Claim Status Category Code	Claim Status Code	Why you received the edit	How to resolve the edit
A3	21&562	NPI sent in Invalid format	Ensure the NPI submitted has a valid last byte (check digit) if sent without Highmark # in the secondary ID
A3	21 &145	NPI sent without valid taxonomy code	If NPI only sent for provider, a valid taxonomy code must be present unless we can make a single match on the NPI.
A3	24	No link between the billing provider and trading partner	Ensure there is a link between the billing provider number and the trading partner number being used.
A3	24	No link between the billing provider and trading partner OR Provider's physical address is out of state	Ensure the provider / facility has a valid flag in CPR for the NAIC code he/she is submitting the claim under. Mountain State or HHIC claims must be from a provider in the state of West Virginia, a provider who is par with MSBCBS (645 flag) or in a MSBCBS network (flags 646-649, 651-653, 659, 660, 662, 654, 984-987).
A3	26	Billing provider not found- The submitted NPI is not on our files.	Ensure the NPI is correct and on Highmark's provider file; submitting the Highmark number during the contingency transition period in the secondary REF segment can resolve this error.
A3	33	Subscriber id invalid	Ensure the submitted subscriber id is a valid Highmark member ID for local claims.
A3	116	You did not use one of the following NAIC codes on the claim: 54771, 54828, or 71768	Ensure the NAIC code in the Payer Name Identification Code (NM109) data element corresponds to 54771(Highmark), 54828 (MSBCBS), or 71768 (HHIC)
A3	116	Submitted NAIC and Alpha Prefix edit	Ensure that on Highmark claims (NAIC=54771) the billing provider and alpha prefix reported belong to Highmark and not Blue Cross of NEPA. If the alpha prefix is NEPA/FPLIC and the provider has NEPA/FPLIC flags, the claim needs to be submitted through NEPA
A3	116	Submitted NAIC and Alpha Prefix edit	If submitted NAIC= 54828 (Mtn St).Ensure that the alpha prefix reported belongs to Mtn. St and not HHIC. If the alpha prefix is HHIC the claim needs to be submitted with 71768 (HHIC) as the payer NAIC.
A3	121	More than one line submitted on claim	For 837I claims, when bill type 322 or 332, ITS delivery method is 7, a, b, c, d, e, f, only one line can be submitted on the claim.
A3	116	Submitted NAIC and Alpha Prefix edit	Ensure the billing provider and alpha prefix reported belong to Highmark and not Capital Blue Cross.
A6	126	Subscriber address required	Ensure the subscriber's address is reported when the subscriber is the patient.
A8	128 & 562	Submitted Tax ID does not match the Tax ID on file in CPR for the submitted NPI	Ensure the submitted Tax ID matches the one on file for that NPI in CPR
A3	128	Failed to submit tax id/SSN	Ensure the Tax ID or SSN is submitted as a secondary id (REF01/REF02) when NPI is submitted as primary id (NM108/109).
A3	130	The submitted provider number is not valid for Professional Claims	For Highmark professional claims, the Billing Provider should be reported with either a 1B (HM Provider ID) or XX (NPI). Bypassed when NPI is submitted without the proprietary id.
A3	129 or 131	The submitted Provider number (Billing(85) or Service Facility(77)) is not valid for Institutional claims	For Highmark claims, the Billing Provider should be reported with either a 1A (HM Facility Provider ID) or 1C (Medicare ID) or XX (NPI) Bypassed when NPI is submitted without the proprietary id. For Mountain State claims (NAIC=54828) or HHIC claims (NAIC=71768), the billing provider MUST be reported with the 1A qualifier for claims For Mountain State claims, the 1A qualifier is reported with the Highmark ID number.
A3	138	The service facility is required if the place of service value is inpatient, skilled nursing or nursing home.	Ensure a service facility is reported when the place of service is 21, 22, 23, 31, 32, 51 or 61. Bypassed when NPI is submitted without the proprietary id.
A6	138 & 676	Service Facility required	Ensure the service facility is reported when the rendering provider is potentially compensated by a service.
A6	138 & 676	Service Facility required	Ensure the service facility is reported when the billing provider is potentially compensated by a service.
A3	145	A valid taxonomy code is required for the provider	Submit a valid taxonomy code in the PRV segment for the specified provider/facility.

Claim Status Category Code	Claim Status Code	Why you received the edit	How to resolve the edit
A8	145, 249 & 454	Conflict between place of service, provider specialty and procedure code.	Ensure that diagnostic pathology services are not submitted by an independent lab with one of the following place of service codes: 03, 06, 08, 15, 26, 50, 54, 60 or 99.
A8	145 & 454	Conflict between rendering provider and submitted procedure	Ensure that the rendering provider specialty is valid for the reported procedure code. (Billing provider is used in validation if no rendering provider is reported).
A3	153	Invalid Operating Physician (This edit is received at line level; however, the fix should be made at claim level)	Ensure an Operating Physician is reported on inpatient claims when the Revenue Code = 360-369, 490-499, or 750-759 and a Principal Procedure Code is reported. NOTE: The name and tax id in the NM1 segment of loop 2310B. The REF segment is no longer required.
A3	153	Invalid Operating Physician (This edit is received at line level; however, the fix should be made at claim level)	Ensure an Operating Physician is reported on outpatient claims when the Revenue Code = 360-369, 490-499, or 750-759 and a HCPCS code = 10000-69999 is reported. NOTE: The name and tax id in the NM1 segment of loop 2310B. The REF segment is no longer required.
A3	153	Attending Physician Required	Ensure an Attending Physician is reported for Inpatient claims. NOTE: The name and tax id in the NM1 segment of loop 2310A. The REF segment is no longer required.
A3	153	Blue Cross or Medicare number not reported and provider site is reported on a Highmark (54771C or 54771W) claim.	Ensure the 1A qualifier with the four digit Blue Cross ID or the IC qualifier with the Medicare ID is reported. Bypassed when NPI is submitted without the proprietary ID.
A3	156	Conflicting relationship codes	Ensure the relationship code is NOT reported in both the subscriber and patient loops.
A6	156	Relationship code required	Ensure the relationship code is reported in the subscriber loop when the subscriber is the patient. If the patient is NOT the subscriber, ensure the relationship code is reported in the patient loop.
A3	158	Invalid Subscriber/Patient Date of Birth	Check the format of your date based on the Imp guide
A3	158	Missing Date of Birth	Ensure the member or patient date of birth is present.
A3	158	Invalid Date of Birth	Ensure the Date of Birth is not greater than the Original Claim Receipt Date.
A8	158 & 187	Conflict between date of service and patient's date of birth	Ensure the patient's reported date of birth is prior to the date of service on professional and institutional claims.
A3	162	Missing Original Reference Number (ICN/DCN)	Ensure the ICN/DCN number (REF02) is submitted for adjustment claims.
A3	164	Missing Member/Patient Identification	Ensure the member or patient level identification (NM109) data element is submitted
A6	164	Missing member/patient identification	Ensure a contract id is reported in addition to the alpha prefix on professional and institutional BlueCard claims.
A6	164	Missing Member/Patient Identification	Ensure the member or patient level identification (NM109) data element is submitted on ALL claims.
A3	178	Allowable values edit for Non-Covered Charge Amount	Ensure the reported value is in a valid numeric format (no spaces or alphas)
A3	178	Invalid Non Covered Amount	Ensure the non-covered line charge is not greater than the charge amount.
A3	181	Service Line Rate amount required	Ensure the rate is greater than zero when the Revenue code is greater than or equal to 0100 and less than or equal to 0179 or between 0190 and 0219.
A3	187	Invalid Date of Service	Ensure a valid line level date of service is submitted.
A3	187	Invalid Begin/End Date	Ensure the Begin/End Date of Service is not greater than the Original Claim Receipt Date.
A3	187	Invalid Dates of Service	Ensure the beginning Date of Service is not before the Admission or after the Discharge date for In-Hospital of SNF claims.
A3	187	Invalid Dates of Service	Ensure the ending Date of Service is not before the Admission or after the Discharge date for In-Hospital of SNF claims.
A3	187	Invalid Dates of Service/Assessment Date	Ensure that an assessment date is submitted for Bill Type 21X with revenue code 0022. Bypass this edit if HIPPS code is default AAA00 value.

Claim Status Category Code	Claim Status Code	Why you received the edit	How to resolve the edit
A7	187	Conflict between begin and end date of service	Ensure the end date is NOT prior to the begin date of service
A6	187	Begin date of service required	Ensure the begin date of service is reported when requesting payment for a service.
A7	187	Invalid Dates of Service	Ensure the dates of service are NOT range dated on prolonged detention care procedures when reported on professional claims.
A3	187	Invalid Dates of Service./Assessment Date	Ensure an assessment date is submitted for Bill Type 21x with revenue code 0022. Bypassed if HIPPS code reported is AAA00.
A3	188	Invalid Statement from/thru Date	Check the format of your date based on the Imp guide
A3	188	Invalid From/Thru Date	Ensure the Statement Covered From Date and/or Statement Covered Thru Date is not greater than the Original Claim Receipt Date.
A3	188	Invalid Date of Service	Ensure the Date of Service is within the Statement Covers From/Thru dates.
A3	188	Invalid Statement From/Thru Dates	Ensure the date of service year is greater 1900
A3	188	Invalid Statement From/Thru Dates	Ensure the Statement Covered Thru date is not less than the Statement Covered From date.
A3	188	Invalid Statement From/Thru Date Span	If the provider has a Reimbursement Method Code of M4 and the Patient Status Code is 30, ensure the Statement From/Thru Date span equals 59 (thru date is not included in the span calculation).
A8	188 & 486	Invalid Principal Procedure Code Date	Ensure the Principal Procedure Code date is no more than three days prior to the statement covered from date and not greater than the statement covered thru dates on all inpatient institutional claims.
A8	188 & 492	Invalid Other Procedure code date	Ensure the other procedure code date is no more than three days prior to the statement covered from date and not greater than the statement covered thru dates on all inpatient institutional claims.
A3	189	Invalid Hospital Admit Date	Check the format of your date based on the Imp guide
A3	189	Invalid Admission Date	Ensure that an Admission date is reported on major medical claims if the type of bill is one of the following: 1st position = 1,2,4,5 or 6 and 2nd position = 1,2 or 5-8 OR 1st position = 3 and 2nd position = 2,3or 4; or 1st position = 8 and 2nd position - 1 or 2 and rev code = 0655 or 0656.
A3	189	Invalid Admission Date	Ensure the Admission Date is not greater than the Original Claim Receipt Date.
A3	189	Invalid Admission Date	Ensure the Admission Date year is greater than 1900
A3	189	Invalid Hospital Admission Date	Ensure the Admission date is not greater than one year prior to Discharge date.
A3	189	Invalid Hospital Admission Date	Ensure the Admission date is submitted when the Type of Bill is IP; or 1st position = 8 and 2nd position - 1 or 2 and rev code = 0655 or 0656.
A3	189	Invalid Hospital Admission Date	Ensure the Admission date is submitted for newborn, intensive care, inpatient, SNF and psychotherapy services. This Edit applies only when the place of service is 21, 22, 31, or 55; and the benefit category is IMPISH, NEWBRN, INTENS, SNF, or PSYCHO.
A3	189	Invalid Admission Date/Assessment Date Compare	Ensure the line Assessment Date is NOT less than the Admission Date for Bill Type 21x and line Revenue Code 022. Bypass this edit if HIPPS code is default AAA00 value.
A3	190	Invalid Hospital Discharge Date	Check the format of your date based on the Imp guide
A3	190	Invalid Discharge Date	Ensure that the Discharge Date is not prior to the Admission date for In-Hospital or SNF claims.
A3	190	Invalid Discharge Date	Ensure that the Discharge Date is not greater than Original Receipt Date
A3	190	Invalid Discharge Date	Ensure that the Discharge Date year is greater than 1900
A3	192	Invalid Initial Treatment Date	Check the format of your date based on the Imp guide
A3	195	Invalid Disability Begin Date	Check the format of your date based on the Imp guide
A3	196	Invalid Disability End Date	Check the format of your date based on the Imp guide
A3	214	Invalid Order and/or Prescription Date	Check the format of your date based on the Imp guide
A7	218	Invalid NDC (national drug code)	If provider has a 602 flag, ensure reported NDC is valid.
A8	218	Invalid NDC (national drug code)	If provider has a 602 flag, ensure the NDC and procedure code combination are correct.
A3	222	Invalid units for NDC	If provider has a 602 flag and is reporting an NDC, the drug units must be greater than 0
A3	228	Room and Board Required	Ensure that a Room and Board or Inpatient Hospice (0655-0656) Revenue Code is used when the Type of Bill is inpatient.

Claim Status Category Code	Claim Status Code	Why you received the edit	How to resolve the edit
A3	228	Invalid Type of Bill	Ensure the Units of Service is between 8 and 24 when the Revenue Code is 0652 and the Type of Bill is 33*, 81* or 82*.
A3	228	Invalid Type of Bill	Ensure the Type of Bill is a valid value.
A3	228	Invalid Type of Bill for Provider	If provider has a Reimbursement Method Code of M4, Bill Type must be 327, 337, 329 or 339.
A3	229	Invalid Source of Admission	Ensure the Admission Source Code is an allowable value of 1-9 or A-C.
A3	229	Invalid Source of Admission	Ensure a valid Admission Source is present when the Bill Type is 11X or 21X; or when Bill Type is 81X or 82X and revenue code = 655 or 656.
A3	230	Allowable values edit for the Admission Hour	Ensure the hour reported is between 00-23 and the minutes are between 00-59.
A3	231	Allowable values edit for the Admission Type Code	Ensure the Admission Type Code is an allowable value of 1,2,3,4,5, or 9.
A3	231	Invalid Type of Admission	Ensure that a valid Admission Type is present when the Bill Type is 11X or 21X; or Bill Type is 81X or 82X and revenue code = 655 or 656.
A3	232	Admitting DX Code Required	Ensure that an Admitting DX Code is reported when Bill Type = 11X Ensure that an Admitting DX Code is reported when the billing provider is PA provider, Bill Type = 13X or 85X, the admission type = 1, 2, or 5 and revenue code = 45X; or 51X; or 526; or 762 are reported. NOTE: PA Act 112 (state mandate), requires the admitting diagnosis with a final or principle diagnosis on ALL claims with emergency services. This does not apply to Mountain State (NAIC=54828) or HHIC (NAIC 71768).
A3	233	Allowable values edit for the Discharge Hour	Ensure the hour is between 00-23 and the minutes are between 00-59. (10/10/03)
A3	234	Invalid Patient Status Code	Ensure the Patient Status Code is an allowable value of 01-09, 20, 30, 40-43, 50, 51, 61, 62, 63, or 64.
A3	234	Invalid Patient Status Code	Ensure that Patient Status is 30 (still patient) if using a Bill type of XX2 or XX3 (interim bill).
A3	234	Patient Status Required	Ensure that the Patient Status is reported when the Bill Type indicates Inpatient.
A3	247	Informational only- Multiple Line level errors exist	Correct the various line level errors.
A3	248	On Professional claims there is a cross edit between the Accident date and the Related Cause code if the cause code is AA or OA (Auto or Other)	Ensure that there is an Accident date when AA or OA Related Cause Code is sent
A3	248	On Professional claims there is a cross edit between the Related Cause code and the Accident State	Ensure that there is a valid state abbreviation given when the Related Cause Code = AA or OA.
A3	248	Invalid Accident Date	Check the format of your date based on the Imp guide
A3	249	Place of Service Required	Ensure claim level place of service is present
A3	249	Place of Service Invalid	Ensure place of service code at claim level or line level are valid national codes.
A8	249 & 675	Conflict between begin date of service & admission/discharge dates	Ensure the begin date is NOT within the admission/discharge dates when the place of service is NOT inpatient hospital or skilled nursing on a professional claim.
A8	249 & 675	Conflict between end date of service & admission/discharge dates	Ensure the end date is NOT within the admission/discharge dates when the place of service is NOT inpatient hospital or skilled nursing on a professional claim.
A8	249 & 454	Conflict between place of service and procedure code reported	Ensure that the place of service is valid for the procedure code is reported on all professional claims.
A3	255	DX code not valid	Ensure the DX code is valid and the date of service is within the effective and cancel dates

Claim Status Category Code	Claim Status Code	Why you received the edit	How to resolve the edit
A3	255	DX code not valid	Ensure the DX is coded to the highest level of specificity which was available for the date of service. Use 4th or 5th digit if available. **Professional** - compares begin and ending dates of service on the line against the diagnosis specificity begin and end dates **Inpatient institutional** - compares the statement end date against the diagnosis specificity begin and end dates **Outpatient institutional** - compares the statement begin and end dates against the diagnosis specificity begin and end dates.
A3	255	DX Code (principal, other, admitting or emergency) not valid	Ensure that the DX code (principal, other, admitting or emergency) is valid based on the statement from and thru dates and the effective and deletion dates on the DX db.
A6	255	E-code is required	For inpatient institutional claims, an emergency diagnosis code is required if reporting an e-code POA indicator after the terminator.
A6	255	E-code is required	For inpatient, institutional claims, ensure that if the e-code POA indicator after the terminator indicator of Z or X is reported that the emergency diagnosis code present.
A3	258	Date Units Conflict/non interim claims	Ensure that when the Revenue Code = 0100-0219, 655 or 656 that the Units of service is equal to the covered days. Covered days is calculated for non-interim claims by counting the number of days between the Statement From and To Dates (Do not count the Statement To Date on non-interim claims)
A3	258	Date Units Conflict/interim claims	Ensure when the Revenue Code = 0100-0219, 655 or 656 the Units of Service is equal to the covered days. Covered days is calculated for interim claims by counting the number of days between the Statement From and To Dates (Count BOTH the Statement From and Through date on interim claims, interim claims have a bill type ending in 2 or 3).
A6	286	Other payer adjustments/payment required	Ensure that CAS codes and amounts are reported at the claim or line level when the reported other payer claim level paid amount does NOT= the total claim charge on all local claims. Note: This edit only applies when the claim level payment amount is greater than zero.
A6	286	Other payer adjustments/payment required	Ensure that CAS codes and amounts are reported at the claim level when the sum of the LINE level other payer paid amounts reported does NOT= the CLAIM level paid amount for each payer identified on all local claims.
A3	397	Invalid Date of Onset	Check the format of your date based on the Imp guide
A3	400	Claim is out of balance	Ensure that the sum of all lines of the institutional/ professional claim match the claim total charge amount. This does not include the 0001 revenue code line
A3	400	Claim is out of balance	Ensure the sum of all institutional lines match the 0001 revenue code line if one is reported.
A3	400	Claim is out of balance	Ensure the claim total charge equals the 0001 revenue code line if one is reported.
A3	400	Claim is out of Balance	Ensure the sum of the line charges match the total admission charge.
A3	402	General edit on AMT fields	Must be greater than or equal to zero
A3	448	Invalid Type of bill for IP Hospice	Ensure that if the facility being used, is setup with an RMC of 46 for the product based on the member's coverage and it is effective based on the statement thru date that the bill type is 21X, 81X or 82X. Bypassed if NPI returns multiple providers.
A3	448	Invalid Type of bill for OP Hospice	Ensure that if the facility being used, is setup with an RMC of 86 for the product based on the member's coverage and it is effective based on the statement from date that the bill type is 33X, 81X or 82X. Bypassed if NPI returns multiple providers.
A3	448	Type of Bill is Interim, facility not flagged	Ensure the Facility is flagged for interim billing on CPR when the Bill Type indicates interim bill (XX2, XX3, XX4). Bypassed if NPI returns multiple providers.

Claim Status Category Code	Claim Status Code	Why you received the edit	How to resolve the edit
A3	448	Invalid Admission Date	Ensure the Admission Date is not greater than the Statement From Date when Bill Type indicates XX3 or XX4.
A3	448	Invalid Revenue IP Hospice	Ensure that if the facility being used, is setup with an RMC of 46 for the product based on the member's coverage and it is effective based on the statement thru date that the bill type is 21X, 81X or 82X and Revenue Code 0655 or 0656 are reported. Bypassed if NPI returns multiple providers.
A3	448	Invalid Revenue OP Hospice	Ensure that if the facility being used, is setup with an RMC of 86 for the product based on the member's coverage and it is effective based on the statement from date that the bill type is 33X, 81X or 82X and Revenue Code 0651 or 0652 are reported. Bypassed if NPI returns multiple providers.
A3	448	Invalid HCPCS code	Ensure that a Secondary Procedure Code is submitted when the Bill type is 131, 141 or 831, the HCPCS switch on CPR = Y and the Revenue Code is '0240' THRU '0249', '0260', '0269', '0274', '0280' THRU '0289', '0300' THRU '0324', '0331' THRU '0333', '0335', '0340' THRU '0342', '0350' THRU '0352', '0360' THRU '0369', '0400' THRU '0404', '0410' THRU '0482', '0510' THRU '0539', '0609' THRU '0612', '0619', '0624', '0637', '0669', '0730' THRU '0732', '0739' THRU '0759', '0790' THRU '0799', '0900' THRU '0925', '0929', '0940' THRU '0941', '0943' THRU '0945', '0949', '0960' THRU '0989' for all claims. For host claims with delivery method 7 or C, ensure that the secondary procedure code is submitted when the bill type is 12*, 13*, 14*, or 83* and the revenue code is '0278', '0302', '0305', '0310' THRU '0312', '0314', '0319', '0320' THRU '0324', '0329', '0333', '0340' THRU '0344', '0349', '0360' THRU '0362', '0367', '0369', '0370' THRU '0372', '0374', '0379', '0413', '0450' THRU '0452', '0456', '0459', '0460', '0469', '0480', '0481', '0482', '0483', '0510' THRU '0517', '0519', '0530', '0636', '0730' THRU '0732', '0739', '0740', '0749', '0771', '0880
A3	448	A secondary procedure code required for reported revenue code	Ensure that a secondary procedure code is submitted for outpatient Highmark claims (54771C or 54771W) when revenue code reported has cost sharing code = C, P, M, or I on the revenue code database. This edit does not apply to indemnity products.
A3	448	PIRC - Interim Billing not Allowed	Ensure the hospital stay is greater than 59 days on inpatient continuing interim bill claims when the RMC is 66. Bypassed if NPI returns multiple providers.
A3	448	Invalid DX code for Renal Dialysis	Ensure that when the RMC is 85, the bill type is 721 that the Principal DX code is in the WES (End Stage Renal) Group. Bypassed if NPI returns multiple providers.
A3	448	Invalid Admission Date	Ensure the Admission Date is not equal to the Statement From Date for an inpatient claims and the Bill Type ended with 3 or 4.
A3	448	Invalid Date of Service	Ensure the Dates of Service differ for the Revenue Codes 0651 and 0652 when the Bill Type = 33X, 81X or 82X .
A3	448	Missing Procedure Description	Ensure that a Procedure Description is reported when using an NOC HCPCS code or revenue code.
A3	448	Provider Site Required	Ensure that the Provider Site number is entered when the RMC is 88 and the number of sites field on CPR is greater than 01. Bypassed if NPI returns multiple providers.
A3	448	Anesthesia minutes greater than 4 bytes	Report anesthesia time based on correct number of minutes
A3	448	Invalid Revenue Code	Revenue code 0655 and 0656 cannot both be present when bill type = 21X, 81X or 82X and reimbursement method code = 46.
A3	448	Invalid Revenue Code combination	Inpatient and outpatient hospice revenue codes cannot be submitted on the same claim. (inpatient - 0655 or 0656) (outpatient - 0651 or 0652)
A3	448	Revenue Code must be present	When Bill type is = to 81X or 82X revenue codes 0651, 0652, 0655 or 0656 must be present when reimbursement method is 46 or 86. Bypassed if NPI returns multiple providers.
A3	448	NAIC Code	Ensure the GS Receiver Code and NM1 Payer Code match.
A3	452	Units of Service Greater than 24	Ensure that the number of services is not greater than 24 when the Revenue code is 0989 and the Bill type is 331, 332, 333 or 334.

Claim Status Category Code	Claim Status Code	Why you received the edit	How to resolve the edit
A3	453	The submitted Procedure Code Modifier is verified against the Modifier db. Must be a national value and the date of service must be within the effective and cancel dates. If the Procedure Code Modifier is internal or local the claim will be rejected	Ensure the Procedure Code Modifier is a National value and that the date of service is within the effective and cancel dates.
A6	453	Anesthesia certification modifier required	Ensure that one of the following anesthesia certification modifiers is submitted on professional anesthesia claims when the billing provider is not a CRNA: AA-AE, GC, QK, QX, QY or WP. If the billing provider is NOT par or NOT in PA, one of the following anesthesia certification modifiers is required on anesthesia claims: AA-AE, GC, QK, QX, QY, QZ, WP, or 47. NOTE: Excludes oral surgery claims.
A6	453	Anesthesia certification modifier required	Ensure that one of the following anesthesia certification modifier is submitted on professional anesthesia claims when the billing provider IS a CRNA: QX, QZ or 47. If the CRNA/billing provider is NOT par or NOT in PA, one of the following anesthesia certification modifiers is required on anesthesia claims: AA-AE, GC, QK, QX, QY, QZ, WP, or 47. NOTE: Excludes oral surgery claims.
A8	453 & 454	Conflict between submitted procedure code and modifier	Ensure that anesthesia modifiers are not submitted on non-anesthesia procedure codes.
A3	454	The submitted Procedure Code is verified against the Procedure Code db. Must be a national value and the date of service must be within the effective and cancel dates. If the Procedure Code is internal or local the claim will be rejected	Ensure the Procedure Code is a National value and that the date of service is within the effective and cancel dates.
A3	454	Procedure code not valid	Ensure the secondary HCPCS code is valid based on the Procedure Code database and the date of service or statement from/thru dates are within the procedure codes effective/cancel dates.
A3	454	Procedure code not valid	Ensure the date of service is within the effective and cancel dates and code is not internal
A3	454	Procedure code not valid	Ensure the procedure code reported is not a dental 'D' code. NOTE: Dental 'D' codes will be accepted on Mountain State or HHIC claims.
A8	454 & 145	Provider not eligible for reported procedure	The billing provider must be a professional provider on professional claim.
A3	455	Bill type *7* reported without a 19* Revenue Code	Ensure that if a Bill type X7X is reported that a corresponding 019X Revenue Code is also reported.
A3	460	Allowable values edit for Condition Code	Ensure the values are 01-11, 17-34, 36-44, 46, 48, 55-58, 60, 61, 63, 66-79, AA-AN, A0-A6, A9, B0-B3, C1-C7, D0-D9, E0, G0 or H0 (01/20/04)
A3	460	Occurrence Code M0 (zero) reported without Condition Code C3	Ensure that for non-major medical institutional claim that the Occurrence Code of M0 (zero) is reported with a Condition Code of C3.
A3	461	Invalid Occurrence Code Date	Check the format of your date based on the Imp guide
A3	461	Allowable values edit for the Occurrence Code	Ensure the values are 01-06, 09-12, 16-47, A1-A4, B1-B3, C1-C3, E1-E3, F1-F3 or G1-G3 (10/10/03)
A3	461	Invalid Occurrence Date	Ensure that the Occurrence Date is not greater than the Original Receipt Date.
A3	461	Invalid Occurrence Date	Ensure that identical Occurrence Codes are not used on separate dates.
A3	461	Invalid Occurrence Code	Ensure the Occurrence code is entered when an Occurrence Date is utilized.
A3	462	Invalid Occurrence Span Code Date	Check the format of your date based on the Imp guide
A3	462	Allowable values edit for the Occurrence Span Code	Ensure the values are 70-78, M0 - M4 (10/10/03)
A3	462	Invalid Occurrence Span Date	Ensure that the Occurrence Span Date is not greater than the Original Receipt Date.
A3	462	Invalid Occurrence Span Date	Ensure that the Occurrence Span Thru date is not less than the Occurrence Span From date.
A3	463	Allowable values edit for the Value Code	Ensure the values are 01, 02, 04-06, 08-16, 21-35, 37-55, 56-61, 66 - 69, A0, A3-A6, B3, C3, D3, E1-E3, E7, F1-F3, F7, G1-G3, G7, AA ,AB, BA, BB, CA, CB, EA, EB, FA, FB, GA, GB (01/20/04)
A3	463	Invalid Value Amount	Value amount is required when Value Code is NOT 02, 12, 13, 14,15, 16, 41, 42, 43, 45 or 47

Claim Status Category Code	Claim Status Code	Why you received the edit	How to resolve the edit
A3	463	Invalid Value Code	If provider provider has a Reimbursement Method Code of M4, the Value Code must be 61.
A7	463	Invalid value code	Ensure value codes 80-83, A1, B1, C1, A2, B2, C2, A7, B7 or C7 are NOT reported. Note: These codes must be reported in their distinct fields or for other insurance amounts, report CAS codes.
A3	465	Principal Procedure Code Invalid	Ensure Principal Procedure Code is in a valid format for Procedure Code Method reported. Fifth position must be a space when the procedure coding qualifier is 'BR' . Fifth position must be populated when procedure coding qualifier is 'BP'.
A7	465 & 486	Principal Procedure Code invalid for date of service	Ensure that the procedure code reported is valid for the principle procedure date reported. NOTE: A principal procedure date is not required when the code is reported as a HCPC code; therefore, the code must be valid based on the statement dates reported. NOTE: Procedure is considered valid when the reported date = the procedure deletion date.
A3	475	Procedure code not valid for patient's age	Ensure the age of the patient is between the minimum and maximum eligible for the procedure.
A3	477	Diagnosis code pointer is invalid	Make sure all diagnosis pointers on lines are pointing to the correct number for the submitted diagnoses
A3	479	Invalid Other Carrier Payer Id	Ensure the Other Payer Primary Id (NM109 in 2330B) matches the Payer ID (SVD01 in 2430).
A3	482	Invalid date format	Check the format of your date based on the Imp guide (837I)
A3	486	Invalid Procedure Code Date	Ensure that a Principal Procedure Code Date is entered when a Principle Procedure code is present with 'BR' procedure code qualifier.
A3	488	Professional Diagnosis Occurrence Counter is '0'.	Ensure the appropriate Diagnosis Codes are entered on the claim and that the counter is set properly. Professional.
A3	490	Invalid Other Procedure Code	Ensure the Other Procedure Code is in valid format for the procedure code method reported. Fifth position must be a space when the procedure coding qualifier is 'BQ' . Fifth position must be populated when procedure coding qualifier is 'BO'. Must be in the same format as the principal procedure code.
A7	490 & 492	Other procedure code invalid for date of service	Ensure the other procedure code reported is valid for the other procedure date reported. NOTE: An other procedure date is not required when the code is reported as a HCPC code; therefore, the code must be valid based on the statement dates reported. NOTE: Procedure is considered valid when the reported date = the procedure deletion date.
A3	492	Invalid Other Procedure Code Date	Ensure Other Procedure Code Date is reported when Other Procedure Codes are submitted with a 'BQ' procedure code qualifier.
A3	493	Submitter utilized 4010 version vs. 4010A1	Non-Addenda version of the 837 transactions are not accepted
A3	506	Amerihealth claim submitted to incorrect payer/processor	Ensure claims submitted with NAIC Code 60061 or 93688 for AmeriHealth members go to IBC with 54704 in the ISA08
A3	506	Personal Choice claim submitted to incorrect payer/processor	Ensure claims submitted with NAIC Code 54704 for Personal Choice members go to IBC with 54704 in the ISA08
A3	506	Personal Choice claim submitted to incorrect payer/processor	Ensure claims submitted with NAIC Code 54704 for G3PN members identified by the following alpha prefixes: UPP, NRG, AMS, ATS, NJP, YHF have dates of service prior to 1/1/06. Claims with Dates after 1/1/06 should go to IBC
A3	513	HIPPS Code invalid	Ensure the HIPPS code is valid code.
A3	513	HIPPS Code invalid	Ensure the Receipt Date is within the Effective date and Cancellation date of the HIPPS Code
A3	513	HIPPS Code invalid	Ensure the correct HIPPS code is submitted with the correct Revenue Code.
A3	562	Invalid NPI submitted	Ensure that a correct NPI is submitted for the specified provider/facility
A3	672	Other payer payment information out of balance	Ensure the sum of all LINE level CAS amounts + the LINE level paid amount is = the LINE charge reported for each payer identified on all non-host claims.

Claim Status Category Code	Claim Status Code	Why you received the edit	How to resolve the edit
A3	672	Other payer payment information out of balance	When the other payer reports claim adjudication at the claim level only, ensure the CLAIM level payment amount + the sum of the CLAIM CAS amounts = the total claim charge for each payer identified on all non-host claims. NOTE: This edit applies only when the claim level payment amount is greater than zero & the other payer's adjudication is NOT reported at the line level..
A3	678	Conflict between gender and revenue code	Ensure the patient's gender is valid for the revenue code reported (edit not applied when 'U'/unknown gender is reported)
A6	688	Present on Admission (POA) indicator is required	For inpatient institutional claims, if billing provider is NOT exempt, and admitting date is greater than or equal to 10/01/2007, POA indicators should be reported on the K3 segment.
A6	688	The total number of POA indicators do not equal the total number of secondary diagnosis codes.	For inpatient institutional claims, total number of POA indicators reported must be equal to the total number of secondary diagnosis codes.
A7	688	Valid Present on Admission (POA) indicators are required	For inpatient institutional claims, POA indicators of Y, N, U, W and 1 with a terminator of X or Z, are required in the K3 Segment
A7	688	A terminator of Z or X is required on claims with Present on Admission (POA) indicators	For inpatient institutional claims, a Z or X terminator must be reported NOTE: The Z or X should be reported at the end of the POA string (ex: POANYWIZ) An e-code may be reported after the terminator Z or X.
A8	688/255	Total number of Present on Admission (POA) indicators exceed the total number of secondary diagnosis codes	For inpatient institutional claims, the total number of POA indicators must not exceed the total number of secondary diagnosis codes. NOTE: The 255 edit DOES NOT meant that the diagnosis code is invalid in this case.