where Entity Identifier Code = 85)is not valid with the Facility Type Code "71" (CLM05-1) submitted.
PW00343	P	I	N/A	A6	453	507			When billing mental health services using HCPCS code 90899, S5145, H2014, or H2015 for a member who is under age 22, you are required to include a modifier or the claim will be rejected.	When billing mental health services using HCPCS code 90899, S5145, H2014, or H2015 (SV101-2) for a member who is under age 22 (Loop 2010CA or 2010BA DMG02), you are required to include a modifier (SV101-3 – SV101-6) or the claim will be rejected.
PW00344	P	I	N/A	A7	453	507			When billing mental health services using HCPCS code H2017, the claim must either include no modifiers or include modifier "HM," "HQ," or "U3" (SV101-3 – SV101-6) or the claim will be rejected.	When billing mental health services using HCPCS code H2017 (SV101-2), the claim must either include no modifiers or include modifier "HM," "HQ," or "U3" (SV101-3 – SV101-6) or the claim will be rejected.
PW00345	N/A	N/A	D	A7	116	562	128	85	When a claim is received for a DHS dental facility that is not covered by the payer, the claim will be rejected.	When a claim is received for a DHS dental facility (billing provider's TIN (2010AA REF02) and NPI (2010AA NM109)) that is not covered by the payer, the claim will be rejected.

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PW00349	N/A	I	N/A	A6	725				When a home health claim is received with TOB 32x, a statement "through" date > 12/31/2018, and revenue code 0023, the claim must include a value code "85" and the value amount must include a 4- or 5- digit value (State code = 1 or 2 digits and county code = 3 digits) or the claim will be rejected.	When a home health claim is received with facility type code equal to 32x (CLM05-1), a statement "through" date (DTP03 where DTP01=434) > 20181231 and revenue code (SV201) 0023, the claim must include a value code (HI0x-2, when HI0x-1=BE) "85" and the value amount (HI0x-5, when HI0x-1=BE) must include a 4- or 5-digit value (State code = 1 or 2 digits and county code = 3 digits) or the claim will be rejected.
PW00350	N/A	I	N/A	A7	726				When a home health claim is received with TOB 32x, a statement "through" date >12/31/2018, and revenue code 0023, the claim must include a value code "85," and the value amount must include a 4- or 5-digit value (State code = 1 or 2 digits and county code 3 = digits) or the claim will be rejected.	When a home health claim is received with facility type code equal to 32x (CLM05-1), a statement "through" date (DTP03 where DTP01=434) > 20181231, and revenue code (SV201) 0023, the claim must include a value code (HI0x-2, when HI0x-1=BE)"85" and the value amount (HI0x-5, when HI0x-1=BE) must include a 4- or 5-digit value (State code = 1 or 2 digits and county code = 3 digits) or the claim will be rejected.
PW00351	P	I	N/A	A7	453				When outpatient rehabilitation therapy services are billed on a claim, there are specific code lists based on Medicaid, Medicare, or Medicare and provider specialty (physical, occupational, speech therapist). These codes require only one modifier of "GO," "GN," or "GP" on a service line or the claim will be rejected.	When outpatient rehabilitation therapy (SV101-2 or SV202-2) services are billed on a claim, there are specific code lists based on Medicaid, Medicare (SNBC or MSHO), or Medicare (SNBC or MSHO) and provider specialty (Physical, Occupational, Speech Therapist). These codes require only one modifier of "GO," "GN," or "GP" on a service line (SV101-3: SV101-6 or SV202-3:SV202-6) or the claim will be rejected.
PW00353	N/A	I	N/A	A7	476	234	228		Providers billing for Substance Use Disorder (SUD) services TOB 86x can only include the "through" date in their billed units (HCPCS code H2036), if the discharge status = "30." If the discharge status does not = "30," the number of days billed (HCPCS code H2036) cannot include the statement "through/discharge" date, or the claim will be rejected.	Providers billing for Substance Use Disorder(SUD) Facility Type Code "86" can only include the "through" date in their billed units (SV205) for HCPCS code H2036(SV202-2) , if the discharge status (CL103) = "30." If the discharge status (CL103) does not = "30," the number of days billed (SV205) for HCPCS code H2036(SV202-2) cannot include the statement "through/discharge" date, or the claim will be rejected.
PW00354	N/A	I	N/A	A6	725				ESRD claims (TOB 72x), excluding acute kidney injury (AKI) patients (condition code 84), need to include the following value codes: "A8," "A9," "D5," and "48 or 49," or the claim will be rejected.	ESRD claims (TOB 72x [Loop 2300 CLM05-1]), excluding AKI claims with condition code 84 (HI0x-2, when HI0x-1 = BG), need to include the following value codes: "A8," "A9," "D5," and "48 or 49"(HI0x-2, when HI0x-1 = BE), or the claim will be rejected.
PW00357	P	N/A	N/A	A7	507				Dual member claims received after 3/15/2019 that are billing for services on or after 01/01/2019 cannot include HCPCS S-codes that are included in the EDI Edit Codes table or the claims will be rejected.	Dual member claims (Member division = "MP") received after 3/15/2019 that are billing for services on or after 01/01/2019 (Loop 2400, DTP03 when DTP01=472) cannot include HCPCS S-code s(SV202-2) that are included in the EDI Edit Codes table or the claims will be rejected.
PW00360	P	I	D						When the original claim was denied by the payer, the claim must be submitted as a new claim and not a replacement claim. Providers cannot submit TOB frequency xx7 or xx8 or include a payer claim control number on the claim, or the claim will be denied.	When the original claim was denied by the payer, the claim must be submitted as a new claim and not a replacement claim. Providers cannot submit TOB frequency = 7 or 8 (CLM05-3) or include a payer claim control number (REF02, REF01 = F8) on the claim, or the claim will be denied.