Error Number	837 Edit P=PROFESSIONAL	837 Edit I=INSTITUTIONAL	837 Edit D=DENTAL	EDI Edit "REJECT" or "DENIAL"	Health Care Claim Status Category Code	Health Care Claim Status Code 1	Health Care Claim Status Code 2	Health Care Claim Status Code 3	Entity Identifier Code	EDI Edit - Effective Date	EDI Edit - Discontinued Date	EDI Edit - 5010 Error Description	EDI Edit - 5010 Technical Edits
PW00001	P	I	D	REJECT	A6	135	562		85	2011-01-01	9999-12-31	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	REJECT	A7	128			85	2011-01-01	9999-12-31	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	REJECT	A6	21	564			2012-02-16	9999-12-31	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	REJECT	A6	505			IL	2011-01-01	9999-12-31	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	REJECT	A7	510	158		IL	2011-01-01	9999-12-31	Subscriber date of birth cannot be a future date.	2010BA.DMG02 must not be a future date.
PW00007	P	I	D	REJECT	A7	693	178			2011-01-01	9999-12-31	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	REJECT	A7	400	178			2011-01-01	9999-12-31	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	REJECT	A7	400	672			2011-01-01	9999-12-31	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	REJECT	A7	249				2011-01-01	9999-12-31	Place of service (POS) code must be valid.	2300.CLM05-1 must be a valid POS code.
PW00011	P	I	N/A	REJECT	A6	189				2011-01-01	9999-12-31	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	REJECT	A7	693	183		QC	2011-01-01	9999-12-31	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	REJECT	A7	337				2011-01-01	9999-12-31	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	REJECT	A7	337				2011-01-01	9999-12-31	POS must equal 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	REJECT	A7	254				2011-01-01	9999-12-31	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).
PW00016	P	I	N/A	REJECT	A7	460				2011-01-01	9999-12-31	Must be a valid condition code.	2300.HI01-2 through HI12-2 must be a valid condition code.
PW00017	P	I	D	REJECT	A7	562			DN	2011-01-01	9999-12-31	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	REJECT	A6	286				2011-01-01	9999-12-31	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	REJECT	A6	286				2011-01-01	9999-12-31	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	N/A	REJECT	A7	507	187	188		2011-01-01	9999-12-31	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.	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.
PW00022	P	I	D	REJECT	A7	453				2011-01-01	9999-12-31	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	I	N/A	REJECT	A6	306				2011-01-01	9999-12-31	When Procedure code T1013 is included on the Professional or Institutional claim, the claim must include the oral Interpreter's name in the Procedure Code Description Field, unless the claim contains modifier 93, 95, GT, U3, or U4.	When Procedure code (Loop 2400 SV101-2(837P) or SV202-2 (837I)="T1013," then (Loop 2400 SV101-7 (837P) or SV202-7 (837I) must include the oral Interpreter's name, unless the claim contains a modifier (Loop 2400 SV101-3:SV101-6 (837P) or SV202-3:SV202-6 (837I) 93, 95, GT, U3, or U4.
PW00024	P	I	D	REJECT	A7	693	583			2011-01-01	9999-12-31	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	REJECT	A7	400	583	643		2011-01-01	9999-12-31	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	REJECT	A7	659				2011-01-01	9999-12-31	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	REJECT	A7	476				2011-01-01	9999-12-31	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	REJECT	A7	477				2011-01-01	9999-12-31	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	REJECT	A7	187				2011-01-01	9999-12-31	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.
PW00030	P	N/A	N/A	REJECT	A7	187				2011-01-01	9999-12-31	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	REJECT	A7	584				2011-01-01	9999-12-31	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	REJECT	A7	562	88		85	2011-01-01	9999-12-31	Billing provider's NPI must be valid on the National Plan and Provider Enumeration System (NPPES) Registry. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates or statement date on the claim will be validated to these dates.	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates (Loop 2400 DTP03 where DTP01=472) or statement date (Loop 2300 DTP03 where DTP01=434) on the claim will be validated to these dates.
PW00033	P	N/A	N/A	REJECT	A7	562				2011-01-01	9999-12-31	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	REJECT	A7	562	741	88	82	2011-01-01	9999-12-31	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates or statement date on the claim will be validated to these dates.	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates (Loop 2400 DTP03 where DTP01=472)or statement date (Loop 2300 DTP03 where DTP01=434) on the claim will be validated to these dates.
PW00035	P	I	D	REJECT	A7	562	88		77	2011-01-01	9999-12-31	Service facility's NPI must be valid on the NPPES Registry. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates or statement date on the claim will be validated to these dates.	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates (Loop 2400 DTP03 where DTP01=472) or statement date (Loop 2300 DTP03 where DTP01=434) on the claim will be validated to these dates.
PW00036	P	N/A	D	REJECT	A7	562	741	88	DQ	2011-01-01	9999-12-31	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates on the claim will be validated to these dates.	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates (Loop 2400 DTP03 where DTP01=472) on the claim will be validated to these dates.
PW00037	P	N/A	N/A	REJECT	A7	562	741	88	DK	2011-01-01	9999-12-31	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates on the claim will be validated to these dates.	Ordering provider's NPI (Loop 2420E-NM109 where Entity Identifier Code= 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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates(Loop 2400 DTP03 where DTP01=472) on the claim will be validated to these dates.
PW00039	P	N/A	N/A	REJECT	A7	562	88		QB	2011-01-01	9999-12-31	Purchased service provider's NPI must be valid on the NPPES Registry. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates on the claim will be validated to these dates.	Purchased service provider's NPI (Loop 2420B-NM109 where Entity Identifier Code=QB) must be valid on the NPPES Registry or the claim will be rejected. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates (Loop 2400 DTP03 where DTP01=472) on the claim will be validated to these dates. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates (Loop 2400 DTP03 where DTP01=472) on the claim will be validated to these dates.
PW00042	P	I	D	REJECT	A7	562	741	88	DN	2011-01-01	9999-12-31	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates or statement date on the claim will be validated to these dates.	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates (Loop 2400 DTP03 where DTP01=472)or statement date (Loop 2300 DTP03 where DTP01=434) on the claim will be validated to these dates.
PW00043	P	I	N/A	REJECT	A7	254				2011-01-01	9999-12-31	Principal diagnosis code must be "BK" or "ABK" and be present.	2300.HI01-1 must be "BK" or "ABK."

PW00044	P	I	D	REJECT	A6	478				2011-01-01	9999-12-31	Submitter entity type qualifier must be "85."	2010AA.NM101 must be "85."
PW00045	P	N/A	N/A	REJECT	A6	516				2011-01-01	9999-12-31	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	REJECT	A7	510	516			2011-01-01	9999-12-31	Invalid remittance date. Date reported cannot be greater than current date.	If 2430 DTP=573 is present, 2430.DTP03 cannot be a future date.
PW00047	N/A	I	N/A	REJECT	A7	562	741	88	72	2011-01-01	9999-12-31	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates or statement date on the claim will be validated to these dates.	Operating provider's NPI (Loop 2420A/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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates (Loop 2400 DTP03 where DTP01=472) or statement date(Loop 2300 DTP03 where DTP01=434) on the claim will be validated to these dates.
PW00048	N/A	I	N/A	REJECT	A7	562	741	88	ZZ	2011-01-01	9999-12-31	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates or statement date on the claim will be validated to these dates.	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates (Loop 2400 DTP03 where DTP01=472)or statement date (Loop 2300 DTP03 where DTP01=434) on the claim will be validated to these dates.
PW00050	N/A	I	N/A	REJECT	A7	231				2011-01-01	9999-12-31	Admission type code must be valid.	2300.CL101 must be a valid admission type code.
PW00051	N/A	I	N/A	REJECT	A7	229				2012-07-01	9999-12-31	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	REJECT	A7	234				2011-01-01	9999-12-31	Patient status code must be valid.	2300.CL103 must be a valid patient status code.
PW00053	N/A	I	N/A	REJECT	A7	255				2011-01-01	9999-12-31	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	REJECT	A7	232				2011-01-01	9999-12-31	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	REJECT	A7	673				2011-01-01	9999-12-31	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	REJECT	A7	509				2011-01-01	9999-12-31	E-code must be a valid ICD-9-CM or ICD-10-CM diagnosis code and be an External Cause of Injury code "E800-E9999" and "V00-Y999999," respectively. 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 code and be an external cause of injury code "E800-E9999" and "V00-Y999999," respectively (using the "from" or "through" statement date based on TOB). The code must 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 is rejected.
PW00058	N/A	I	N/A	REJECT	A7	465				2011-01-01	9999-12-31	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).

PW00059	N/A	I	N/A	REJECT	A7	796				2011-01-01	9999-12-31	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	REJECT	A7	721				2011-01-01	9999-12-31	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	REJECT	A7	719				2011-01-01	9999-12-31	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	REJECT	A7	725				2011-01-01	9999-12-31	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	REJECT	A7	562	741	88	71	2011-01-01	9999-12-31	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates or statement date on the claim will be validated to these dates.	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates (Loop 2400 DTP03 where DTP01=472)or statement date (Loop 2300 DTP03 where DTP01=434) on the claim will be validated to these dates.
PW00066	N/A	I	N/A	REJECT	A7	455				2011-01-01	9999-12-31	Revenue code must be valid.	2400.SV201 must be a valid revenue code.
PW00067	N/A	I	N/A	REJECT	A7	513				2014-01-27	9999-12-31	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	REJECT	A7	402	476			2011-01-01	9999-12-31	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	REJECT	A7	693	596			2011-01-01	9999-12-31	Negative amounts are not valid.	2400.SV207 must be greater than or equal to zero.
PW00070	N/A	I	N/A	REJECT	A7	228				2011-01-01	9999-12-31	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	REJECT	A7	254				2011-01-01	9999-12-31	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	REJECT	A7	255				2011-01-01	9999-12-31	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	REJECT	A7	245				2011-01-01	9999-12-31	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	REJECT	A7	242				2011-01-01	9999-12-31	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	REJECT	A7	562			DD	2011-01-01	9999-12-31	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	REJECT	A7	240				2011-01-01	9999-12-31	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	REJECT	A7	737				2011-01-01	9999-12-31	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	REJECT	A3	493				2011-01-01	9999-12-31	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	REJECT	A6	242				2012-03-20	9999-12-31	CDT code requires a mouth location or tooth number, unless the category code in the payer system=OP, NR, or OE.	When a dental claim is received (Loop 2400 SV301-1="AD") and CDT code (SV301-2) does not include a category code of OP, NR, or OE in the payer's system, the mouth location (SV304) or tooth information (TOO02) is required, or the claim will be rejected.
PW00081	P	I	D	REJECT	A7	242				2012-06-01	9999-12-31	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.

PW00082	P	I	D	REJECT	A6	306				2012-07-01	9999-12-31	Detail service description is required for non-specific procedure codes, unless an NDC is present, also claims with incontinence products will need to include the product code in the detail service description or service line NTE; or the claim will be rejected.	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. Also, claims with incontinence products will need to include the product code in the detail service description (SV101-7, SV202-7, or SV301-7) or Service Line NTE, or the claim will be rejected.
PW00083	P	I	N/A	REJECT	A6	453				2012-06-15	9999-12-31	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	REJECT	A7	728				2012-06-01	9999-12-31	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	REJECT	A6	562	560	135	71	2012-06-15	9999-12-31	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	REJECT	A6	562	560		82	2012-06-15	9999-12-31	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	REJECT	A6	562	560	135	DN	2012-06-15	9999-12-31	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	REJECT	A6	673	560			2012-06-01	9999-12-31	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	REJECT	A6	562	560		71	2012-06-18	9999-12-31	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	REJECT	A7	187	188			2012-07-01	9999-12-31	If the Service Date is outside the Statement from and Statement through date, claim will be rejected, unless one of the service lines contain Revenue Code 0022 and Bill Type is 21x or Revenue Code is 0023 and Bill Type is 32x.	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 one of the service lines (Loop 2400)contain Revenue Code 0022 (SV201) and Bill Type is 21x (CLM05-1) or Revenue Code is 0023 (SV201) and Bill Type is 32x (CLM05-1).
PW00093	P	I	N/A	REJECT	A6	306				2012-07-03	9999-12-31	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.
PW00094	P	I	D	REJECT	N/A	N/A				2012-08-16	9999-12-31	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	REJECT	A6	719	159		IL	2012-11-13	9999-12-31	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	REJECT	A7	507	228			2012-11-13	9999-12-31	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	REJECT	A6	216	659			2012-12-14	9999-12-31	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	REJECT	A6	231				2013-04-23	9999-12-31	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	REJECT	A6	244	245			2013-02-22	9999-12-31	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	REJECT	A7	244	245			2013-02-22	9999-12-31	When a claim contains CPT codes 41820, 41828, 41872, or 41874, the oral cavity designations or tooth numbers that were submitted, must be valid or the claim will be rejected.	When a claim contains CPT codes 41820, 41828, 41872, or 41874(SV101-2), the K3 segment must contain a valid oral cavity designations or tooth numbers based on the qualifier submitted (JO or JP). Ex (K3*JOUA~ or K3*JP12 14~)
PW00101	N/A	I	N/A	REJECT	A6	234				2013-04-23	9999-12-31	Patient status code is required on Institutional claims.	Patient status code (CL103) is required on Institutional claims.
PW00103	P	I	D	REJECT	A7	503			85	2013-04-23	9999-12-31	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	REJECT	A7	503			77	2013-04-23	9999-12-31	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	REJECT	A7	562	135	128	85	2013-06-01	9999-12-31	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	REJECT	A7	234				2013-04-26	9999-12-31	If the bill type ends in a "1" or "4" and the patient status is "30," the claim will be rejected.	If the claim frequency code (CLM05-3) ends in a "1" or "4" and the patient status code (CL103) is equal to "30," the claim will be rejected.
PW00109	P	N/A	N/A	REJECT	A6	562			DK	2013-08-24	9999-12-31	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.
PW00110	N/A	I	N/A	REJECT	A6	562			72	2013-09-15	9999-12-31	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	REJECT	A6	562			ZZ	2013-09-15	9999-12-31	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	REJECT	A7	560	135		71	2013-09-18	9999-12-31	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	REJECT	A7	560	135		82	2013-09-18	9999-12-31	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	REJECT	A7	560	135		DN	2013-09-18	9999-12-31	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	REJECT	A7	228				2014-01-13	9999-12-31	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	REJECT	A6	216				2013-08-24	9999-12-31	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.
PW00119	P	I	N/A	REJECT	A6	306				2013-08-24	9999-12-31	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	REJECT	A7	228				2013-10-01	9999-12-31	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	REJECT	A7	476				2013-12-05	9999-12-31	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	REJECT	A7	187	158		IL	2013-12-15	9999-12-31	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	REJECT	A7	189	187			2014-01-09	9999-12-31	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	REJECT	A6	763	740			2014-01-17	9999-12-31	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, A0434, A0435, or A0436 require 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	REJECT	A6	763	725	455		2014-01-17	9999-12-31	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 revenue code 054x require 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	REJECT	A7	477				2014-03-17	9999-12-31	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.

PW00129	P	I	N/A	REJECT	A6	218				2014-09-29	9999-12-31	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	REJECT	A7	254				2015-03-18	9999-12-31	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	REJECT	A7	189	188			2014-03-17	9999-12-31	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	REJECT	A7	228	455	507		2014-03-17	9999-12-31	Claims for Medicare members will be rejected if the claim contains an outpatient TOB 13x, 14x, 23x, 34x, 43x, 71x, 72x, 74x,75x, 76x, 77x, 79x, 81x, 82x, 83x, or 85x and one or more of the following revenue codes: 0500, 0509, 0583, 0660 – 0663, 0669, 0905 – 0907, 0931, or 0932, unless the claim has a TOB 85x and the procedure code has been entered into the Edi Edit Codes table "MEDICARE_NONCOV_COMMERCIAL_NON." *(These revenue codes are not recognized by Medicare if billed on outpatient claims.)*	Claims for Medicare members will be rejected if the claim contains an outpatient Facility Type Code (Loop 2300 CLM05-1) 13x, 14x, 23x, 34x, 43x, 71x, 72x, 74x,75x, 76x, 77x, 79x, 81x, 82x, 83x, or 85x and one or more of the following revenue codes: 0500, 0509, 0583, 0660 – 0663, 0669, 0905 – 0907, 0931, or 0932, unless the claim has a TOB 85x and the procedure code has been entered into the Edi Edit Codes table "MEDICARE_NONCOV_COMMERCIAL_NON." *(These revenue codes are not recognized by Medicare if billed on outpatient claims.)*
PW00134	N/A	I	N/A	REJECT	A6	460				2014-04-14	9999-12-31	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	REJECT	A6	286				2014-04-14	9999-12-31	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	REJECT	A6	719				2014-05-08	9999-12-31	When claims are submitted with revenue code 0022 and the claim doesn't include a HIPPS code containing "AAAxx" or "ZZZZZ," the claim will be rejected, unless the claim includes occurrence code "50" or the TOB="18x" and the taxonomy code 282NC0060X is included on the 837 claim.	When claims are submitted with Revenue Code (SV201) "0022" and the claim doesn't include a HIPPS Code (SV202-2) containing "AAAxx" or "ZZZZZ" where (SV202-1)="HP," the claim will be rejected, unless the EDI claim data includes Occurrence Code (HI01-2:HI12-2, where HI01-1:HI12-1=BH) "50" or the Facility Type Code (Loop 2300 CLM05-1)="18x" and the taxonomy code (Loop 2000A PRV03) 282NC0060X is included on the 837 claim.
PW00138	N/A	I	N/A	REJECT	A6	254	255	228		2014-07-16	9999-12-31	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."

PW00139	N/A	I	N/A	REJECT	A7	510	188			2016-08-01	9999-12-31	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: A4244-A4290, B4034-B5200, B9000-B9999, E0776-E0791, E0910-E0948, S0012-S0208, S0210-S0214, S0216-S5099, S5200-S9122, S9124-S9999, 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: A4244-A4290, B4034-B5200, B9000-B9999, E0776-E0791, E0910-E0948, S0012-S0208, S0210-S0214, S0216-S5099, S5200-S9122, S9124-S9999, the claim will be rejected.
PW00140	P	I	D	REJECT	A7	510	187			2016-08-01	9999-12-31	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: A4244-A4290, B4034-B5200, B9000-B9999, E0776-E0791, E0910-E0948, S0012-S0208, S0210-S0214, S0216-S5099, S5200-S9122, S9124-S9999, 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: A4244-A4290, B4034-B5200, B9000-B9999, E0776-E0791, E0910-E0948, S0012-S0208, S0210-S0214, S0216-S5099, S5200-S9122, S9124-S9999, the claim will be rejected.
PW00141	N/A	I	N/A	REJECT	A6	233				2014-07-16	9999-12-31	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	REJECT	A7	21	481		82	2014-08-16	9999-12-31	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	REJECT	A7	21	247		82	2014-08-16	9999-12-31	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.
PW00145	P	I	D	REJECT	A7	145			85	2015-03-17	9999-12-31	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	REJECT	A7	145			71	2015-03-17	9999-12-31	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	REJECT	A7	145			DN	2015-03-17	9999-12-31	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.
PW00148	P	N/A	D	REJECT	A7	145			82	2015-03-17	9999-12-31	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	REJECT	A7	145			AS	2015-03-17	9999-12-31	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	REJECT	A7	218				2015-05-11	9999-12-31	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.

PW00152	N/A	I	N/A	REJECT	A7	228				2015-03-17	9999-12-31	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, except when the TOB=13J. (13J is only allowed when member has Medicare primary.)	When a CAH submits an 837I claim and the claim contains Facility Type Code (CLM05-1)="13" or "83," the claim will be rejected back to the provider unless the claim frequency="J" with the Facility Type Code "13." (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.) (13J is only allowed when member has Medicare primary.)
PW00154	P	I	D	REJECT	A8	164			IL	2015-02-26	9999-12-31	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	REJECT	A7	158			IL	2015-02-26	9999-12-31	The subscriber's DOB does not exist or does not match the South Country DOB from the DHS Enrollment file. All members are their own policy holder and should be listed as the subscriber including minors.	The subscriber's date of birth (Loop 2010BA, DMG02) does not exist or does not match the South Country DOB from the DHS Enrollment file. All members are their own policy holder and should be listed as the subscriber including minors.
PW00157	P	I	D	REJECT	A7	88			IL	2015-02-26	9999-12-31	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	REJECT	A6	489	252		PR	2015-03-18	9999-12-31	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	REJECT	A6	464				2015-05-11	9999-12-31	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, through June 30, 2019.	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, through June 30, 2019.
PW00160	P	N/A	D	REJECT	A7	464				2015-05-11	9999-12-31	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, through June 30, 2019.	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, through June 30, 2019.
PW00161	P	I	N/A	REJECT	A7	512	724			2015-03-17	9999-12-31	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	REJECT	A7	481				2015-05-12	9999-12-31	Payers are required to forward FQHC/RHC claims for non-Medicare members to DHS (MHCP) for payment for service date through 06/30/2019; 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 for service date through 06/30/2019, 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	REJECT	A7	743	562		82	2015-05-13	9999-12-31	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, through June 30, 2019.	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, through June 30, 2019.
PW00164	P	I	N/A	REJECT	A7	88	229	234	IL	2015-05-13	9999-12-31	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	REJECT	A7	228	507			2015-11-23	9999-12-31	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	REJECT	A7	745	560		85	2015-05-12	9999-12-31	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	REJECT	A7	187				2015-06-30	9999-12-31	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.
PW00170	P	I	N/A	REJECT	A6	453				2015-07-20	9999-12-31	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	REJECT	A3	746				2015-08-05	9999-12-31	Trading partners cannot submit a duplicate 837 submission file. This claim file has already been received and processed.	Trading partners cannot submit the same interchange control number (ISA13). If ISA13 number, is the same number that was submitted in a previous 837 file, the claims will be rejected.
PW00172	N/A	I	D	REJECT	A7	476				2015-07-29	9999-12-31	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, D9243, and D9990.	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, D9243, and D9990.
PW00175	N/A	I	N/A	REJECT	A7	234				2015-09-03	9999-12-31	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	REJECT	A7	234				2015-10-09	9999-12-31	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	REJECT	A6	721	460			2015-11-19	9999-12-31	Claims submitted with TOB 211, 212, 213, 214, 217, or 18x and Revenue Code 0022 must include the occurrence span code "70"; if not included, the condition code DR or 57 must be present 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); if not included, the condition code DR or 57 (HI0x-2, when HI0x-1=BG) must be present or the claim will be rejected.

PW00178	P	N/A	N/A	REJECT	A7	453				2015-11-19	9999-12-31	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).
PW00179	P	N/A	N/A	REJECT	A6	453				2015-11-19	9999-12-31	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	REJECT	A7	453				2015-11-19	9999-12-31	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	REJECT	A6	725				2016-01-20	9999-12-31	Claims submitted with a "statement through" date after 10/01/2015 and a TOB equal to 11x or 86x must include the NUBC value code "80" and/or "81" or the claim will be rejected.	Claims submitted with a "statement through" date after 10/01/2015 (DTP03 where DTP01=434) and a facility type code equal to 11x or 86x (CLM05-1) must include the value code "80" and/or "81" (HI0x-2, when HI0x-1=BE) or the claim will be rejected.
PW00182	N/A	I	N/A	REJECT	A6	725				2016-01-21	9999-12-31	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 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, 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	REJECT	A7	700	255	726		2016-01-21	9999-12-31	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	REJECT	A7	725	726	258		2016-01-20	9999-12-31	For claims submitted with a "statement through" date on or after 10/01/2015, a TOB equal to 11x or 86x, and a NUBC value code of "80" and "81" (if present), the value amount must match the room and board charges or the claim will be rejected.	For claims submitted with a "statement through" date after 10/01/2015 (DTP03 where DTP01=434), a facility type code equal to 11x or 86x (CLM05-1), and a 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) or the claim will be rejected.
PW00185	P	I	N/A	REJECT	A7	476				2015-12-16	9999-12-31	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.

PW00186	P	I	N/A	REJECT	A6	507	453			2016-02-05	9999-12-31	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	REJECT	A7	228				2016-02-05	9999-12-31	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.
PW00190	P	I	N/A	DENIAL						2016-01-15	9999-12-31	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 denied.	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 denied. Vaccine codes and administration codes are updated annually in the EDI Edit Code table.
PW00191	P	I	N/A	REJECT	A6	453				2016-01-27	9999-12-31	When member's age is < 18 and claim includes procedure code T2023, 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) T2023, 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	REJECT	A7	254	255	509		2016-01-15	9999-12-31	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	REJECT	A6	453				2016-01-27	9999-12-31	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	REJECT	A6	562	453		77	2016-01-28	9999-12-31	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.
PW00197	P	N/A	N/A	REJECT	A7	562			77	2016-01-28	9999-12-31	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	REJECT	A7	228	454			2016-02-08	9999-12-31	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	REJECT	A7	659				2016-02-24	9999-12-31	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	REJECT	A7	275	247	562	82	2016-03-02	9999-12-31	Claims with service dates prior to 01/01/2024 cannot have the rendering provider's NPI at the claim or line level be a doula provider's NPI or the claim will be rejected.	Claims with service dates prior to 01/01/2024 cannot have the rendering provider's NPI at the claim (2310B) or line (2420B) level be a doula provider (payer system provider specialty="DL") NPI (NM109) or the claim will be rejected.
PW00201	P	N/A	N/A	REJECT	A6	275	247	562	82	2016-03-02	9999-12-31	For claims with service dates prior to 01/01/2024 billed by a doula provider, 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.	For claims with service dates prior to 01/01/2024 being billed by a doula provider (Loop 2010AA) where the payer system 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	REJECT	A7	481				2016-05-18	9999-12-31	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	REJECT	A7	453				2016-05-18	9999-12-31	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	REJECT	A7	453				2016-05-18	9999-12-31	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.
PW00205	P	I	N/A	REJECT	A7	562	453		82	2016-05-18	9999-12-31	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	REJECT	A7	228	455	507		2016-05-25	9999-12-31	For Medicare claims with TOB="77x" where the claim does not have at least one of the revenue code/HCPCS code combinations of 052x or 0519 and G0466, G0467, G0468, G2025 or revenue code/HCPC code combination of 0900 or 0519 and G0469, G0470, or G2025, the claim will be rejected, except with the revenue code/HCPCS code combination of 052x and G0008 or G0009.	For Medicare claims with the facility type code (CLM05-1)="77" where the claim does not have at least one of the revenue code/HCPCS code combinations of 052x or 0519 (SV201) and G0466, G0467, G0468, or G2025 (SV202-2) or revenue code/HCPC code combination of 0900 or 0519 (SV201) and G0469, G0470, or G2025 (SV202-2), the claim will be rejected, except with the revenue/HCPCS code combination of 052x (SV201) and G0008 or G0009 (SV202-2).
PW00207	N/A	I	N/A	REJECT	A7	228	455	507		2016-05-25	9999-12-31	For Medicare claims with TOB="77x" where the claim service line contains revenue code 029x, 054x, or one of the non-covered FQHC procedure codes listed in the EDI Edit Codes table, 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 or 054x or if the procedure code (SV202-2) is included in the EDI Edit Codes table, the claim will be rejected.
PW00208	P	I	N/A	REJECT	A7	453	454	490		2016-05-24	9999-12-31	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	REJECT	A7	21	625			2016-06-28	9999-12-31	When a Predetermination of Dental Benefits claim is received, the claim will be rejected, except for the exception codes D8010-D8090, D8670, and D8999.	When a Predetermination of Dental Benefits claim (CLM19=PB) is received, the claim will be rejected, except for the exception codes D8010-D8090, D8670, and D8999 (SV301-2).
PW00211	P	N/A	N/A	REJECT	A6	562	560	135	DN	2017-03-14	9999-12-31	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	REJECT	A6	562	560	135	DK	2017-03-14	9999-12-31	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.
PW00214	P	I	D	REJECT	A7	743			85	2016-07-11	9999-12-31	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	REJECT	A7	743			82	2016-07-11	9999-12-31	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	REJECT	A6	562	560	135	82	2016-07-11	9999-12-31	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	REJECT	A7	562	560		82	2016-07-11	9999-12-31	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	REJECT	A7	460				2016-07-08	9999-12-31	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	REJECT	A7	460	455	188		2016-07-08	9999-12-31	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	REJECT	A7	476				2016-07-28	9999-12-31	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	REJECT	A7	157			IL	2016-07-07	9999-12-31	If the subscriber's gender 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 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.
PW00222	P	N/A	N/A	REJECT	A7	741			82	2016-08-24	9999-12-31	When specific CPT codes or CPT/Modifier 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) or CPT/Modifier (SV101-2_SV101-3_SV101-6) 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	REJECT	A7	741			85	2016-08-24	9999-12-31	When specific CPT codes or CPT/Modifier 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) or CPT/Modifier (SV101-2_SV101-3_SV101-6) 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.
PW00230	N/A	I	D	REJECT	A8	507				2016-08-15	9999-12-31	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.
PW00232	P	I	N/A	REJECT	A7	453	507			2016-08-23	9999-12-31	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	REJECT	A7	453	507			2016-08-17	9999-12-31	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	REJECT	A7	453				2016-08-17	9999-12-31	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	REJECT	A7	507	187	453		2017-01-01	9999-12-31	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.
PW00236	N/A	I	N/A	REJECT	A7	507	228			2017-01-05	9999-12-31	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	REJECT	A7	507	455			2017-01-05	9999-12-31	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	REJECT	A6	453	507			2017-02-01	9999-12-31	When billing CTSS services using HCPCS code H0031 or H2012 for a member who is under age 18, you must include modifier "UA" or "UB" or the claim will be rejected.	When billing CTSS services using HCPCS code H0031 or H2012 (SV101-2) for a member who is under age 18 (Loop 2010CA or 2010BA DMG02), you must include modifier "UA" or "UB" (SV101-3 – SV101-6) or the claim will be rejected.
PW00239	P	N/A	N/A	REJECT	A6	453	507			2017-02-02	9999-12-31	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	REJECT	A7	453	507			2017-02-02	9999-12-31	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	REJECT	A7	453				2017-02-08	9999-12-31	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).

PW00243	P	N/A	D	REJECT	A7	187	507			2017-02-16	9999-12-31	Claims that include service dates billed across multiple months will be rejected unless Medicare is the primary payer and has paid, or the claim includes one of the following HCPCS codes without the HC, PZ, or S3 modifier: B9000–B9999, S0012–S0208, S0210–S0214, S0216–S5099, S5200–S9122, S9124–S9999, E0776–E0791, B4034–B5200, A4238, A4239, A4244–A4290, or E0910–E0948.	Claims that include service dates (Loop 2400, DTP03 where DTP01=472) spanning multiple months will be rejected unless Medicare is the primary payer and has paid, or the claim includes one of the following HCPCS codes (SV101-2, SV301-2) without the HC, PZ, or S3 modifier (SV101-3 to SV101-6, SV202-3 to SV202-6): B9000–B9999, S0012–S0208, S0210–S0214, S0216–S5099, S5200–S9122, S9124–S9999, E0776–E0791, B4034–B5200, A4238, A4239, A4244–A4290, or E0910–E0948.
PW00244	P	I	N/A	REJECT	A7	453				2017-02-08	9999-12-31	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	REJECT	A7	460				2017-07-01	9999-12-31	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.
PW00246	N/A	I	N/A	REJECT	A7	460	228			2017-02-16	9999-12-31	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	REJECT	A7	507	562		82	2017-03-10	9999-12-31	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	REJECT	A7	562	741	88	P3	2017-02-20	9999-12-31	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates on the claim will be validated to these dates.	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates (Loop 2400 DTP03 where DTP01=472) on the claim will be validated to these dates.
PW00249	N/A	N/A	D	REJECT	A7	562	741	88	DD	2017-02-20	9999-12-31	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates on the claim will be validated to these dates.	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. If the NPI in the NPPES Registry has a deactivated or reactivated date, the service dates (Loop 2400 DTP03 where DTP01=472) on the claim will be validated to these dates.
PW00250	N/A	I	N/A	REJECT	A6	725	507			2017-02-24	9999-12-31	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	REJECT	A6	731	507			2017-02-24	9999-12-31	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	REJECT	A6	453	507			2017-02-23	9999-12-31	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.	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.
PW00254	P	N/A	D	REJECT	A7	453	249			2017-02-23	9999-12-31	When professional telehealth claims/charges are received with modifier "GQ," the POS should be "02" or "10," or the claim will be rejected. If the claim is received after 5/12/2023 with modifier "GT" or modifier "95"(Medicaid only), it will also be rejected if the claim doesn't include the POS "02" or "10." Claims will not be rejected if Medicare has paid.	When 837P telehealth claims/charges are received with a modifier (SV101-3, 4, 5, 6) "GQ," the POS (CLM05-1) should be "02" or "10," or the claim will be rejected. If the claim is received after 5/12/2023 with modifier (SV101-3, 4, 5, 6) "GT" or modifier "95" (Medicaid only), it will also be rejected if the claim doesn't include the POS "02" or "10." Claims will not be rejected if Medicare has paid.
PW00255	P	N/A	N/A	REJECT	A7	249	507			2017-02-23	9999-12-31	When professional telehealth claims/charges are received with POS "02," "04," "10," "12," "16," or "27" and HCPCS code Q3014, the claim will be rejected.	When 837P telehealth claims/charges are received with POS (CLM05-1) "02," "04," "10," "12," "16," or "27" and HCPCS code (SV101-2) Q3014, the claim will be rejected.
PW00256	P	N/A	N/A	REJECT	A7	507	453			2017-02-23	9999-12-31	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	REJECT	A7	507				2017-03-16	9999-12-31	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.
PW00259	N/A	I	N/A	REJECT	A7	460	228			2017-02-23	9999-12-31	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	REJECT	A7	720	722	460		2017-02-23	9999-12-31	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	REJECT	A6	562			DQ	2017-02-23	9999-12-31	When a claim is submitted with the rendering provider as a community health worker, the supervising provider must be present on the claim and validated against the PECD file or, if the supervising provider is a certified public health nurse or a registered nurse, then the billing provider must be found in the PECD file 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 and validated against the PECD or, if the supervising provider (Loop 2420D/2310D NM109) is a certified public health nurse (specialty=45) or a registered nurse (specialty=75), then the billing provider (2010AA) must be found in the PECD file or the claim will be rejected.
PW00264	P	N/A	D	REJECT	A7	775			82	2017-05-02	9999-12-31	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	REJECT	A7	775			QB	2017-05-02	9999-12-31	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	REJECT	A6	562	560	135	71	2017-03-14	9999-12-31	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	REJECT	A7	453	228			2017-03-17	9999-12-31	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	REJECT	A7	743			DN	2017-04-21	9999-12-31	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	REJECT	A7	743			DK	2017-04-21	9999-12-31	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	REJECT	A7	743			71	2017-04-21	9999-12-31	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	REJECT	A7	743			72	2017-04-21	9999-12-31	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	REJECT	A7	743			ZZ	2017-04-21	9999-12-31	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.
PW00274	P	N/A	D	REJECT	A7	743			DQ	2017-04-21	9999-12-31	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	REJECT	A7	743			QB	2017-04-21	9999-12-31	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	REJECT	A7	743			P3	2017-04-21	9999-12-31	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	REJECT	A7	743			DD	2017-04-21	9999-12-31	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	REJECT	A7	258	228	455		2017-04-11	9999-12-31	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	REJECT	A7	453	455			2017-04-11	9999-12-31	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	REJECT	A7	228				2017-04-26	9999-12-31	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	REJECT	A7	507	453	187		2017-05-19	9999-12-31	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 month of 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 month of the DOS (Loop 2400 DTP03 where DTP01=472), the claim will be rejected.
PW00282	P	I	N/A	REJECT	A7	507	453	187		2017-05-19	9999-12-31	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 month of 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 month of the DOS (Loop 2400 DTP03 where DTP01=472), the claim will be rejected.
PW00283	P	I	N/A	REJECT	A7	507	453	187		2017-05-19	9999-12-31	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 month of 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 month of the DOS (Loop 2400 DTP03 where DTP01=472), the claim will be rejected.
PW00284	P	I	N/A	REJECT	A7	507	453	187		2017-05-19	9999-12-31	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 month of 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 month of the DOS (Loop 2400 DTP03 where DTP01=472), the claim will be rejected.

PW00285	N/A	I	N/A	REJECT	A7	188				2017-05-22	9999-12-31	When a claim is received with the statement "from" and "through" dates spanning multiple months, the claim will be rejected, except when the TOB=11x, 12x, 18x, 86x, or 33x, or the claim includes at least one revenue code 762 or 450, or claim has a TOB 32x with revenue code 0023 and a Gxxxx code on another line, or TOB=211, 214 or 217 and statement "through" date is the first of the month and the patient status is not equal to 30, or TOB=34x and patient 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 revenue code (SV201)=0023 and a Gcode (SV202 - 2)on another line, or Facility Type Code (CLM05-1)=211, 214 or 217 and statement through date is the first of the month and the patient status (CL103) is not=30, or Facility Type Code (CLM05-1)=34x and patient status (CL103)=01.
PW00288	P	I	N/A	REJECT	A7	116	507	453		2017-07-21	9999-12-31	When a claim is received with a HCPCS code or HCPCS/modifier that is covered/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	REJECT	A6	460	228	725		2017-08-22	9999-12-31	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	REJECT	A6	725	228	460		2017-08-22	9999-12-31	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	REJECT	A7	507	562		82	2017-10-27	9999-12-31	When a claim contains certain mental, substance use disorder, or housing stabilization 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 a UMPI as the billing provider.	When a claim contains certain mental , substance use disorder, or housing stabilization 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) is checked. If the claim is submitted with a UMPI as the billing provider, the claim is excluded from this edit.
PW00293	P	I	D	REJECT	A7	743			85	2018-01-30	9999-12-31	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	REJECT	A7	743			82	2018-01-30	9999-12-31	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.

PW00295	N/A	I	N/A	REJECT	A7	507	453	455		2018-01-25	9999-12-31	ESRD claims (TOB 72x) excluding acute kidney injury (AKI) patients (condition code 84) and service dates starting in 2020 will need to include modifier "AX" when billing HCPCS code J0604 or J0606 or if claim includes modifier "AX," then 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) and service dates (Loop 2400 DTP03) starting in 2020 (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	REJECT	A7	507	460			2018-01-25	9999-12-31	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	REJECT	A7	507	453	460		2018-01-25	9999-12-31	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	REJECT	A7	743			DN	2018-01-30	9999-12-31	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	REJECT	A7	743			DK	2018-01-30	9999-12-31	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.
PW00300	N/A	I	N/A	REJECT	A7	743			71	2018-01-30	9999-12-31	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	REJECT	A7	743			72	2018-01-30	9999-12-31	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	REJECT	A7	743			ZZ	2018-01-30	9999-12-31	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	REJECT	A7	743			DQ	2018-01-30	9999-12-31	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	REJECT	A7	743			QB	2018-01-30	9999-12-31	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.
PW00305	P	N/A	D	REJECT	A7	743			P3	2018-01-30	9999-12-31	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	REJECT	A7	743			DD	2018-01-30	9999-12-31	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	REJECT	A6	556				2018-02-15	9999-12-31	Professional and Institutional claims that contain a principle or secondary diagnosis code "Z00.6" and modifier Q0 and/or Q1, will need to include the National Clinic Trial (NCT) number, or the claim will be rejected, unless the CPT Code 33240, 33241, 33243, 33244 or 33249, is on the claim. The NCT Number needs to be in the Demonstration Project ID(837I or 837P) or for the 837I it could be included in the Value Code Amount where value code is D4.	837P and 837I claims that contain a principle or secondary diagnosis code "Z00.6"(Loop 2300-HI0x-2 when HI0x-1=ABK or HI0x-2 when HI0x-1=ABF) and modifier Q0 and/or Q1, (Loop 2400-SV101-3:SV101-6/SV202-3:SV202-6). The National Clinic Trial (NCT) number will need to be included on the claim or the claim will be rejected, unless the CPT Code is 33240, 33241, 33243, 33244 or 33249(Loop 2400-SV202-2), is present. The NCT Number needs to sent in the Demonstration Project ID (837I or 837P) (Loop2300-REF02 when REF01=P4), or for the 837I the NCT can be located in the Value Code Amount where value code is D4 (Loop 2300-HI0x-5, when HI0x-1=BE and HI0x-2= D4).
PW00308	P	I	N/A	REJECT	A6	254	255	460		2018-02-15	9999-12-31	When the claim contains a Demonstration Project ID (837I or 837P) or the value code "D4" referencing the National Clinical Trial (NCT) number (837I) and the claim contains a principle/secondary diagnosis code "Z00.6" and modifier Q0 and/or Q1, the claim must include both the diagnosis code and modifier Q0 and/or Q1. If the claim is an Institutional claim, the condition code "30" is also required or the claim will be rejected.	When the claim contains the Demonstration Project ID (Loop2300-REF02 when REF01=P4) (837I or 837P) or the value code "D4" (Loop 2300-HI0x-5, when HI0x-1=BE and HI0x-2= D4) referencing the National Clinical Trial (NCT) number and the claim contains a principle/secondary diagnosis code "Z00.6" (Loop 2300-HI0x-2 when HI0x-1=ABK or HI0x-2 when HI0x-1=ABF) and/or modifier Q0 and/or Q1 (Loop 2400-SV101-3:SV101-6/SV202-3:SV202-6), the claim must include both the diagnosis code "Z00.6" (Loop 2300-HI0x-2 when HI0x-1=ABK or HI0x-2 when HI0x-1=ABF), and modifier Q0 and/or Q1 (Loop 2400-SV101-3:SV101-6/SV202-3:SV202-6). If the claim is an 837I, the condition code 30 (Loop 2300-HI0x-2, when HI0x-1=BG) is also required or the claim will be rejected.
PW00309	P	I	N/A	REJECT	A6	286	643			2018-03-15	9999-12-31	When 837 Professional or 837 OP Institutional claims (excluding nonpayment and voids) are submitted from a provider and the prior payer was Medicare or a Medicare replacement payer, the prior payment information must be reported at the line level or the claim will be rejected.	When 837P claims 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 and the prior payer was Medicare or a Medicare replacement payer (Loop 2320 [SBR09]=MA or MB), the prior payment information must be reported at the line level (Loop 2430) or the claim will be rejected.
PW00310	P	I	N/A	REJECT	A7	116				2018-03-21	9999-12-31	When an 837 Professional or Institutional claim includes an abortion diagnosis codes O04.xxx or Z33.2 or abortion CPT codes 59840, 59841, 59850-59852, 59855 - 59857, or S0190 and S0191 are billed together on the same claim for the same DOS, the claim will be rejected. The claims need to be submitted to MHCP.	When an 837 Professional or Institutional claim includes abortion diagnosis codes O04.xxx or Z33.2 (Loop 2300 - HI01-2:HIxx-2, when HI01-1:HIxx-1="'ABF', 'ABJ', 'ABK', 'ABN', 'APR'".) or abortion CPT codes 59840, 59841, 59850-59852, 59855 - 59857, or S0109 and S0191 when billed together on the same claim for the same DOS, Loop 2400 SV202-2 (Institutional) or Loop 2400 SV101-2 (Professional), the claim will be rejected. The claims need to be submitted to MHCP.
PW00311	N/A	I	N/A	REJECT	A6	453	455	454		2018-02-28	9999-12-31	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.
PW00312	P	N/A	N/A	REJECT	A7	562	135		82	2018-03-26	9999-12-31	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.

PW00316	P	I	D	REJECT	A7	171				2018-04-04	9999-12-31	When a claim has been adjusted because of subrogation, we cannot receive a void for that claim from the provider. The rejection will occur when the 837 claim type of bill=8, and the claim remarks in the payer's system contains a claim remark "RM" with an identification code "SR."	When a claim has been adjusted because of subrogation, we cannot receive a void for that claim from the provider. The rejection will occur when the 837 claim has a claim frequency (Loop 2300 CLM05-3)=8, and the claim remarks in the payer's system contains a claim remark "RM" with an identification code "SR."
PW00317	P	N/A	N/A	REJECT	A7	453				2018-04-11	9999-12-31	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	REJECT	A7	454				2018-04-05	9999-12-31	When claims are received for MSHO or Medicare/Medicaid members age 21 and over with a disability billing for the procedure code G9878, G9879, or G9888 for the 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 Medicare/Medicaid members age 21 and over with a disability billing for the procedure code G9878, G9879, or G9888 (Loop 2400 SV101-2 or SV202-2) for the 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.
PW00319	P	I	N/A	REJECT	A7	453				2018-04-05	9999-12-31	When claims are received for MSHO or SNBCDI members billing for the the Medicare Diabetes Prevention Program (MDPP), the procedure code G9873, G9880, G9881, G9886, or G9887 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 the Medicare Diabetes Prevention Program (MDPP), the procedure code (Loop 2400 SV101-2 or SV202-2) G9873, G9880, G9881, G9886, or G9887 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	REJECT	A6	453				2018-05-21	9999-12-31	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	REJECT	A7	453				2018-04-16	9999-12-31	When a claim includes procedure code T1016, the procedure code can only include the following modifiers: U4, TF, 52, U3, U6, U2, U5, or U8. If the member is over age 64, the T1016 procedure code could include any of the modifiers listed previously or the UC modifier. If other modifiers are included with procedure code T1016, the claim will be rejected. There are two exceptions: one is the U8 modifier–the procedure code T1016 can also include the HN modifier; the other exception is the U2 modifier–the procedure code T1016 can also include the TS modifier.	When a claim includes procedure code T1016 (SV101-2), the procedure code can only include the following modifiers: U4, TF, 52, U3, U6, U2, U5, or U8 (SV101-3 through SV101-6). If the member is over age 64, the procedure code could include any of the modifiers listed previously or the UC (SV101-3 through SV101-6) modifier. If other modifiers are included with procedure code T1016 (SV101-2), the claim will be rejected. There are two exceptions: one is the U8 modifier (SV101-3 through SV101-6)–the procedure code T1016 (SV101-2) can also include the HN modifier (SV101-3 through SV101-6); the other exception is the U2 modifier(SV101-3 through SV101-6)–the procedure code T1016 (SV101-2) can also include the TS modifier (SV101-3 through SV101-6).
PW00323	P	N/A	N/A	REJECT	A7	453	507			2018-05-07	9999-12-31	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.

PW00324	P	N/A	N/A	REJECT	A6	306				2018-08-08	9999-12-31	When public transit claims include HCPCS code A0130, T2003, or T2005 and the modifier "UC" or "U6" is not in any position, the claim must include the driver's license number in the Service Line Description Field or the claim will be rejected.	When public transit claims (provider specialty “S2” or “T2”) include HCPCS code (Loop 2400 SV101-2) "A0130," "T2003," or "T2005" and the modifier "UC" or "U6" (SV101-3 through SV101-6) is not in any position, then SV101-7 must include the driver's license number or the claim will be rejected. (The edit will check for no dashes or spaces. Number must be > 5 and < 25 and cannot be all 0s, 9s, or 12345, etc.).
PW00325	P	I	N/A	REJECT	A7	556	116			2018-08-08	9999-12-31	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	REJECT	A6	465	455			2019-03-26	9999-12-31	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.
PW00328	N/A	I	N/A	REJECT	A7	228	116			2018-08-10	9999-12-31	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.
PW00332	N/A	I	N/A	REJECT	A7	234				2018-10-29	9999-12-31	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	REJECT	A6	507	228	455		2018-11-13	9999-12-31	Institutional OP claims with TOB 13x, 22x, 23x, 83x, or 85x that include ambulance revenue code 054x require HCPCS code A0998 or one of the following HCPCS codes: A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 with one of the following mileage HCPCS codes: A0021, A0425, A0435, or A0436 or the claim will be rejected, unless the "QL" modifier is present on one of the service lines.	Institutional OP claims with Facility Type Code (CLM05-1) 13, 22, 23, 83, or 85 that include ambulance revenue code (SV201) 054x, require HCPCS code (SV101-2) A0998 or one of the following HCPCS codes (SV101-2): A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 with one of the following mileage HCPCS codes: A0021, A0425, A0435, or A0436 or the claim will be rejected, unless the "QL" modifier (SV202-3:SV202-6) is present on one of the service lines.
PW00337	N/A	I	N/A	REJECT	A6	721	455			2018-10-29	9999-12-31	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.
PW00338	P	I	N/A	REJECT	A7	187	188			2019-05-11	9999-12-31	As of 05/11/2019, any South Country Health Alliance professional or institutional claims received with a service from date (837P) or statement from date (837I) prior to 01/01/2018 will be rejected.	As of 05/11/2019, any South Country Health Alliance professional or institutional claims received with a service from date (837P [Loop 2400, DTP03 where DTP01=472]) or statement from date [837I(Loop 2300, DTP03 where DTP01=434)] prior to 01/01/2018 will be rejected.
PW00339	P	I	N/A	REJECT	A7	187	188			2020-07-01	9999-12-31	As of 07/1/2020, any South Country Health Alliance professional or institutional claims received with a service from date (837P) or statement from date (837I) prior to 01/01/2019 will be rejected.	As of 07/1/2020, any South Country Health Alliance professional or institutional claims received with a service from date (837P [Loop 2400, DTP03 where DTP01=472]) or statement from date (837I [Loop 2300, DTP03 where DTP01=434]) prior to 01/01/2019 will be rejected.

PW00340	N/A	I	N/A	REJECT	A7	228	145	455	85	2018-11-16	9999-12-31	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	REJECT	A7	562	228		85	2018-11-16	9999-12-31	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.
PW00342	P	N/A	N/A	REJECT	A7	507				2019-01-01	9999-12-31	As of 05/11/2019, any South Country Health Alliance claims that contain HCPCS code V2797 must also contain one of the following HCPCS codes: V2199, V2299, V2321, V2399, V2499, V2762, V2782, or V2783 or the claim will be rejected. Prior to 5/11/2019 only service dates > 12/31/2018 will be rejected if they do not contain one of the above HCPCS codes.	As of 05/11/2019, any South Country Health Alliance claims that contain HCPCS code V2797 (SV101-2) must also contain one of the following HCPCS codes (SV101-2) : V2199,V2299, V2321, V2399, V2499, V2762, V2782, or V2783 or the claim will be rejected. Prior to 5/11/2019 only service dates > 12/31/2018 (Loop 2400 DTP03, DTP01=472) will be rejected if they do not contain one of the above HCPCS codes.
PW00343	P	I	N/A	REJECT	A6	453	507			2019-01-01	9999-12-31	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.
PW00345	N/A	N/A	D	REJECT	A7	116	562	128	85	2019-01-03	9999-12-31	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.
PW00346	P	N/A	N/A	REJECT	A7	258	453			2019-03-14	9999-12-31	Claims with HCPCS codes A0100, A0130, T2001, T2003, or T2005; and with units greater than 2; and with no "UC" or "U6" modifier will be rejected, unless procedure code A0100 or T2003 contains modifier "52" or "TP" in any position. If two units are billed with the above HCPCS codes, two or more modifiers are required, or the claim will be rejected, unless the "UC" modifier is present.	When a claim contains HCPCS codes (SV101-2) A0100, A0130, T2001, T2003, or T2005; and units (SV104) are greater than 2; and modifier (SV101-3:SV101-6) “UC” or "U6" is not present, the claim will be rejected, unless procedure code (SV101-2) A0100 or T2003 contains modifier (SV101-3:SV101-6) "52" or "TP" in any position. If two units (SV104) are billed with the above HCPCS codes, two or more modifiers (SV101-3:SV101-6) are required, or the claim will be rejected, unless the "UC" modifier (SV101-3:SV101-6) is present.
PW00347	P	I	N/A	REJECT	A6	507				2019-03-14	9999-12-31	When a claim contains HCPCS code S0215 for mileage and the provider specialty is "95" for interpreter, the claim must include the HCPCS code T1013 or the claim will be rejected.	When a claim contains HCPCS code S0215 for mileage (Loop 2400 SV101-2 [Professional] or Loop 2400 SV202-2 [Institutional]) and the provider specialty is "95" for interpreter, the claim must include the HCPCS code T1013 or the claim will be rejected.
PW00348	P	N/A	N/A	REJECT	A7	507	453			2019-03-22	9999-12-31	When a claim contains HCPCS code S0215, S0209, or T2049 and doesn't include the modifier "UC," "U6," or "52," the claim will be rejected, unless the claim includes one of the following HCPCS codes: T2003, T2005, A0100, or A0130.	When a claim contains HCPCS code S0215, S0209, or T2049 (SV101-2) and doesn't include the modifier "UC," "U6," or "52" (SV101-3_ SV101-6), the claim will be rejected, unless the claim includes one of the following HCPCS codes: T2003, T2005, A0100, or A0130 (SV101-2).
PW00349	N/A	I	N/A	REJECT	A6	725				2019-03-26	9999-12-31	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	REJECT	A7	726				2019-03-26	9999-12-31	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	REJECT	A7	453				2019-03-26	9999-12-31	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	REJECT	A7	476	234	228		2019-05-13	9999-12-31	Providers billing for substance use disorder services TOB 86x with HCPCS code H2036 or Revenue Code 944, 945, or 953 can only include the "through" date in their billed units if the discharge status="30." If the discharge status does not="30," the number of days billed cannot include the statement "through/discharge" date, or the claim will be rejected.	Providers billing for substance use disorder Facility Type Code [Loop 2300 CLM05-1])"86" with HCPCS code (SV202-2) "H2036" or Revenue Code (SV201) 944, 945, or 953 can only include the "through" date in their billed units (SV205) if the discharge status (CL103)="30." If the discharge status (CL103) does not="30," the number of days billed (SV205) cannot include the statement "through/discharge" date, or the claim will be rejected.
PW00354	N/A	I	N/A	REJECT	A6	725				2019-05-13	9999-12-31	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.
PW00355	P	N/A	N/A	REJECT	A7	187				2019-07-22	9999-12-31	When a professional claim is billing a procedure code with a service date range and the same procedure code is billed with a service date within the service date range, the claim will be rejected for duplicate services billed. The edit will compare procedure codes, modifiers, service description, and NDC.	When a professional claim is billing a procedure code (SV101-2) with a service date range (Loop 2400 DTP03, DTP01=472 and DTP02=RD8) and the same procedure code (SV101-2) is billed with a service date (Loop 2400 DTP03, DTP01=472 and DTP02=D8) within the service date range, the claim will be rejected for duplicate services billed. The edit will compare procedure codes (SV101-2), modifiers (SV101-3_SV101-6), service description (SV101-7), and NDC (LIN03).
PW00356	N/A	I	N/A	REJECT	A6	507				2019-07-08	9999-12-31	When billing hospice claims (TOB 81x or 82x) that include revenue code 0651, 0652, 0655, or 0656, the claim must include one procedure code from Q5001 to Q5010, or the claim will be rejected.	When billing hospice claims (TOB 81x or 82x [Loop 2300 CLM05-1]) that include revenue code 0651, 0652, 0655, or 0656 (Loop 2400 SV201), the claim must include one procedure code from Q5001 to Q5010 (Loop 2400 SV202-2 [Institutional]), or the claim will be rejected.
PW00357	P	N/A	N/A	REJECT	A7	507				2019-05-13	9999-12-31	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	REJECT	A7	787				2019-05-29	9999-12-31	When the original claim was denied by the payer, the claim must be submitted as a new claim and not a voided claim. Providers cannot submit TOB frequency xx8 or include a payer claim control number on the claim, or the claim will be rejected.	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=8 (CLM05-3) or include a payer claim control number (REF02, REF01=F8) on the claim, or the claim will be rejected.

PW00361	N/A	I	N/A	REJECT	A7	228	455	507		2019-07-24	9999-12-31	Rural Health Clinic claims received with TOB 71x that include a procedure code on the CMS I/OCE non-covered list or a RHC non-covered revenue code: the claim will be rejected, unless the modifier GA or GY is present.	Rural Health Clinics Claims received with facility type code (CLM05-1)=71 and include a procedure code (SV202-2) or revenue codes (SV201) not covered by CMS will be rejected, unless the modifier GA or GY (SV202-3_6) is present. For use only by payer: The Edi Edit Codes table with EdiEditCodeType="TOB_71x_INVALID_CODES" and the EdiEditCodeField="PRODUCT_SERVICE_ID" or "Revenue_Code" will include the procedure codes and the revenue codes, respectively, that cannot be billed on a claim with a TOB "71x". Claims will be rejected unless the modifier GA or GY is present.
PW00362	P	I	D	REJECT	A3	116				2019-07-01	9999-12-31	Due to changes in the FQHC_RHC process for DOS 07-01-2019 going forward, payers are no longer required to forward Federally Qualified Health Center (FQHC) provider claims for non-Medicare members to DHS (MHCP) for payment. FQHC providers must submit non-Medicare member claims directly to DHS, unless the FQHC claim is part of the MinnesotaCare carve out or for claims with medical home procedure code S0280 or S0281. Those claims will be paid by the MCO as of July 1, 2019.	Due to changes in the FQHC_RHC (service facility [2310E]/billing provider [2010AA] [NPI]) process for DOS 07-01-2019 going forward, payers are no longer required to forward FQHC non-Medicare member claims (where 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) to DHS (MHCP) for payment. FQHC providers must submit non-Medicare member claims directly to DHS, unless the FQHC claim is part of the MinnesotaCare carve out or for claims with medical home procedure code S0280 or S0281. Those claims will be paid by the MCO as of July 1, 2019.
PW00363	P	N/A	D	REJECT	A6	464				2019-07-01	9999-12-31	When replacement or void claims for a non-Medicare member are from a Rural Health Clinic (RHC) provider, the payer claim control number must contain the DHS claim control number (TCN), unless the RHC claim is part of the MinnesotaCare carve out or the claim includes a medical home procedure code S0280 or S0281. Those claims will be paid by the managed care organization (MCO) as of July 1, 2019.	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 RHC provider, the payer claim control number (REF02, REF01=F8) must contain the DHS claim control number (TCN), unless the RHC claim is part of the MinnesotaCare carve out or the claim includes a medical home procedure code S0280 or S0281. Those claims will be paid by the managed care organization (MCO) as of July 1, 2019, so the claims will not have a DHS claim control number (TCN).
PW00364	P	N/A	D	REJECT	A7	464				2019-07-01	9999-12-31	When a replacement or void claim for a non-Medicare member is from an RHC provider, and contains an invalid payer claim control number or the claim information doesn't match the original claim, the claim will be rejected. The payer claim control number will be validated against the TCN file from DHS that South Country receives through Cirdan, when the TCN starts with a 0, 1, 2, 5, 8, or 9. If South Country hasn't haven't received a recent DHS TCN file from Cirdan, South Country will continue to check the payer claim control number to ensure that: 1) it is 17 characters long; 2) it starts with a 0, 1, 2, 4, 5, 8, or 9; 3) the second and third digits are not greater than the last two digits of the current year (e.g., 23); and 4) the fourth through sixth digits do not correspond to a Julian date later than the latest Julian date from the Cirdan file. If the RHC claim is part of the MinnesotaCare carveout or the claim includes a medical home procedure code of S0280 or S0281, it will be paid by the MCO as of July 1, 2019.	When a replacement or void claim (frequency=7 or 8 [CLM05-3])for a non-Medicare RHC provider contains an invalid payer claim control number or the claim information doesn't match the original claim, the claim will be rejected. The payer claim control number (REF02, REF01=F8) must be included in the TCN file South Country received from Cirdan (etl.etl.DHS_TCN_To_Amisys_Claim_Xref), when the TCN starts with a 0, 1, 2, 5, 8, or 9. If South Country hasn't received a recent DHS TCN file from Cirdan, South Country will continue to check the payer claim control number to ensure that: 1) it is 17 characters long; 2) it starts with a 0, 1, 2, 4, 5, 8, or 9; 3) the second and third digits are not greater than the last two digits of the current year (e.g., 23); and 4) the fourth through sixth digits do not coresond to a Julian date later than the latest Julian date from the Cirdan file. If the RHC claim is part of the MinnesotaCare carveout or the claim includes a medical home procedure code of S0280 or S0281, it will be paid by the MCO as of July 1, 2019 (so would not have a DHS claim control number [TCN]).

PW00365	N/A	I	N/A	REJECT	A7	481				2019-07-01	9999-12-31	Payers are required to forward RHC claims for non-Medicare members to DHS (MHCP) for payment, unless the claim is part of the MinnesotaCare carve out or it includes a medical home procedure code S0280 or S0281. DHS (MHCP) only accepts the 837P and 837D claim formats; others will be rejected.	Payers are required to forward RHCs (service facility [2310E]/billing provider [2010AA] [NPI]) claims for non-Medicare members to DHS (MHCP) for payment, unless the claim is part of the MinnesotaCare carve out or it includes a medical home procedure code S0280 or S0281. DHS (MHCP) only accepts the 837P and 837D claim formats(GS08=005010X222A2 or 005010X224A2); others will be rejected. DHS does not accept the 837I claim format (GS08=005010X223A2) for RHC facilities/providers.
PW00366	p	N/A	D	REJECT	A7	743	562		82	2019-07-01	9999-12-31	When the payer receives a 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. If the claim is part of the MinnesotaCare carve out or claim includes a medical home procedure code S0280 or S0281, it will be paid by the managed care organization (MCO) as of July 1, 2019.	When the payer receives an 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. If the claim is part of the MinnesotaCare carve out or claim includes a medical home procedure code S0280 or S0281, it will be paid by the managed care organization (MCO) as of July 1, 2019.
PW00367	P	I	D	REJECT	A6	464				2019-07-01	9999-12-31	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 RHC claims. The MinnesotaCare and medical home procedure codes S0280 or S0281 carve out claims for FQHC/RHC are included in the edit.
PW00368	P	I	D	REJECT	A7	464				2019-07-01	9999-12-31	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 RHC claims. The MinnesotaCare and medical home procedure codes S0280 or S0281 carve out claims for FQHC/RHC is included in the edit.
PW00369	N/A	I	N/A	REJECT	A7	453	228			2019-07-22	9999-12-31	Due to the sunset of procedure code modifier "CB" for independent lab, the ESRD claims (TOB 72x) can no longer include the procedure code modifier "CB" on claims with service dates on or after 07/01/2019 or they will be rejected.	Due to the sunset of procedure code modifier "CB" (SV202-3, 4, 5, or 6) for independent lab, the ESRD claims (TOB 72x [Loop 2300 CLM05-1]) can no longer include the procedure code modifier "CB" (SV202-3, 4, 5, or 6) on claims with service dates on or after 07/01/2019 (Loop 2400 DTP03 when DTP01=472) or they will be rejected.
PW00370	P	I	N/A	REJECT	A7	453				2019-08-09	9999-12-31	When member's age is over 18 and claim includes procedure code H0035, the claim cannot include the modifier "HA" or it will be rejected. If the member's age is over 21 and claim includes procedure code T2023, the claim cannot include the modifier "HA" or it will be rejected.	When the procedure code (SV101-2; SV202-2) H0035 is included on the claim and the member's age is over 18 (2010BA-DMG02, 2400-DTP03 [Service Date]), the claim cannot include the modifier (SV101-3, 4, 5, 6; SV202-3, 4, 5, 6) "HA" or it will be rejected. When the procedure code (SV101-2; SV202-2) T2023 is included on the claim and the member's age is over 21 (2010BA-DMG02, 2400-DTP03 [Service Date]), the claim cannot include the modifier (SV101-3, 4, 5, 6; SV202-3, 4, 5, 6) "HA" or it will be rejected.
PW00371	N/A	I	N/A	REJECT	A7	234	719	228		2019-10-30	9999-12-31	When claim contains type of bill (TOB) 21X or 18X with occurrence code 22, and the occurrence code date is equal to the statement through date of the claim, the claim must include a discharge status=30 or it will be rejected.	When a claim contains a facility type code (Loop 2300 CLM05-1) equal to 21X or 18X with occurrence code equal to 22 (HI0x-2 where HI0x-1=BH) and the occurrence code date (HI0x-2='22' where HI0x-1=BH and HI0x-4) is equal to the statement through date (Loop 2300, DTP03 where DTP01=434) of the claim, the claim must include a patient status code (CL103) equal to 30 or it will be rejected.

PW00372	P	I	D	REJECT	A7	481	507	187		2019-12-10	9999-12-31	Based on Federal and State requirements, specific procedure codes/HCPCS codes need to be sent in a specific claim format (Professional, Institutional, or Dental) or the claim will be rejected.	Based on Federal and State requirements, specific procedure codes/HCPCS codes (Loop 2400 SV101-2, SV201-2 or SV301-2) are required to be sent in a specific claim format (837P, 837I or 837D). Claims that are billed with DOS 11/15/2019 or later (Loop 2400 DTP03 when DTP01=472) will be rejected if sent in on the incorrect claim format (GS08).
PW00373	N/A	N/A	D	REJECT	A7	481				2019-12-13	9999-12-31	Third Party Administrator (TPA) dental services are not contracted; dental claims for MCO will be rejected. Submit dental claims to correct TPA.	Third Party Administrator (TPA) dental services (GS08=005010X224A2) are not contracted; dental claims for MCO will be rejected. Submit dental claims to correct TPA.
PW00374	P	N/A	N/A	REJECT	A6	504			DQ	2019-12-11	9999-12-31	When specific Early Intensive Developmental and Behavioral Intervention (EIDBI) or counseling service CPT codes and modifiers are billed on a Professional claim, and the rendering provider is in the MN PECD file, the MN PECD file must include the specialty code QP signifying the rendering provider is the supervising provider or the claim will be rejected, unless the supervising provider is included on the claim.	When specific Early Intensive Developmental and Behavioral Intervention (EIDBI) or counseling service CPT codes (SV101-2) and modifiers (SV101-3_6) are billed on a Professional claim, and the rendering provider (2420A/2310B/2010AA) is in the MN PECD file, the MN PECD file must include the specialty code QP signifying the rendering provider (2420A/2310B/2010AA) is the supervising provider or the claim will be rejected, unless the supervising provider(2420D/2310D) is included on the claim.
PW00375	P	I	D	REJECT	A7	696				2020-03-20	9999-12-31	When the professional, institutional, or dental claim is received with the claim adjustment reason code (CARC) "45" in the Claim or Service line level, only the group code "CO" or "PR" are allowed, or the claim will be rejected.	When an 837P, 837I, or 837D claim is received with the claim adjustment reason code (CARC) (CAS02, CAS05, CAS08, CAS11, CAS14, CAS17) "45" in the Claim (Loop 2320) or Service line (2430) level, only the group code (CAS01) "CO" or "PR" are allowed, or the claim will be rejected.
PW00376	P	N/A	N/A	REJECT	A7	481				2020-03-10	9999-12-31	The ADA codes are not allowed to be billed on the professional claim format.	The procedure code (Loop 2400 SV101-2) cannot include ADA codes on the 837P claim format.
PW00379	P	N/A	N/A	REJECT	A6	454				2020-07-15	9999-12-31	When professional claims are received with procedure code G2078, the procedure code G2067 must also be included on the claim or when the professional claim is received with procedure code G2079, the procedure code G2068 must also be included on the claim, or the claims will be rejected.	When professional claims are received with procedure code G2078 (Loop 2400 SV101-2), the procedure code G2067 (Loop 2400 SV101-2) must also be included on the claim or when the professional claim is received with procedure code G2079 (Loop 2400 SV101-2), the procedure code G2068 (Loop 2400 SV101-2) must also be included on the claim, or the claims will be rejected.
PW00380	P	I	N/A	REJECT	A6	306				2020-07-27	9999-12-31	When claims are received with Continuous Glucose Monitor supply codes A9276, A9277, A9278, K0554, and K0553, Medicare has not paid on the claim and there is no attachment type indicator EB, OZ, or MT on the claim, the claim must include the make and model in the service line description field or the claims will be rejected.	When claims are received with Continuous Glucose Monitor supply codes A9276, A9277, A9278, K0554, and K0553 (Loop 2400 SV101-2 [837P] or SV202-2[837I]), Medicare has not paid on the claim and there is no attachment type indicator EB, OZ, or MT (Loop 2300 or 2400, PWK01) on the claim, the claim must include the make and model in the service line description field (SV101-7[837P] or SV202-7[837I]); or the claims will be rejected.
PW00381	P	I	D	REJECT	A7	535				2020-07-15	9999-12-31	Claims received with the invalid Type of bill 0XX6, will be rejected.	Claims received with the invalid claim frequency type code of "6" (CLM05-3) will be rejected.
PW00382	N/A	I	N/A	REJECT	A7	486	188			2020-11-26	9999-12-31	Principal procedure date must be between the statement "from" and "to" date or the claim will be rejected, unless the claim frequency="8"	When an 837I claim is received with a principle procedure code (2300.HI01-1 is "BR" or "BBR,") then the principal procedure date (2300.HI01-4) must be between the statement "from" and "to" date (2300.DTP03 when DTP01=434) or the claim will be rejected, unless the claim frequency="8" (2300.CLM05-3).
PW00383	N/A	I	N/A	REJECT	A7	492	188			2020-11-26	9999-12-31	Other Procedure date must must be between the statement "from" and "to" date or the claim will be rejected, unless the claim frequency="8"	When an 837I claim is received with an other procedure code (2300.HI01-1 is "BQ" or "BBQ,") then the other procedure date (2300.HI01-4) must be between the statement "from" and "to" date (2300.DTP03 when DTP01=434) or the claim will be rejected, unless the claim frequency='8' (2300.CLM05-3).

PW00384	P	N/A	N/A	REJECT	A6	453	507			2020-12-29	9999-12-31	Prior to 7/31/2020, when billing HCPCS code H2019, for a member under age 18, the modifier "UA" or "UB" was required. After 07/31/2020, HCPCS code H2019 requires a modifier "UA," "UB," "U1," or "HA" or the claim will be rejected.	Prior to 7/31/2020, when billing HCPCS code H2019 (SV101-2) for a member under age 18 (Loop 2010CA or 2010BA DMG02), the modifier "UA" or "UB" was required. After 07/31/2020, HCPCS code H2019 (SV101-2) requires a modifier "UA," "UB," "U1," or "HA" (SV101-3 – SV101-6) or the claim will be rejected.
PW00385	P	I	D	REJECT	A7	521				2021-01-11	9999-12-31	When claim contains prior payer payments, the reason codes must be valid, or the claim will be rejected.	When claim contains prior payer payments, the reason codes must be valid (Loop 2320, CAS02, CAS05, CAS08, CAS11, CAS14, CAS17) and will be validated against the EDI EDIT CODES table where EdiEditCodeType=Reason_Code and EdiEditField=CARC; if reason code is invalid, the claim will be rejected.
PW00386	P	I	D	REJECT	A7	634				2021-01-11	9999-12-31	When claim contains prior payer payments, the remark codes must be valid, or the claim will be rejected.	When claim contains prior payer payments, the remark codes must be valid (Loop 2320, MIA05, MIA20:MIA23 or MOA03:MOA07) and will be validated against the EDI EDIT CODES table where EdiEditCodeType=REMARK_CODE and EdiEditField=RARC; if remark code is invalid, the claim will be rejected.
PW00387	P	N/A	N/A	REJECT	A6	453	507			2021-01-13	9999-12-31	When previously billing HCPCS code H0032, for a member who is under age 18, the modifier "UA" or "UB" was required. On or after 10/01/2020, HCPCS code H0032 requires a modifier UA, UB, or Q2 or the claim will be rejected.	When previously billing HCPCS code H0032 (SV101-2) for a member who is under age 18 (Loop 2010CA or 2010BA DMG02), the modifier "UA" or "UB" was required. On or after 10/01/2020, HCPCS code H0032(SV101-2) requires a modifier UA, UB, or Q2 (SV101-3 – SV101-6) or the claim will be rejected.
PW00388	N/A	I	N/A	REJECT	A7	773				2021-03-24	9999-12-31	When a claim is received with the statement "from" and "through" dates spanning multiple years, the claim will be rejected when the TOB=13x or 85x, and the claim includes at least one revenue code 0762 or 0450.	When a claim is received with the statement "from" and "through" dates (DTP03 when DTP01=434) spanning multiple years, the claim will be rejected when the Facility Type Code (CLM05-1)=13x or 85x, and the claim includes at least one revenue code (SV201) 0762 or 0450.
PW00389	N/A	I	N/A	REJECT	A7	732	455	228		2021-03-31	9999-12-31	When a claim is received with TOB 13x and the claim includes the revenue code 096x-098x, excluding 0964 without a HCPCS code, the claim will be rejected.	When a claim is received with Facility Type Code (CLM05-1)=13x and the claim includes the revenue code(SV201) 096x-098x, excluding 0964 without a HCPCS code, the claim will be rejected.
PW00391	P	I	D	REJECT	A7	516	187		PR	2021-07-16	9999-12-31	When the COB paid date is prior to the service date on the claim, the claim will be rejected.	When a claim contains a prior paid amount, the COB paid date (Loop 2330B DTP03, DTP01=573), must be after the Service Date (Loop 2400 DTP03, DTP01=472), or the claim will be rejected.
PW00392	P	N/A	N/A	REJECT	A7	187	258			2021-07-16	9999-12-31	When a professional claim contains select procedure codes for customized living, the billing span dates and units billed must equal or the claim will be rejected.	When a professional claim contains select procedure codes (SV101-2) for customized living, the service date range (Loop 2400 DTP03, DTP01=472 and DTP02=RD8) and and the service units (SV104) must equal or the claim will be rejected.
PW00394	P	N/A	N/A	REJECT	A7	481				2021-07-16	9999-12-31	When a professional claim contains a procedure code that begins with a "C," the claim will be rejected for incorrect claim format. Procedure codes that begin with a "C" are only allowed to be billed on the Institutional claim format.	When an 837P claim contains a procedure code (SV101-2) that begins with a "C," the claim will be rejected for incorrect claim format.
PW00395	N/A	I	N/A	DENIAL						2022-01-07	9999-12-31	As of 01/01/2021, home health therapy claims will no longer pay a split percentage for revenue code 0023. The informational claim (TOB 322 and 32A) with revenue code 0023 or informational service line (TOB 327) with revenue code 0023 will be automatically denied.	As of 01/01/2021, home health therapy claims will no longer pay a split percentage for revenue code (SV201) 0023. The informational claim with facility type code (CLM05-1) "32" and claim frequency code (CLM05-3) "2" or "A" with revenue code (SV201) 0023; or the informational service line (CLM05-1) "32" and claim frequency code (CLM05-3) "7" with revenue code (SV201) 0023 will be automatically denied.
PW00396	P	I	D	REJECT	A7	254	509			2021-10-13	9999-12-31	When an External Cause of Injury code is submitted as a Principal diagnosis code, the claim will be rejected.	When Loop 2300 HI01-1 is "BK" or "ABK," then Loop 2300 HI01-2 cannot be an External Cause of Injury code "V00-Y999999" or the claim will be rejected.

PW00397	N/A	I	N/A	REJECT	A7	232	509			2021-10-13	9999-12-31	When an External Cause of Injury code is submitted as an Admitting diagnosis code, the claim will be rejected.	When Loop 2300 HI01-1 is "BJ" or "ABJ," then Loop 2300 HI01-2 can not be an External Cause of Injury code "V00-Y999999" or the claim will be rejected.
PW00398	N/A	I	N/A	REJECT	A7	673	509			2021-10-13	9999-12-31	When an External Cause of Injury code is submitted as a Patient reason for visit code, the claim will be rejected.	When Loop 2300 HI01-1:HI03-1 is "PR" or "APR," then Loop 2300 HI01-2:HI03-2 can not be an External Cause of Injury code "V00-Y999999" or the claim will be rejected.
PW00400	N/A	I	N/A	REJECT	A7	455	228	507		2022-01-17	9999-12-31	ESRD claims received on or after 01/01/2021 with Facility Type Code 72x and HCPCs code J0604 must have 0250 as the revenue code for HCPCs code J0604 or the claim will be rejected.	ESRD claims received on or after 01/01/2021 with Facility Type Code (CLM05-01) 72x and HCPCs code (SV202-2) J0604 must have the revenue code (SV201) 0250 for HCPCS code J0604 or the claim will be rejected.
PW00401	P	I	N/A	REJECT	A7	454				2022-01-07	9999-12-31	When the billing provider is an Ambulatory Surgical Center (ASC), certain procedure codes are not allowed to be billed on a claim. If one of those procedure codes is included on the claim, the claim will be rejected.	When the billing provider is an Ambulatory Surgical Center (ASC), certain procedure codes (SV101-2 or SV202-2) are not allowed to be billed on a claim. If the Billing Provider provider specialty code is a 12 and if the procedure code is included in the edit codes table, the claim will be rejected.
PW00402	N/A	I	N/A	REJECT	A7	228				2022-01-06	9999-12-31	When an Acute Care Hospital submits an 837I claim and the claim contains the TOB 85x, the claim will be rejected back to the provider.	When an Acute Care Hospital submits an 837I claim and the claim contains Facility Type Code (CLM05-1)="85," 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 provider specialty [SP] field will have a "DC" for Acute Care Hospital.)
PW00403	P	N/A	N/A	REJECT	A6	564				2022-01-06	9999-12-31	When the Professional claim includes an Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) Referral, and the indicator indicates that a referral was given to the patient (response indicator="Y"), the condition Indicator cannot have a value of "NU," or the claim will be rejected.	When the 837P claim includes an Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) Referral, and the response indicator (CRC02) indicates that a referral was given to the patient (response indicator="Y"), the condition Indicator (CRC03) cannot have a value of "NU," or the claim will be rejected.
PW00404	P	I	N/A	DENIAL						2022-01-28	9999-12-31	As of 8/01/2020, Professional and Institutional claims that contain modifier "Q0" are no longer covered by Medicaid. The claim will be denied.	As of 8/01/2020, 837P and 837I claims that contain modifier "Q0" (Loop 2400-SV101-3:SV101-6/SV202-3:SV202-6) are no longer covered by Medicaid. The claim will be denied.
PW00405	P	I	N/A	REJECT	A7	252			PR	2022-02-03	9999-12-31	When submitting Institutional or Professional claims with unlisted or non-specified laboratory/pathology, radiology, or diagnostic services on a claim, you must include a valid prior authorization number or attach documentation to justify the use of the unlisted procedure code and to describe the procedure or service rendered.	When submitting 837I or 837P claims with unlisted or non-specified laboratory/pathology, radiology, or diagnostic services (SV101-2 and SV202-2) on a claim, you must include a valid prior authorization number (REF02 where REF01=G1) or attach documentation (PWK segment).
PW00406	P	I	N/A	REJECT	A6	453				2022-02-25	9999-12-31	When therapy claims are billed with modifier "CQ," the claim must also contain the modifier "GP." If the therapy claim is billed with modifier "CO," the claim must also contain the modifier "GO." If the additional modifier is missing, the claim will be rejected.	When therapy claims are billed with modifier "CQ" (SV101-3: SV101-6 or SV202-3:SV202-6), the claim must also contain the modifier "GP" (SV101-3: SV101-6 or SV202-3:SV202-6). If the therapy claim is billed with modifier "CO" (SV101-3: SV101-6 or SV202-3:SV202-6), the claim must also contain the modifier "GO" (SV101-3: SV101-6 or SV202-3:SV202-6). If the additional modifier is missing, the claim will be rejected.
PW00407	P	N/A	N/A	REJECT	A7	788				2022-04-04	9999-12-31	Claims received with a DOS on or after 04/01/2022 with charges for Continuous Glucose Monitor A4239, A4271, E2103, E2104, K0553, or K0554 need to be billed to the Pharmacy Benefit Manager. Claims billed to the payer will be rejected, unless the member has Medicare or there has been a prior payment on the claim.	Claims received with a DOS on or after 04/01/2022 with charges for Continuous Glucose Monitor HCPCS codes (SV101-2) A4239, A4271, E2103, E2104, K0553, or K0554 need to be billed to the Pharmacy Benefit Manager. Claims billed to the payer will be rejected, unless the member has Medicare or there has been a prior payment (AMT01 =D) on the claim.

PW00408	N/A	I	N/A	REJECT	A6	719	455	228		2022-07-01	9999-12-31	When claims contain TOB 11x and revenue code 161, the claim must include the occurrence span code "82" or the claim will be rejected.	When claims contain TOB 11x (Loop 2300 CLM05-1) and revenue code 161 (SV201), the claim must include the occurrence span code "82" (HI01:HI12-2 when HI01:HI12-1=BI), or the claim will be rejected.
PW00409	N/A	I	N/A	REJECT	A7	258	455	719		2022-07-01	9999-12-31	When claims contain TOB 11x, revenue code 161, and occurrence span code "82", the total number of days reported with occurrence span code "82" must match the number of units reported for revenue code 161 or the claim will be rejected.	When claims contain TOB 11x (Loop 2300 CLM05-1), revenue code 161 (SV201), and occurrence span code "82" (HI01:HI12-2 when HI01:HI12-1=BI), the total number of days reported with occurrence span code "82" must match the number of units reported for revenue code 161 (SV201) or the claim will be rejected.
PW00410	P	I	D	REJECT	A7	481				2022-07-22	9999-12-31	Reject claim if the Billing Provider NPI is not billed on the correct EDI claim type 837I, 837P, 837D.	Reject claim if the Billing Provider NPI (Loop 2010AA - NM109) is not billed on the correct EDI claim type 837I, 837P, 837D (GS08).
PW00412	P	I	N/A	REJECT	A7	453				2022-08-16	9999-12-31	The LT and RT modifiers are not allowed on the same service line or the claim will be rejected.	The LT and RT modifiers (SV101-3 – SV101-6, SV202-3 – SV202-6) are not allowed on the same service line or the claim will be rejected.
PW00413	N/A	I	N/A	REJECT	A7	228	455			2022-08-16	9999-12-31	When a home health therapy claim with TOB 32x and at least one revenue code is in the range of 0001-0239, the claim must also contain the revenue code 0023 or the claim will reject (unless one of the revenue codes on the claim is outside the range of 0001-0239 or 0023 is the only revenue code on the claim).	When a home health therapy claim with facility type code (CLM05-1) 32x and at least one revenue code (SV201) is in the range of 0001-0239, the claim must also contain the revenue code (SV201) 0023 or the claim will reject (unless one of the revenue codes [SV201] on the claim is outside the range of 0001-0239 or 0023 is the only revenue code [SV201] on the claim).
PW00414	P	N/A	N/A	REJECT	A6	453	507			2022-09-01	9999-12-31	When billing for Housing Stabilization services, only approved HSS providers are allowed to bill. When billing services, only HCPCS code H2015 or T2024 will be accepted (and the HCPCS code must include the modifier U8) or the claim will be rejected.	When billing for housing stabilization services, only approved HSS providers are allowed to bill. When billing services, only HCPCS codes H2015 or T2024 (SV101-2) will be accepted, and the HCPCS code must include the modifier U8 (SV101-3 – SV101-6) or the claim will be rejected.
PW00415	P	N/A	N/A	DENIAL						2022-11-29	9999-12-31	When billing for Housing Stabilization moving expenses, only approved HSS providers are allowed to bill. When billing the moving expenses, claim will include the HCPCS code T2038 and modifier U8. The claim must include an attachment of expenses or the claim will be denied.	When billing for Housing Stabilization moving expenses, only approved HSS providers are allowed to bill. When billing the moving expenses, the claim will include the HCPCS code T2038 (SV101-2) and the modifier U8 (SV101-3 – SV101-6). The claim must include an attachment of expenses or the claim will be denied.
PW00416	P	N/A	N/A	REJECT	A7	145	454	228	82	2023-01-10	9999-12-31	Medication Therapy Management Services 99605-99607 must be completed by an appropriate rendering provider. If rendering provider doesn't have a pharmacist taxonomy code in NPPES (starts with 1835) or the service was provided in a nursing home POS 31x, the claim will be rejected.	Medication Therapy Management Services (SV101-2) 99605-99607 must be completed by an appropriate rendering provider. If rendering provider doesn't have a pharmacist taxonomy code in NPPES (starts with 1835) or the service was provided in a nursing home POS 31x (Loop 2300 CLM05-1), the claim will be rejected.
PW00417	P	I	N/A	REJECT	A6	489				2023-01-12	9999-12-31	When billing HCPCS code B4088 for a kit, not a single tube, use modifier U3. The claim must also include an attachment of manufacturer's suggested retail price (MSRP) for product specific pricing or invoice from the manufacturer if the MSRP is unavailable or the claim will be rejected.	When billing HCPCS code B4088 (SV101-2 or SV202-2) for a kit, not a single tube, use modifier U3 (SV101-3:SV101-6 or SV202-3:SV202-6). The claim must also include an attachment of manufacturer's suggested retail price (MSRP) for product specific pricing or invoice from the manufacturer if the MSRP is unavailable or the claim will be rejected.
PW00418	P	I	N/A	REJECT	A7	775			85	2022-02-03	9999-12-31	DME capped rental claims that include procedure codes with the modifier "RR" and either KH, KI, or KJ cannot be billed with a Billing Provider identified as an individual provider NPI or the claim will be rejected.	DME capped rental claims that include procedure codes (Loop 2400 SV101-2) with the modifier "RR" (SV101-2_SV101-3_SV101-6) and either modifier KH, KI, or KJ (SV101-2_SV101-3_SV101-6) cannot be billed with a Billing Provider (Loop 2010AA NM102) identified as an individual provider NPI or the claim will be rejected.

PW00419	P	I	N/A	REJECT	A7	775			82	2022-02-03	9999-12-31	DME capped rental claims that include procedure codes with the modifier "RR" and either KH, KI, or KJ cannot be billed with a Rendering Provider identified as an individual provider NPI or the claim will be rejected.	DME capped rental claims that include procedure codes (Loop 2400 SV101-2) with the modifier "RR" (SV101-2_SV101-3_SV101-6) and either modifier KH, KI, or KJ (SV101-2_SV101-3_SV101-6) cannot be billed with a Rendering Provider (837I-Loop 2420C/2310D (NM102) 837P-Loop 2420A/2310B (NM102) identified as an individual provider NPI or the claim will be rejected.
PW00420	N/A	I	N/A	REJECT	A6	507	228	455		2023-02-07	9999-12-31	Home Health Telehealth claims will need to bill the HCPCS code G0320, G0321, or G0322; the claim must include the TOB 32x; and the claim must include one of the following revenue codes: 042x, 043x, 044x, 055x, 056x or 057x. The claim will also need to include another "G" code for the actual service. The revenue code included with this HCPCS code will need to match the same telehealth revenue code group used or the claim will be rejected.	Home Health Telehealth claims will need to bill the HCPCS code (SV202-2) G0320, G0321, or G0322; the claim must include the TOB (CLM05-1) 32x; and the claim must include one of the following revenue codes: (SV201) 042x, 043x, 044x, 055x, 056x or 057x. The claim will also need to include another HCPCS "G" code (SV202-2) for the actual service. The revenue code (SV201) included with this HCPCS code (SV202-2) will need to match the same telehealth revenue code(SV201) group used or the claim will be rejected.
PW00421	P	N/A	N/A	REJECT	A3	746				2023-03-10	9999-12-31	When duplicate claims are received in the same Professional claim file, both claims will need to be rejected. Duplicate claims are determined by checking subscriber PMI, service dates, billing provider (TIN/NPI or UMPI), rendering provider (NPI-UMPI), referring provider (NPI-UMPI), service facility, POS, frequency, charge amount, procedure, modifier, service line descriptions, units, diagnosis codes, NDC, authorization number, and minutes.	When duplicate claims are received in the same Professional claim file, both claims will need to be rejected. Duplicate claims are determined by checking subscriber PMI (2010BA-NM109), service dates (2400-DTP03 when DTP01=472), billing provider TIN/NPI or UMPI (2010AA-REF02 when REF01="EI" or "SY," 2010AA-NM109 or 2010BB-REF02 when REF01=G2), rendering provider NPI or UMPI (2310B-NM109 or REF02 when REF01=G2), referring provider NPI-UMPI (2310A-NM109 or REF02 when REF01=G2), service facility (2310C), POS (CLM05-1:CLM05-2), frequency (CLM05-3), charge amount (CLM02), procedure (SV101-2), modifier (SV101-3:SV101-6), service line descriptions (SV101-7), units (SV104 when SV103="UN"), diagnosis codes (HI01-2:HI12-2), NDC (LIN03), authorization number (REF02 when REF01="G1"), and minutes (SV104 when SV103="MJ").
PW00422	N/A	I	N/A	REJECT	A6	460				2023-03-29	9999-12-31	When a replacement or void claim is submitted with a TOB=xx7 or xx8, a condition code is required (if TOB=xx7 and condition code is not D0, D1, D2, D3, D4, D7, D8, D9, or E0 or TOB=xx8 and condition code is not D5 or D6), the claim will be rejected.	When a replacement or void claim is submitted with a Claim Frequency Type Code (CLM05-3)=7 or 8 a condition code (HI01-2:HI12-2 when HI01-1:HI12-1=BG) is required. If Claim Frequency Code (CLM05-3)=7 and condition code (HI01-2:HI12-2 when HI01-1:HI12-1=BG) is not D0, D1, D2, D3, D4, D7, D8, D9 or E0 or Claim Frequency Code (CLM05-3)=8 and condition code (HI01-2:HI12-2 when HI01-1:HI12-1=BG) is not D5 or D6, or the claim will be rejected.
PW00423	P	N/A	N/A	REJECT	A7	453				2023-04-06	9999-12-31	When a claim includes procedure code S0250, the procedure code can only include the following modifiers: HC, TS, U4, or blank. If the member is over age 64, the S0250 procedure code could include any of the modifiers listed previously or the UC modifier. If other modifiers are included with procedure code S0250, the claim will be rejected.	When a claim includes procedure code S0250 (SV101-2), the procedure code can only include the following modifiers: HC, TS, U4, or blank (SV101-3 through SV101-6). If the member is over age 64, the procedure code could include any of the modifiers listed previously or the UC (SV101-3 through SV101-6) modifier. If other modifiers are included with procedure code S0250 (SV101-2), the claim will be rejected.

PW00424	P	I	N/A	REJECT	A7	116	189			2023-05-26	9999-12-31	When Institutional claims (TOB 11x with provider specialty DC, CH, T1 ,or R2) or Professional claims (POS 21, 51, or 61) are received as part of an inpatient hospital stay, prior to the member obtaining coverage by the MCO, the claims will need to be paid by the prior payer until the member is discharged. Claims received with an admission date that doesn't fall within the member span will be rejected.	When 837I claims with Facility Type Code (CLM05-1=11) and with provider specialty DC, CH, T1, or R2 or 837P claims with Place of Service Code (CLM05-1=21, 51, or 61) and are received as part of an inpatient hospital stay, prior to the member obtaining coverage by the MCO, the claims will need to be paid by the prior payer until the member is discharged. Claims received with an admission date (Loop 2300 DTP03 where DTP01=435) that doesn't fall within the member span will be rejected.
PW00425	P	N/A	N/A	REJECT	A7	562			82	2023-06-14	9999-12-31	When pharmacy claims are received from the pharmacy billing provider, the rendering provider must be an individual or the claim will be rejected.	When pharmacy claims are received from the pharmacy billing provider (Loop 2010AA), the rendering provider (Loop 2310B) must be an individual (NM102=1 when NM101=82) or the claim will be rejected.
PW00427	P	N/A	N/A	REJECT	A7	228	454	455		2023-08-10	9999-12-31	When the institutional claim includes TOB 85x; Revenue codes 096x, 097x, or 098x; and the procedure code begins with a "C," the institutional claim will be rejected, due to procedure only allowed for facility services.	When the 837I claim includes Facility Type Code (CLM05-1)="85" with revenue code (SV201) 096x, 097x, or 098x and the procedure code (SV101-2) begins with a "C," the institutional claim will be rejected, due to procedure only allowed for facility services.
PW00428	N/A	N/A	D	REJECT	A6	306				2023-07-28	9999-12-31	When Procedure code D9990 is included on the dental claim, the claim must include the oral Interpreter's name in the service line description or the claim level note segment. If not found, the claim will be rejected.	When Procedure code (Loop 2400 SV301-2(837D)="D9990," is included on the claim then (Loop 2400 SV301-7 or Loop 2300 NTE02) must include the oral Interpreter's name, or the claim will be rejected.
PW00429	P	N/A	D	REJECT	A6	727	633			2023-08-11	9999-12-31	When claims are received with a related cause code of AA or OA; or related cause code EM and diagnosis code V00-X58, the accident date must be included on the claim or the claim will be rejected.	When claims are received with a related cause code of (CLM11-1- CLM11-2) "AA" or "OA"; or related cause code EM and diagnosis code V00-X58, the accident date(DTP03 when DTP01=439) must be included on the claim or the claim will be rejected.
PW00430	P	I	D	DENIAL						2023-08-04	9999-12-31	When claims are received with incorrect or invalid COB information, the claim will be denied.	When claims are received with incorrect or invalid COB information (2300/2400 CAS) based on the edit Edit Table "COB_CARC_VERIFICATION," the claim will be denied.
PW00431	N/A	I	N/A	REJECT	A7	258	455	228		2023-09-13	9999-12-31	ESRD Revenue codes should be itemized. If the Type of Bill (TOB) is 72x and the claim contains revenue codes 082x, 083x, 084x, 085x, or 088x, each revenue code line (08xx) must contain a unit of 1 per date of service. If the unit is greater than 1, the claim will be rejected.	ESRD Revenue codes should be itemized. If the Type of Bill (TOB) (CLM05-1) is 72x and the claim contains revenue codes 082x, 083x, 084x, 085x, or 088x (SV201), each revenue code line (08xx) must contain a unit of 1 (SV205)per date of service(Loop 2400 - DTP03). If the unit is greater than 1 (SV205), the claim will be rejected.
PW00432	N/A	I	N/A	REJECT	A7	455	228			2023-09-13	9999-12-31	Only 1 dialysis revenue category allowed per ESRD claim. If the Type of Bill (TOB) is 72x and the claim contains a combination of charges with multiple revenue categories of 082x, 083x, 084x, 085x, or 088x, the claim will be rejected.	Only 1 dialysis revenue category allowed per ESRD claim. If the Type of Bill (TOB) (CLM05-1) is 72x and the claim contains a combination of charges with multiple revenue categories of 082x, 083x, 084x, 085x, or 088x (SV201), the claim will be rejected.
PW00433	N/A	I	N/A	REJECT	A7	460	228			2023-09-13	9999-12-31	ESRD claims must contain an ESRD Condition code and must only contain 1 ESRD condition code per claim. If the Type of Bill (TOB) is 72x and the condition codes do not contain an "84," and there is more than one of the following condition codes 70, 71, 72, 73, 74, 75, 76, or 87, the claim will be rejected.	ESRD claims must contain an ESRD Condition code and must only contain 1 ESRD condition code per claim. If the Type of Bill (TOB) is 72x and the condition code does not contain an 84 (HI0x-2, when HI0x-1=BG), and there is more than one of the following condition codes 70, 71, 72, 73, 74, 75, 76, or 87 (HI0x-2, when HI0x-1=BG), the claim will be rejected.

PW00434	N/A	I	N/A	REJECT	A6	453	507	228		2023-09-13	9999-12-31	ESRD claims where vascular access is used for the delivery of the hemodialysis, the Type of Bill (TOB) is 72x, and the condition codes do not contain an "84," there must be a modifier "V5," "V6," or "V7" on one of the service lines with revenue code 082x or the claim will be rejected.	ESRD claims where vascular access is used for the delivery of the hemodialysis, the Type of Bill (TOB) is 72x (CLM05-1), and the condition codes do not contain an "84" (HI0x-2, when HI0x-1=BG), there must be a modifier "V5," "V6," or "V7" (SV202-3:SV202-6) on one of the service lines with revenue code 082x (SV201) or the claim will be rejected.
PW00435	N/A	I	N/A	REJECT	A6	719	725	726		2023-09-13	9999-12-31	ESRD claims require a hematocrit reading. If the Type of Bill(TOB) is 72x and the condition codes do not contain an "84", and there is a value code of D5, there must be an occurrence code 51, if the value amount of D5 is not 9.99 or 8.88, the claim will be rejected.	ESRD claims require a hematocrit reading.If the Type of Bill (TOB) (CLM05-1) is 72x and the condition code does not contain an 84 (HI0x-2, when HI0x-1=BG), and there is a value code of D5 (HI0x-2, when HI0x-1=BE), there must be an occurrence code 51 (HI0x-2, when HI0x-1=BH), if the value amount of D5 (HI0x-5, when HI0x-1=BE) is not 9.99 or 8.88, the claim will be rejected.
PW00437	P	I	N/A	REJECT	A7	453				2023-10-11	9999-12-31	When claims for a dual eligible member are received on or after 5/12/2023 and include modifier "CS," the claim will be rejected, unless the claim is from a Rural Health Clinic or Federally Qualified Health Center (TOB 71X and 77X).	When claims for a dual eligible member are received on or after 5/12/2023 and include modifier "CS," (SV101-3, 4, 5, 6) the claim will be rejected, unless the claim is from a Rural Health Clinic or Federally Qualified Health Center 71X or 77X (CLM05-1).
PW00438	P	N/A	N/A	REJECT	A6	453	507			2023-11-16	9999-12-31	When a travel time procedure code "99082" is included on an Elderly Waiver claim, the procedure code must include the "UC" modifier and at least one of the procedure codes from the EDI Edit code table must be included or the claim will be rejected.	When a travel time procedure code "99082" (SV101-2 [837P]) is included on an Elderly Waiver claim, the procedure code must include the "UC" modifier (SV101-3_SV101-6 [837P]) and at least one of the procedure codes from the EDI Edit code table must be included or the claim will be rejected.
PW00439	N/A	I	N/A	DENIAL						2023-11-16	9999-12-31	When claims are received with chiropractic procedure codes 98940, 98941, or 98942, the attending or rendering provider needs to be a chiropractor or the line will be denied.	When claims are received with chiropractic procedure codes 98940, 98941, or 98942 (Loop 2400 SV202-2 [Institutional]), the attending (2310A) and/or rendering provider (2330G/2420C) needs to be a chiropractor (payer system specialty code [SP35]) or the line will be denied.
PW00440	P	I	N/A	REJECT	A6	453	507			2023-12-13	9999-12-31	When Professional or Institutional claims are received with single use or single dose drug codes, the drug services line needs to include modifier JZ (zero drug waste) or, if some of the drug was discarded, the drug service line should show the amount that was administered along with another drug service line including the modifier JW (drug amount discarded) or the claim will be rejected. This does not apply to the following: 1) Claims with TOB 71x, 77x, and 11x; 2) Claims with dates of service after 1/1/2025 with TOB 72x, unless the claim includes modifier AY; and 3) Claims with dates of service after 1/1/2025 with TOB 13x when the billing provider specialty is a Rural Emergency Hospital (“RE”) or Ambulatory Surgery Center “(12”).	When 837P or 837I claims are received with single use or single dose drug codes (the specific codes will all be found in the EDI edit code list "SINGLE_USE_DRUG"), the drug services line (SV101-2 or SV202-2) needs to include modifier JZ (zero drug waste [SV101-3_SV101-6, SV202-3_SV202-6]) or, if some of the drug was discarded, the drug service line (SV101-2 or SV202-2) should show the amount that was administered along with another drug service line (SV101-2 or SV202-2) including the modifier JW (drug amount discarded [SV101-3 – SV101-6, SV202-3 – SV202-6]) or the claim will be rejected. This does not apply to the following: 1) Claims with TOB 71x, 77x, and 11x [CLM05-1]; 2) Claims with dates of service after 1/1/2025 with TOB 72x [CLM05-1], unless the claim includes modifier AY [SV101-3_SV101-6, SV202-3_SV202-6]; and 3) Claims with dates of service after 1/1/2025 with TOB 13x [CLM05-1] when the billing provider specialty is a Rural Emergency Hospital (“RE”) or Ambulatory Surgery Center (“12”).

PW00441	P	N/A	N/A	REJECT	A7	481	507			2023-11-20	9999-12-31	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, in which case it can be billed in the 837P format: POS is 20, 21, 22, or 23; or the claim is for a Health Care Home and includes procedure code S0280 and S0281; or the claim is for the vaccine or administration of vaccine for pneumococcal, influenza, or COVID-19; or the claim is from a Consolidated Billing Provider found in the EDI Edit Codes table.	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, in which case it can be billed on the 837P format: The facility type code (CLM05-1) is equal to 20, 21, 22, or 23; or the claim is for a Health Care Home and includes procedure code (Loop 2400 SV101-2) S0280 and S0281; or the claim is for the vaccine or administration of vaccine for pneumococcal, influenza, or COVID-19 (Loop 2400 SV101-2) where the specific procedure codes are found in the EDI Edit Codes table PNEUMOCOCCAL_VACCINE_ADMIN_CODES, INFLUENZA_VACCINE_ADMIN_CODES, COVID_VACCINE_ADMIN_CODES; or the Consolidated Billing Provider's NPI or HOUSE_NBR, ZIP are found in the CONSOLIDATED_RHC EDI Edit Code table.
PW00442	P	I	N/A	REJECT	A7	453				2023-12-08	9999-12-31	When Professional or Institutional claims are received from an Ambulatory Surgical Center provider, the claim cannot include modifier 53 or the claim will be rejected.	When 837P or 837I claims are received from an Ambulatory Surgical Center provider (Payer System-Specialty=12) , the claim cannot include modifier 53 (SV101-3_SV101-6, SV202-3_SV202-6) or the claim will be rejected.
PW00444	P	N/A	N/A	REJECT	A7	562			DQ	2024-01-024	9999-12-31	When a claim is submitted with the rendering provider as a community health worker, the supervising provider cannot have the same NPI/UMPI as the rendering provider 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) cannot have the same NPI/UMPI as the rendering provider or the claim will be rejected.
PW00446	P	N/A	N/A	REJECT	A7	454	453			2024-02-08	9999-12-31	When a doula claim includes the procedure code and modifier S9445 U4 or 99199 U4 and the service date is after 12/31/2023, the claim will be rejected, because the codes are no longer valid.	When a doula claim includes the procedure code and modifier S9445 (SV101-2) U4 (SV101-3 through SV101-6) or 99199 (SV101-2) U4 (SV101-2, SV101-3 through SV101-6) is after 12/31/2023 (DTP03 where DTP01=472), the claim will be rejected, because the codes are no longer valid.
PW00447	P	I	N/A	DENIAL						2024-03-19	9999-12-31	When Medicare claims are received with consulting CPT codes 99241 – 99245 and 99251 – 99255, the service lines will be denied. Medicare consulting services require claims be billed with E/M codes.	When Medicare claims are received with consulting CPT codes 99241 – 99245 and 99251 – 99255 (Loop 2400 SV202-2 [Institutional]), or (Loop 2400 SV101-2 [Professional]), the service lines will be denied. Medicare consulting services require claims be billed with E/M codes.
PW00448	P	N/A	N/A	REJECT	A7	507	560		82	2024-04-01	9999-12-31	When a claim is submitted with the rendering provider as a community health worker, the HCPC/CPT codes must be 98960, 98961, 98962, or 0591T – 0593T; if the claim is for a Medicare member, HCPC code G0019 and G0022 are also accepted. Claims with other codes 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, 98962 or 0591T – 0593T; if the claim is for a Medicare member, HCPC code G0019 and G0022 are also accepted. Claims with other codes will be rejected.
PW00449	N/A	I	N/A	REJECT	A6	507	460	228		2024-06-06	9999-12-31	Claims submitted after 1/1/2024 with TOB 71x, Revenue Code 0905, Modifier CG, and Condition Code 92 must include at least one Intensive Outpatient Program service HCPCS code from the Primary Service list or the claim will be rejected.	Claims submitted after 1/1/2024 with Facility Type Code (CLM05-1) 71x, Revenue Code (SV201) 0905, Modifier (SV202-3:SV02-6) "CG" and Condition Code "92" (Loop 2300 [HI01-2:HI12-2] where [HI01-1:HI12-1]=BG) must include at least one Intensive Outpatient Program service HCPCS code (SV202-2) from the Primary Service list found in the EDI Edit Codes table or the claim will be rejected.

PW00450	N/A	I	N/A	REJECT	A6	507	460	228		2024-06-06	9999-12-31	Claims submitted after 1/1/2024 with TOB 77x, Revenue Code 0905 or 0519, and Condition Code 92 must include at least one Intensive Outpatient Program service HCPCS code from the Primary Service list or the claim will be rejected.	Claims submitted after 1/1/2024 with Facility Type Code (CLM05-1) 77x, Revenue Code (SV201) 0905 or 0519 and Condition Code "92" (Loop 2300 [HI01-2:HI12-2] where [HI01-1:HI12-1]=BG) must include at least one Intensive Outpatient Program service HCPCS code (SV202-2) from the Primary Service list found in the EDI Edit Codes table or the claim will be rejected.
PW00451	P	N/A	N/A	REJECT	A6	562	453		82	2024-08-12	9999-12-31	When a claim is received with a drug procedure code starting with a "J" and the drug code has been entered in the EDI Edit Codes table, the individual rendering provider is required or the claim will be rejected, unless the billing provider is enrolled as a home infusion provider.	When a claim is received with a drug procedure code (SV101-2) starting with a "J" and the drug code has been entered in the EDI Edit Codes table, the individual rendering provider (Loop 2420A or 2310B) is required or the claim will be rejected, unless the billing provider (2010BB) is enrolled as a home infusion provider identified by a specialty code "HI" in the PECD file.
PW00452	P	I	D	REJECT	A8	453				2024-07-19	9999-12-31	When modifiers are received on a claim, they must be entered in the modifier fields available with no gaps (Modifier1, Modifier2, etc.) or the claim will be rejected.	When modifiers are received on a claim, they must be entered in the modifier fields available with no gaps (SV101-3:SV101-6 [P], SV202-3:SV202-6 [I], SV301-3:SV301-6 [D]) or the claim will be rejected.
PW00453	N/A	I	N/A	REJECT	A7	228				2024-08-01	9999-12-31	When claims are received from select providers at Psychiatric Residential Treatment Facilities (PRTF) and the claim contains revenue codes 0101, 0180, or 0183, the claim must include the TOB 86x or the claim will be rejected.	When claims are received from select providers at Psychiatric Residential Treatment Facilities (PRTF) and the claim contains revenue codes (SV201) 0101, 0180, or 0183, the claim must include the Facility Type Code (CLM05-1) 86x or the claim will be rejected.
PW00454	P	N/A	N/A	REJECT	A7	507	453			2024-08-01	9999-12-31	Housing stabilization services are not covered for MinnesotaCare members. If claims are received with HCPCS code T2024, T2038, or H2015 and modifier U8, the claims will be rejected.	Housing stabilization services are not covered for MinnesotaCare members. If claims are received with HCPCS code T2024, T2038, or H2015" (SV101-2 [837P]) and modifier U8 (SV101-3_SV101-6 [837P]), the claims will be rejected.
PW00455	P	N/A	N/A	REJECT	A7	116	507			2024-08-28	9999-12-31	When a professional claim contains HCPCS code H2016, the claim will be rejected and will need to be forwarded to the correct payer.	When the 837P claim contains the HCPCS code H2016 (SV101-2), the claim will be rejected and will need to be forwarded to the correct payer.
PW00459	N/A	I	N/A	REJECT	A7	228				2024-12-06	9999-12-31	When a Medicare OP 837I claim is received for a Rural Emergency Hospital, it must include TOB 13X or 14X; otherwise, the claim will be rejected and sent back to the provider.	When a Medicare OP 837I claim is received for a Rural Emergency Hospital, the claim must include the Facility Type Code (CLM05-1) as 13 or 14; otherwise, it will be rejected and returned to the provider. This edit identifies the facility type by matching the group practice TIN/NPI to the appropriate affiliation record in Amisys. The provider specialty (SP) field will display "RE" for a Rural Emergency Hospital.
PW00460	P	N/A	N/A	REJECT	A7	562	453		82	2024-12-06	9999-12-31	When a claim is received with the Community First Services and Supports (CFSS) Consultation Services procedure code T1023, the rendering provider must have a specialty code of S4 in the PECD file for that date of service, or the claim will be rejected.	When a claim is received with the Community First Services and Supports (CFSS) Consultation Services procedure code T1023 (SV101-2), the rendering provider (Loop 2420A or 2310B) must have a specialty code of S4 in the PECD file for the date of service (Loop 2400 DTP03 where DTP01=472), or the claim will be rejected.
PW00461	P	N/A	N/A	REJECT	A7	562	453		85	2024-12-20	9999-12-31	When a claim is received with the Community First Services and Supports (CFSS) Consultation Services or Financial Management Services (FMS) procedure code T1019, T5999, S5116, S5160, S5161, S5162, or T2040 with modifier U8, U9, or UB in any position, the billing provider's specialty code in the PECD file must be S2 or S3 or the claim will be rejected.	When a claim is received with the Community First Services and Supports (CFSS) Consultation Services or Financial Management Services (FMS) procedure code T1019, T5999, S5116, S5160, S5161, S5162, or T2040 with modifier U8, U9, or UB in any position, (SV101-2), the billing provider (Loop 2010AA) must have a specialty code S2 or S3 in the PECD file or the claim will be rejected.

PW00462	N/A	I	N/A	REJECT	A6	507	725	726		2025-01-01	9999-12-31	Substance use disorder (SUD) services billed with TOB 86x and Revenue Code 944, 945, or 953, but without a procedure code or with procedure code H2036 the claim will be rejected when the value code is missing or the SUD value is not valid. If procedure code H2036 includes modifier HA and no value code is submitted, the claim will be allowed.	Substance use disorder (SUD) services billed with Facility Type Code 86x [Loop 2300 CLM05-1] and Revenue Code 944, 945, or 953 [Loop 2400 SV201] but without a procedure code (Loop 2400 SV202-2) or with procedure code H2036 (Loop 2400 SV202-2) the claim will be rejected when the value code (Loop 2300 HI0x-2, when HI0x-1 = BE) is missing or the SUD value (Loop 2300 HI0x-5, when HI0x-1 = BE) is not found on the EDI Edit Codes table SUD_RESIDENTIAL_TREATMENT_RATES IN Keycode. If procedure code H2036 (Loop 2400 SV202-2) includes modifier HA (Loop 2400 SV202-3:SV202-6) and no value code (Loop 2300 HI0x-2, when HI0x-1 = BE) is submitted, the claim will be allowed.
PW00463	N/A	I	N/A	REJECT	A6	188				2025-01-30	9999-12-31	When institutional claims are received without a statement from and through date, the claim will be rejected.	When institutional claims are received without a statement from and through date (Loop 2300 DTP03 where DTP01=434), the claim will be rejected.
PW00464	P	N/A	N/A	REJECT	A7	109	562	128	85	2024-12-20	9999-12-31	When claims are received from select providers whose NPI/TIN is entered in the Edi Edit Codes table as not eligible for payment, claims will be rejected.	When claims are received from select providers (Loop 2010AA NM109 [NPI] and Loop 2010AA REF02 where REF01=EI [TIN]) whose TIN/NPI entered into the Edi Edit Codes table as not eligible for payment, claims will be rejected.
PW00467	N/A	I	N/A	DENIAL						2025-05-23	9999-12-31	When a claim is submitted with a chiropractor listed as the attending provider, the procedure code must be included in the approved list of chiropractic procedure codes. Otherwise, the procedure code will be denied.	When a claim is submitted with a chiropractor listed as the attending provider (Loop 2310A)(payer system specialty code [SP35]), the procedure code (Loop 2400 SV202-2 [Institutional]), must be included in the approved list of chiropractic procedure codes. Otherwise, the procedure code will be denied.
PW00469	N/A	I	N/A	REJECT	A7	463	460	228		2025-06-11	9999-12-31	Starting January 1, 2025, Value Code D6 is required to indicate the number of dialysis sessions. ESRD claims will be rejected when TOB is 72x, the Revenue Code is 0821, and the Condition Code includes 59, 71, 72, 73, 76, or 87 without Condition Code 84, and either Value Code D6 is missing or the amount is not greater than 1.	Starting January 1, 2025, Value Code D6 is required to indicate the number of dialysis sessions. ESRD claims will be rejected when TOB (Loop 2300, CLM05-1) = "72", Revenue Code "0821" (Loop 2400, SV201), and the Condition Code (Loop 2300, HI segment with HI01-1 = "BG", HI01-2 = 59/71/72/73/76/87) is present, with no HIxx-2 = 84, and either Value Code D6 (Loop 2300, HI01-1 = "BE", HI01-2 = "D6") is missing or the amount (HI01-5) is not greater than 1.

PW00470	P	N/A	N/A	REJECT	A7	507	562	135	G2	2025-06-18	9999-12-31	837 Professional transportation claims that include Procedure Codes A0100, A0130, S0209, S0215, T2003, T2005, or T2049 and have a rendering provider (NPI/UMPI) at the service line and the rendering provider is different than the claim level, all service lines will need to have a rendering provider and each rendering provider at the service line level will need to include a HCPCS code for a trip and mileage code, or claim will be rejected.	837 Professional transportation claims that include Procedure Codes A0100, A0130, S0209, S0215, T2003, T2005, or T2049 (reported in Loop 2400 SV101-2) and have a rendering provider at the service line level (either NPI in Loop 2400 NM109 or UMPI in Loop 2400 REF02 where REF01=G2), and the rendering provider at the claim level (either NPI in Loop 2310B NM109 or UMPI in Loop 2300 REF02 where REF01=G2) is different, must include a rendering provider on each service line. Additionally, each service line must contain both a HCPCS code for a trip and a mileage code. Claims that do not meet both conditions will be rejected.
PW00471	N/A	I	N/A	DENIAL						2025-06-27	9999-12-31	When 837 Institutional chiropractic services are received, the claims are required to have a chiropractor as the attending provider and include valid subluxation diagnosis codes, with a minimum number of codes depending on the procedure code. Procedure code 98940 requires at least 1, procedure code 98941 requires at least 3, and procedure code 98942 requires at least 5 valid subluxation diagnosis codes. If the required number of subluxation diagnosis codes is not received, the claim will be denied.	When 837 Institutional chiropractic services are received, the claims are required to have a chiropractor as the attending provider and include valid subluxation diagnosis codes (HI01-2 where the qualifier is HI01-1=ABK or ABF), with a minimum number of diagnosis codes depending on the procedure code (Loop 2400 SV202-2). Procedure code 98940 (Loop 2400 SV202-2) requires at least 1, procedure code 98941 (Loop 2400 SV202-2) requires at least 3, and procedure code 98942 (Loop 2400 SV202-2) requires at least 5 valid subluxation diagnosis codes (HI01-2 where the qualifier is HI01-1=ABK or ABF). If the required number of subluxation diagnosis codes is not received, the claim will be denied.
PW00472	P	N/A	N/A	REJECT	A7	453				2025-09-11	9999-12-31	When DME claims are received for dual members with modifier "GA," "GZ," or "GY," the service line cannot include the "KX" modifier, or the claim will be rejected.	When DME claims are received for dual members with modifier "GA," "GZ," or "GY" (SV101-3:SV101-6), the service line cannot include the "KX" modifier (SV101-3:SV101-6), or the claim will be rejected.
PW00475	N/A	I	N/A	REJECT	A7	229	455	228		2025-10-20	9999-12-31	If the 837I IP Psychiatric claim has a discharge date on or after October 1, 2025, and includes charges for ER services and the patient was discharged and readmitted into the same facility as determined by a source of admission = “D,” the claim is not eligible for an ED adjustment and will be rejected.	837I IP Psychiatric claims with a discharge date (DTP03 where DTP01=434) on or after October 1, 2025; facility code (CLM05-1) 11; psych revenue codes (SV-201) 0114, 0124, 0134, 0144, or 0154; ER revenue code (SV201) 045x; provider specialty DC or CH; and source of admission (CL102) = “D” are not eligible for an ED adjustment, if the patient was discharge and readmitted into the same facility (determined by the source of admission) and will be rejected.
PW00476	P	N/A	N/A	DENY						2025-11-01	9999-12-31	As of November 1, 2025, the Housing Stabilization Program has been terminated. Claims with dates of service after October 31, 2025, that include HCPCS codes H2015, T2024, or T2038 and the modifier U8 will be denied.	As of November 1, 2025, the Housing Stabilization Program has been terminated. Claims with dates of service after October 31, 2025, that include HCPCS codes H2015, T2024, or T2038 (SV101-2) and the modifier U8 (SV101-3 – SV101-6) will be denied.
PW00477	N/A	I	N/A	REJECT	A3	228	455	460		2025-12-15	9999-12-31	Recuperative Care Facility rate claims submitted after January 1, 2024, with TOB 86x, Revenue Code 0169, and Condition Code 17 must be submitted to DHS for payment. MCOs are only responsible for the recuperative care daily services.	Recuperative Care Facility rate claims submitted after January 1, 2024, with Facility Type Code (CLM05-1) 86x, Revenue Code (SV201) 0169, and Condition Code "17" (Loop 2300 [HI01-2:HI12-2] where [HI01-1:HI12-1]=BG) must be submitted to DHS for payment. MCOs are only responsible for the recuperative care daily services.

PW00478	p	N/A	N/A	REJECT	A7	128	562	187	85	2025-12-30	9999-12-31	When procedure code T1013 is billed on a professional claim with a service date on or after January 1, 2026, and the provider’s TIN is listed in the EDI Edit Codes table, the claim will be rejected. The interpreting provider may no longer bill directly and must submit charges to the requesting facility, which will bill the payer.	When procedure code (Loop 2400 SV101-2(837P) ="T1013," is included on a professional claim with a service date (Loop 2400 DTP03 where DTP01=472) on or after January 1, 2026, and the provider's TIN is listed in the Edi Edit Codes table, the claim will be rejected. The interpreting provider may no longer bill directly and must submit charges to the requesting facility, which will bill the payer.