# Utah Specific Transaction Instructions
# ENCOUNTER RECORDS

837 Health Care Claim: Institutional
ASCX12N 837 (004010X096A1)

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, and all health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for healthcare as established by the Secretary of Health and Human Services. The ANSI ASC X12N 837P Version 4010 implementation guide has been established as the standard of compliance. For encounter records, Utah Medicaid will implement the Addenda corrections for the Health Care Claim: Institutional (004010X096A1). The implementation guide is available electronically at www.wpc-edi.com. The following supplemental requirements are specific to Utah Medicaid and are intended to serve as a companion guide to the HIPAA ANSI X12N implementation guide.

**Requirements:**

1. An Electronic Commerce Agreement must be in place. The form is available at www.UHIN.com.

2. A Utah Medicaid EDI Enrollment form must be completed and on file prior to the submission of encounter records. The form is available at http://www.health.utah.gov/hipaa/medicaid_pcn.htm . Transactions submitted without an Electronic Transmitter Identification Number (ETIN) or Trading Partner Number (TPN) on file with Medicaid will be rejected back to the sender.

3. 837 encounter records may be sent anytime 24 hours a day, 7 days a week.

4. The 12-digit Medicaid Provider number will not be allowed on or after May 23, 2007, unless you area a provider type not eligible for the NPI. The Provider Taxonomy Code is required if there are multiple provider types/services under the same NPI.

5. Effective January 1, 2007, Medicaid requires the reporting of the National Drug Code (NDC) in addition to the HCPS/CPT code on all drugs identified by a NDC.

6.

| Page | Loop | Segment | Element No. | Data Element | Values / Comments |
|---|---|---|---|---|---|
| HEADER | | | | | |
| 59 | | BHT06 | 640 | Claim or Encounter Identifier | "RP" |
| SUBMITTER | | | | | |
| 63 | 1000A | NM109 | 67 | Submitter Primary Identification Number | Electronic Address – Trading Partner Number (TPN) |
| RECEIVER | | | | | |
| 68 | 1000B | NM103 | 1035 | Receiver Name | "Utah Medicaid - MCO" |
| 68 | 1000B | NM109 | 67 | Receiver Primary Identifier | "HT000004-002" |
| 72 | 2000A | PRV02 | | Reference Identification Qualifier | "ZZ" – Taxonomy Code |
| 72 | 2000A | PRV03 | | Reference Identification | Provider Taxonomy Code required if multiple provider types/services under same NPI |
| BILLING PROVIDER | | | | | |
| 77 | 2010AA | NM101 | 98 | Entity Identifier | 85 – Billing Provider |
| 77 | 2010AA | NM102 | 1065 | Entity Type Qualifier | 1- Person<br>2- Non Person |
| 77 | 2010AA | NM103 | 1035 | Billing Prov Last Name | This is the provider who gave the service |
| 77 | 2010AA | NM104 | 1036 | Billing Prov First Name | |
| 77 | 2010AA | NM105 | 1037 | Billing Prov Middle Name | |

| Page | Loop | Segment | Element No. | Data Element | Values / Comments |
|---|---|---|---|---|---|
| 77 | 2010AA | NM108 | 66 | Primary ID Code Qualifier | 24- EIN<br>34 SSN<br>XX - NPI |
| 78 | 2010AA | NM109 | 67 | Primary ID Code | |
| 92 | 2010AA | REF01 | 128 | Reference ID Qualifier | “1D” – Medicaid Provider Number |
| 92 | 2010AA | REF02 | 127 | Billing Provider Secondary ID Number | Medicaid assigned number for the billing provider. |
| PATIENT INFORMATION | | | | | |
| 109 | 2010BA | NM103 | 1035 | Patient Last Name | |
| 109 | 2010BA | NM104 | 1036 | Patient First Name | |
| 109 | 2010BA | NM105 | 1037 | Patient Middle Name | |
| 110 | 2010BA | NM108 | 66 | Identification Code Qualifier | Use ‘MI’ |
| 110 | 2010BA | NM109 | 67 | Identification Code | Client PACMIS Number |
| 116 | 2010BA | DMG02 | 1251 | Patient’s Date of Birth | |
| 116 | 2010BA | DMG03 | 1068 | Patient Gender Code | “F”, “M”, or “U”. |
| 127 | 2010BC | NM108 | 66 | Payer ID Type | USE ‘PI’ |
| 128 | 2010BC | NM109 | 67 | Payer ID | MCO State Assigned Medicaid ID |
| CLAIM INFORMATION | | | | | |
| 158 | 2300 | CLM01 | 1028 | Patient Account Number | . |
| 159 | 2300 | CLM02 | 782 | Total Claim Charge Amount | Amount charged by provider for service |

| Page | Loop | Segment | Element No. | Data Element | Values / Comments |
|---|---|---|---|---|---|
| 159 | 2300 | CLM05-1 | 1331 | Facility Type Code<br><br>(Type of Bill) | Use appropriate codes as identified in the UB92 Manual. |
| 159 | 2300 | CLM05-3 | 1325 | Claim Frequency Code<br><br>(Type of Bill) | "1" – Original<br><br>"7" – Replacement<br><br>"8" – Void |
| 161 | 2300 | CLM09 | 1363 | Release of Information From Client | |
| 167 | 2300 | DTP01 | 374 | Date/Time Qualifier | '434' Statement |
| 167 | 2300 | DTP02 | 1250 | Date Time Period Format Qualifier | 'D8' CCYYMMDD<br><br>'RD8 CCYYMMDD-CCYYMMDD |
| 168 | 2300 | DTP03 | 1251 | Date Time Period | Statement Covers Period |
| 169 | 2300 | DTP01 | 374 | Date/Time Qualifier | '435' Admission |
| 169 | 2300 | DTP02 | 1250 | Date Time Period Format Qualifier | 'DT' |
| 170 | 2300 | DTP03 | 1251 | Admission Date and Hour | CCYYMMDDHHMM |
| 172 | 2300 | CL103 | 1352 | Patient Status Code | |
| 176 | 2300 | CN1 | 1166 | Contract Information | '05' capitated arrangement with billing provider<br><br>'01' if DRG |
| 178 | 2300 | AMT01 | 522 | Amount Qualifier Code | Use 'C5 |
| 179 | 2300 | AMT02 | 782 | Monitary Amount | Enter the allowed amount for the claim |
| 182 | 2300 | AMT01 | 522 | Amount Qualifier Code | Use F5 to indicate Patient Amount Paid. This is where the co-pay will be put. |
| 182 | 2300 | AMT02 | 782 | Monetary Amount | |

| Page | Loop | Segment | Element No. | Data Element | Values / Comments |
|---|---|---|---|---|---|
| 208 | 2300 | NTE01 | 363 | Claim Note | Use 'Add' for all reasons |
| 209 | 2300 | NTE02 | 352 | Claim Note Information (for entire claim) | **Claim Entry Date** (date claim entered MCO system) -- Start with 'E' and enter date in format CCYYMMDD<br><br>**Claim Paid/Adjudicated Date** – Start with 'A' and enter date in format CCYYMMDD<br><br>**SPMI/SED Status** – Start with 'S' and enter 'Y' or 'N' (PMHP only, SPMI is adults, SED is child)<br><br>**Payment Amount** – Start with 'P' and enter amount, use explicit decimal<br><br>**Denial Reason** – Start with 'D' and enter denial reason |
| 227 | 2300 | HI01-HI03 | C022 | Principal, Admitting, E-code Diagnosis Information | |
| 232 | 2300 | HI01-HI12 | CO22 | Other Diagnosis Information | |
| 242 | 2300 | HI01-2 | C022 | Principal Procedure Information | |
| 243 | 2300 | HI01-4 | 1251 | Date Time Period | Date of Surgery CCYYMMDD format |
| 244 | 2300 | HI01-HI12 | C022 | Other Procedure Information | |
| 245 | 2300 | HI01-4 thru HI12-4 | 1251 | Date Time Period | Other Procedure Date CCYYMMDD format |
| 307 | 2300 | QTY01 | 673 | Quantity Qualifier | "CA" - covered days<br>"NA" - non-covered days. |
| 307 | 2300 | QTY02 | 380 | Claim Days Count | This should be based off the MCO covered (paid for) days, not eligibility |

| Page | Loop | Segment | Element No. | Data Element | Values / Comments |
|---|---|---|---|---|---|
| 321-358 | 2310A-E | NM101 | 98 | Physician Identifier Code | 71 – Attending<br>72 – Operating<br>73 – Other<br>DN – Referring<br>P3 – Primary Care Physician<br>FA - Facility |
| 321-358 | 2310A-E | NM103 | 1035 | Physician Last Name | |
| 321-358 | 2310A-E | NM104 | 1036 | Physician First Name | |
| 321-358 | 2310A-E | NM105 | 1037 | Physician Middle Name | |
| 321-358 | 2310A-E | NM109 | 67 | Physician Primary Identifier | 24 – EIN or TIN<br>34 – SSN<br>XX - NPI |
| 321 - 358 | 2310A-E | REF01 | 128 | Physician Reference ID Qualifier | 1D |
| 321 - 358 | 2310A-E | REF02 | 127 | Secondary ID Number | Utah State Assigned Medicaid ID Number |
| 321 - 358 | 2310A-E | PRV03 | 127 | Specialty | |
| 356 | 2310E | N403 | | Postal Code | Required for FA –facility Provider Only |
| COORDINATION OF BENEFITS INFORMATION - Repeat loop for other payers. | | | | | |
| 360 | 2320 | SBR01 | 1138 | Payer Responsibility Sequence Number Code | P - Primary payer<br>S – Secondary Payer<br>T – Tertiary Payer<br><br>If Medicare is Primary put P in SBR01 and (MP or MB in SBR05 OR SBR09). |
| 363 | 2320 | SBR05 | 1336 | Insurance Type Code | Use ‘MP’ if Medicare is primary |
| 363 | 2320 | SBR09 | 1032 | Type of claim | Use ‘MB’ to indicate the client has Medicare |

| Page | Loop | Segment | Element No. | Data Element | Values / Comments |
|---|---|---|---|---|---|
| This segment is only required If there is TPL and the TPL Primary payer is Medicare. | | | | | |
| 367 | 2320 | CAS01 | 1033 | Patient Responsibility | If SBR01 and (SBR05 or SBR09 indicates Medicare), use PR to indicate the patient responsibility |
| 367 | 2320 | CAS02 | 1034 | Reason Code | 1 – Deductible<br>2 - Coinsurance |
| 367 | 2320 | CAS03 | 782 | Monetary Amount | Amount client is responsible to pay after Medicare |
| This segment is not required as the MCO Paid amount is in the note segment on the claim level above. | | | | | |
| 367 | 2320 | CAS01 | 1033 | MCO Paid Amount | Use CO – Contractual Obligation |
| 367 | 2320 | CAS02 | 1034 | Reason Code | Use 42 |
| 367 | 2320 | CAS03 | 782 | Monetary Amount | Amount MCO paid for this claim |
| 371 | 2320 | AMT01 | 522 | Amount Qualifier Code | Use ‘C4’ to indicate Payor Amount Paid and put COB amount in AMT02. |
| 371 | 2320 | AMT02 | 782 | COB Payer Paid Amount | Amount paid by other payer for service. |
| 372 | 2320 | AMT01 | 522 | Amount Qualifier Code | Use ‘B6’ to indicate Allowed Amount in AMT02. |
| 372 | 2320 | AMT02 | 782 | Allowed Amount | Amount allowed for service by other payer (if available). |
| 411 | 2330B | NM108 | 66 | PayerID Qualifier | “PI” |
| 411 | 2330B | NM109 | 67 | PayerID | SSN or TIN |
| LINE INFORMATION (MAX 59 LINES PER CLAIM) | | | | | |
| 446 | 2400 | SV201 | 234 | Revenue Code | |
| 446 | 2400 | SV202-1 | 235 | Product/Service Qualifier ID | |

| Page | Loop | Segment | Element No. | Data Element | Values / Comments |
|---|---|---|---|---|---|
| 447 | 2400 | SV202-2 | 234 | Procedure Code | |
| 448 | 2400 | SV203 | 782 | Service Line Charge Amount | |
| 448 | 2400 | SV204 | 355 | Unit or Basis for Measurement Code | |
| 449 | 2400 | SV205 | 380 | Service Line Units | |
| 456 | 2400 | DTP01 | 374 | Date/Time Qualifier | |
| 457 | 2400 | DTP02 | 1250 | Date Time Period Format Qualifier | 'D8' CCYYMMDD<br>'RD8 CCYYMMDD-CCYYMMDD |
| 457 | 2400 | DTP03 | 1251 | Date Time Period | Service Date |
| 37A | 2410 | LIN02 | | ID Qualifier | 'N4' – NDC |
| 37A | 2410 | LIN03 | | NDC Number | NDC is required on all drugs containing a NDC in addition to the HCPCS/CPT code. Do not submit hyphens or spaces. |
| 39A | 2410 | CPT03 | | Unit Price | Drug Unit Price |
| 39A | 2410 | CPT04 | | Quantity | National Drug Unit Count |
| 39A | 2410 | CPT05 | | Unit or Basis of Measurement | 'GR' – Gram<br>'ME' – Milligram<br>'ML' – Milliliter<br>'UN' – Unit |
| 40A* | 2410 | REF01 | | Reference Identification Qualifier | "XZ" – Prescription<br>Applicable if dispensing of the drug has been done with an assigned RX number. |
| 41A* | 2410 | REF02 | | Prescription Number | Pharmacy Prescription Number |
| 462-489 | 2420A-D | NM101 | 98 | Physician Identifier Code | 71 – Attending<br>72 – Operating<br>73 – Other<br>DN – Referring |
| 462-489 | 2420A-D | NM103 | 1035 | Physician Last Name | |

| Page | Loop | Segment | Element No. | Data Element | Values / Comments |
|---|---|---|---|---|---|
| 462-489 | 2420A-D | NM104 | 1036 | Physician First Name | |
| 462-489 | 2420A-D | NM105 | 1037 | Physician Middle Name | |
| 462-489 | 2420A-D | NM109 | 67 | Physician Primary Identifier | 24 – EIN or TIN<br>34 - SSN |
| 462-489 | 2420A-D | REF01 | 128 | Physician Reference ID Qualifier | 1D |
| 462-489 | 2420A-D | REF02 | 127 | Secondary ID Number | Utah State Assigned Medicaid ID Number |
| 462-489 | 2420A-D | PRV03 | 127 | Specialty | |
| **LINE TPL INFORMATION (COB) -- This is needed to send through the Pricing system, if it is not sent in the TPL total amount is sent in at claim level and if there are more than 6 lines the TPL may affect amount that prices.** | | | | | |
| 491 | 2430 | SVD01 | 67 | ID Code | Use MCO Payer ID |
| 491 | 2430 | SVD02 | 782 | TPL Amount | TPL Amount for this Line |
| 495 | 2430 | CAS01 | 1033 | MCO Paid Amount | Use CO – Contractual Obligation |
| 496 | 2430 | CAS02 | 1034 | Reason Code | Use 42 |
| 496 | 2430 | CAS03 | 782 | Monetary Amount | Amount MCO paid for this line. |

*Addenda page numbers

ERRORS THAT WILL RETURN ON THE 277

## Institutional HMO Edits

| Status Category Code | Status Code | Status Entity Code | Reject Encounter | MMCS Status Description | WPC -EDI Status Description(Standard) |
|---|---|---|---|---|---|
| A6 | **21** | 1E | Y | Rate missing | Missing or invalid information. |
| A6 | **26** | 1E | Y | Recipient ID missing (not submitted on encounter) | Entity not found. |
| A7 | **26** | 1E | Y | Recipient ID not on file | Entity not found. |

## Institutional HMO Edits

| Status Category Code | Status Code | Status Entity Code | Reject Encounter | MMCS Status Description | WPC -EDI Status Description(Standard) |
|---|---|---|---|---|---|
| A4 | **35** | 1E | Y | No match found on history for replacement | Claim/encounter not found. |
| A4 | **35** | 1E | Y | No match found on history for replacement | Claim/encounter not found. |
| A4 | **35** | 1E | Y | No match found on history for void | Claim/encounter not found. |
| A6 | **35** | 1E | Y | Previous TCN not present for replacement/void code | Claim/encounter not found. |
| A3 | **54** | 1E | Y | Possible duplicate encounter. | Duplicate of a previously processed claim/line. |
| A2 | **86** | 1E | N | Diagnosis to sex mismatch | Diagnosis and patient gender mismatch. |
| A3 | **97** | 1E | Y | Recipient enrolled with another plan on admission date | Patient eligibility not found with entity. |
| A3 | **97** | 1E | Y | Recipient enrollment not reflected on system | Patient eligibility not found with entity. |
| A7 | **122** | 1E | Y | Invalid Claim frequency code | Missing/invalid data prevents payer from processing claim. |
| A6 | **122** | 1E | Y | Missing claim frequency code | Missing/invalid data prevents payer from processing claim. |
| A6 | **122** | 1E | Y | Replacement/void code not present for previous TCN | Missing/invalid data prevents payer from processing claim. |
| A3 | **122** | 1E | Y | TCN has already been replaced | Missing/invalid data prevents payer from processing claim. |
| A3 | **122** | 1E | Y | TCN has already been voided | Missing/invalid data prevents payer from processing claim. |
| A7 | **125** | 1E | Y | Recipient name does not match file name | Entity's name. |
| A6 | **125** | 1E | Y | Recipient name missing | Entity's name. |
| A2 | **126** | 1E | N | Zip code is invalid | Entity's address. |
| A2 | **126** | 1E | N | Zip code is missing | Entity's address. |
| A6 | **143** | 1E | Y | Attending physician ID missing or invalid | Entity's state license number. |
| A1 | **153** | 1E | N | Invalid/Missing State Assigned Medicaid ID | Entity's id number. |
| A7 | **158** | 1E | Y | Month and year does not match file month and year | Entity's date of birth |
| A6 | **158** | 1E | Y | Recipient DOB missing | Entity's date of birth |
| A6 | **178** | 1E | Y | Charges missing | Submitted charges. |
| A6 | **178** | 1E | Y | Total charge missing | Submitted charges. |
| A6 | **183** | 1E | Y | Other payer amount missing | Amount entity has paid. |
| A6 | **183** | 1E | Y | Plan Paid Amount missing | Amount entity has paid. |
| A3 | **187** | 1E | Y | From date after submit date | Date(s) of service. |
| A6 | **187** | 1E | Y | From date of service missing | Date(s) of service. |

## Institutional HMO Edits

| Status Category Code | Status Code | Status Entity Code | Reject Encounter | MMCS Status Description | WPC -EDI Status Description(Standard) |
|---|---|---|---|---|---|
| A6 | **187** | 1E | Y | Procedure date of service missing | Date(s) of service. |
| A3 | **188** | 1E | Y | Encounter is greater than 12 months FROM | Statement from-through dates. |
| A3 | **188** | 1E | Y | Procedure date not between admit date and statement through date | Statement from-through dates. |
| A7 | **188** | 1E | Y | Through date after submit date | Statement from-through dates. |
| A7 | **188** | 1E | Y | Through date prior to from date | Statement from-through dates. |
| A7 | **188** | 1E | Y | Through date Missing | Statement from-through dates. |
| A7 | **189** | 1E | Y | Admit date after statement covers begin date | Hospital admission date. |
| A6 | **189** | 1E | Y | Admit date missing | Hospital admission date. |
| A2 | **228** | 1E | N | Type of bill is invalid | Type of bill for UB-92 claim. |
| A2 | **229** | 1E | N | Admit source invalid | Hospital admission source. |
| A2 | **229** | 1E | N | Admit source missing | Hospital admission source. |
| A7 | **230** | 1E | Y | Admit hour invalid | Hospital admission hour. |
| A6 | **230** | 1E | Y | Admit hour missing | Hospital admission hour. |
| A2 | **231** | 1E | N | Admit type invalid | Hospital admission type. |
| A2 | **231** | 1E | N | Admit type missing | Hospital admission type. |
| A7 | **232** | 1E | Y | Admitting diagnosis code invalid | Admitting diagnosis. |
| A7 | **232** | 1E | Y | Admitting diagnosis code missing | Admitting diagnosis. |
| A2 | **233** | 1E | N | Discharge hour invalid | Hospital discharge hour. |
| A2 | **233** | 1E | N | Discharge hour missing | Hospital discharge hour. |
| A2 | **234** | 1E | N | Discharge status invalid | Patient discharge status. |
| A2 | **234** | 1E | N | Discharge status missing | Patient discharge status. |
| A3 | **247** | 1E | Y | Must contain at least one service line | Line information. |
| A6 | **249** | 1E | Y | Place of service missing | Place of service. |
| A7 | **254** | 1E | Y | Primary Diagnosis code Invalid | Primary diagnosis code. |
| A6 | **254** | 1E | Y | Primary Diagnosis code Missing | Primary diagnosis code. |
| A7 | **255** | 1E | Y | Diagnosis code not on file | Diagnosis code. |
| A7 | **255** | 1E | Y | E-code is invalid | Diagnosis code. |
| A7 | **256** | 1E | Y | DRG code invalid | DRG code(s). |
| A7 | **454** | 1E | Y | Other procedure code not on file | Procedure code for services rendered. |
| A7 | **454** | 1E | Y | Procedure code invalid | Procedure code for services rendered. |
| A6 | **454** | 1E | Y | Procedure code missing | Procedure code for services rendered. |
| A1 | **454** | 1E | Y | Too many proc. Code T1015 for client for year | Procedure code for services rendered |

## Institutional HMO Edits

| Status Category Code | Status Code | Status Entity Code | Reject Encounter | MMCS Status Description | WPC -EDI Status Description(Standard) |
|---|---|---|---|---|---|
| A1 | **454** | 1E | Y | Procedure code for non-traditional is invalid | Procedure code for services rendered |
| A1 | **455** | 1E | Y | Revenue code invalid for non-traditional client | Revenue code for services rendered |
| A7 | **455** | 1E | Y | Revenue code invalid | Revenue code for services rendered. |
| A6 | **455** | 1E | Y | Revenue code missing | Revenue code for services rendered. |
| A2 | **456** | 1E | N | Covered days missing/invalid | Covered Day(s) |
| A2 | **457** | 1E | N | Non covered days missing/invalid | Non-Covered Day(s) |
| A2 | **460** | 1E | N | Condition code invalid | NUBC Condition Code(s) |
| A7 | **461** | 1E | Y | Occurrence code invalid | NUBC Occurrence Code(s) and Date(s) |
| A6 | **461** | 1E | N | Occurrence code missing | NUBC Occurrence Code(s) and Date(s) |
| A6 | **461** | 1E | Y | Occurrence date missing | NUBC Occurrence Code(s) and Date(s) |
| A7 | **462** | 1E | Y | Spanned occurrence begin date after end date | NUBC Occurrence Span Code(s) and Date(s) |
| A7 | **462** | 1E | Y | Spanned occurrence code invalid | NUBC Occurrence Span Code(s) and Date(s) |
| A6 | **462** | 1E | Y | Spanned occurrence code missing | NUBC Occurrence Span Code(s) and Date(s) |
| A6 | **462** | 1E | Y | Spanned occurrence dates missing | NUBC Occurrence Span Code(s) and Date(s) |
| A7 | **463** | 1E | Y | Value amount invalid | NUBC Value Code(s) and/or Amount(s) |
| A6 | **463** | 1E | Y | Value amount missing | NUBC Value Code(s) and/or Amount(s) |
| A7 | **463** | 1E | Y | Value code invalid | NUBC Value Code(s) and/or Amount(s) |
| A6 | **463** | 1E | Y | Value code missing | NUBC Value Code(s) and/or Amount(s) |
| A6 | **465** | 1E | Y | Principle procedure code missing | Principal Procedure Code for Service(s) Rendered |
| A7 | **465** | 1E | Y | Principle procedure code not on file | Principal Procedure Code for Service(s) Rendered |
| A7 | **476** | 1E | N | Max units exceeded | Missing or invalid units of service |
| A6 | **476** | 1E | Y | Units missing | Missing or invalid units of service |
| A2 | **478** | 1E | N | Patient account number is missing | Claim submitter's identifier (patient account number) is missing |

## Institutional HMO Edits

| Status Category Code | Status Code | Status Entity Code | Reject Encounter | MMCS Status Description | WPC -EDI Status Description(Standard) |
|---|---|---|---|---|---|
| A7 | **536** | 1E | Y | Through date missing | |

## Institutional PMHP Edits

| Status Category Code | Status Code | Status Entity Code | Reject Encounter | MMCS Status Description | WPC -EDI Status Description(Standard) |
|---|---|---|---|---|---|
| A6 | **21** | 1E | Y | Rate missing | Missing or invalid information. |
| A7 | **21** | 1E | Y | Rate invalid | Missing or invalid information |
| A6 | **21** | 1E | N | Missing SPMI indicator | Missing or invalid information |
| A6 | **26** | 1E | Y | Recipient ID missing (not submitted on encounter) | Entity not found. |
| A7 | **26** | 1E | Y | Recipient ID not on file | Entity not found. |
| A4 | **35** | 1E | Y | No match found on history for replacement | Claim/encounter not found. |
| A4 | **35** | 1E | Y | No match found on history for replacement | Claim/encounter not found. |
| A4 | **35** | 1E | Y | No match found on history for void | Claim/encounter not found. |
| A6 | **35** | 1E | Y | Previous TCN not present for replacement/void code | Claim/encounter not found. |
| A3 | **54** | 1E | Y | Possible duplicate encounter. | Duplicate of a previously processed claim/line. |
| A2 | **86** | 1E | N | Diagnosis to sex mismatch | Diagnosis and patient gender mismatch. |
| A2 | **97** | 1E | N | Recipient enrolled with another plan on admission date | Patient eligibility not found with entity. |
| A2 | **97** | 1E | N | Recipient enrollment not reflected on system | Patient eligibility not found with entity. |
| A7 | **122** | 1E | Y | Invalid Claim frequency code | Missing/invalid data prevents payer from processing claim. |
| A6 | **122** | 1E | Y | Missing claim frequency code | Missing/invalid data prevents payer from processing claim. |
| A6 | **122** | 1E | Y | Replacement/void code not present for previous TCN | Missing/invalid data prevents payer from processing claim. |
| A3 | **122** | 1E | Y | TCN has already been replaced | Missing/invalid data prevents payer from processing claim. |
| A3 | **122** | 1E | Y | TCN has already been voided | Missing/invalid data prevents payer from processing claim. |
| A7 | **125** | 1E | Y | Recipient name does not match file name | Entity's name. |
| A6 | **125** | 1E | Y | Recipient name missing | Entity's name. |
| A2 | **126** | 1E | N | Zip code is invalid | Entity's address. |
| A2 | **126** | 1E | N | Zip code is missing | Entity's address. |
| A6 | **143** | 1E | Y | Attending physician ID missing or invalid | Entity's state license number. |
| A6 | **153** | 1E | Y | Primary surgeon ID required | Entity's id number. |
| A7 | **158** | 1E | Y | Month and year does not match file month and year | Entity's date of birth |
| A6 | **158** | 1E | Y | Recipient DOB missing | Entity's date of birth |

## Institutional PMHP Edits

| Status Category Code | Status Code | Status Entity Code | Reject Encounter | MMCS Status Description | WPC -EDI Status Description(Standard) |
|---|---|---|---|---|---|
| A6 | **178** | 1E | Y | Charges missing | Submitted charges. |
| A6 | **178** | 1E | Y | Total charge missing | Submitted charges. |
| A6 | **183** | 1E | Y | Other payer amount missing | Amount entity has paid. |
| A6 | **183** | 1E | Y | Plan Paid Amount missing | Amount entity has paid. |
| A3 | **187** | 1E | Y | From date after submit date | Date(s) of service. |
| A6 | **187** | 1E | Y | From date of service missing | Date(s) of service. |
| A6 | **187** | 1E | Y | Procedure date of service missing | Date(s) of service. |
| A3 | **188** | 1E | Y | Encounter is greater than 12 months FROM_ | Statement from-through dates. |
| A3 | **188** | 1E | Y | Procedure date not between admit date and statement through date | Statement from-through dates. |
| A7 | **188** | 1E | Y | Through date after submit date | Statement from-through dates. |
| A7 | **188** | 1E | Y | Through date prior to from date | Statement from-through dates. |
| A7 | **188** | 1E | Y | Through date Missing | Statement from-through dates. |
| A6 | **188** | 1E | N | MCO's Paid Date Missing | |
| A6 | **188** | 1E | N | MCO's Entry Date Missing | |
| A7 | **189** | 1E | Y | Admit date after statement covers begin date | Hospital admission date. |
| A6 | **189** | 1E | Y | Admit date missing | Hospital admission date. |
| A2 | **228** | 1E | N | Type of bill is invalid | Type of bill for UB-92 claim. |
| A2 | **229** | 1E | N | Admit source invalid | Hospital admission source. |
| A2 | **229** | 1E | Y | Admit source missing | Hospital admission source. |
| A7 | **230** | 1E | Y | Admit hour invalid | Hospital admission hour. |
| A6 | **230** | 1E | Y | Admit hour missing | Hospital admission hour. |
| A2 | **231** | 1E | N | Admit type invalid | Hospital admission type. |
| A2 | **231** | 1E | N | Admit type missing | Hospital admission type. |
| A7 | **232** | 1E | Y | Admitting diagnosis code invalid | Admitting diagnosis. |
| A7 | **232** | 1E | Y | Admitting diagnosis code missing | Admitting diagnosis. |
| A2 | **233** | 1E | N | Discharge hour invalid | Hospital discharge hour. |
| A2 | **233** | 1E | N | Discharge hour missing | Hospital discharge hour. |
| A2 | **234** | 1E | N | Discharge status invalid | Patient discharge status. |
| A2 | **234** | 1E | N | Discharge status missing | Patient discharge status. |
| A3 | **247** | 1E | Y | Must contain at least one service line | Line information. |
| A6 | **249** | 1E | Y | Place of service missing | Place of service. |
| A7 | **254** | 1E | Y | Primary Diagnosis code Invalid | Primary diagnosis code. |
| A6 | **254** | 1E | Y | Primary Diagnosis code Missing | Primary diagnosis code. |
| A7 | **255** | 1E | Y | Diagnosis code not on file | Diagnosis code. |

## Institutional PMHP Edits

| Status Category Code | Status Code | Status Entity Code | Reject Encounter | MMCS Status Description | WPC -EDI Status Description(Standard) |
|---|---|---|---|---|---|
| A7 | **255** | 1E | Y | E-code is invalid | Diagnosis code. |
| A7 | **256** | 1E | Y | DRG code invalid | DRG code(s). |
| A7 | **454** | 1E | Y | Other procedure code not on file | Procedure code for services rendered. |
| A7 | **454** | 1E | Y | Procedure code invalid | Procedure code for services rendered. |
| A6 | **454** | 1E | Y | Procedure code missing | Procedure code for services rendered. |
| A7 | **455** | 1E | Y | Revenue code invalid | Revenue code for services rendered. |
| A6 | **455** | 1E | Y | Revenue code missing | Revenue code for services rendered. |
| A2 | **456** | 1E | N | Covered days missing/invalid | Covered Day(s) |
| A2 | **457** | 1E | N | Non covered days missing/invalid | Non-Covered Day(s) |
| A2 | **460** | 1E | N | Condition code invalid | NUBC Condition Code(s) |
| A7 | **461** | 1E | Y | Occurrence code invalid | NUBC Occurrence Code(s) and Date(s) |
| A6 | **461** | 1E | N | Occurrence code missing | NUBC Occurrence Code(s) and Date(s) |
| A6 | **461** | 1E | Y | Occurrence date missing | NUBC Occurrence Code(s) and Date(s) |
| A7 | **462** | 1E | Y | Spanned occurrence begin date after end date | NUBC Occurrence Span Code(s) and Date(s) |
| A7 | **462** | 1E | Y | Spanned occurrence code invalid | NUBC Occurrence Span Code(s) and Date(s) |
| A6 | **462** | 1E | Y | Spanned occurrence code missing | NUBC Occurrence Span Code(s) and Date(s) |
| A6 | **462** | 1E | Y | Spanned occurrence dates missing | NUBC Occurrence Span Code(s) and Date(s) |
| A7 | **463** | 1E | Y | Value amount invalid | NUBC Value Code(s) and/or Amount(s) |
| A6 | **463** | 1E | Y | Value amount missing | NUBC Value Code(s) and/or Amount(s) |
| A7 | **463** | 1E | Y | Value code invalid | NUBC Value Code(s) and/or Amount(s) |
| A6 | **463** | 1E | Y | Value code missing | NUBC Value Code(s) and/or Amount(s) |
| A6 | **465** | 1E | Y | Principle procedure code missing | Principal Procedure Code for Service(s) Rendered |
| A7 | **465** | 1E | Y | Principle procedure code not on file | Principal Procedure Code for Service(s) Rendered |
| A7 | **476** | 1E | Y | Max units exceeded | Missing or invalid units of service |
| A6 | **476** | 1E | Y | Units missing | Missing or invalid units of service |

## Institutional PMHP Edits

| Status Category Code | Status Code | Status Entity Code | Reject Encounter | MMCS Status Description | WPC -EDI Status Description(Standard) |
|---|---|---|---|---|---|
| A2 | **478** | 1E | N | Patient account number is missing | Claim submitter's identifier (patient account number) is missing |