Region D DMERC
EDI Department

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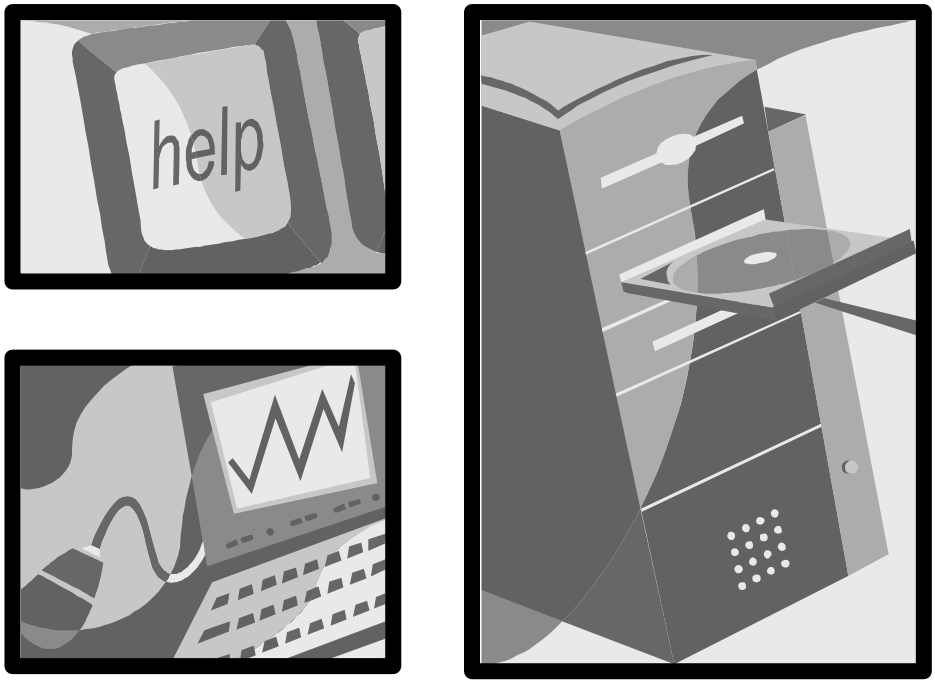
Region D DMERC

EDI Manual



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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

CIGNA HealthCare
Medicare Administration

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Introduction

Congratulations on your recent decision to start billing electronically. Electronic Media Claims (EMC) is *transmitting* your claims via computer rather than *submitting* your claims on paper. (*MCM 5240C)* The ***Region D DMERC EDI Manual*** has been developed to assist electronic billers in successfully transmitting their Region D DMERC claims to CIGNA Medicare. Below is an overview of what you can expect to find in this manual.

When you elect to transmit your claims electronically, you open yourself up to many opportunities that will ultimately benefit your business by improving your processes. ***Chapter 1*** identifies the various benefits of billing electronically.

As an existing biller, one of the benefits of billing electronically is the opportunity to sign-up for additional EDI products and services. ***Chapter 2*** provides detailed explanations and specific requirements for each of the additional EDI products and services such as: Claim Status Inquiry (CSI), Electronic Remittance Notices (ERNs) and Beneficiary Eligibility.

Chapter 3 describes the two types of EDI reviews that may be conducted by CIGNA Medicare. We will conduct EDI reviews periodically to ensure that the necessary source documents are being maintained and that the guidelines for submitting electronic claims are being followed.

New electronic billers must test their software compatibility before they are approved to transmit production claims. ***Chapter 4*** of this manual describes the testing process and identifies the requirements for passing successfully. There is also a list of common questions and answers regarding the testing process.

Chapter 5 contains the Stratus Network User Guide. You will find step-by-step instructions on transmitting claims from start to finish, including how to download reports such as the Functional Acknowledgement report (997) and the Electronic Report Package.

Information on electronic reports may be found in ***Chapter 6***, which includes sample reports with descriptions.

Transmitted claims are checked against three levels of front-end edits to make sure the claims are complete and correct. If there are errors detected on the transmitted claims, then the claim will not make it into the system for processing. In this case, a front-end edit will occur. There is an entire chapter dedicated to each level of edits that may be received when transmitting claims electronically. Each edit contains the edit number, edit description, and edit explanation to assist in correcting the error. ***Chapter 7*** contains the Implementation Guide edits. ***Chapter 8*** contains the Medicare edits and ***Chapter 9*** contains the DMERC edits.

If you have questions about transmitting your claims please turn to ***Chapter 10***, Contact Information. This chapter will help you find the correct contact to answer your specific question. Please read the options carefully to determine whom to contact for your specific issue. To contact the EDI Department, call 866.224.3094 (toll-free), option 1 for customer service or option 2 for technical support.

Finally, in the back of this manual is an ***Appendix*** which includes the DMERC Region D Companion Document/Trading Partner Agreement, followed by an ***EDI Glossary***.

We are confident that you will be pleased with your decision to bill electronically and encourage you to stay up-to-date with the latest on EDI and utilize all possible options to maximize your business' efficiency.

EDI … Working together to meet your needs

Chapter One:

Benefits of Billing Electronically

When you elect to bill electronically, you elect to open yourself up to many benefits of transmitting claims electronically. The following provides a brief overview of the various benefits of billing electronically.

Faster payment

Billing electronically cuts the disbursement time in half and improves cash flow. The payment floor for clean paper claims is 26 days, which means that on the 27th day, if it is a clean claim, you will be eligible to receive payment. A "clean" claim is one which does not require "you" to investigate or develop outside your Medicare operation on a pre-payment basis. (*MCM 5240.11.1A)* Whereas with electronic claims, the payment floor is 13 days, which means that on the 14th day, a clean claim will be eligible to receive payment. Simply put, by transmitting electronically, your Medicare payments are processed and mailed out 13 days faster than submitting on paper.

Increased tracking capabilities and increased control over the billing process

Electronic billing allows more tracking methods than paper billing, which gives you more control over the billing process. With electronic billing, claims can be tracked in the following ways:

Online receipt verification

After transmitting your claims to us, you will receive automatic verification that the transmission was successful. Although the confirmation will not give you details about your claims, it will acknowledge receipt of that file. The number of claims received and the total dollar value of the claims transmitted may also be verified. (*MCM 3023.2*)

Electronic reports

Within two days of a successful transmission, you may download an Electronic Report Package. Included in the reports package is the Received Claims Listing report which will identify the claims that were accepted into our system for processing by assigning each claim a Claim Control Number (CCN). If claims were rejected, an Error Listing report will also be included in the reports package. The Error Listing report will identify which claims contained errors due to a lack of, or an error in, critical information transmitted. Rejected claims may then be corrected and retransmitted with minimal impact on reimbursement time.

Reduces costs

Transmitting electronically reduces the need for paper claim forms. Postage and handling costs will also be reduced since you will not have to mail your claim. In addition, billing electronically results in more efficient use of office staff by freeing up time spent manually processing claims and transactions.

24-hour claim transmission

Billing electronically allows you to transmit claims 24 hours a day. You are not bound by daily mail pick-ups, unnecessary trips to the post office or holiday and weekend mail restrictions. Additionally, you are able to select the time you want to transmit your claims based around your schedule.

Automatic transferring to other DMERCs

Paper claims must be mailed to the appropriate DMERC and will be returned by mail if they are received by another DMERC. Whereas, if a claim is transmitted electronically for a beneficiary who resides in another region, we will automatically transfer the claim to the appropriate DMERC based on the beneficiary's address indicated on the claim.
Note: In order for the claim to be processed by another DMERC, you must have an EDI Enrollment Form on file with each DMERC for which the claim will be transferred.

Free electronic billing software and support

The Centers for Medicare and Medicaid Services (CMS) mandates that all DMERCs provide and support a free billing software designed to build and transmit Medicare claims electronically. DMERC Medicare Automated Claims System (DMACS32) is a basic, easy-to-use software package offered by the DMERC EDI Department. *(MCM 3023*) An upgrade, or equivalent, based on the HIPAA-standard ANSI X12N 4010 format, is scheduled for release in April 2002.

Electronic Funds Transfer (EFT)

This is an optional benefit available to both electronic and/or paper billers. Your payment checks will be direct deposited into your bank account and available two days after payment is disbursed. Paper checks can take as long as one week to process. (*MCM 3021.2*)

EDI Web site section

This section has been developed specifically as a resource for potential and existing electronic billers. You may access this section via the CIGNA Medicare Web site. Point your browser to *www.cignamedicare.com/edi* to access information on EDI products and services, system updates, getting started information, technical requirements and contact information, a link to the *EDI Edge*, vendor lists, and, most importantly, the EDI forms and applications.

EDI Edge

This is the quarterly newsletter that serves as an information source for electronic billers. This newsletter is available exclusively via the CIGNA Medicare Web site. It contains information on new updates to the EDI Department, tips on fixing front-end rejections, frequently asked questions, and other articles to assist electronic billers.

Electronic Mailing List

Sign up for our electronic mailing list and receive the latest on EDI automatically. In addition to being notified of the most up-to-date news on Medicare, you will also be notified when there is a new issue of the *EDI Edge* available on the Web site. To sign up for the list, go to *www.cignamedicare.com*. There is no charge for this membership.

Additional EDI products and services

Once you are enrolled and an active electronic biller, there are several additional EDI products and services available to improve your productivity and to allow for more claim control. Below is a brief overview of each of the options. Refer to Chapter 2 of this manual for more details and specific requirements on EDI products and services.

Electronic Remittance Notices (ERNs)

ERNs are electronic reports of claim payment and/or denial information from CIGNA Medicare. This information, when used in conjunction with the necessary ERN reader software, may be posted automatically to your accounts receivable and/or patient billing system. You are given the option of receiving the ERNs on a daily or weekly basis. The ERN is the electronic equivalent to a Medicare Remittance Notice. (*MCM 3023.2*)

Claim Status Inquiry (CSI)

Within three days of a successful transmission, you can log into the system and check the status of your claims. This is an additional tracking device available once Medicare has received claims. Through CSI, you will know if your claims have been paid, denied, or are still pending. CSI enables you to search for specific claims and view individual claims. (*MCM 3023.2C*) CSI is available Monday - Saturday from 7:00 a.m. to 6:00 a.m. ET. You may obtain this software by contacting the EDI Department.

Beneficiary Eligibility

This option is available only to ***participating*** suppliers. This function allows participating suppliers to send us a file containing the beneficiary name, HICN, and date of birth. (*MCM 3021.5-3021.6)* We will then send a file back including information on the beneficiary's eligibility dates, deductible information, and HMO enrollment status. This function requires a program to build the file to send to us and to read the file when it is returned. CIGNA Medicare does not provide this software.

Chapter Two:

EDI Products and Services

Once you are enrolled and an active electronic biller, there are additional EDI products and services available to improve your business' productivity. These include **Claim Status Inquiry, Electronic Remittance Notices, and Beneficiary Eligibility.** The following pages provide a detailed explanation and the requirements for each EDI option. **Remember:** To apply for any of these options, you must submit the DMERC EDI Customer Profile located in the Appendix of this manual.

Claim Status Inquiry (CSI)

Claim Status Inquiry (CSI) allows you to electronically check the status of production claims after they have passed the front-end edits and received Claim Control Numbers (CCNs). *(MCM 3023.2)*

Through CSI, you will know if your claim has been paid, denied, or is still pending. At least three working days after you successfully transmit an electronic claim, you will be able to locate your claim in the processing cycle. If you are checking the status of pending claims, there are additional screens available which contain more detailed status information. CSI is available for both electronic and paper claims.

Overview of CSI

CSI is divided into the following two main functions:

- General claims information
- Pending claims information

General claims information

The provider claims display screen provides the following information about electronic claims transmitted during the last 18 months:

- Paid or denied claims (**Note:** CSI does not display payment amounts for non-assigned claims.)
- Claims not paid due to full payment made by other insurance(s) or through deductible requirements
- Claims electronically transferred to another DMERC for processing (**Note:** These claims do not display after 45 days of the transmission.)
- Pending claims (**Note:** These are claims that have not been resolved or have not processed completely.)

Pending claims information

This function of CSI gives more detailed information about pending claims, including the check date and estimated mailing date. The pending claims screen does not include information on a claim if a check for that claim has already been mailed or if the claim has been denied.

Assigned pending claims fall into three categories:

1. Claims waiting for information from the Common Working File (CWF), i.e. grandfathered Certificates of Medical Necessity (CMNs) or patient eligibility, before they can be processed.
2. Claims that have been processed but the check has not been mailed.
3. Claims which require additional information or review to complete processing, such as medical or utilization review, and/or development letters.

Hours of operation and support

CSI is available Monday through Saturday from 7:00 a.m. to 6:00 a.m. ET. For questions about the software and/or about transmitting claims, contact the EDI Department between the hours of 8:00 a.m. and 5:00 p.m. MT.

Accessing CSI

To access CSI, AT&T Passport for Windows communications software is available for Region D DMERC billers. CIGNA Medicare provides this software for a fee of $25.00 to cover shipping and handling costs.

AT&T charges all users a monthly fee of $3.00 for an AT&T account and UserID. If you are using the AT&T Global Network, you will be billed by AT&T for their network usage at the following rates:

- Hourly rate for prime time usage - $6.50 (8:00 a.m. to 8:00 p.m. ET)
- Hourly rate for non-prime time usage - $4.45 (8:00 p.m. to 8:00 a.m. ET)
- Hourly surcharge for an 800 number (if a local node is unavailable) - $6.00

Note: You will not incur expenses from the phone company if dialing the local AT&T number provided. AT&T rates are subject to change.

Minimum hardware requirements

Requirements listed below are minimum requirements for running the AT&T Passport for Windows communications software. Some PCs may require higher standards.

- Any PC capable of running MS Windows version 95 or higher in 386 enhanced mode or better
- At least 2.5 MB of available disk space
- At least 12 MB of RAM, but more is recommended. We highly recommend at least 32 MB of RAM.
- A 3.5-inch (1.44 MB) disk drive (required for installation)
- A mouse (optional, but highly recommended)
- A serial port
- A Hayes-compatible asynchronous modem that is 2400 bps or faster (at least 9600 bps is highly recommended) **Note:** Rockwell modems are NOT considered Hayes-compatible and, therefore, cannot be supported
- An analog telephone line attached to your modem

Enrolling in CSI

The following are the necessary steps for enrolling in CSI.

1. Complete the DMERC EDI Customer Profile form and select CSI as an additional feature. This form is located in the Appendix of this manual. It is also available through the EDI Web site section, located at *www.cignamedicare.com/edi/*.
2. Return completed form to CIGNA Medicare along with a $25 check for AT&T Passport for Windows software.
3. Upon receipt, CIGNA Medicare will process your request and mail your CSI Manual, your RCD number, and the AT&T Passport for Windows communications software. **Note:** Please allow 10-21 business days for processing.
4. Sign and return the AT&T Global Network Services Limited Service User's Agreement to AT&T. A copy of this agreement is located in the CSI Manual.
5. Upon receipt of the signed agreement, AT&T will issue you an AT&T account and User ID.
6. Once you receive your AT&T account and User ID you are ready to use CSI.

Electronic Remittance Notices

An **Electronic Remittance Notice (ERN)** is an electronic data file that shows claims that have been paid and the dollar amounts for each claim. ***(MCM 3023.2)*** In addition, it shows claims denied with the reason for denial. This file is the same as the Provider Remittance Notices suppliers receive through the mail. You will be given the option of receiving the ERNs on a daily or weekly basis.

Once the ERN file has been downloaded from your Stratus mailbox, an ERN reader is required to view and print out in a readable format. ERN reader software may be purchased from a software vendor.

If you would like to program your own ERN reader software, you will need to download the ANSI X12N 4010 835 Implementation Guide. This may be downloaded free-of-charge from *www.wpc-edi.com.*

Receiving ERNs

The following are the necessary steps to begin receiving ERNs.

1. Complete the DMERC EDI Customer Profile form and select ERNs as an additional feature. This form is located in the Appendix of this manual. It is also available through the EDI Web site section, located at *www.cignamedicare.com/edi/.*
2. Return completed form to CIGNA Medicare.
3. Upon receipt, CIGNA Medicare will process your request to begin receiving your remittance advices electronically. **Note:** Please allow 10-21 business days for processing.

Note: If you have elected to sign up to receive ERNs, and are currently using the Electronic Funds Transfer (EFT) option, all paper remittance notices will be discontinued in 30 days.

Beneficiary Eligibility

Beneficiary Eligibility is an option available to ***participating**** suppliers only. This function allows participating suppliers to send CIGNA Medicare a file containing beneficiary information, and CIGNA Medicare will send a file back including information on beneficiary eligibility dates and deductible information. *(MCM 3021.5 - 3021.7)*

Process

The process begins by creating a file that contains the following beneficiary information. This file is sent to CIGNA Medicare via the Stratus Network.

- Beneficiary's ID number (your account number)
- Beneficiary's Health Insurance Claim Number (HICN)
- A portion of the beneficiary's name
- The sex of the beneficiary

Approximately 48 hours later, CIGNA Medicare will return a response file containing the following information on the beneficiary.

- Beneficiary's Medicare Part B eligibility entitlement date
- Medicare Part B termination date (if applicable)
- Current year deductible information
- HMO information (if applicable)

Requirements

To take advantage of this option, you must have a software program that creates the Beneficiary Eligibility upload (request) file and reads the return (response) file. Beneficiary Eligibility software may be purchased from a software vendor. The EDI Department does not supply Beneficiary Eligibility software. If you would like to program your own software, please contact the EDI Department.

Once you have obtained your software, you will need to apply for Beneficiary Eligibility. The following are the necessary steps to apply.

1. Complete the DMERC EDI Customer Profile form and select Beneficiary Eligibility as an additional feature. This form is located in the Appendix of this manual. It is also available through the EDI Web site section, located *at www.cignamedicare.com/edi/.*
2. Return completed form to CIGNA Medicare.
3. Upon receipt, CIGNA Medicare will process your request and mail you a Beneficiary Eligibility Manual. **Note:** Please allow 10-21 business days for processing.

*Privacy Act

According to guidelines set by the Centers for Medicare and Medicaid Services (CMS), Beneficiary Eligibility will *"allow only Medicare **participating** Part B physicians and suppliers and their authorized billing agents automated access to beneficiary eligibility data as long as the provider bills electronically in the National Standard Format (NSF) or the ANSI X12 837 Transaction Set. Disclosure of Medicare eligibility data is restricted under the provisions of the Privacy Act of 1974. Under limited circumstances, the Privacy Act permits us to disclose information without prior written consent of the individual to whom the information pertains; one of these is for 'routine uses': that is, disclosure for purposes that are compatible with the purpose for which we collect the information. In the case of Part B provider access, a routine use exists which permits release of data to providers and/or their authorized billing agents for the purpose of preparing an accurate claim."*

Chapter Three:

EDI Reviews

CIGNA Medicare may conduct an EDI review on your company. (*MCM 5240*)

It is important that you maintain accurate records both electronically and in your paper files. It is mandatory that you retain all original source documents for seven years. In the event of an audit, you will be requested to provide original documentation and it must be accessible. As a service to our electronic billers, EDI reviews are conducted periodically to ensure that you are maintaining accurate records. EDI reviews are conducted by our employees via telephone, at your place of business, or at CIGNA Medicare. An EDI review may either be an initial or a subsequent review.

In an initial review your company may randomly be selected for an EDI review. An initial review will be conducted *before* you transmit electronic claims.

An initial review will:

- Ensure the validity of procedure and diagnosis codes.
- Verify the satisfactory completion of source documents that reflect actual equipment/supplies delivered.
- Determine whether EDI Enrollment Forms have been properly completed and returned. You may not transmit electronic claims without completing the EDI Enrollment Form.
- Discuss and resolve any problems prior to the first electronic claim transmission.

Once you have begun transmitting electronic claims, CIGNA Medicare may also perform a subsequent review. You will be notified in advance of this review and of the specific claims we will be reviewing.

A subsequent review will:

- Verify that patient signatures are being obtained in the appropriate manner.
- Verify that the supplies billed were actually delivered by reviewing the source documents.
- Confirm that procedure and diagnosis codes are being used appropriately.
- Verify the compliance of assignment-based claims. This will be done by confirming there was a collection of deductible and coinsurance.

Once a review has been completed, the results are presented to you and, if applicable, CIGNA Medicare will make suggestions for resolving any problems. If major discrepancies are found, you will be expected to refund any resulting overpayments and implement corrective actions to prevent future errors.

Chapter Four:

Testing

All EMC submitters must test software compatibility in order to verify that claim data is transferred in the appropriate elements, as designated by ANSI X12N version 4010.

Upon receiving this manual, you should have also received a submitter ID and any other applicable IDs. Once you have received the necessary IDs for electronic billing and software, you are ready to begin the testing process. The testing process is divided into two different phases. Phase I verifies that you have submitted in the correct format based on the ANSI X12N version 4010 837 format. A 997 Functional Acknowledgment report will be generated to acknowledge the receipt of the file and also to indicate if you passed Phase I. Phase II verifies that the information you have transmitted is accurate, i.e. you have used valid HCPCS codes, modifiers, etc. (*MCM 3023.4*)

The following are the steps necessary for completing the testing process:

1. Send a minimum of 25 claims contained in one batch into the test facility. Refer to Chapter 5 of this manual for instructions on transmitting your claims into the test facility. (*MCM 3023.4*) We encourage you to test a variety of claims representative of the actual claims you will be transmitting in production. Any claims you send during testing will not be processed for payment.

2. Within 1-2 hours of transmitting your claims, your test results will be available to download. The results will appear on the 997 report, and will be available to download directly from your Stratus mailbox. The 997 report will indicate an "**Accepted**" or "**Rejected**" message. If you receive an "**Accepted**," this is an indication that there was a 100% error-free acceptance rate and your test claims will automatically move to Phase II of the testing process. Go to Step 3. If you receive a "**Rejected**," this is an indication that there were errors detected. If you receive errors in Phase I, you must correct the errors and retransmit your claims. Go back to Step 1. See Example 1 of the 997 report section in Chapter 6 of this manual.

   Note: You must pass the ANSI X12N file validation in Phase I of the testing process in order for your claims to move to Phase II of the testing process. If you don't download the 997 report for Phase I, and there are errors, CIGNA Medicare will not contact you. Errors reported on the 997 report should be addressed by the software vendor who provided your ANSI X12N software.

3. After you have received an "**Accepted**" message on the 997 report, you have passed Phase I, and your test claims will automatically move to Phase II. During Phase II, an Electronic Report Package will be generated and available to download from your Stratus mailbox within 2 hours. The Electronic Report Package generated in Phase II is identical to the Electronic Report Package that will be generated during production. For more information on the Electronic Report Packages, refer to Chapter 6 of this manual.

4. Upon receipt of your Phase II results, the EDI Department will contact you within 3 business days to review any errors you may have received and explain how to correct them. You must have a 95% or higher acceptance rate in order to pass the Phase II of the testing process. If you do not have a 95% acceptance rate, you will need to re-transmit the claims after correcting the errors. Go back to Step 1.

   Note: The acceptance rate is determined by counting all errors on a single claim as only one error regardless of the number of errors it may contain. For example, if you transmit a claim and it contains five errors, it will only be counted as one error.

   Note for software vendors, billing services and clearinghouses: You must test a minimum of 25 test claims with 25 different procedure codes. The test claims should be representative of products you or your customer may potentially bill. The test claims must be submitted as a single batch. To qualify to be included on the Certified Vendor List, you must receive a 100% error-free test. There are no exceptions made if your company

would like to be included on the list. If your company does not want to be included on the Certified Vendor List, then refer to the requirements for supplier above.

5. Once you have successfully passed Phase II of the testing process, your results will then be turned over to the EDI Customer Service Department for processing. **Note:** Please allow 10-21 business days for processing. Before we can activate your submitter ID and supplier numbers in our claims processing system, we must have an EDI Enrollment Form and DMERC EDI Customer Profile on file. Once we have activated your submitter ID, you will receive a telephone call from the EDI Department informing you that your company is set up to bill electronically and that you may begin transmitting production claims to CIGNA Medicare for payment. Refer to Chapters 5 and 6 of this manual for instructions on transmitting live claims and downloading 997 reports. (*MCM 3023.4*)

   Note: When in production, it is imperative you continue to download your 997 reports and error reports as CIGNA Medicare will not provide the comp limentary phone calls that we provide during in the testing process.

   If you have questions about the testing process or require assistance, please give our office a call at 866.224.3094 (toll-free). Please have your submitter ID number and your logon ID available when contacting the EDI Department.

Loops

If you receive errors in testing, the loop names listed on the report are identified below.

Header/Billing/Pay to Provider

Loop	Description
1000A	Submitter Name
1000B	Receiver Name
2000A	Billing/Pay-To Provider Hierarchical Level
2010AA	Billing Provider Name
2010AB	Pay-To Provider Name
2000B	Subscriber Hierarchical
2010BA	Subscriber Name
2010BB	Payer Name
2010BC	Responsible Party Name
2010BD	Credit/Debit Card Holder
2000C	Patient Hierarchical Level
2010CA	Patient Name

Claim Information

Loop	Description
2300	Claim Information
2305	Home Health Care Plan Information
2310A	Referring Provider Name
2310B	Rendering Provider Name
2310C	Purchased Service Provider Name
2310D	Service Facility Location
2310E	Supervising Provider Name

Other Subscriber and Payer Information

Loop	Description
2320	Other Subscriber Information
2330A	Other Subscriber Name
2330B	Other Payer Name
2330C	Other Payer Patient Information
2330D	Other Payer Referring Provider
2330E	Other Payer Rendering Provider
2330F	Other Payer Purchased Service Provider
2330G	Other Payer Service Facility Location
2330H	Other Payer Supervising Provider

Service Line

Loop	Description
2400	Service Line
2420A	Rendering Provider Name
2420B	Purchased Service Provider
2420C	Service Facility Location
2420D	Supervising Provider Name
2420E	Ordering Provider Name
2420F	Referring Provider Name
2420G	Other Payer Prior Authorization or Referral Number
2430	Line Adjudication Information
2440	Form Identification Code

Frequently Asked Questions about Testing

For your convenience, we have provided some common questions about testing and the testing process as received by the EDI Department.

Q How long does it take to complete the testing process?

A *The testing process can be completed in as little as three working days, if both phases are passed without errors on the first transmission. Otherwise, the testing process should take no longer than seven working days. The time is dependent on how many errors you receive in both the Phase I and Phase II of the testing process, as well as how long it takes you to fix your errors and retransmit the claims.*

Q I sent in a test two weeks ago. Why haven't I received a response on my results?

A *If you have not received a telephone call from the CIGNA Medicare EDI Department on Phase II of your test, that usually indicates that you never passed Phase I (see step 2 on page 1 of this chapter). If you have errors reported on the 997 Functional Acknowledgement report, you must correct the errors and retransmit them into the test facility. Continue to do this step until your 997 report indicates your transaction was accepted. Once you receive this message, your file will move into Phase II of the testing process. CIGNA Medicare will receive a report of the results of your Phase II test and will contact you with the results within 3 business days. You may also download your Phase II test results for your review.*

Q Why do I need to send a test with 25 claims? Why can't I send just one claim?

A *The purpose of a test is to make sure you are familiar with how to enter claims in your claims entry (billing) software. When you test with 25 claims, that provides for us a better indication of the type of problems you may experience when you begin transmitting your production claims electronically for payment. Our intention is to eliminate as many of your questions or problems as possible as this will greatly increase the chance of your claims being accepted into the system for processing.*

Chapter Five:

Stratus Network User Guide

Introduction

The Stratus Network is an asynchronous transmission mailbox system that allows users to dial directly into CIGNA Medicare's Gateway Service. This network is used to:

- Upload your electronic transactions to CIGNA Medicare
- Download electronic transactions and reports from CIGNA Medicare

This chapter will give you step-by-step instructions on using the Stratus Network. It will go through the process of modem setup, dialing in, and logon. It also shows how to transmit, list, view, and download files.

For demonstrative purposes, we have selected to use HyperTerminal in the following instructions. Once you are logged on to the Stratus Network, the instructions will be the same regardless of the software.

These instructions are given with the assumption that your software is not scripted. If you are not sure whether your software is scripted, contact your software vendor.

If your software is scripted, your process may not follow our instructions. In this case, your software vendor should instruct you on how to send your files.

Helpful Information

Submittal Times for Claims

Claims are received into the Stratus Network minutes after transmission. After being received, claim files are held in the user's mailbox until the Stratus Network downloads your claim file(s) and transmits it to CIGNA Medicare. The Stratus Network will sweep your mailbox several times a day (see chart below). However, ***5:00 p.m. Eastern Standard Time is the cutoff time for that business day's production files***. Anything that is collected from the Stratus Network **after** 5:00 p.m. will contain the next business day as the date CIGNA Medicare received your claim file. This will be reflected in the Julian date included in the Claim Control Number.

Stratus Sweep Times
9:00 a.m. Eastern Time
12:00 p.m. Eastern Time
2:00 p.m. Eastern Time
5:00 p.m. Eastern Time
8:00 p.m. Eastern Time

Customer Support Center

If you have a Stratus Network password reset or inactive user ID support issue, contact the Customer Support Center's Electronic Commerce Helpdesk at 1.800.810.3388. This service is available 7 days a week, 24 hours a day.

Please have the following information available:

- Logon ID (MB####),
- Submitter ID (alpha character followed by 8 numeric characters)
- Telephone number you have on file with the EDI Department.

Connection Requirements

The following information describes the settings to setup your communications software. All users of the Stratus Network must have their own communications software (i.e. HyperTerminal, ProComm Plus, pc Anywhere) that will support X-Modem, 1K-X-Modem, Y-Modem, Z-Modem, or Kermit protocols. For information on setting up HyperTerminal, ProComm Plus, and pc Anywhere, please see page 4.

Baud Rate	**Up to 56K**
Terminal Emulation Type	**VT-100**
File Transfer Protocol:	**X-Modem, 1K-X-Modem, Y-Modem, Z-Modem*, Kermit**
Parity:	**None**
Data Bits:	**8**
Stop Bits:	**1**
Duplex:	**Full**
Flow Control:	**None**
Comm Buffer:	**2K-16K**
Capture:	**Off**
Telephone Access Number	**860-602-0000**

*CIGNA Medicare recommends using the Z-modem.

User ID Number	**MB_ _ _ _**
Initial Password	**FIRST**

Note: The User ID Number and Initial Password are assigned by CIGNA Medicare. Both the User ID Number and Password are case sensitive. Use upper/lowercase characters as shown.

Dial-Up Setup

We have included instructions for the communication packages that we support. These are general instructions. If you are not using one of the software packages listed below, or need detailed information regarding these software packages please contact the manufacturer of the software or refer to the user's manual that came with the software.

HyperTerminal (Windows 95, 98 and NT 4.0)

1. Open HyperTerminal: Click **Start**, and then point to **Programs**. Click **Accessories**, click **Communications** (this may or may not be a step, depending on which version of Windows is installed) and then click **HyperTerminal**. When the subfolder opens, click on **HyperTerminal**.
2. In the **Connection Description** dialog box, type "**Stratus Network**" in the Name field and select an icon. Click **OK**.
3. This will take you to the **Connect To** dialog box. In the **Area code** field type "**860**". In the **Phone number** field type "**602.0000**". Click **OK**.
4. This will open the **Connect** dialog box. Click on **Modify** and make sure there is a checkmark in the box next to "**Use country/region code when dialing this number**". Click the **Settings** button and change the emulation to "**VT100**". Click **OK** to save your changes.
5. To connect to the Stratus Network, click **Dial** in the **Connect** dialog box.
6. Exit the program when you are finished. You will be prompted to save your settings.

ProComm Plus

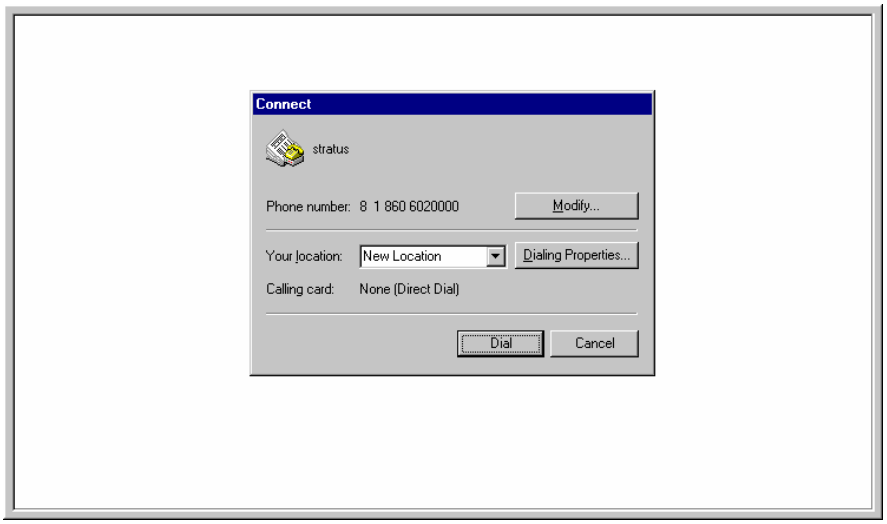
1. Click **Start**, and then point to **Programs**. Click on **ProComm Plus**. When the subfolder opens, click on **ProComm Plus**.
2. On the **File** menu, click **Connection Directory**.
3. On the **Connection** menu, click **New Entry**. This will display the **Add Directory Entry** dialog box.
4. On the **Data** tab type "**Stratus Network**" in the **Name** field. Type "**860**" in the **Area Code** field and "**602.0000**" in the **Data Number** field. Click **OK.**
5. Make sure you are on the **Data** tab of the **Connection Directory** dialog box. Click on **Stratus Network** in the **Entries** field.
6. Click **Basic Options** and verify that the information shown matches the Connection Requirements on page 3 of this chapter. Leave the **Script** and **Capture** fields blank or on "**None**".
7. Click **Port Settings** and select your **Modem Connection**.
8. Click **OK** to save your settings or click **Dial** to connect to the Stratus Network.

pc ANYWHERE 32

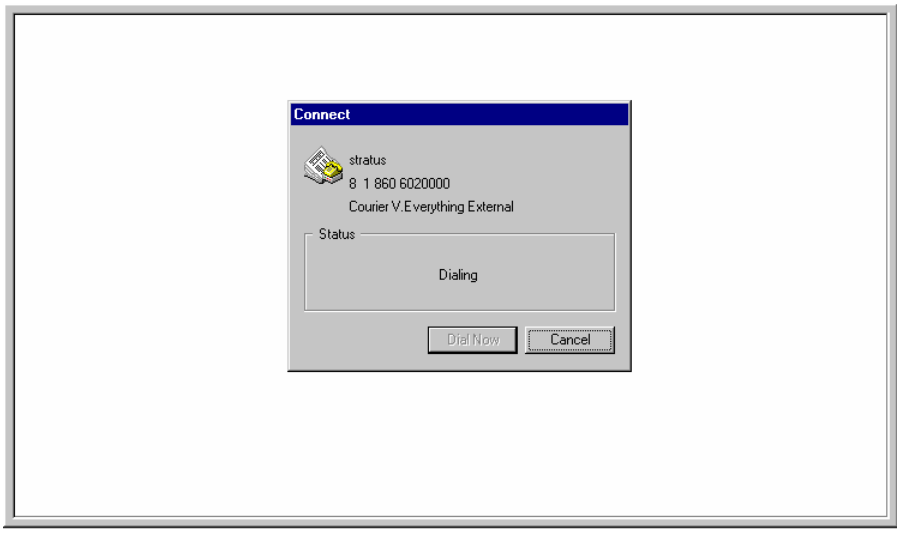
1. Click **Start**, and then point to **Programs**. Click on **pc ANYWHERE 32**. When the subfolder opens, click on **pc ANYWHERE** to open the program.
2. Click on the **Call Online Service** button on the toolbar.
3. Double-click **Add Online Service Item** to bring up the **Call an Online Service Wizard**.
4. When prompted for a name, enter "**Stratus Network**", for the **Online Service Phone Number** enter "**860.602.0000**".
5. Select **VT100** for the terminal emulation.
6. Click **Finish** to save your work.
7. Double-click on the **Stratus Network** icon to dial the telephone number.

Connect and Logon

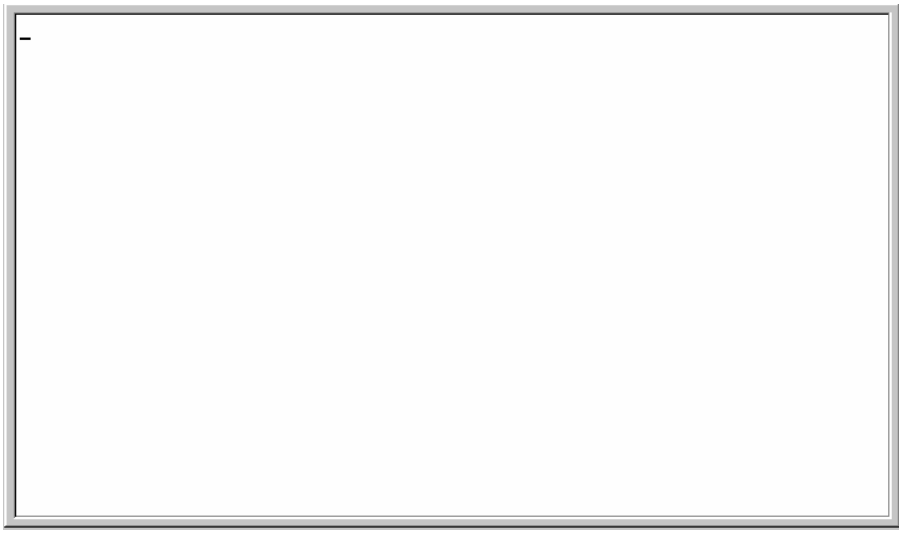
1. Open your communications software package.
2. Select the **Stratus Network** connection.
3. Click **Dial**.



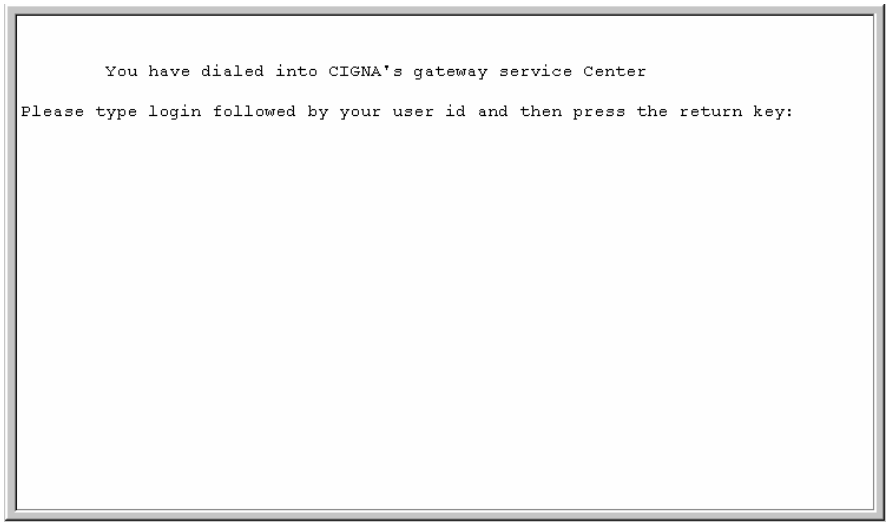
4. The following screen will appear while your modem is trying to connect.



5. After your modem has connected, you will see a blank screen with a blinking cursor.

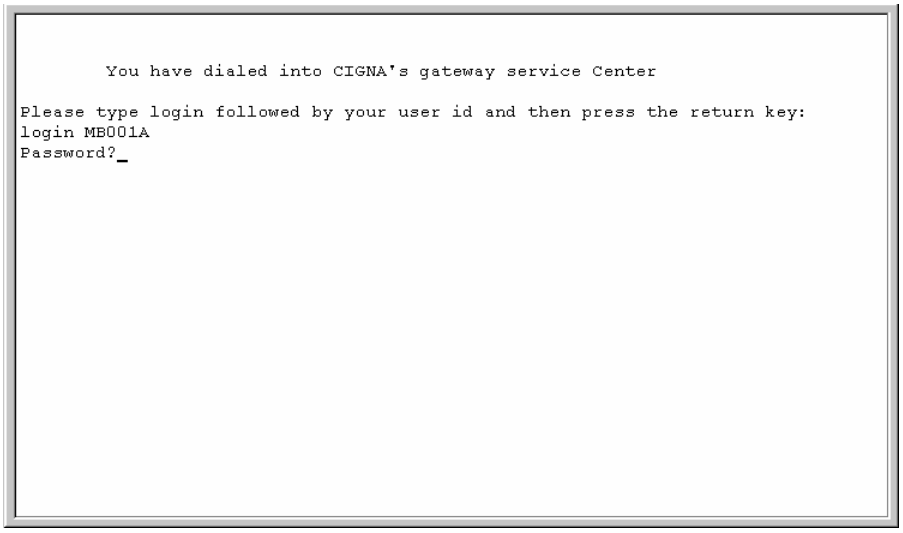


6. Press **Enter**. The following screen verifies that you have successfully dialed into the Stratus Network. If this screen does not appear, make sure that your **Scroll Lock** is not on, If the **Scroll Lock** is on, press the Scroll Lock button on your keyboard to turn it off and press **Enter**. If you have timed out, you will need to redial.



7. Type "**login**" in lowercase letters followed by a space and your **User ID** (MBXXXX). The alpha characters in your **User ID** need to be in uppercase. (i.e. login MB0001A). Press **Enter**.

8. You will then be prompted to enter your password.



9. Type your password and press **Enter**.

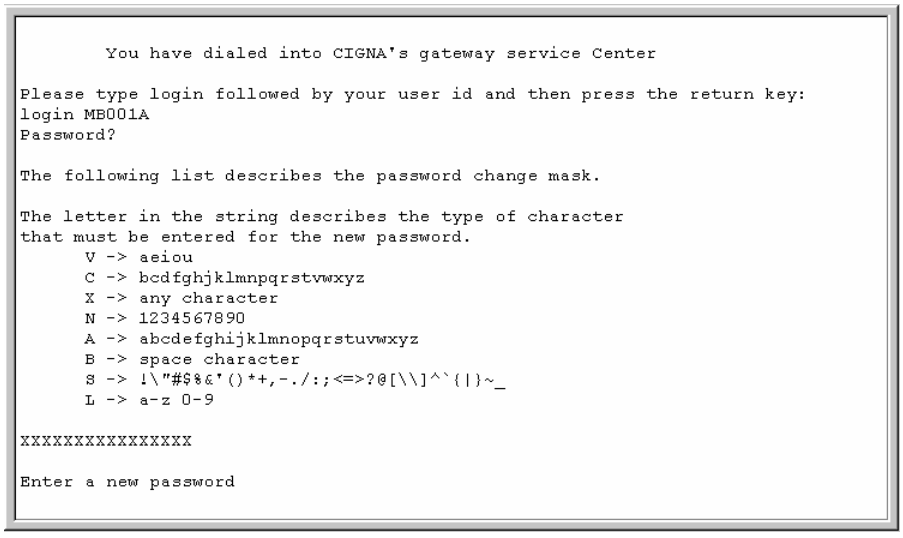
   If this is the first time you have logged in:

   a. The initial password will be "**FIRST**". "**FIRST**" must be entered in all uppercase letters.

   b. You will be prompted to change the password, the first time you log in.

   c. Once the new password is entered, you will be prompted to enter the password a second time for verification. Please remember your password. Once you change the initial password, CIGNA Medicare is not able to verify your password.

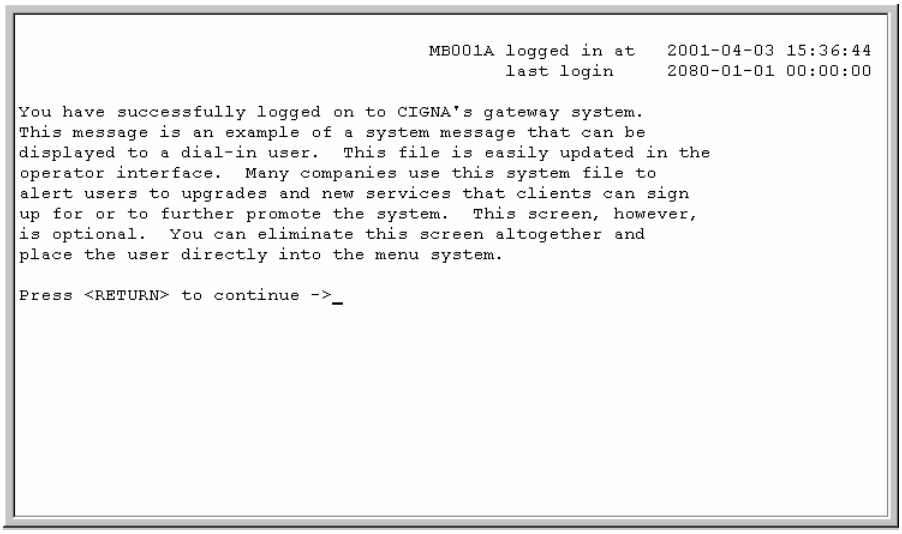
      Password hints: Your password must contain 5-8 characters. The password is case sensitive, which means it must be entered in the same upper and lowercase combination each time. In addition, the password cannot contain the same character consecutively (i.e. *happy* would be invalid because of the repeating P's). For security reasons, your password will not show on the screen when typed.



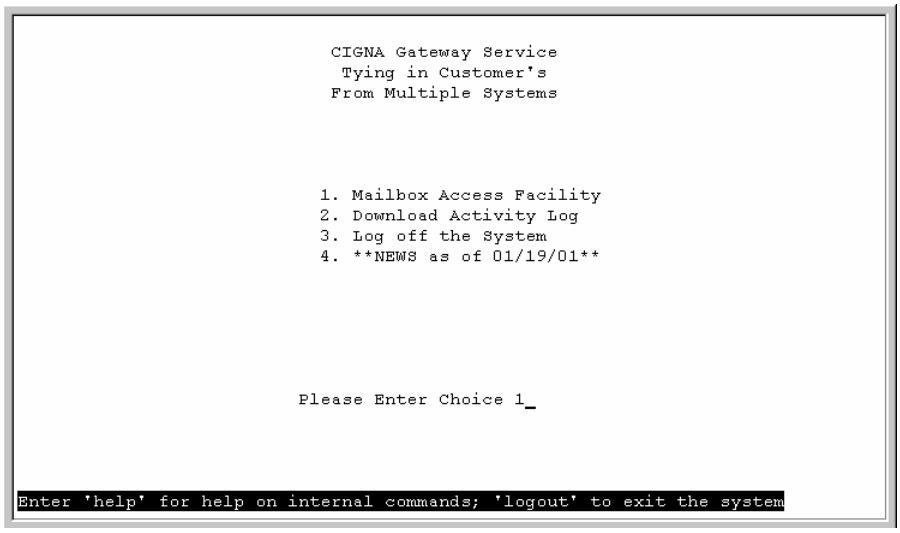
Note:
The Centers for Medicare and Medicaid Services (CMS) requires all passwords to be secure and changed at periodic intervals. This is to ensure the security of all electronic data interchange (EDI) transactions and data. You will be prompted to change the password every 60 days and cannot be any of the past three passwords used.

In order to maintain the highest level of security, the User ID and password you were assigned are for the use of your company only. Please do not share your User ID or password with others. CIGNA Medicare's EDI Department or the Customer Support Center will verify your User ID and Submitter ID when you call for support. However, once you change the initial password, CIGNA Medicare is not able to verify your password. Please keep this information in mind when calling the EDI Department or the Customer Support Center.

10. Once your password is verified, you will receive this message:



11. Press **Enter** to continue.
12. The **Main** menu will appear.

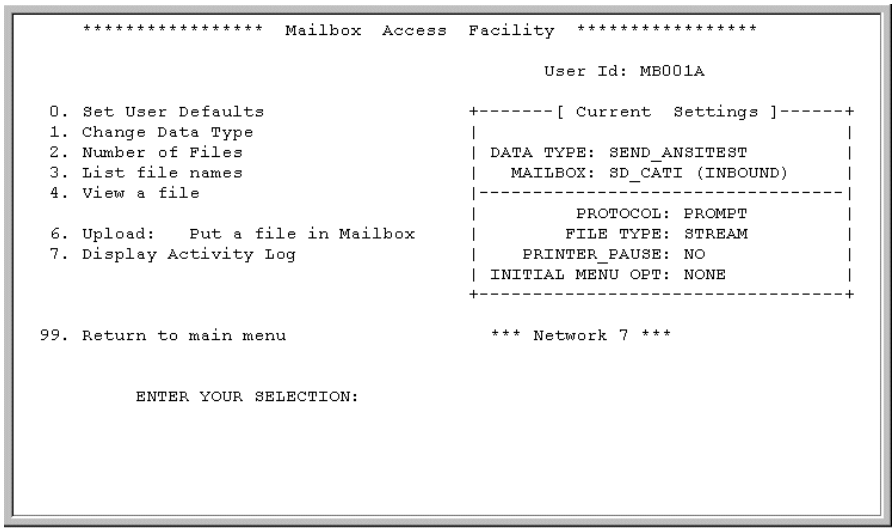


13. At the Main Menu, type "**1**" to select the **Mailbox Access Facility** menu and press **Enter**.

Mailbox Access Facility Menu

The **Mailbox Access Facility** menu allows you to select from several options and provides a view of the current settings for your mailbox.

The Current Settings box is located on the right side of the screen. Always verify the settings before selecting an option.



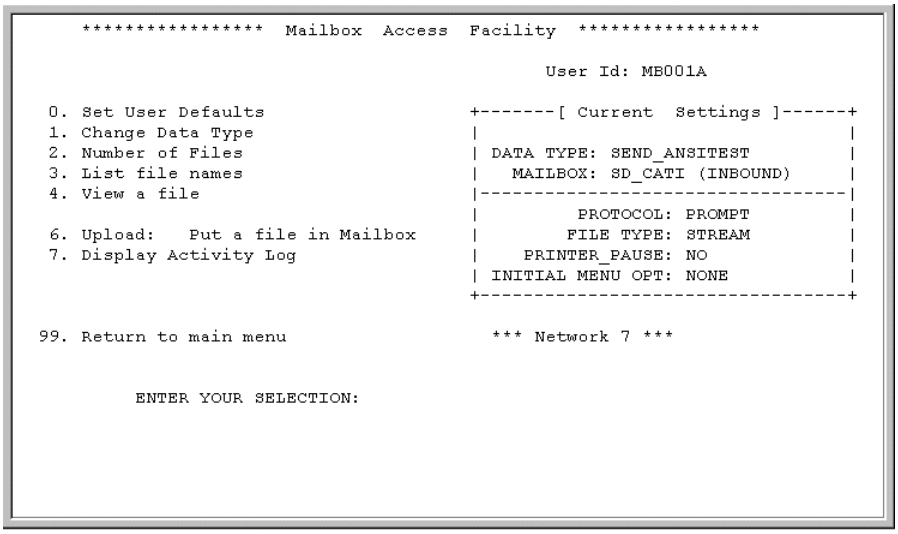
Mailbox Access Facility Menu, Option 0 - Set User Defaults

The user defaults have been preset for your convenience and are displayed in the bottom half of the Current Settings box. **In most cases, changing the user defaults is not recommended.** The protocol default is the only default that should be changed. Below are the instructions to display all the defaults and to change the protocol default.

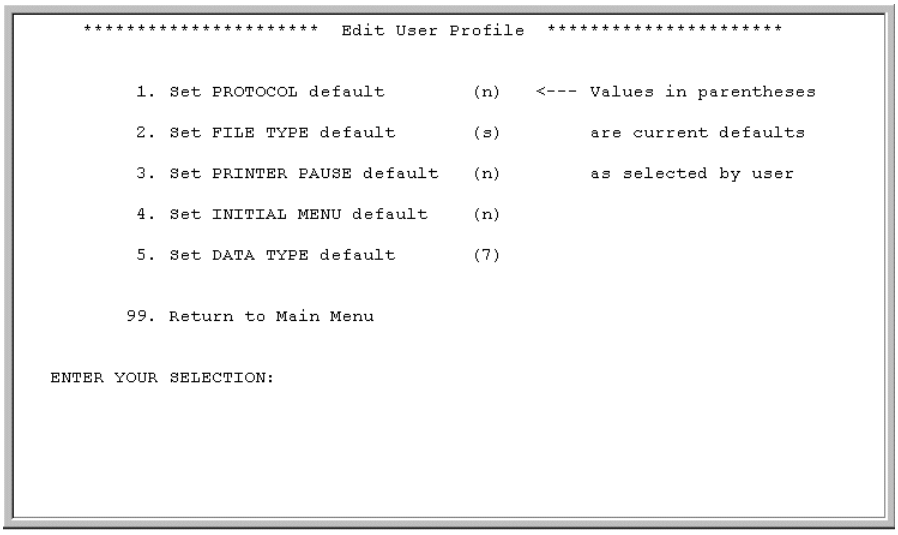
The following table describes each default:

1. Set PROTOCOL default	Use this option to select the modem protocol default, such as X Modem, 1K-Modem, Y-Modem, Z-Modem and Kermit, for uploading and downloading your files. The current default is (n) for none. If you select **NONE** as your modem protocol you will be prompted each time you transmit or receive to select one.
2. Set FILE TYPE default	Use this option to select the type of file that will be sent. The current default is (s) for stream. Unless arrangements have been made with CIGNA Medicare, you should always be sending stream files. **This option should not be changed.**
3. Set PRINTER PAUSE default	Use this option to change the printer pause. The current default is (n) for no. Changing this option could result in printing errors. **This option should not be changed.**
4. Set INITIAL MENU default	Use this option to change the initial screen. It is preset to display the Mailbox Access Facility menu. The current default is (n) for none. **This option should not be changed.**
5. Set DATA TYPE default	Use this option to change the data type. The current default is (7) for SEND_ANSI TEST. Changing this could result in a file going into the wrong mailbox.

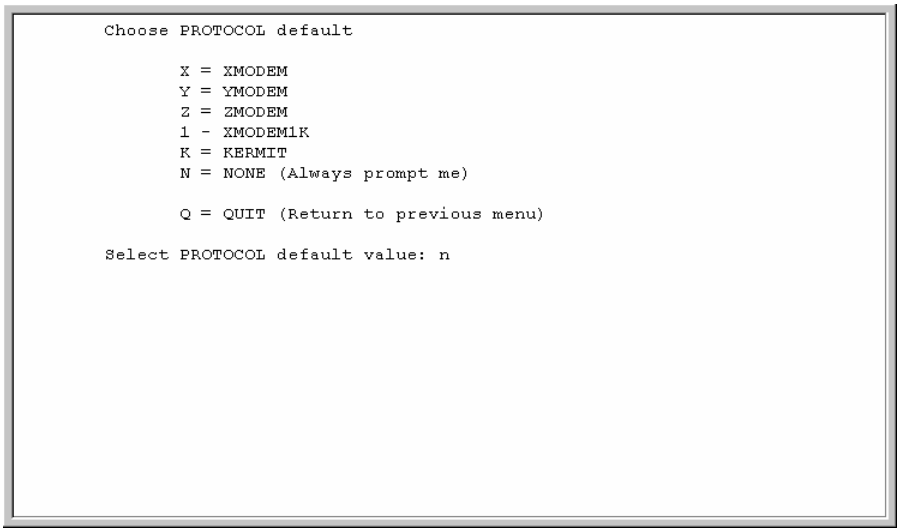
1. To display your user defaults, type "**0**" and press **Enter**.



2. This will bring you to the **Edit User Profile** menu. Each default is listed with the current defaults in parentheses. These defaults are also displayed on the **Mailbox Access Facility** menu.



3. From the **Edit User Profile** menu, type "**1**" to select the Protocol default. A menu listing modem protocol options will appear.



4. To select your default protocol, type the character that corresponds to your selection (i.e. type "**Z**" for ZMODEM) and press **Enter**.
5. To return to the **Mailbox Access Facility** menu, type "**99**" and press **Enter**.

Note:

The EDI Department recommends using Z-modem to send and receive files for the following reasons:

- Z-modem is not as susceptible to altering a transmission due to line noise in your communication line.
- Z-modem is a faster protocol and is more effective at sending files at speeds greater than 4800 bps.
- Z-modem allows better error detection than other protocols.

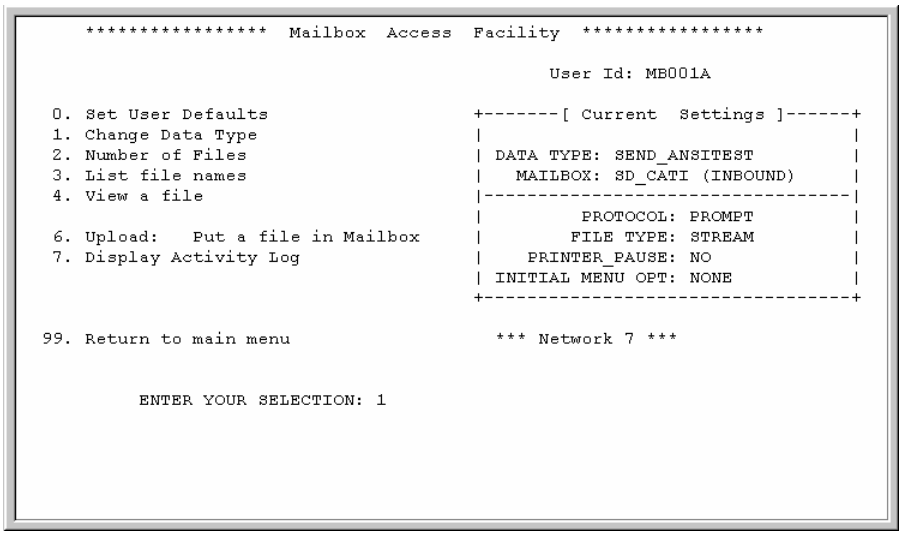
The protocol setting on this screen must match the protocol setting within your software. For software settings refer to the user guide for your communications software. If you select **NONE** as your protocol you will be prompted each time you transmit to select your protocol.

Mailbox Access Facility Menu, Option 1 - Change Data Type

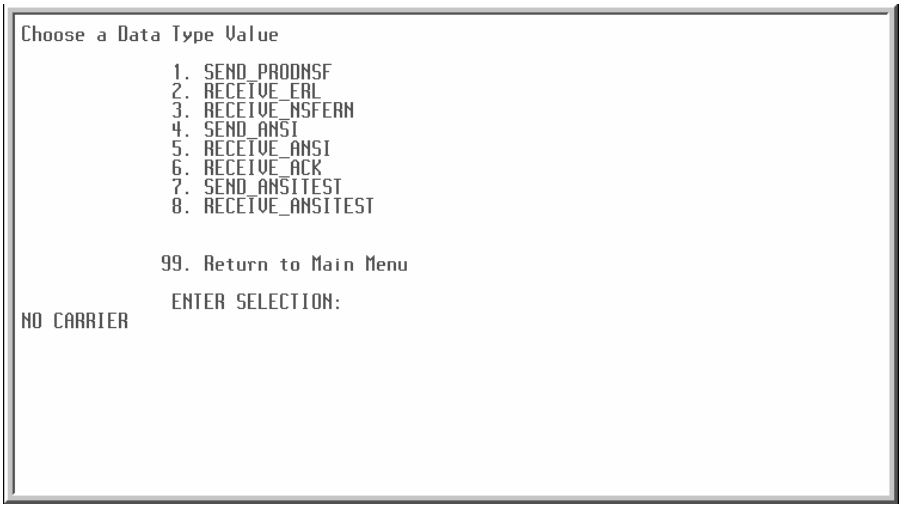
This option allows you to select the type of transaction you wish to send or receive. Before changing the data type, look at the **Current Settings** box to see what data type is currently selected.

To change your data type:

1. At the **Mailbox Access Facility** menu, type "**1**", and press **Enter**.



2. The **Data Type Value** menu will appear. To select a data type, type the corresponding number and press **Enter**.



3. To return to the Mailbox Access Facility menu, type "**99**" and press **Enter**.

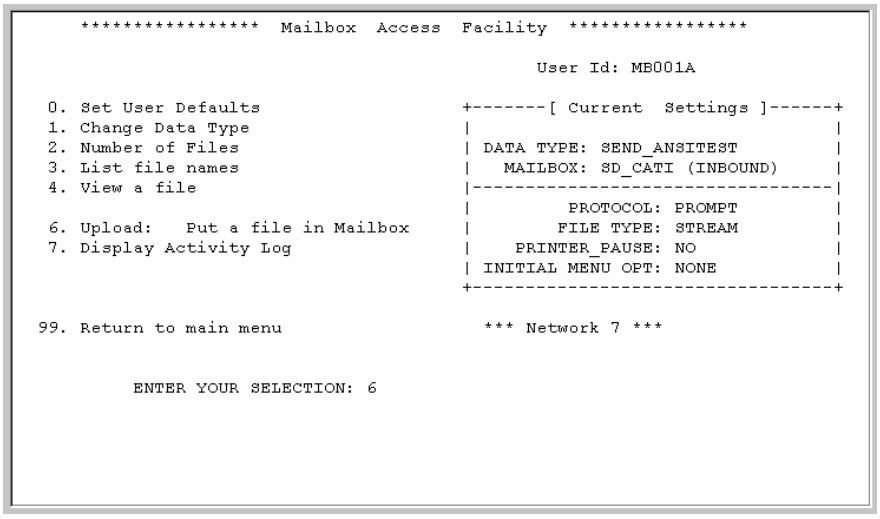
Description of the data types:

1. SEND_PRODNSF	Select this option to send a production file in the National Standard Format. **Note**: if you have been approved to send ANSI production files, you must select option 4, SEND_ANSICLAIM.
2. RECEIVE_ERL	Select this option to download Electronic Report Packages.
3. RECEIVE_NSFERN	Select this option to download Electronic Remittance Notices in the National Standard Format.
4. SEND_ANSI	Select this option to send production transactions in the ANSI 4010 format.
5. RECEIVE_ANSI	Select this option to download transactions in the ANSI 4010 format.
6. RECEIVE_ACK	Select this option to download 997 Functional Acknowledgement reports.
7. SEND_ANSITEST	Select this option to send a test 837 transaction in the ANSI 4010 format.
8. RECEIVE_ANSITEST	Select this option to download your phase II test results sent using Option 7.

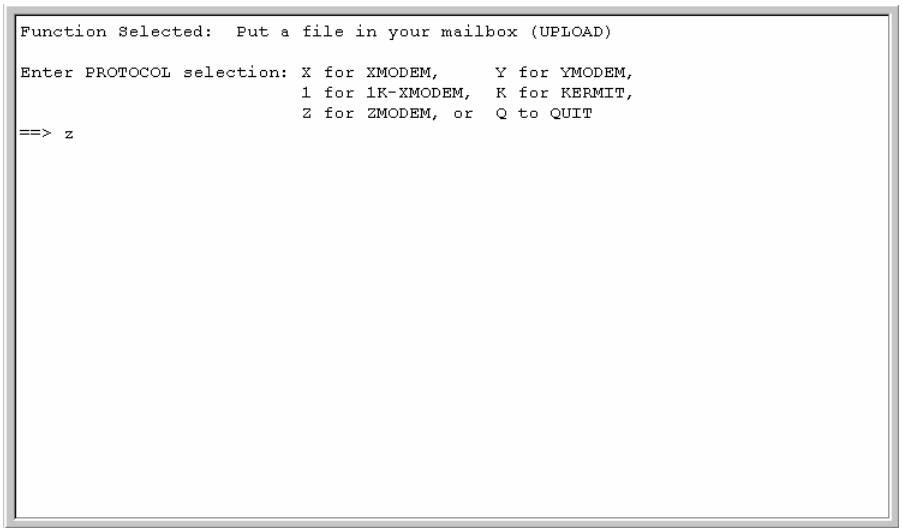
Mailbox Access Facility Menu, Option 6 – Upload: Put a file in Mailbox

This option would be used to upload ANSI test and production files.

1. Make sure that the data type is **Send_XXXX** (where XXXX represents the type of data to be sent) in the **Current Settings** box. If it is incorrect, you will need to change the data type. Please see page 12 of this chapter for information on changing data types.
2. Type "**6**" to select **Upload: Put a file in Mailbox** and press **Enter**.

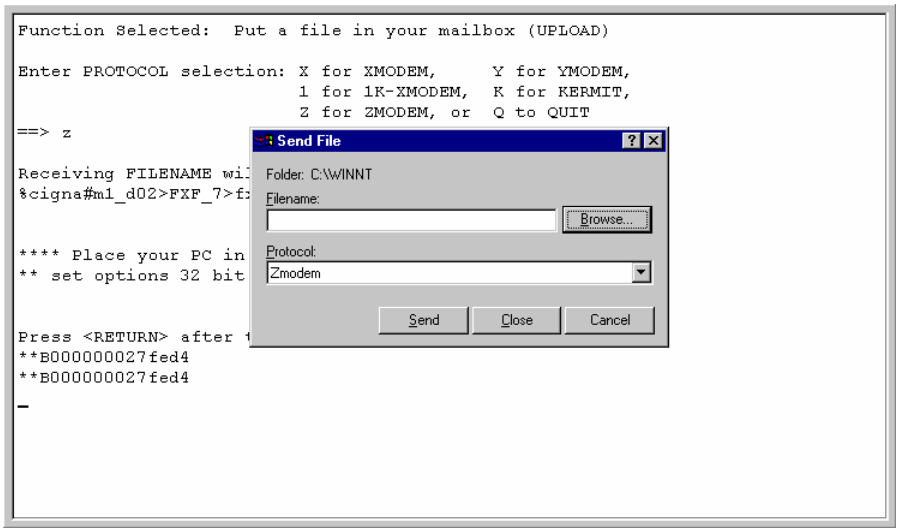


3. If you have previously selected **NONE** for the protocol default, you will be prompted to select a protocol.
   a. Select your protocol (x-modem, 1k-x modem, y-modem, z-modem or Kermit) by entering the character that corresponds to your selection (i.e. type "**Z**" for ZMODEM). Your modem protocol selected in your communications software and the Stratus Network protocol default must match (*i.e.* if your communications software is set to z-modem then your Stratus Network connection should be set to z-modem as well).

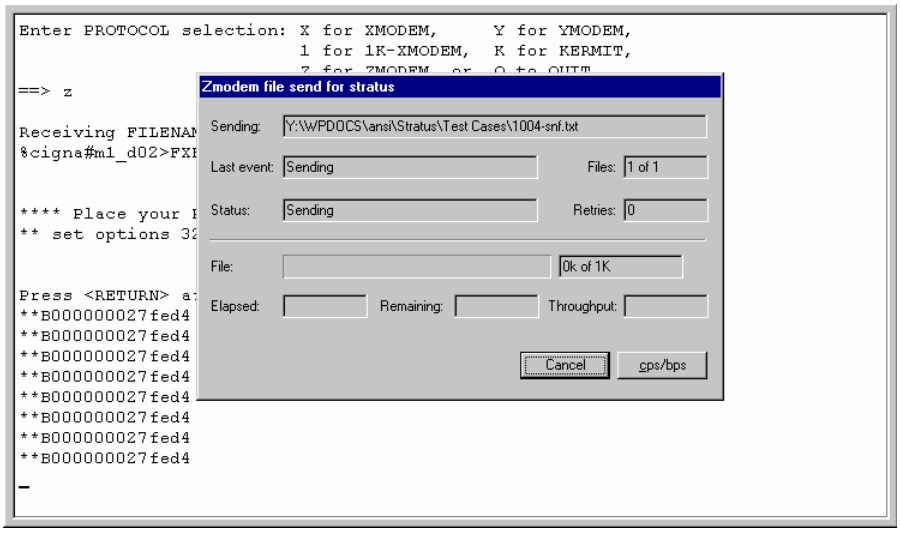


4. In your software, click the **Transfer** pull-down menu and select **Send File**. For additional assistance in uploading files, refer to your communications software user guide.

5. Your software will prompt you to select the file to send. To find your file, click on **Browse**. Once you have selected the file, click on **Open** and then **Send**. The file will begin downloading to your computer.

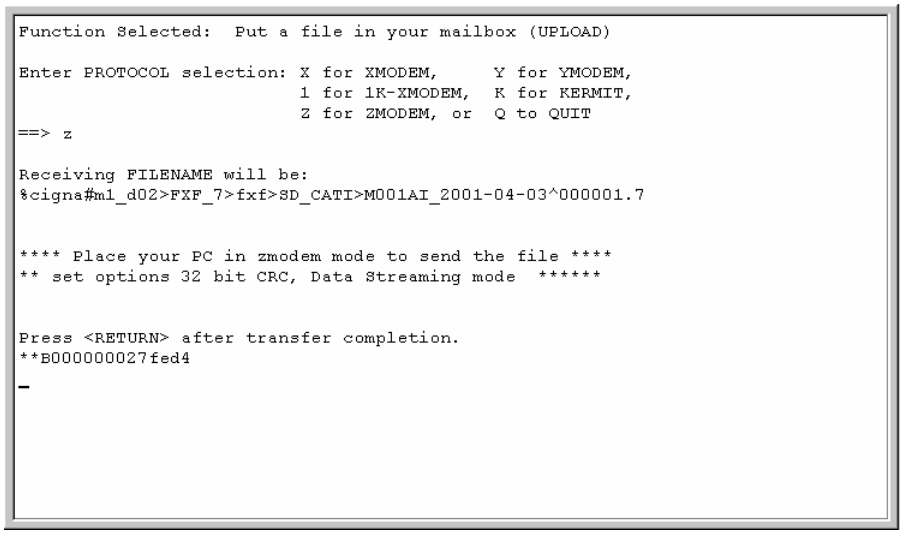


6. An informational screen will appear showing the status of the file transfer. This box will disappear when the transfer is complete or aborted. When your transmission is complete, you will receive the message "**Transfer Complete**".



Note: Please consult your claims development software for filename and location of your ANSI 4010 837 transaction.

Press **Enter** after the transfer is complete to return to the **Mailbox Access Facility** menu. (If **Enter** is pressed prior to completion of the file transmission, the transmission will be aborted).



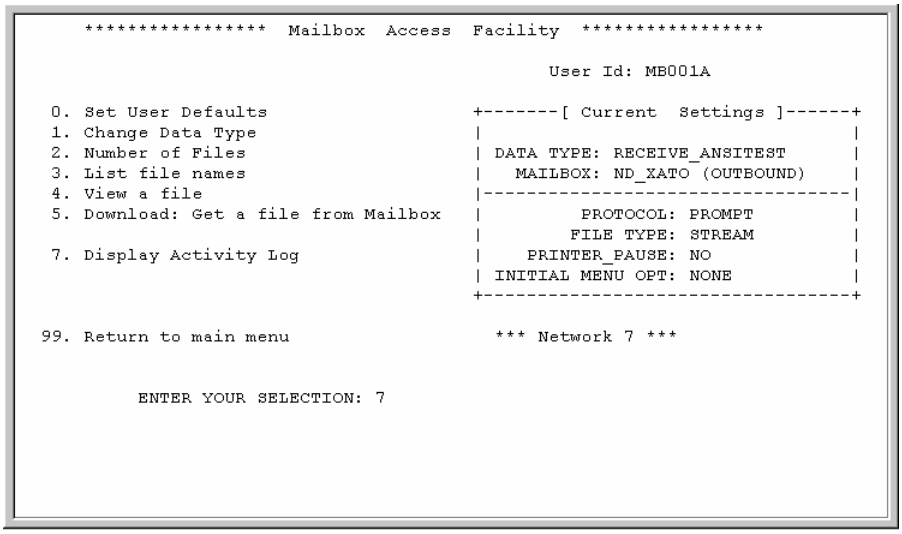
Mailbox Access Facility Menu, Option 5 - Download, Get a File From Mailbox

Using the download option you can receive your test or production electronic reports, 997 Functional Acknowledgment reports, and production ANSI 835 Remittance Notices.

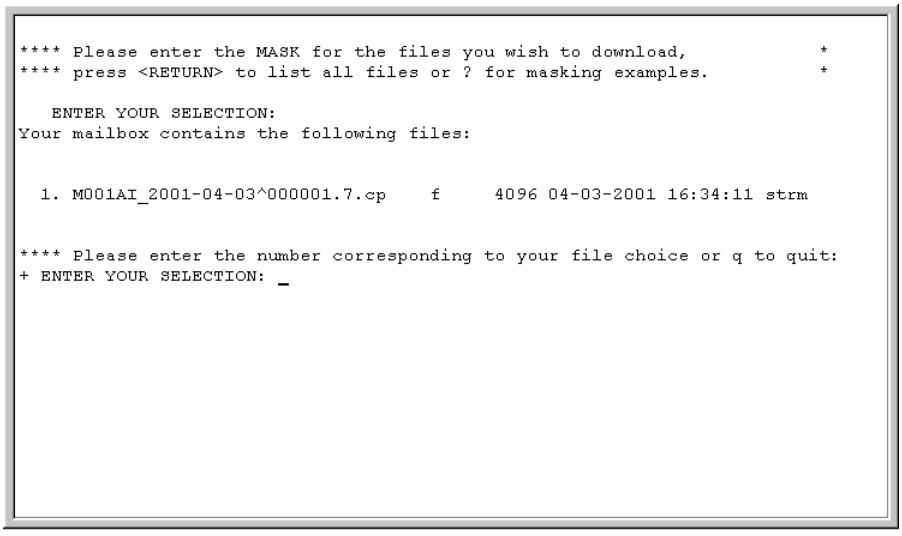
1. Check your **Current Settings** box and make sure your **data type** begins with **Receive_XXXXX**. If not, please refer to page 12 of this chapter to change your data type.

   Note: Until a correct data type is selected, option 5 will not appear as a menu option.

2. From the **Mailbox Access Facility** menu, type "**5**" and press **Enter**.



3. This will display the download screen, press **Enter** to see a list of the files available for downloading.
4. Enter the corresponding number of the file that you would like to download or "**q**" to quit.
5. Press **Enter**.



6. In your software, select "**Transfer**" then "**Receive File**". This will start the download process. When the download process is finished you will receive the message "**Transfer Complete**".

7. Press **Enter** after the transfer is complete to return to the **Mailbox Access Facility** menu. (If **Enter** is pressed prior to completion of the file transmission, the transmission will be aborted).

Note:

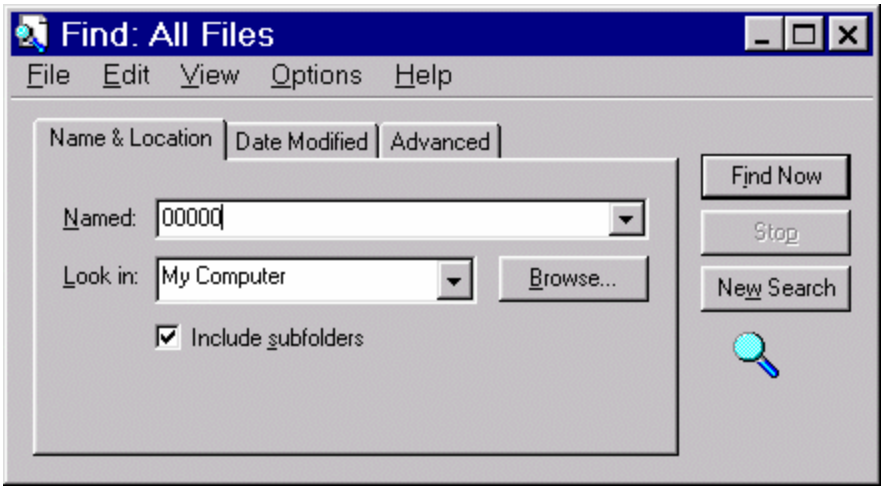
Electronic Reports and Electronic Remittance Notice (ERN) files are stored in your Stratus Network mailbox for seven days (including weekends and holidays), unless a download was attempted. If a download was attempted, the file will remain in your Stratus Network mailbox for only three days after the attempt. To ensure that the receipt listings are downloaded within this time frame, it is helpful to log the date of your claim transmission so that you do not miss downloading a receipt listing.

CIGNA Medicare stores copies of your files for 30 days. If you need a file to be put back into your Stratus Network mailbox, please contact the EDI Department.

Locating Downloaded Files

When downloading from the Stratus Network using the Z-modem protocol, users sometimes find it difficult to locate their files because the Z-modem protocol does not allow the user to choose a destination folder or directory when downloading. Here is an easy way to locate those files using tools in Windows 95, 98 or NT 4.0. This process may not work on computers using other operating systems.

1. Download the file from the Stratus Network.
2. Exit your communications program used to connect to the Stratus Network.
3. Click on **Start** and then point to **Find.** Click **Files or Folders**.
4. In the **Named** box, type "**00000**" (five zeroes).
5. In the **Look In** box, select **My Computer**.
6. Make sure there is a checkmark in the **Include subfolders** box. If not, click on the box to select.
7. Click **Find Now**.



8. Once you click on **Find Now**, the computer will start looking for files containing "**00000"** in the file name. The search results will appear in the window at the bottom of the Find dialog box. The results will include the file name, the folder that contains the file, the file size, the file type, and the date modified for each file found.

   To view the entire path of a specific file, expand the width of the **In Folder** column by positioning the pointer on the right border of the column heading.

   When the pointer becomes a double-headed arrow, ↔, drag the column border to the right until the entire path is displayed (i.e., C:\Program Files\ProComm\Download). The z-modem protocol will always save a downloaded file to this location, you can save time by writing down this path and keeping it for the next time you download.
9. Once the path of the Stratus Network file has been identified and you have written it down, close out of the **Find** dialog box.
10. Using any word-processing program or text editor (i.e., Word, WordPerfect, WordPad, or Notepad) open the file.
    a. On the **File** menu, click **Open**.
    b. In the **Files of Type** field, select **All Files**.
    c. In the **File Name** field, type the complete path as written down in Step 9 (i.e., C:\Program Files\ProComm\Download).
    d. Click **Open**.

e. Highlight the file name that you would like to open and click **Open**.

Below is a description of the file name that the Stratus Network assigns to each file.

File Name Example: TM_MDTI>MXXXXO_2001-08-22^000002.7

- The first part of the filename shows what type of transfer was attempted. It will show TM_MDTI for test or TM_MDPI for production. The final character of this block shows if the file was uploaded (I- Inbound) or downloaded (O-Outbound). In our example above, the filename indicates it was a test file (TM_MDTI) and it was uploaded (I).
- The last block starts with the login ID. This will be the MB number that sent or received this file. In our example the login ID is **MXXXXO**.
- The date the file was created. This will be the original date this file was entered into your mailbox. Outbound files are only available for seven days after this date under most circumstances. In the above example, the file was entered into your mailbox on August 22, 2001 (denoted by 2001-08-22).
- Sequence number. Each file sent in a day will have a different sequence number assigned by the Stratus Network. The sequence number for the above example is **000002.7**.

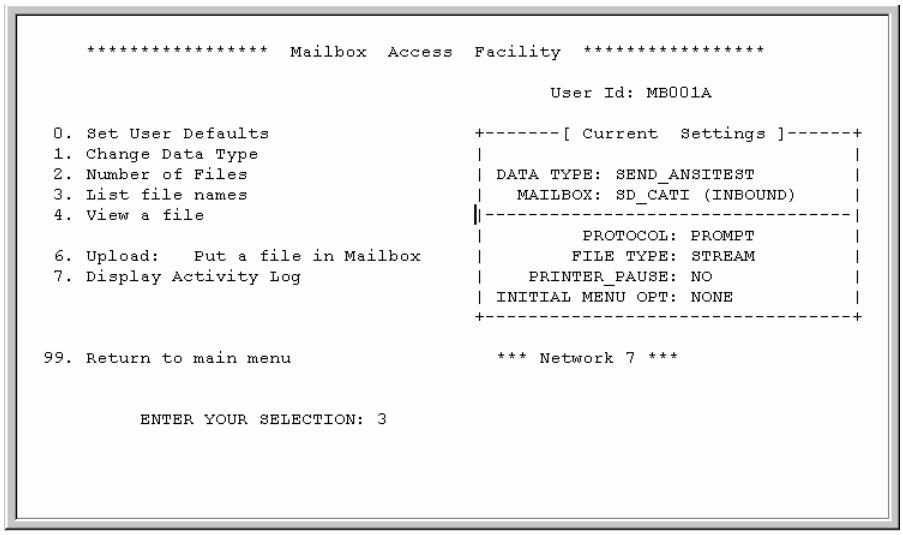
Opening Your Downloaded Files

When opening the file, if the **Open With** dialog box appears, it means that your computer has not associated a program with the file name extension assigned by the Stratus Network. Select either WordPad or Notepad from the list of programs.

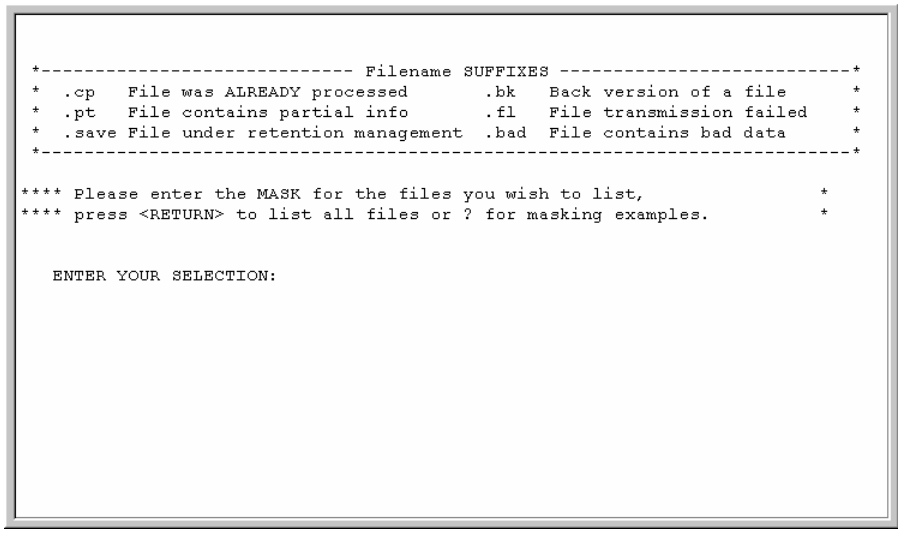
List File Names

This option allows you to see a list of your files available to download as well as files you have recently uploaded.

1. To see a list of your files, type "**3**" and press **Enter**.



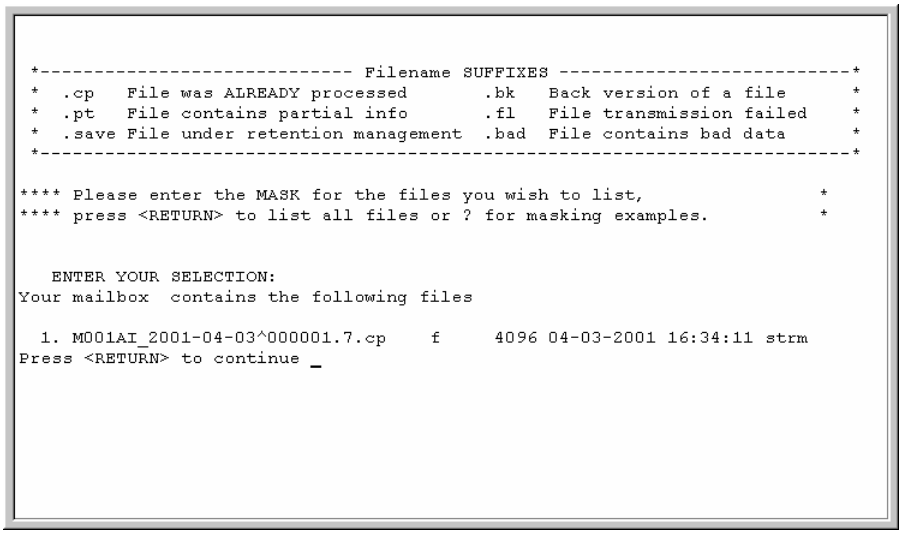
2. The following screen will appear giving a short description for filename suffixes that appear on your files.



The filename suffixes explain the status of each file as follows:

.cp	You will see this mask after the file has been successfully uploaded or downloaded. We recommend you search for the file on your computer before downloading files again. See *Locating Downloaded Files* on page 19.
.pt	When a file is aborted during an upload, this extension will appear on the filename. Any file with a **.pt** extension will need to be uploaded again.
.save	This extension is not very common. This means that the Stratus Network has retained the file in a "raw" format for future reference.
.bk	Files restored by the Stratus Network will have this extension. Files restored by CIGNA Medicare will not contain this extension.
.fl	When a file is aborted during a download, the **.fl** extension will be added to the file. Any file with a **.fl** extension must be downloaded again.
.bad	Files received that do not contain a valid format may receive a **.bad** extension. If this occurs, double-check the file being sent is in the ANSI X12 format.

3. Press **Enter** to display all files.

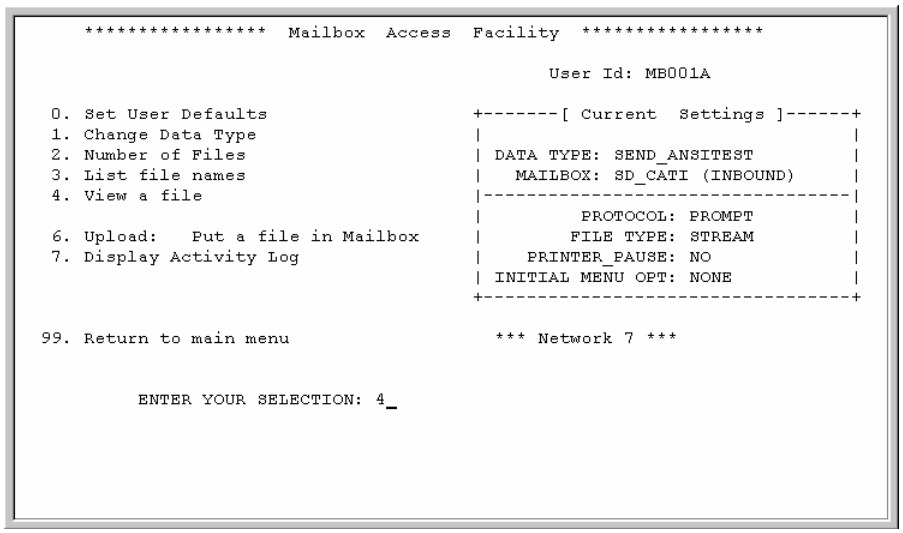


4. After viewing the list of files press **Enter** to return to the **Mailbox Access Facility** menu.

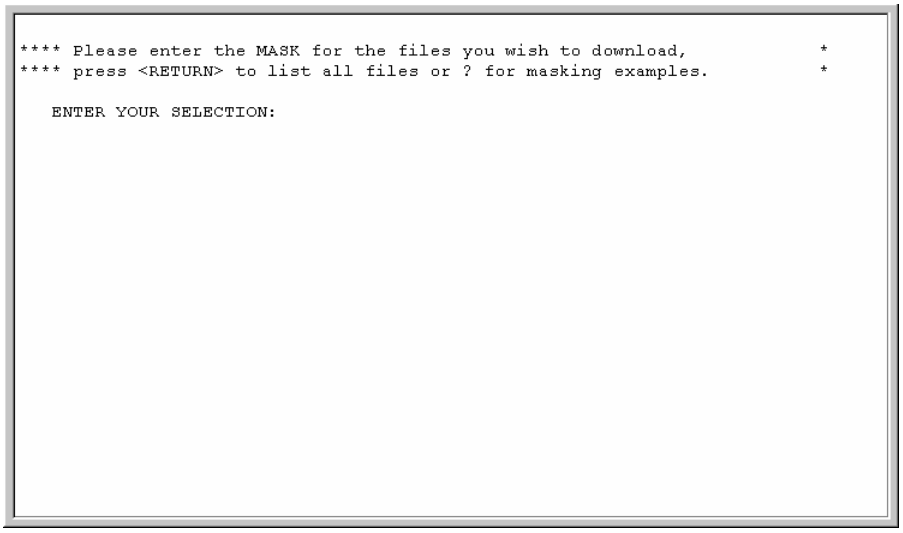
Viewing a File

The **Mailbox Access Facility** menu allows you to view files available to download and files you have recently uploaded. This is helpful if you are looking for a particular file and you have several available.

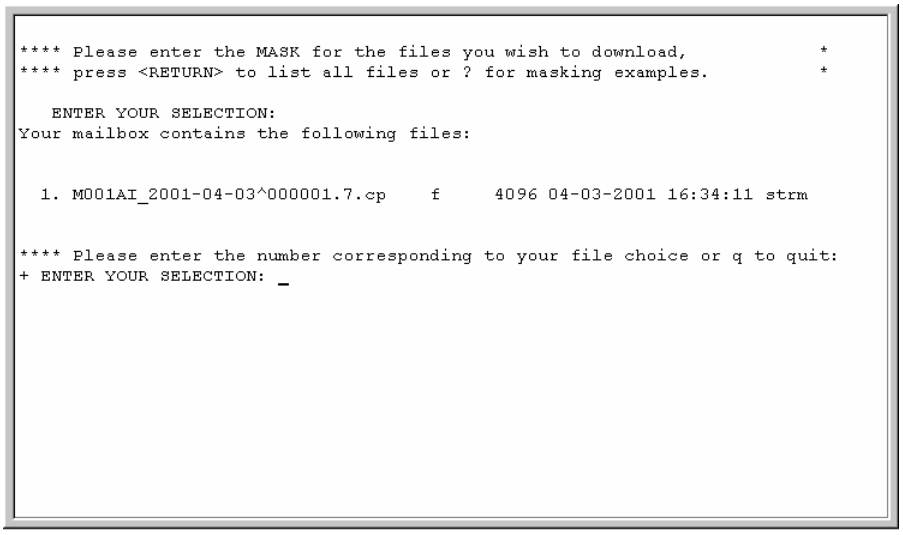
1. From the **Mailbox Access Facility** menu, type "**4**" and press **Enter**.



2. The following screen will appear. Press **Enter** to see a list of all files.

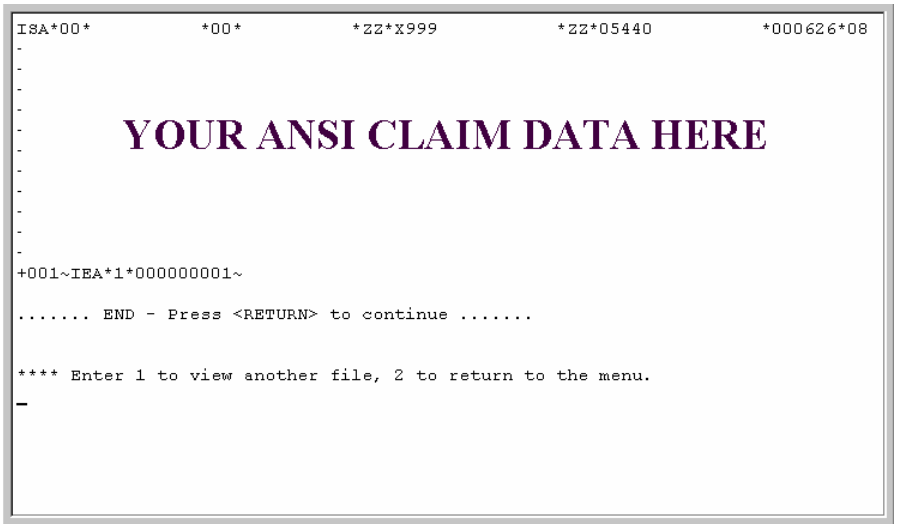


3. The following screen will list the files available to download and/or files that you have just uploaded into your Stratus Network mailbox.



4. To select the file that you wish to view, type the number that corresponds to the file and press **Enter**.

5. The file information will appear. When you are finished viewing the current information, press **Enter** to return to the previous screen. At that time you may select another file to view.

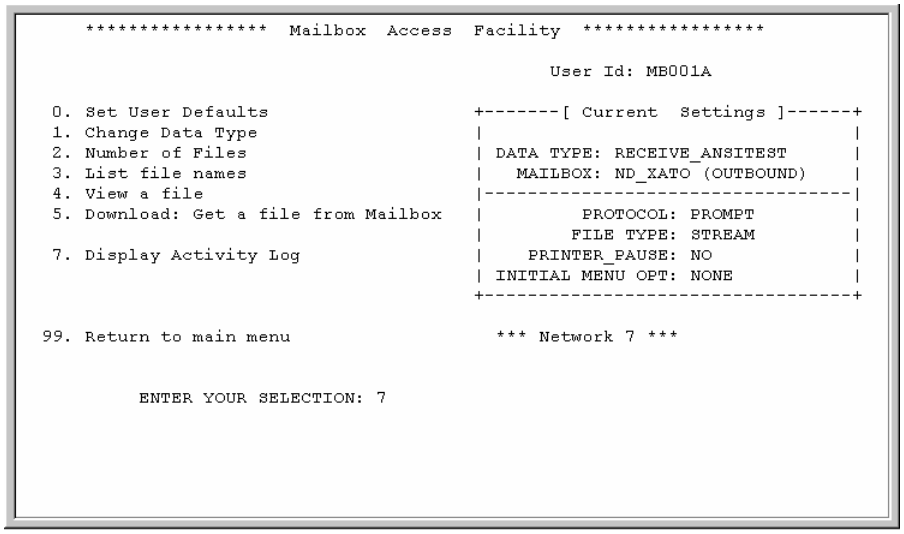


6. Follow the instructions on the screen to continue, view another file or return to the **Mailbox Access Facility** menu.

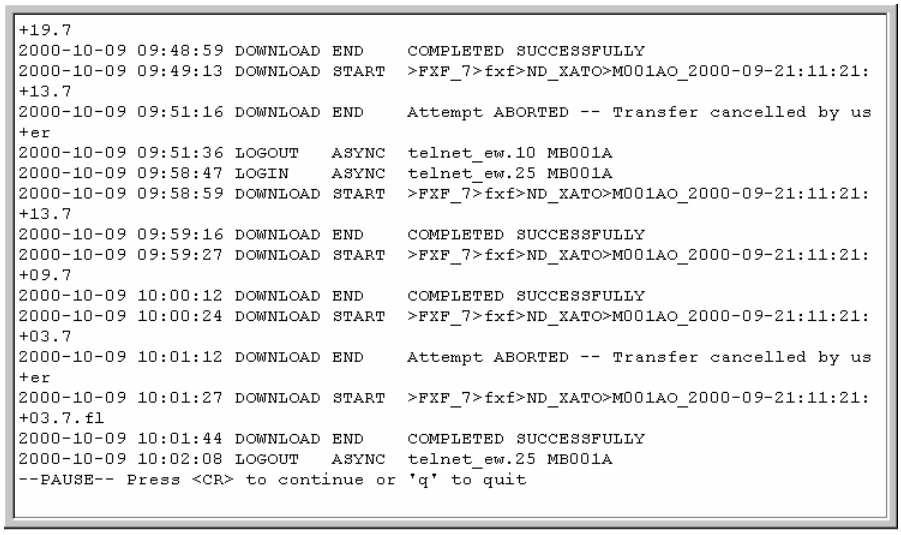
Activity Log

View your activity log to verify that your transmission was received by the Stratus Network. This information can be very helpful when trying to determine why you have not received an Electronic Report Package or to see if your files were uploaded successfully. You can access the activity log online anytime you are connected to the Stratus Network.

1. From the **Mailbox Access Facility** menu, type "**7**" and press **Enter**.



2. The activity log screen will appear. The time and date of your login and logout will be listed. In addition, each transmission that was attempted, completed or aborted will be listed in the log.
3. You can view additional screens by pressing **Enter**.
4. To return to the **Mailbox Access Facility** menu, type **"q"** and press **Enter**.

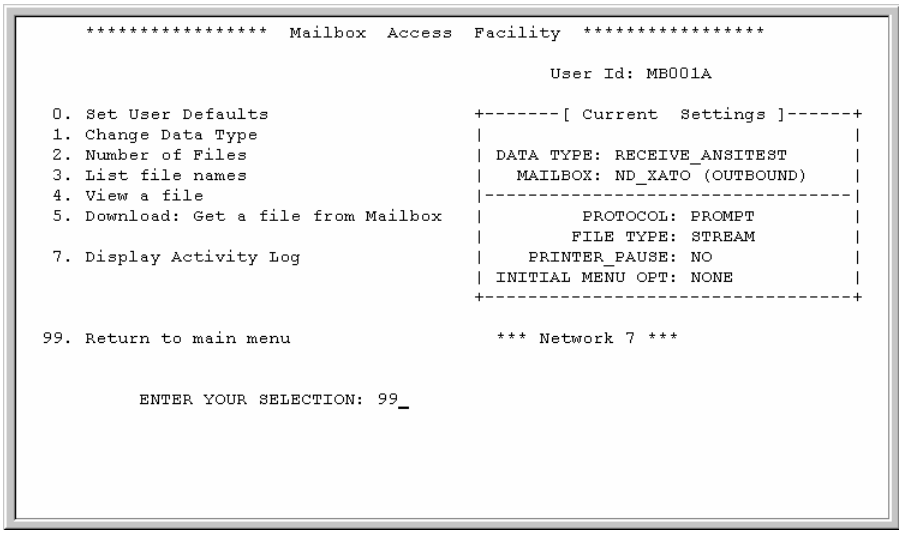


Explanation of the Activity Log:

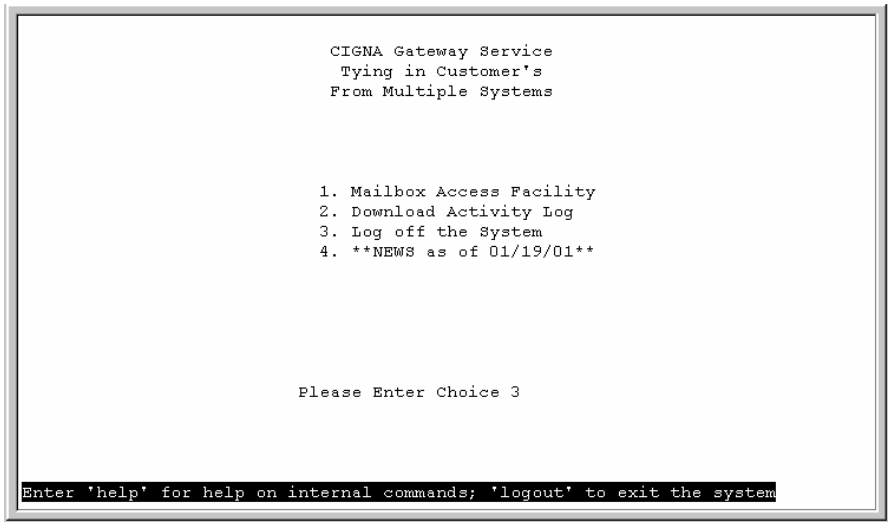
- Each line begins with a Date and Time Stamp. All times are recorded in Eastern Time. Files that have been successfully received prior to 5:00 p.m. will be processed on the same day. Files received after 5:00 p.m. will be processed the following business day.
- The first line, LOGIN, indicates that your connection was successful. The string of characters after it describes details about the type of connection you established.
- The following lines indicates the action that was being attempted. You will either see **UPLOAD** (when you send us a file) or **DOWNLOAD** (when you receive a file from us). It is important to have both a **START** and **END** line for each action. If the **END** line does not say "**COMPLETED SUCCESSFULLY**", the file transfer was not successful and you will need to either download or upload the file again.
- The string of characters that follows **START** is the filename that the Stratus Network assigns to that transmission.
- **LOGOUT** indicates the date and time your connection to the Stratus Network ended.

Exit or Logoff

1. From the **Mailbox Access Facility** menu, type "**99**" and press **Enter**. You will be returned to the **Main** menu.



2. To logoff, type "**3**" and press **Enter**.



3. You have now successfully logged out of the Stratus Network. You may now close your communications software.

Chapter Six:

Electronic Reports

One of the many advantages of transmitting your claims electronically is the ability to track your claims as soon as they are received by our system. (*MCM 3021.2*) This allows for more control over the claim's processing cycle. The following reports are generated to assist you in the tracking of your claims.

- Online Receipt Verification
- 997 Functional Acknowledgment report (997)
- Electronic Report Package
  - Report 7I6001 – Submitter Reports Cover Page
  - Report 7I6002 – Received Claims Listing
  - Report 7I6004 – Submission Summary
  - Report 7I6003 – Error Listing
  - Report 7I6006 – CMN Reject Listing

All electronic reports provided by CIGNA Medicare will be available to download for up to seven days. However, if a download is attempted and failed on a report, that report will no longer be available after three days. If necessary, the report can be redistributed to your Stratus mailbox for a period of 30 days from the date the file was sent. You may contact the EDI Department for assistance.

The next few pages contain information regarding these reports along with examples. For information on downloading reports in the Stratus Network, please see Chapter 5.

Online Receipt Verification

Once a file is transmitted via the Stratus Network, the supplier will automatically receive verification electronically that the transmission was successful. Although this confirmation will not tell you if your claims have been accepted into our processing system, it will confirm that a file was transmitted successfully to the Stratus Network.

997 Functional Acknowledgment report (997 report)

The 997 Functional Acknowledgment report is a report generated to recognize received ANSI X12N files. This report will be generated for each transaction received by CIGNA Medicare that contains enough data in a valid format to identify the user. In most cases, this report will tell you that the file received was a valid ANSI file. In which case, the 997 (in element AK901) will contain a code of "**A"** for accepted and you will not need to do anything with the 997. However, if an "**R"** appears in the 997 the file sent must be corrected and retransmitted.

This is a new report to all DMERC electronic billers and provides an intermediary status of the sender's file between Stratus and the front-end edits (see Chapter 7 of this manual for more information on edits). This report does not replace the Electronic Report Package. The Electronic Report Package will still be generated to acknowledge data errors. The 997 report is validating high level formatting, where the Electronic Report Package validates data and detailed formatting requirements.

The 997 report will be available within 2 hours of transmission of the file. The 997 will be returned to the user's Stratus Network mailbox identified in the incoming 837 transaction. This file may be downloaded by selecting **RECEIVE_ACK** from the Select Data Type option. See Chapter 5 for downloading instructions.

Note: During production, the 997 reports will be available upon the following schedule:

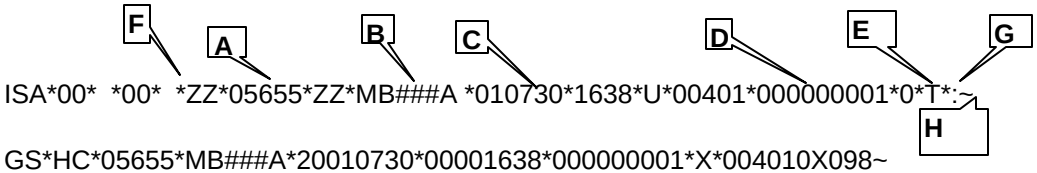
If submitted before:	997 report available after:
9:00 a.m. ET	9:30 a.m. ET
12:00 p.m. ET	12:30 p.m. ET
2:00 p.m. ET	2:30 p.m. ET
5:00 p.m. ET	6:00 p.m. ET
8:00 p.m. ET	6:00 a.m. ET

This report will be generated in the ANSI X12 997 format and will require a reader program for interpretation. If you do not have a 997 reader program, please contact your software vendor. CIGNA Medicare does not provide reader software.

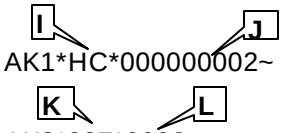
The following pages contain examples of the 997 report for both an accepted and a rejected transaction. They are broken down by element with descriptions provided for the key elements. If you download a 997 and it indicates a rejected status, correct the errors identified on the 997 and retransmit the transaction. If you need help in determining what caused the transaction to reject, contact your software vendor. If you would like more information on the specific elements of the 997, you may download the ANSI X12N 837 version 4010 Implementation Guide free-of-charge at *www.wpc-edi.com.*

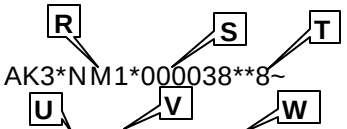
Example: Rejected 997

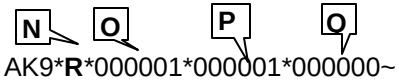
ISA*00* *00* *ZZ*05655*ZZ*MB001A
*010730*1638*U*00401*000000001*0*T*:~GS*HC*05655*MB001A*20010730*00001638*000000001*X*004010X098~ST*837*000000001~AK1*H
C*000000002~AK2*837*0002~AK3*NM1*000038**8~AK4*01*007*000000001~AK5*R*5~AK9*R*000001*000001*000000~SE*0000000012*000000
001~GE*1*000000001~IEA*1*000000001~



GS*HC*05655*MB###A*20010730*00001638*000000001*X*004010X098~
ST*837*000000001~





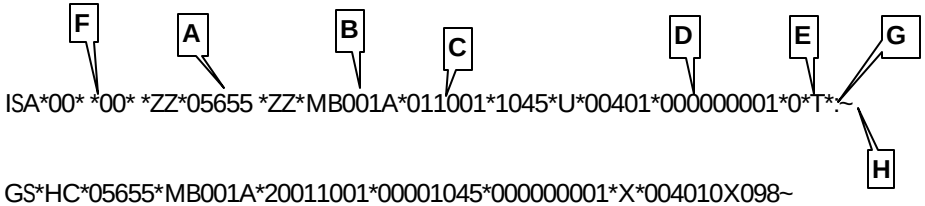


SE*0000000012*000000001~
GE*1*000000001~
IEA*1*000000001~

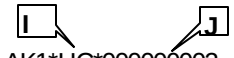
A	ISA06- 997 Sender Identification Number	**M**	**AK501-**
B	ISA08- 997 Receiver Identification Number	**N**	**AK901-**
C	ISA09- 997 Creation Date	**O**	AK902-
D	ISA13- Interchange Control Number- Assigned by CIGNA Medicare for this 997	**P**	AK903-
E	ISA15- 997 Test/Production Indicator	**O**	AK904-
F	*- Element Separator- Used to separate elements within a segment	**R**	AK301-
G	ISA16 {:} -Sub- Element Separator- Used to separate components in a sub-element	**S**	AK302-
H	~ Segment Terminator- Used to indicate the end of a segment	**T**	AK304-
I	AK101-	**U**	AK401-
J	AK102-	**V**	AK402-
K	AK201-	**W**	AK403-
L	AK202-	**X**	AK502-

Example: Accepted 997

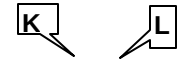
ISA*00* *00* *ZZ*05655 *ZZ*MB001A
*011001*1045*U*00401*000000001*0*T*:~GS*HC*05655*MB001A*20011001*00001045*000000001*X*004010X098~ST*837*000000001~AK1*H
C*000000002~AK2*837*0002~AK5*A~AK9*A*000001*000001*000001~SE*0000000006*000000001~GE*1*000000001~IEA*1*000000001~



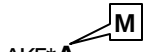
GS*HC*05655*MB001A*20011001*00001045*000000001*X*004010X098~
ST*837*000000001~



AK1*HC*000000002~



AK2*837*0002~



AK5***A**~

AK9***A***000001*000001*000001~

SE*0000000006*000000001~
GE*1*000000001~
IEA*1*000000001~

A	ISA06- 997 Sender Identification Number
B	ISA08- 997 Receiver Identification Number
C	ISA09- 997 Creation Date
D	ISA13- Interchange Control Number- Assigned by CIGNA Medicare for this 997
E	ISA15- 997 Test/Production Indicator
F	*- Element Separator- Used to separate elements within a segment
G	ISA16 {:} -Sub- Element Separator- Used to separate components in a sub-element
H	~ Segment Terminator- Used to indicate the end of a segment
I	AK101-
J	AK102-
K	AK201-
L	AK202-
M	**AK501-**
N	**AK901-**
O	AK902-
P	AK903-
Q	AK904-

The 997 report will validate the basic format and sequencing of the file. It is broken down into segments which report specific information within the submitted transaction as follows:

Segment	Description
AK1	This segment identifies the type of transaction being acknowledged. For example, if a claim file was being submitted, the AK1 and AK2 will notify the user that this 997 report is acknowledging an 837 transaction.
AK2	This segment identifies the transaction set control number on the original submitted file. This is a unique number assigned to each transaction submitted, and will have a one-to-one correlation to the original submitted transaction.
AK3	This segment reports errors with segments in the originally submitted transaction. This segment will provide the segment information including segment ID and position within the transaction where the error occurred. This segment will not be present on the 997 report if an Accepted (A) status code is reported. This status code can be found in AK901.
AK4	This segment reports errors with data elements within the segment identified in AK3. This segment will provide the element information including position in the segment and a copy of the data included within this element. This segment will not be present on the 997 report if an Accepted (A) status code is reported. This status code can be found in AK901.
AK5	This segment indicates the result of the transaction set originally submitted. The most common values are "**A**" for Accepted and "**R**" for Rejected when used. If an "**R**" appears in the AK5 segment, you must correct the errors noted in AK3 and AK4 and resubmit the transaction.
AK9	This segment indicates the result of the Functional Group originally submitted. The most common values "**A**" for Accepted and "**R**" for Rejected. If an "**R**" appears in the AK9 segment, you must correct the errors noted in AK3 and AK4 and resubmit the transaction.

Each segment can be broken down by element. Below is a list of the elements for each segment. For example, **AK101** is Segment **AK1**, Element **01**. Along with the element edit number is the element name, description and valid values. If you encounter these edits, it may indicate a data entry error, or formatting issues with your billing software. For formatting issues, please contact your software vendor for instruction and assistance.

Segment and Element	Element Name	Element Description	Valid Values with Description
AK101	Functional Identifier Code	X12 code identifying the functional group being acknowledged (For 837 will = HC)	
AK102	Group Control Number	Functional group number as appears in the submitted GS06	
AK201	Transaction Set Identifier Code	Code identifying the transaction being acknowledged from the originally submitted ST01 (I.e. for 837, it would be 837)	
AK202	Transaction Set Control Number	Transaction set number as appears in the submitter ST02	
AK301	Segment ID Code	Segment in which the error occurred	
AK302	Segment Position	Position of the segment. The segments ordered within the transaction, which segment it is. ST would =1, and count each segment from there	
AK303	Loop ID Number	Number assigned to the loop	

Segment and Element	Element Name	Element Description	Valid Values with Description
AK304	Segment Syntax Error Code	Code identifying the error with the named segment	1 - Unrecognized segment ID- segment name not complete or not a valid segment ID per X12 (I.e. NM would get this error if it did not read NM1) 2 - Unexpected segment - this would occur if segments came in out of order (I.e. if a NM1 followed a CLM segment. 3 - Mandatory segment missing- if a segment is required by X12 and was not present, then this error would occur (I.e., if CLM was not present) 4 - Loop occurs over maximum times - for those loops that repeat and a max is assigned, if one was exceeded, this error would be generated (I.e. If there were 101 CLM segments signifying 101 2300 Loops, this rejection would occur) 5 - Segment exceeds maximum use- within a loop, if the segment repeats more than standard allows (I.e. 16 DTP's in the 2400 loop would cause this rejection since only 15 are allowed.) 6 - Segment not in defined transaction set- If a valid X12 segment was used in this transaction, however it was not named for this transaction, then this error would occur (I.e. TS3 is a valid segment for the 835, if sent in a 837, it would reject with this error) 7 - Segment not in proper sequence- segment positions are defined by the X12 standard, if they come in out of order, this error would occur (I.e. CRC (pos. 220) comes before DTP (pos. 135) in the 2300 loop would cause this error) 8 - Segment has data element errors- If any of the elements have errors, this error will show and be followed by an AK4 segment
AK401	Position in segment	Composite element if referencing a composite in the incoming file	
AK401-1	Element Position in Segment	Position of element in error in the segment identified in AK3 (I.e. the number 9 here with a AK301 of NM1 would be the identifier in NM109)	

Segment and Element	Element Name	Element Description	Valid Values with Description
AK401-2	Composite Data Element Position in Composite	Identifies position within composite in the element identified in AK401-1	
AK402	Data Element Reference Number	Data element number (3rd column in IG)	
AK403	Data Element Syntax Code	Error code for identified element	1 - Mandatory data element missing- X12 defined mandatory element was not included (not IG Required, just X12 mandatory- See Attributes in 837 Implementation Guide) 2 - Conditional required data element missing- X12 defined conditional element not included (Not IG relational, X12 relational- attribute of X, if element comes as X attribute, must contain "pair") 3 - Too many data elements- number of allowed elements for the identified segment were exceeded. (most likely too many *'s) 4 - Data element too short- element does not meet the minimum length requirement 5 - Data element too long- element exceeds maximum length restriction 6 - Invalid character in data element- characters restricted based on attribute. Used invalid character in this element. (I.e. used alpha character in a "N0" type element) 7 - Invalid code value- code or qualifier used does not appear on the X12 list of valid qualifiers for this element. (X12 code sets, not IG code sets) 8 - Invalid date- entered future date, invalid date (I.e. 2/30/2001), or not in the correct format (D8= CCYYMMDD or RD8= CCYYMMDD-CCYYMMDD) 9 - Invalid time- entered invalid time (261315) or not in correct format (HHMM or HHMMSS or HHMMSSSS) 10 - Exclusion condition violated

Segment and Element	Element Name	Element Description	Valid Values with Description
AK404	Copy of Bad Data Element	Copy of specific data that caused the error code in AK403	
AK501	Transaction Set Acknowledgement Code	Code acknowledging the transaction set identified in the AK202	A - Accepted- transaction was accepted and passed on to VMS for editing E - Accepted but errors were noted M - Rejected, Message Authentication Code (MAC) failed R - Rejected- transaction was rejected, errors noted in AK3 and/or AK4 need corrected and transaction needs to be resubmitted W - Rejected, assurance failed validity test X - Rejected, content after decryption could not be analyzed
AK502	Transaction Set Syntax Error Code	Code required if an error exists	1 - Transaction set not supported- the submitted transaction is not supported by the receiver. (i.e. If someone sent us a 270 and we did not have it available, or sent us a 271 which we would never receive) 2 - Transaction set trailer missing- transaction being acknowledged did not contain a SE segment 3 - Transaction set control number in header and trailer don't match- SE02 must be identical to ST02 4 - Number of included segments does not match actual count- SE01 does not equal the number of segments within the ST-SE including both the SE and SE 5 - One or more segments in error- used if AK3 shows segment error 6 - Missing or invalid transaction set identifier- ST01 must properly identify the transaction being sent (I.e. 837, 997, etc.) 7 - Missing or invalid transaction set control number- SE02 or SE02 is missing or contains too many, too few, or invalid characters 8 - Authentication key name unknown 9 - Encryption key name unknown 10 - Requested service (authentication or encrypted) not available 11 - Unknown security recipient 12 - Incorrect message length (encryption only)

Segment and Element	Element Name	Element Description	Valid Values with Description
			13 - Message authentication code failed 15 - Unknown security originator 16 - Syntax error in decrypted text 17 - Security not supported- will send this error when security information is sent ISA03 or ISA04 23 - Transaction set control number not unique within the functional group- If more than 1 transaction set (ST-SE) is sent in 1 functional group (GS-GE), each ST02 must be unique 24 - S3E security end segment missing for S3S security start segment 25 - S3S security start segment missing for S3E security end segment 26 - S4E security end segment missing for S4S security start segment 27 - S4S security start segment missing for S4E security end segment
AK503	Transaction Set Syntax Error Code	Used if multiple error codes are needed, repeated values above	
AK504	Transaction Set Syntax Error Code	Used if multiple error codes are needed, repeated values above	
AK505	Transaction Set Syntax Error Code	Used if multiple error codes are needed, repeated values above	
AK506	Transaction Set Syntax Error Code	Used if multiple error codes are needed, repeated values above	

Segment and Element	Element Name	Element Description	Valid Values with Description
AK901	Function Group Acknowledgement Code	Code acknowledging the functional group (GS-GE) identified in the AK102	A - Accepted- functional group was accepted and passed on to VMS for editing E - Accepted but errors were noted M - Rejected, Message Authentication Code (MAC) failed R - Rejected- functional group was rejected, errors noted in AK3 and/or AK4 need corrected and transaction needs to be resubmitted W - Rejected, assurance failed validity test X - Rejected, content after decryption could not be analyzed
AK902	Number of Transaction Sets (ST-SE) Included	Total number of transaction sets included in this functional group (GS-GE). This is identical to the GE01on the originally received transaction.	
AK903	Number of Received Transaction Sets	Actual number of transaction sets received.	
AK904	Number of Accepted Transaction Sets	Total number of transaction sets accepted out of the number in AK902	

Segment and Element	Element Name	Element Description	Valid Values with Description
AK905	Functional Group Syntax Code	Code indicating error in functional group	1 - Functional group not supported- the submitted group is not supported by the receiver. (i.e. If someone sent us a "HP" in the GS01 indicating the group was an 835 rather than the HC for 837- X12 level) 2 - Functional group version (GS08) not supported- the submitted group is not supported by the receiver. (i.e. If someone sent us an earlier version (3051) and we do not support it) 3 - Functional group trailer missing- functional group being acknowledged did not contain a GE segment 4 - Group control number in the functional group header and trailer don't match- GS0602 must be identical to GE02 5 - Number of included transaction sets does not match actual count- GE01 does not equal the number of transaction sets within the GS-GE 6 - Group control number violates syntax- if characters other than that specified for a "N0" data type is sent (i.e. an alpha character), or if it is out of bounds of the Min/Max 10 - Authentication key name unknown 11 - Encryption key name unknown 12 - Requested service (authentication or encrypted) not available 13 - Unknown security recipient 14 - Unknown security originator 15 - Syntax error in decrypted text 16 - Security not supported- will send this error when security information is sent ISA03 or ISA04 17 - Incorrect message length (encryption only) 18 - Message authentication code failed 23 - S3E security end segment missing for S3S security start segment 24 - S3S security start segment missing for S3E security end segment 25 - S4E security end segment missing for S4S security start segment 26 - S4S security start segment missing for S4E security end segment

Segment and Element	Element Name	Element Description	Valid Values with Description
AK906	Functional Group Syntax Code	Repeat AK905 if additional codes apply	
AK907	Functional Group Syntax Code	Repeat AK905 if additional codes apply	
AK908	Functional Group Syntax Code	Repeat AK905 if additional codes apply	
AK090	Functional Group Syntax Code	Repeat AK905 if additional codes apply	

Electronic Report Package

The most valuable advantage of billing electronically is the ability to track your claims once they are received by CIGNA Medicare. Within 48 hours after you transmit your claims, an Electronic Report Package is available for downloading. This is a set of reports that provide specific information as it relates to each claim you transmitted. Using these reports will allow you to quickly determine the total number of claims you transmitted, the number of claims accepted into our system for processing, and when applicable, the reasons why claims were rejected. This section identifies and describes each of the reports that are generated. Although there are multiple reports, you may not receive every one when you download your Electronic Report Package. The reports are referenced by report number. The report numbers are located in the upper left-hand corner of each page of the reports.

CARRIER: 05655
PROGRAM: X837I600
REPORT: 7I6001

The reports included in the Electronic Report Package are:

- Report 7I6001 – Submitter Reports Cover Page
- Report 7I6002 – Received Claims Listing
- Report 7I6004 – Submission Summary
- Report 7I6003 – Error Listing
- Report 7I6006 – CMN Reject Listing

Reports 7I6001, 7I6002 and 7I6004 will be included in every Electronic Report Package. Reports 7I6003 and 7I6006 will only be included if there are errors in the claim or CMN file.

The next few pages provide a description and example of each report included in the Electronic Report Package. Instructions for downloading the package may be found in Chapter 5.

Report 7I6001 – Submitter Reports Cover Page

This report is included with every Electronic Report Package. The Submitter Reports Cover Page indicates the following information:

- The date the file was received by CIGNA Medicare.
- The date and time the file was transmitted.
- The Submitter ID and contact person.
- The submitter name and address. This information is derived from CIGNA Medicare's submitter records.
- The Interchange Sender ID as included in the ANSI X123N 837 transaction.
- The Claim Control Number (CCN) assigned by the submitter of the ANSI X123N 837 transaction.
- The type of file transmitted based on data sent in the ANSI X123N 837 transaction.
  T = Test
  P = Production
- Contact information for the entity that transmitted the file.

CARRIER: 05655
PROGRAM: X837I600
REPORT: **7I6001**

CIGNA, INC. (A)
MEDICARE DMERC
SUBMITTER REPORTS COVER PAGE (B)

(C) RUN DATE: 09/09/01
(D) RUN TIME: 6:48:32
PAGE: 1

ON THIS DATE, 09/09/2001, WE RECEIVED THE SUBMITTED DATA AS DESCRIBED ON THE ATTACHED REPORTS

(J)

SUBMISSION DATE AND TIME: (F)	090901 0100
SUBMITTER ID:	D08699999
NAME:	ANY BILLING COMPANY
ADDRESS:	1850 S EXAMPLE BLVD
	SUITE #100
CITY, STATE, ZIP:	MY CITY ST 99999
CONTACT:	SUBMITTER CONTACT
INTERCHANGE SENDER ID:	MB001A
CONTROL NUMBER: (G)	123456789
TEST OR PROD:	P
ACKNOWLEDGE: (H)	0
EDI NBR:	
PHONE: (I)	(866) 244-3094
EXT:	
FAX:	
EMAIL:	EDI.CONTACT@SUPPLIER.COM

A	Name of Carrier issuing this report	**E**	VMS Report number unique to each report	**H**	Test/Production indicator as submitted on the incoming 837 transaction
B	Report Title	**F**	Submission date and time as reported on the incoming 837 transaction	**I**	EDI number- Submitter contact information- not used for CIGNA DMERC. Blank indicates no information to display.
C	Date report was generated by claim processing system	**G**	Interchange control number (ISA13) as submitted on the incoming 837 transaction	**J**	Information contained in this section, with the exception of Submitter Name and Address information, is what was originally submitted on the incoming 837 transaction. The company name and address information comes from DMERC submitter records.
D	Time report was generated by claim processing system				

Report 7I6002 – Received Claims Listing

The Received Claims Listing report is included with every Electronic Report Package and will follow the Submitter Reports Cover Page (Report 7I6001). This report will provide Claim Control Numbers (CCNs) assigned by CIGNA Medicare to claims that were accepted into the claims processing system. If there is not a CCN assigned to an individual claim, this is an indication that the claim either contains errors or it was transferred to another DMERC.

This report will be organized by the billing provider's supplier number. This is beneficial for billing services or large companies that bill using multiple supplier numbers in a single transaction. Rather than locating a particular supplier's claims among the total claims transmitted, a separate Received Claims Listing report will be generated for each supplier.

The information contained on the Received Claims Listing report includes:

- The subscriber's HICN (Medicare number)
- The name of the beneficiary
- The patient account number
- The date of service
- The Claim Control Number (CCN)
  - If a CCN is not assigned, the claim may have been rejected on the front-end due to data errors, or transferred to another region for processing. To determine the cause, look to the right under the column heading ST and/or TX.
- The amount billed
- The status of the claim
  - A = accepted for processing
  - R = rejected due to data errors
  - T = transferred to another DMERC for processing
- Transferred claims
  - A = transferred to Region A for processing
  - B = transferred to Region B for processing
  - C = transferred to Region C for processing
- The level at which the errors occurred (if the claim was rejected)
  - IN = error occurred at the interchange level
    For example, if you did not include the receiver's identification code (the DMERC's carrier code) in the submitted transaction. An error at this level will require the entire file to be retransmitted once the error is corrected.
  - FG = error occurred at the functional group level.
    At this time there are no edits that will cause an FG to be present in this field.
  - TS = error occurred at the transaction set level.
    For example, if an invalid submitter identification number was used. The error would need to be corrected, and the 837 transaction would need to be retransmitted.
  - BP = error occurred at the billing/pay-to provider level.
    For example, if a billing provider (supplier) number was transmitted before it was set up to transmit electronic claims to Region D DMERC. If an edit occurs at this level, correct the error that occurred and retransmit every claim for the affected supplier.
  - SP = error occurred at the beneficiary/patient level.
    For example, if the beneficiary's HICN was not included on the claim. If an edit at this level occurs, every claim for that beneficiary would have to be retransmitted.

- CL = error occurred at the claim or service line level.
  For example, if the ordering provider's UPIN was not included on the claim. If an error occurs at this level, this claim would need to be corrected and retransmitted.

CARRIER: 05655 CIGNA, INC. RUN DATE: 09/09/01
PROGRAM: X837I600 MEDICARE DMERC RUN TIME: 6:48:32
REPORT: **7I6002** RECEIVED CLAIMS LISTING PAGE: 1

SUBMITTER ID/NAME: D0869999 ANY BILLING COMPANY
BILLING ID/NAME: 9999990001 SUPPLIER COMPANY
PAY-TO ID/NAME: SAME AS BILLING

HICN	PATIENT LAST NAME	FIRST NAME	M	PAT ACCT NBR	FROM	TO	CCN	BILLED AMT	ST	TX	LVL
999999999D	SUBSCRIBER	JOE	L	TEST1323	03212001	03212001	01252810001000	50.00	A		
111100011A	TRANSFER	MY		TEST1111	08152001	08152001		100.00	A	B	
222200011B	REJECTED	TEST		TEST2222	09012001	09012001		75.00	R		CL
990000025C	TRANSFER	REJECTED	C	TEST4444	08012001	08012001		142.25	R	C	CL

A	HICN for the subscriber for this claim	**C**	Claim Control Number assigned by CIGNA DMERC for all accepted claims. Transfer and rejected claims do not contain a CCN	**E**	Transferred to. This field will show the DMERC this claim was transferred to on accepted claims, or the DMERC the claim should have transferred to on Rejected claims
B	Patient Account Number assigned by the submitter/supplier for this subscriber	**D**	Status of this claim. A- Accepted, R- Rejected, T- Transferred	**F**	Level of rejection. For rejected claims, the rejection level will be reported here. Please see introduction of this chapter for further explanation on the levels of editing.

Report 7I6004 – Submission Summary

The Submission Summary report is included with every Electronic Report Package and is an excellent tool for balancing your claim totals. This report summarizes the number and dollar amounts of assigned and/or non-assigned claims received, accepted, rejected, and transferred by Region D DMERC for each transaction transmitted for a particular run date.

The information contained in this report includes:

Assigned claims information

- The total number of assigned claims received, accepted, rejected and transferred by Region D DMERC.
- The percentage of assigned claims that were accepted, rejected, and transferred in relation to the total number of assigned claims received.
- The total dollar amount of assigned claims received, accepted, rejected and transferred.
- The percentage in dollar amount of assigned claims accepted, rejected transferred as that dollar amo unt relates to the dollar amount of received assigned claims.

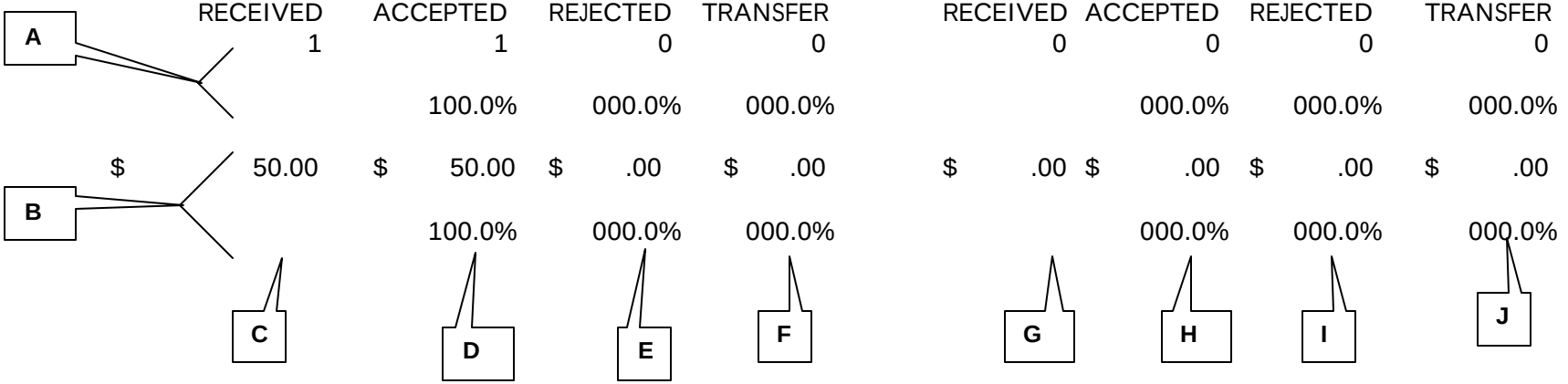
Non-assigned claims information

- The total number of non-assigned claims received, accepted, rejected and transferred by Region D DMERC.
- The percentage of non-assigned claims that were accepted, rejected, and transferred in relation to the total number of non-assigned claims received.
- The total dollar amount of non-assigned claims received, accepted, rejected and transferred.
- The percentage in dollar amount of non-assigned claims accepted, rejected transferred as that dollar amount relates to the dollar amount of received non-assigned claims.

CARRIER: 05655 CIGNA, INC. RUN DATE: 09/09/01
PROGRAM: X837I600 MEDICARE DMERC RUN TIME: 6:48:32
REPORT: **7I6004** SUBMISSION SUMMARY PAGE: 1

SUBMITTER ID/NAME: D08601212 ANY BILLING COMPANY

BILLING ID PAY-TO ID
9999990001 9999990001



A	These rows shows total number of claims shown on this report and lists amount and percent totals by type of claims received	**E**	This column reports the number and dollar amount of *rejected* Assigned claims	**H**	This column reports the number and dollar amount of *accepted* Non-Assigned claims
B	These row shows total dollar amount shown on this report and lists amount and percent totals by type of claims received	**F**	This column reports the number and dollar amount of *transferred* Assigned claims	**I**	This column reports the number and dollar amount of *rejected* Non-Assigned claims
C	This column reports the number and dollar amount of *received* Assigned claims	**G**	This column reports the number and dollar amount of *received* Non-Assigned claims	**J**	This column reports the number and dollar amount of *transferred* Non-Assigned claims
D	This column reports the number and dollar amount of *accepted* Assigned claims				

Report 7I6003 – Error Listing

The Error Listing report is included in the Electronic Report Package if there were one or more claims missing information or not meeting specified criteria, and therefore, not accepted into the processing system. If, on the Received Claims Listing report (Report 7I6002), a CCN was not assigned to a claim and the ST column shows an "**R**", the Error Listing report will be generated. The Error Listing report will identify the reason why a claim was rejected. Refer to Chapters 7, 8, and 9 for an explanation of the edit number received and to quickly identify what needs to be corrected. You may receive multiple 7I6003 reports as a separate report is generated at each level in which the error occurred (IN, FG, TX, BP, SP, CL).

It is your responsibility to correct your errors and retransmit the file(s). Claims containing errors that were corrected and retransmitted for processing are NOT considered duplicate transmissions since the original claim was not accepted for processing. These claims are considered new claims and may be transmitted electronically.

The information contained on this report includes:

- Claim sequence number
  - Position of this claim in relation to the total received claims from this submitter for the run date listed on this report.
- Patient account number
- Total lines
  - This number represents the total number of lines submitted on this claim.
- Earliest from date
  - This date represents the earliest service from date reported on all lines of the claim.
- Latest to date
  - This date represents the latest service to date reported on all lines of the claim.
- Total billed amount
  - This is the total dollar amount as reported on the claim.
- LN
  - This column represents the line on which the error occurred.
  - For example, if a six -line claim is submitted with an invalid date of service reported on line three causing the claim to reject, the value in LN would be 03.
- Edit number
  - This is a five-digit number that represents the reason why the claim was rejected.
- Edit description
  - This is a description provided to help you quickly identify the cause of the error.
- Actual submitted data
  - The actual claim data entered by the submitter is shown under the edit number.
  - This is beneficial for helping identify at a glance what may have caused the error to occur. For example, it is possible that the letter O was keyed instead of the number 0.
- Implementation Guide references
  - The information presented on the right hand side of the report is useful if you are familiar with an ANSI file.
  - It shows the loop, segment, and element information in which the error occurred. This will be useful if you have to contact your software vendor to request assistance in resolving a particular edit.

CARRIER: 05655 CIGNA, INC. RUN DATE: 08/16/01
PROGRAM: X837I600 MEDICARE DMERC RUN TIME: 14:45:05
REPORT: **7I6003** CL LEVEL ERROR LISTING PAGE: 1

SUBMITTER ID/NAME: D0869999 ANY BILLING COMPANY
BILLING ID/NAME: 9999990001 SUPPLIER COMPANY
PAY-TO ID/NAME: SAME AS BILLING
BENEFICIARY ID/NAME: 222200011B REJECTED TEST
PATIENT ID/NAME: 222200011B REJECTED TEST

A CLAIM SEQ#	PATIENT ACCOUNT NO.	B TOTAL LINES	EARLIEST FROM DATE	LATEST TO DATE	TOTAL BILLED AMT
0001	TEST2222001	0001	03252001	03252001	2000.00

C LN	D		LOOP	LOOP SEQ	SEG	SEG SEQ	VERSION	DATA ELEMENT NUMBER AND NAME
01	10199	RELATED CAUSE 2 CODE INVALID	2300	0001	CLM	0001	A	11-2 RELATED CAUSES CODE-2
.23								
01	10203	SPEC PROG IND INVALID	2300	0001	CLM	0001	A	12 SPECIAL PROGRAM INDICATOR
F PWK								

E G H I J K L M

A	Sequence of claim that received the rejection out of all claims received for this Run Date	**F**	Originally submitted data that caused this edit	**J**	Segment sequence within the loop submitted containing the data that received this edit
B	Total number of lines on this claim	**G**	Loop containing the data that received this edit	**K**	Edit version number assigned by claims processing system
C	Line number within the claim that this error occurred on	**H**	Loop sequence within the transaction set submitted containing this claim	**L**	Data element position within the segment containing data that caused this edit
D	Edit number- Refer to Chapters 7, 8, and 9 for edit explanations	**I**	Segment containing the data that received this edit	**M**	Data element name for the element containing data that caused this edit
E	Edit description- Refer to Chapters 7, 8, and 9 for edit explanations				

Report 7I6006 – CMN Reject Listing

The CMN Reject Listing report is included in the Electronic Report Package if there were one or more CMNs are rejected off of a claim. The CMN Reject Listing report lists any CMNs that were rejected after the claim was accepted into our system.

Information present on this report includes:

- HICN
  - This is the HICN for the beneficiary for whom the CMN was rejected.
- CCN (Claim Control Number)
  - This is the CCN of the claim the CMN was rejected from. Please note, since a CCN was assigned to the claim, the claim will be processed, and, depending on the CMN rejection code listed on this report, the claim may be denied.
- Procedure code
  - The procedure code submitted on the claim for which the CMN was rejected.
- Original initial date
  - This is the initial date Region D DMERC has on file. This date can be very useful in determining and correcting the CMN rejects.
- Submitted initial date
  - This is the initial date the billing provider submitted on the rejected CMN.
- Type
  - The type of CMN submitted with the claim.
    INIT = Initial
    RECER = Recertification
    REVIS = Revised
- Recert/revised date
  - This date is the recertification or revision date submitted on the rejected CMN.
- Form
  - This is the CMN form number.
- Error Codes
  - The error code explains why the CMN was rejected.
  - A brief description is provided next to the error code.
- Total CMNs Rejected
  - This number indicates the total number of CMNs rejected per submitter.
  - This report will print only once per submitter, per run date.

The Certificate of Medical Necessity (CMN) reject report appears at the end of the Electronic Report Package and lists claims with rejected CMNs. Rejected CMNs have a four-digit reject code. The rejection codes and explanations can be found in Chapter 6 of this manual. It is possible a claim will be accepted into our processing system but the CMN may still be rejected.

Many CMNs are rejected simply because they are not completed properly. Here are some tips to help ensure your CMNs are completed correctly. In addition, these simple guidelines will help prevent ANSI Code B17 claim denials.

All CMN rejections occur when another CMN is on file in our system for the same procedure code and beneficiary. Remember that duplicate CMNs will be rejected. In addition, if another supplier has provided same or similar equipment previously, a current CMN may already be on file in our system.

Review CMNs before transmitting with any claims. CMNs should only be transmitted when needed and not with every claim. Following are some questions to consider before transmitting claims:

- Is the correct type of CMN being transmitted according to the documentation requirements in the various policies: initial, revision, or recertification?
- Are all the sections of the CMN completed?
- Is the correct CMN being sent with the first claim that will be affected?
- Does the date on the CMN you are transmitting overlap that of a CMN already transmitted to CIGNA?

The following are definitions of the CMN reject error codes, what causes that rejection, and possible resolutions to these situations. In order to obtain information regarding CMNs on file and the dates listed, CIGNA Medicare suggests contacting the beneficiary, the ordering physician and/or the previous supplier. A final option is to have the beneficiary utilize the toll-free line 800.899.7095 to inquire about previous services. CIGNA Medicare is unable to release specific information to a supplier until they have filed a claim. Once a claim has been received for the item indicated on the CMN reject report, the supplier may contact the CIGNA Medicare Public Relations Department toll-free at 866.224.3094, **option 3**.

If the claim has been denied with ANSI code M3 "Equipment is the same or similar to equipment already being used" CIGNA Medicare is unable to release any information to a supplier. The beneficiary needs to contact the Customer Service Department toll-free at 800.899.7095.

The six valid error codes for CMN rejections are as follows:

Error Code	EDIT DESCRIPTION	Edit Explanation
3030	INIT DATE DUP	The initial CMN transmitted electronically has the same initial date as the original CMN on file for this procedure code. This error occurs when a duplicate initial CMN was transmitted. An initial CMN should be transmitted only with the initial claim for that item. For example, a claim is transmitted for a wheelchair with a date of service of 01/14/01 along with an initial CMN with an initial date of 01/14/01. The following month a claim is transmitted with the date of service 02/14/01 along with the same CMN previously transmitted with an initial date of 01/14/01. Since CIGNA Medicare already has the first initial CMN with an initial date of 01/14/01, the duplicate CMN would be rejected with an error code of 3030. *Resolution:* Suppliers should check their software to make sure that a CMN will be transmitted only when necessary. Remember to only transmit a CMN when necessary and not with every subsequent claim.

Error Code	EDIT DESCRIPTION	Edit Explanation
3031	INIT DATE< PREV END DATE	The initial CMN transmitted electronically has an initial date that is prior to the end date of the original CMN on file for the same procedure code. This error most often occurs when a beneficiary changes suppliers for rental equipment. The initial CMN was already on file from the original supplier and then another initial CMN was transmitted either by the same supplier or subsequent supplier. CMNs are categorized in our system by beneficiary not supplier. For example, ABC Oxygen transmits an initial oxygen CMN for Jane Doe with an initial date of 06/01/00 for a 12-month length of need. On 09/01/00, Jane Doe changes suppliers and XYZ Oxygen transmits an initial oxygen CMN with an initial date of 09/01/00. The CMN from XYZ Oxygen would be rejected with an error code of 3031 because the initial oxygen CMN from ABC Oxygen is not scheduled to end until 06/01/01. *Resolution:* In the example above, the therapy for the oxygen starts with the initial date the beneficiary needed the oxygen. Therefore, even if a beneficiary changes suppliers assuming the medical need has not ended, the initial date of therapy has not changed. The subsequent supplier should have obtained a revised CMN. The revised date would be the date the new supplier took over the services for the beneficiary. If the oxygen order is the same, the CMN does not have to be transmitted with the claim. However, the subsequent supplier would need to furnish the revised CMN upon request from the DMERC. If a change occurred in the medical condition of the beneficiary that has caused a break in medical necessity of at least 60 days plus whatever days remain in the rental month during which the need for oxygen ended, the supplier should obtain a new initial CMN. An explanation is needed to document this change in medical condition stating why a new medical need is being established. This CMN would need to be submitted on paper with the documentation for the break of medical necessity. In this case, the CMN cannot be transmitted electronically.
3032	CUR REC/REV DATE <= PREV	The recertification or revised CMN transmitted electronically has a recertification or revised date that is prior to or the same as the recertification or revised date on the CMN on file for this procedure code for this beneficiary. This error most often occurs when duplicate recertification or revised CMNs are transmitted, or when recertification or revised CMNs are transmitted out of order. For example, The Enteral Company transmits a revised CMN with an 08/01/00 date for procedure code B4150 (enteral formula). The CMN is transmitted electronically and posted to CIGNA Medicare's CMN files. Then, a day or more later, The Enteral Company realizes they have a revised CMN with a date of 07/01/00 for B4150. The Enteral Company transmits the revised CMN for 07/01/00. This CMN rejects with edit 3032 because CIGNA Medicare has already posted the CMN with the revised date of 08/01/00. *Resolution*: Make sure CMNs are transmitted in sequence. If you receive this error and the claim was processed and paid incorrectly due to the wrong CMN for that date of service, request a review. If the claim was processed and payment was not made, submit the claim and recertification or revised CMN to Nashville on paper for processing. CMNs cannot be transmitted electronically once the recertification or revised CMN has been transmitted out of sequence.

Error Code	EDIT DESCRIPTION	Edit Explanation
3047	RCT/REV INIT DATE INVALID	The recertification or revised CMN transmitted electronically has an initial date that is not the same as the initial date on the initial CMN currently on file for the same procedure code. For example, CIGNA Medicare already has an initial CMN for a hospital bed set up with an initial date of 06/01/01 sent in by either Company A or Company B. A recertification or revised CMN for 09/01/01 is transmitted by Company B and the initial date is 06/11/01. This would cause a 3047 CMN reject error code since CIGNA Medicare has on file an initial date of 06/01/01. *Resolution:* The initial date on file with CIGNA Medicare will be returned on the CMN Reject Listing. Verify the date submitted with the initial date on the CMN Reject Listing and if necessary, correct the CMN and retransmit the claim and CMN. If, after contacting the beneficiary, physician, and/or other supplier it still cannot be resolved call the Public Relations Department in Boise.
3048	CANNOT REC/REV DISC	The recertification or revised CMN transmitted electronically cannot be accepted for this procedure code. The initial CMN on file for this procedure code has been discontinued. Any CMN in a discontinued status cannot be recertified or revised. For example, if a beneficiary had been renting a K0001 wheelchair and then their medical need changed and now they qualified for a K0011 wheelchair. CIGNA Medicare would set the K0001 CMN to be discontinued. *Resolution:* If this happens, contact the beneficiary, physician, and/or other supplier. Check your own files and if it still cannot be resolved, call the Public Relations Department in Boise.
3052	CMN CLSD-NO REV	The revision CMN that was transmitted electronically cannot be accepted for this procedure code. The CMN on file for this procedure code has been closed. Any CMN in a closed status cannot be revised. For example, if the item was an inexpensive or routinely purchased piece of durable medical equipment such as a Power Operated Vehicle and it had reached the purchased price, CIGNA Medicare would close the CMN since the maximum allowed had been paid. Another example would be if a beneficiary chose the purchase option for a capped rental item. In this instance, the equipment would belong to the beneficiary in the 14th month and further payment would not be due. *Resolution:* Contact the beneficiary, physician, and/or other supplier. Check your files to see how many months the beneficiary rented the item or if the beneficiary purchased at initial issuance. If still cannot be resolved, call the Public Relations Department in Boise.

CARRIER: 05655 CIGNA, INC. RUN DATE: 09/09/01
PROGRAM: X837I600 MEDICARE DMERC RUN TIME: 6:48:32
REPORT: **7I6006** CMN REJECT LISTING PAGE: 1

BILLER/SUBMITTER ID: D08601212

SUPPLIER/PAY-TO ID:9999990001

HICN	CCN	PROC CODE (A)	ORIGINAL INITIAL DATE (B)	SUBMIT INITIAL DATE (C)	TYPE (D)	RECERT/ REVISED DATE (E)	LENGTH OF NEED	FORM (F)	ERROR CODES (G)
999999999D	01252810001000	K0001RR	01212000	01212000	RECER	05212001	99	02.03	3048 - CANNOT RCT/REV DISC CMN

TOTAL CMNS REJECTED: 0000001 (H)

A	Procedure Code sent in for this CMN	**D**	CMN Type- Initial (INIT), Recertification (RECER), Revision (REV)	**G**	CMN Edit Number- Refer to Chapters 7, 8, and 9 for edit explanations
B	Initial date on file for this CMN as on file at the DMERC	**E**	Recertification/Revision Date submitted with this CMN	**H**	Total number of CMN's rejected for all transactions received on this date as shown on this report
C	Initial date reported for this CMN on the submitted line	**F**	CMN Form number reported for this line		

Chapter Seven:

Front-End Edits

Introduction

Front-end edits are broken down into three categories or levels. It is important to understand the differences between these levels to determine error resolution. In addition to Medicare specific and DMERC specific edits, CMS has required Implementation Guide (IG) edits, to ensure electronic files meet the HIPAA standard. The IG edits and descriptions start on page 5 of this chapter. The Medicare edits and descriptions are contained in Chapter 8 and the DMERC-specific edits and descriptions are contained in Chapter 9.

The ***IG edits*** check your electronic claims for format validation and are not specific to Medicare data requirements. The IG edits can occur on any data element within the transaction, even if it is not information used by Medicare. Because the same transaction can accommodate multiple payers (i.e. Medigap, Medicaid, and complementary crossover payers) it is critical that all data within a transaction meet the standards set forth by the Implementation Guide.

The ***Medicare-specific edits*** are designed to make sure that valid Medicare data is being transmitted in order to properly adjudicate the electronic claims. These edits will only perform data validation to ensure we have the data required to process a Medicare claim.

The ***DMERC-specific edits*** will validate data requirements specific to DMERC, such as DMERC HCPCS/NDC codes, proper dates, places of service, and CMN data requirements. Since our system processes both DMERC and Part B Medicare claims, a separate level for editing DMERC requirements has been developed.

To allow you to quickly identify the level in which the error occurred, the edits are numbered as follows:

10XXX - **Implementation Guide edits**

20XXX - **Medicare-specific edits**

40XXX - **DMERC-specific edits**

Though these edits occur at separate levels, they are all reported to you on the same error report. For examples and for an explanation of the error reports, refer to chapter 6 of this manual.

Key to Manual:

NOT USED = These edits are currently not used but may be added at a later date.

General Guidelines

We have provided some general guidelines for entering data. Due to the variety of software available to DMERC submitters, we can only provide the requirements as set forth by the ANSI X12N 837 v. 4010 Implementation Guide and CMS requirements. For data entry assistance, please consult your software program's user manual or your software vendor. The ANSI X12N 837 v. 4010 Implementation Guide may be downloaded free-of-charge from *www.wpc-edi.com*. The Implementation Guide will provide valid qualifier values, data requirements, and provide information how to obtain code sources including state abbreviations, zip codes, taxonomy codes, procedure codes, etc.

Dates

- As a general rule, all dates, with the exception of the interchange creation date (if entered by the submitter), must be reported using a CCYYMMDD format where:

  CC = Century

  YY = Year

  MM = Month

  DD = Day

- When spanning dates for dates of service, it must be reported as CCYYMMDD-CCYYMMDD, including the hyphen.

- When reporting a date/time combination, the CCYYMMDDHHMM format must be used where:

  CC = Century

  YY = Year

  MM = Month

  DD = Day

  HH = Hour (based on 24-hour clock)

  MM = Minute

- All dates must be less than the current date. When reporting a span of dates, the "from" date must be prior to the "to" date.

Names

Generally, names are reported as last name (or company name), middle name, and first name.

- **Last Name or Company Name:** This name field requires data to be present in each occurrence of a name. The first position of this name element cannot contain spaces.

- **Middle Name:** This name field is optional and should not be used unless a person is being reported and the middle name is known.

- **First Name:** If a person is being reported, the first name must be present. When submitted, the first position cannot contain spaces, and the first three characters cannot be any of the following:

MR	DR	JR
MR.	DR.	JR.

Addresses

When reporting the address, you must include a street address, a city, a state, and a zip code. If the address being reported is outside of the country, then a valid country code must also be submitted.

- **Street Address:** When submitted, the first position of this element cannot contain a space. When an address requires a second line, the first position must contain data. Characters such as #,.,&, etc. are allowed; however, we discourage use of these symbols.
- **City:** When submitting address information, the city name is required and must contain the city name for the address being reported. Characters such as #,.,&, etc. are allowed; however, we discourage use of these symbols.
- **State:** When submitting address information, the state abbreviation must be submitted. When reported, this element must contain a valid two-position state code.
- **Zip Code:** When submitting address information, the postal zip code must be submitted when the address is within the United States or Province. When submitted, the zip code must be a valid five or nine-digit code and must not contain all nines in the code.
- **Country Code:** When reporting an address outside of the United States, a valid country code must be submitted.

Dollar and Decimal Amounts:

Dollar and decimal amounts will be assumed to be whole numbers if no decimal is submitted. When using the decimal, it may not exceed two positions after the decimal point.

- **Dollar Amounts:** In general, dollar amounts being submitted to Medicare may not exceed $99,999.99.
- **Percentages:** When reporting percentages, they must not exceed five positions including the decimal point (i.e. 99.99).

For information about code sets used within this transaction (i.e. taxonomy codes, state abbreviations, country codes, claim adjustment reason codes, etc.), refer to Chapter C.1 of the ANSI X12N 837 v. 4010 Implementation Guide.

Implementation Guide Edits

The following pages contain a list of every edit that a submitter may receive along with a brief explanation of the error. Please keep in mind when looking up an edit, that the edits are separated by level. This chapter contains the IG level edits and can occur on any data that was submitted.

Since this level of editing is validating against the IG, we have listed all valid IG values under the valid value section of each edit. In an effort to prevent future edits from occurring at the Medicare or DMERC levels, we have ***bolded and italicized*** the valid DMERC values that may be used for that element.

For your convenience, we have indicated data elements in this section that are not used for DMERC. If you receive an edit on data that is not used for DMERC, and the information is not needed for another payer, please remove the erroneous data and resubmit the file. If the data is needed for another payer, please correct the claim and retransmit.

We have also noted those elements that contain data specific to Medicare Secondary Payer, Medigap, and Payer-to-Payer transactions. These elements should not be used unless the specific condition is met. Payer-to-Payer elements should never be submitted to DMERC by a supplier.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10001	IN AUTH INFORMATION QUAL INVALID	ISA01	The qualifier indicating authorization information for this interchange is invalid. This element requires one of the following valid values to be present. *Valid Values:* ***00 - No Authorization Information Present*** 03 - Additional Data Identification This edit indicates an invalid format and should be resolved by contacting your software vendor.
10002	IN AUTH INFORMATION MISSING	ISA02	The authorization information is missing for this interchange. If you indicated that authorization information is present, then this element must be filled with 10 alpha/numeric characters. If you indicated no authorization information is submitted, then this must be spaces. This edit indicates an invalid format and should be resolved by contacting your software vendor.
10003	IN SECURITY INFORMATION QUAL INVALID	ISA03	The qualifier indicating security information for this interchange is invalid. This element requires one of the following valid values to be present. *Valid Values:* ***00 - No security information present*** 01 - Password This edit indicates an invalid format and should be resolved by contacting your software vendor.
10004	IN SECURITY INFORMATION MISSING	ISA04	The security information is missing for this interchange. If you indicated that security information is present, then this element must be filled with 10 alpha/numeric characters. If you indicated no security information is submitted, then this must be spaces. This edit indicates an invalid format and should be resolved by contacting your software vendor.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10005	IN SENDER ID QUAL INVALID	ISA05	The qualifier indicating the sender of this interchange is invalid. This element requires one of the following valid values to be present. *Valid Values:* 01 - Duns (Duns and Bradstreet) 14 - Duns Plus Suffix 20 - Health Industry Number 27 - Carrier ID Number assigned by HCFA 28 - Fiscal Intermediary ID assigned by HCFA 29 - Medicare Supplier number assigned by HCFA 30 - US Federal Tax ID 33 - National Association of Insurance Commissioners Company Code (NAIC) ***ZZ - Mutually Defined***
10006	IN RECIEVER ID QUAL INVALID	ISA07	The qualifier indicating the receiver of this interchange is invalid. This element requires one of the following valid values to be present. *Valid Values:* 01 - Duns (Duns and Bradstreet) 14 - Duns plus suffix 20 - Health industry number ***27 - Carrier ID number assigned by HCFA*** 28 - Fiscal Intermediary ID assigned by HCFA 29 - Medicare supplier number assigned by HCFA 30 - US Federal Tax ID 33 - National Association of Insurance Commissioners Company Code (NAIC) ZZ - Mutually defined
10007	IN CREATE DATE INVALID	ISA09	The creation date entered is invalid for this interchange. This information must be entered in a YYMMDD format. This edit indicates an invalid format and should be resolved by contacting your software vendor.
10008	IN CREATE DATE FUTURE DATE	ISA09	The creation date entered is invalid for this interchange. This information must not be greater than today's date. This edit indicates an invalid format and should be resolved by contacting your software vendor.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10009	IN CREATE TIME INVALID	ISA10	The creation time entered is invalid for this interchange. The information must be entered in a HHMM format based on a 24-hour clock. This edit indicates an invalid format and should be resolved by contacting your software vendor.
10010	IN CONTROL QUAL INVALID	ISA11	The code identifying the interchange control standards is invalid for this interchange. This element requires the following value to be used. *Valid Value:* ***U - U.S. EDI Community of ASC X12, TDCC, and UCS*** This edit indicates an invalid format and should be resolved by contacting your software vendor.
10011	IN VERSION NUMBER INVALID	ISA12	The version number for this interchange is invalid. This element requires the following value to be used. *Valid Value:* ***00401 - ASC X12 Standard Version*** This edit indicates an invalid format and should be resolved by contacting your software vendor.
10012	IN ACK REQUEST CODE INVALID	ISA14	The qualifier indicating a request for an interchange acknowledgement is invalid. This element requires one of the following values be used. CIGNA DMERC will acknowledge every interchange received, regardless of the value submitted. *Valid Values:* ***0 - No acknowledgement requested*** 1 - Interchange acknowledgement requested
10013	IN TEST/PROD IND INVALID	ISA15	The test/production indicator for this interchange is invalid. You must enter the correct usage indicator in this element. *Valid Values:* P - Production indicator T - Test data
10014	FG TYPE CODE INVALID	GS01	The qualifier identifying the type of functional group being submitted is invalid. *Valid Value:* ***HC - Health Care Claim (837)*** This edit indicates an invalid format and should be resolved by contacting your software vendor.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10015	FG CREATE DATE INVALID FORMAT	GS04	The creation date entered is invalid for this functional group. This information must be entered in a CCYYMMDD format. This edit indicates an invalid format and should be resolved by contacting your software vendor.
10016	FG CREATE DATE FUTURE DATE	GS04	The creation date entered is invalid for this functional group. This information must not be greater than today's date. This edit indicates an invalid format and should be resolved by contacting your software vendor.
10017	FG CREATE TIME INVALID FORMAT	GS05	The creation time entered is invalid for this functional group. This information must be entered in one of the following formats: HHMM HHMMSS HHMMSSD HHMMSSDD This edit indicates an invalid format and should be resolved by contacting your software vendor.
10018	FG RESP AGENCY CODE INVALID	GS07	The code identifying the functional group responsible agency for this functional group is invalid. *Valid Value:* ***X - ASC X12*** This edit indicates an invalid format and should be resolved by contacting your software vendor.
10019	X12 VERSION CODE INVALID	GS08	The ANSI ASC X12 N version code for this functional group is invalid. *Valid Values:* ***004010X098 – ASC X12 version number*** ***004010X098A1 – ASC X12 version number***
10020	TX TYPE QUAL INVALID	ST01	The qualifier identifying the type of transaction set being submitted is invalid. *Valid Value:* ***837 - Health Care Claim*** This edit indicates an invalid format and should be resolved by contacting your software vendor.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10021	X12 HL TYPE CODE INVALID	BHT01	The code specifying the type of X12 hierarchical structure within the transaction set is invalid. *Valid Value:* ***0019 - Information Source, Subscriber, Dependant*** This edit indicates an invalid format and should be resolved by contacting your software vendor.
10022	TX PURPOSE CODE INVALID	BHT02	The code specifying the purpose of this transaction is invalid. Medicare only allows for original claims to be submitted. *Valid Values:* ***00 - Original*** 18 - Reissue
10023	TX SEQ NUMBER MISSING	BHT03	The number assigned by the submitter to identify this transaction is missing. This number is assigned by the submitter and is not used by Medicare; however, it will be sent back on the 997 functional acknowledgement (see Chapter 6 for information on the 997's) and must be unique for each transaction. This edit indicates an invalid format and should be resolved by contacting your software vendor.
10024	TX CREATE DATE INVALID FORMAT	BHT04	The creation date for this transaction set was submitted in an invalid format. The date must be in a CCYYMMDD format. This edit indicates an invalid format and should be resolved by contacting your software vendor.
10025	TX CREATE TIME INVALID FORMAT	BHT05	The creation time for this transaction set was submitted in an invalid format. The time must be in a HHMM format based on a 24-hour clock. This edit indicates an invalid format and should be resolved by contacting your software vendor.
10026	TX TYPE CODE INVALID	BHT06	The code specifying the type of transaction being used is invalid for this transaction. DMERC only allows for chargeable claim transactions. *Valid Values:* ***CH - Chargeable*** RP - Reporting

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10027	X12 TRANS TYPE CODE SEGMENT MISSING	REF	The segment identifying the X12 transmission type code for this transaction is missing. *This information is required on all DMERC transactions.*
10028	X12 TRANS TYPE QUAL INVALID	REF01	The qualifier for the submitter identification number information for this transaction is invalid. *Valid Value:* ***87 - Functional Category***
10029	X12 TRANS TYPE CODE INVALID	REF02	The code specifying the transmission type is invalid for this transaction. X12 requires one of the following values to identify the transaction being submitted. *Valid Values:* 004010X098D - Used only in piloting this transaction set **004010X098 - Used for all production claims**
10030	SUBMITTER NAME SEGMENT MISSING	NM1	The segment providing name information for the submitter of this transaction is missing. *This information is required on all DMERC transactions.*
10031	SUBMITTER NAME QUAL INVALID	NM101	The qualifier identifying the submitter for this transaction is invalid. *Valid Value:* ***41 - Submitter***
10032	SUBMITTER ENTITY TYPE QUAL INVALID	NM102	The qualifier identifying the submitter type is invalid for this transaction. *Valid Values:* 1 - Person 2 - Non-person entity
10033	SUBMITTER LAST/ORG NAME MISSING	NM103	The last name or company name is missing for this transaction. If you have specified the submitter type to be a person, this element must contain the last name of that person. If the submitter was identified as a non-person entity, this element must contain the company name.
10034	SUBMITTER FIRST NAME MISSING	NM104	The first name of the submitter is missing for this transaction. If you have specified the submitter type to be a person, this element must contain the first name of that person. If the submitter was identified as a non-person entity, this element is not used.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10035	SUBMITTER ID NUMBER QUAL INVALID	NM108	The qualifier identifying the submitter identification number for this transaction is invalid. *Valid Value:* ***46 – Submitter***
10036	SUBMITTER ADD NAME SEGMENT EXC MAX USE	N2	The segment providing additional name information for the submitter for this transaction exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10037	SUBMITTER CONTACT INFO SEGMENT MISSING	PER	The segment providing contact information for the submitter of this transaction is missing. *This information is required on all DMERC transactions.*
10038	SUBMITTER CONTACT QUAL INVALID	PER01	The qualifier for the submitter contact information for this transaction is invalid for this transaction. *Valid Value:* ***IC - Information contact***
10039	SUBMITTER CONTACT NAME MISSING	PER02	The submitter contact person's name is missing for this transaction. A contact name for the submitter must be submitted with this transaction.
10040	SUBMITTER CONTACT TYPE QUAL 1 INVALID	PER03	The qualifier identifying the type of contact information being provided for the submitter is invalid for this transaction. *Valid Values:* ED - EDI access number EM - E-mail FX - Facsimile ***TE - Telephone***
10041	SUBMITTER CONTACT TYPE QUAL 2 INVALID	PER05	The qualifier identifying the second type of contact information being provided for the submitter is invalid for this transaction. *Valid Values:* ED - EDI access number EM - E-mail EX - Telephone extension number FX - Facsimile TE - Telephone

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10042	SUBMITTER CONTACT TYPE QUAL 3 INVALID	PER07	The qualifier identifying the third type of contact information being provided for the submitter is invalid for this transaction. *Valid Values:* ED - EDI access number EM - E-mail EX - Telephone extension number FX - Facsimile TE - Telephone
10043	RECEIVER NAME SEGMENT MISSING	NM1	The segment providing name information for the receiver of this transaction is missing. *This information is required on all DMERC transactions.*
10044	RECEIVER NAME QUAL INVALID	NM101	The qualifier identifying the receiver for this transaction is invalid. *Valid Value:* ***40 - Receiver***
10045	RECEIVER ENTITY TYPE QUAL INVALID	NM102	The qualifier identifying the receiver type is invalid for this transaction. *Valid Value:* ***2 - Non-person entity***
10046	RECEIVER LAST/ORG NAME MISSING	NM103	The last name or company name is missing for this transaction. If you have specified the receiver type to be a person, this element must contain the last name of that person. If the receiver was identified as a non-person entity, this element must contain the company name.
10047	RECEIVER ID NUMBER QUAL INVALID	NM108	The qualifier identifying the receiver Identification number for this transaction is invalid. *Valid Value:* ***46 - Electronic Transmission Identification Number (ETIN)***
10048	RECEIVER ADD NAME SEGMENT EXC MAX USE	N2	The segment providing additional name information for the receiver for this transaction exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10049	TRANS TYPE OR CLAIM SOURCE QUAL INVALID	REF01	The qualifier identifying the transmission type or claim source is invalid for this transaction. Valid Values: +PR 87 *If you receive this error, please contact the EDI Department.*
10050	HL TYPE QUAL INVALID	HL03	The code identifying this hierarchical level is invalid. *Valid Value:* ***20 - Information source*** This edit indicates an invalid format and should be resolved by contacting your software vendor.
10051	HL CHILD CODE INVALID	HL04	The hierarchical child code is invalid. *Valid Value:* ***1 - Additional subordinate HL data segment in this hierarchical structure*** This edit indicates an invalid format and should be resolved by contacting your software vendor.
10053	BILL/PAYTO PROV QUAL INVALID	PRV01	The qualifier identifying the type of provider being reported for this transaction is invalid. *Valid Values:* ***BI - Billing*** PT - Pay-to
10054	BILL/PAYTO PROV ENTITY TYPE QUAL INVALID	PRV02	The qualifier identifying the type of identification number being reported for the billing provider is invalid for this transaction. *Valid Value:* ***ZZ - Mutually Defined (Health Care Provider Taxonomy Code List)***
10055	FORIEGN CURRENCY SEGMENT USED	CUR	The segment containing foreign currency information is not a valid segment for Medicare claims and should not be sent.
10056	BILL PROV NAME SEGMENT MISSING	NM1	The segment providing name information for the billing provider of this transaction is missing. *This information is required on all DMERC transactions.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10057	BILL PROV NAME QUAL INVALID	NM101	The qualifier identifying the billing provider for this transaction is invalid. *Valid Value:* ***85 - Billing Provider***
10058	BILL PROV ENTITY TYPE QUAL INVALID	NM102	The qualifier identifying the billing provider type is invalid for this transaction. *Valid Values:* 1 - Person 2 - Non-Person Entity
10059	BILL PROV LAST/ORG NAME MISSING	NM103	The last name or company name is missing for this transaction. If you have specified the billing provider type to be a person, this element must contain the last name of that person. If the billing provider was identified as a non-person entity, this element must contain the company name.
10060	BILL PROV FIRST NAME MISSING	NM104	The first name of the billing provider is missing for this transaction. If you have specified the billing provider type to be a person, this element must contain the first name of that person. If the billing provider was identified as a non-person entity, this element is not used.
10061	BILL PROV ID NUMBER QUAL INVALID	NM108	The qualifier identifying the billing provider identification number for this transaction is invalid. *Valid Values:* 24 - Employer's Identification Number 34 - Social Security Number XX - Health Care Financing Administration National Provider Identifier
10062	BILL PROV ADD NAME SEGMENT EXC MAX USE	N2	The segment providing additional name information for the billing provider for this transaction exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10063	BILL PROV ADR SEGMENT EXC MAX USE	N3	The segment providing the billing provider's address for this transaction exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used.
10064	BILL PROV C/S/Z SEGMENT MISSING	N4	The segment providing city, state, and zip code information for the billing provider for this transaction is missing. When reporting address information, the city, state, and zip code information must be included.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10065	BILL PROV CITY MISSING	N401	The billing provider's city is missing for this transaction. When reporting address information, the city, state, and zip code information must be included.
10066	BILL PROV STATE ABR MISSING	N402	The billing provider's state abbreviation is missing for this transaction. When reporting address information, the city, state, and zip code information must be included.
10067	BILL PROV ZIP CODE MISSING	N403	The billing provider's zip code is missing for this transaction. When reporting address information, the city, state, and zip code information must be included.
10068	ADD BILL PROV ID SEGMENT EXC MAX USE	REF	The segment containing additional billing provider identification information exceeds maximum use. When this information is reported, only 8 occurrences per transaction may be used.
10069	CREDIT/DEBIT QUAL INVALID	REF01	The qualifier for the credit/debit card secondary identification number is invalid for this transaction. *Valid Values:* 06 – System Number 8U – Bank Assigned Security Identifier EM – Electronic Payment Reference Number IJ – Standard Industry Classification (SIC) code LU – Location Number RB – Rate code number ST – Store Number TT – Terminal Code *This information is not used for DMERC.*
10070	CREDIT/DEBIT SEC ID MISSING	REF02	The secondary identification number for the credit/debit cardholder information is missing for this transaction. *This information is not used for DMERC.*
10072	BILL PROV CONTACT INFO SEG EXC MAX USE	PER	The segment containing billing provider contact information exceeds maximum use. When this information is reported, only 2 occurrences per transaction may be used.
10073	BILL PROV CONTACT QUAL INVALID	PER01	The qualifier for the billing provider contact information for this transaction is invalid for this transaction. *Valid Value:* ***IC - Information contact***

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10074	BILL PROV CONTACT NAME MISSING	PER02	The billing provider contact person's name is missing for this transaction. A contact name for the billing provider must be submitted with this transaction.
10075	BILL PROV CONTACT TYPE QUAL 1 INVALID	PER03	The qualifier identifying the type of contact information being provided for the billing provider is invalid for this transaction. *Valid Values:* EM - Electronic mail FX - Facsimile TE - Telephone
10076	BILL PROV CONTACT TYPE QUAL 2 INVALID	PER05	The qualifier identifying the second type of contact information being provided for the billing provider is invalid for this transaction. *Valid Values:* EM - Electronic mail EX - Telephone extension FX - Facsimile TE - Telephone
10077	BILL PROV CONTACT TYPE QUAL 3 INVALID	PER07	The qualifier identifying the third type of contact information being provided for the billing provider is invalid for this transaction. *Valid Values:* EM - Electronic mail EX - Telephone extension FX - Facsimile TE - Telephone
10078	PAYTO NAME SEGMENT EXC MAX USE	NM1	The segment providing the pay-to provider name information for this transaction exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10079	PAYTO NAME QUAL INVALID	NM101	The qualifier identifying the pay-to provider for this transaction is invalid. *Valid Value:* 87 - Pay–to provider *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10080	PAYTO ENTITY TYPE QUAL INVALID	NM102	The qualifier identifying the pay-to provider type is invalid for this transaction. *Valid Values:* 1 - Person 2 - Non-Person Entity *This information is not used for DMERC.*
10081	PAYTO LAST/ORG NAME MISSING	NM103	The last name or company name is missing for this transaction. If you have specified the pay-to provider type to be a person, this element must contain the last name of that person. If the pay-to provider was identified as a non-person entity, this element must contain the company name. *This information is not used for DMERC.*
10082	PAYTO FIRST NAME MISSING	NM104	The first name of the pay-to provider is missing for this transaction. If you have specified the pay-to provider type to be a person, this element must contain the first name of that person. If the pay-to provider was identified as a non-person entity, this element is not used. *This information is not used for DMERC.*
10083	PAYTO ID NUMBER QUAL INVALID	NM108	The qualifier identifying the pay-to provider identification number for this transaction is invalid. *Valid Values:* 24 - Employer's Identification Number 34 - Social Security Number XX - Health Care Financing Administration National Provider Identifier *This information is not used for DMERC.*
10084	PAYTO PROV ADD NAME SEGMENT EXC MAX USE	N2	The segment providing additional name information for the pay- to provider for this transaction exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10085	PAYTO ADR SEGMENT EXC MAX USE	N3	The segment providing the pay-to provider address for this transaction exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10086	PAYTO C/S/Z SEGMENT MISSING	N4	The segment providing city, state, and zip code information for the pay-to provider for this transaction is missing. When reporting address information, the city, state, and zip code information must be included. *This information is not used for DMERC.*
10087	PAYTO CITY MISSING	N401	The pay-to provider city is missing for this transaction. When reporting address information, the city, state, and zip code information must be included. *This information is not used for DMERC.*
10088	PAYTO STATE ABR MISSING	N402	The pay-to provider state abbreviation is missing for this transaction. When reporting address information, the city, state, and zip code information must be included. *This information is not used for DMERC.*
10089	PAYTO ZIP CODE MISSING	N403	The pay-to provider zip code is missing for this transaction. When reporting address information, the city, state, and zip code information must be included. *This information is not used for DMERC.*
10090	ADD PAYTO PROV ID SEGMENT EXC MAX USE	REF	The segment containing additional pay-to provider identification information exceeds maximum use. When this information is reported, only 5 occurrences per transaction may be used. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10091	PAYTO PROV ID 2 QUAL INVALID	REF01	The qualifier for the pay-to provider secondary identification number information for this transaction is invalid. *Valid Values:* 0B - State license number 1A - Blue Cross provider number 1B - Blue Shield provider number 1C - Medicare provider number 1D - Medicaid provider number 1G - Provider UPIN number 1H - CHAMPUS identification number 1J - Facility ID number B3 - Preferred Provider Organization number BQ - Health Maintenance Organization number EI - Employer's Identification Number FH - Clinic number G2 - Provider commercial number G5 - Provider site number LU - Location number SY - Social Security Number, this may not be used for Medicare U3 - Unique Supplier Identification Number (USIN) X5 - State industrial accident provider number *This information is not used for DMERC.*
10092	PAYTO PROV ID 2 MISSING	REF02	The pay-to provider secondary (supplier number) is missing for this transaction. *This information is not used for DMERC.*
10093	SBR HL PARENT CODE MISSING	HL02	The code identifying the hierarchical level (HL) that this HL relates to is missing. This edit indicates an invalid format and should be resolved by contacting your software vendor.
10094	HL TYPE QUAL INVALID	HL03	The code identifying this hierarchical level is invalid. *Valid Value:* ***22 - Subscriber*** This edit indicates an invalid format and should be resolved by contacting your software vendor.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10095	HL CHILD CODE INVALID	HL04	The hierarchical child code is invalid. *Valid Values:* ***0 - No subordinate HL segment in this hierarchical structure*** 1 - Additional subordinate HL data segment in this hierarchical structure. This edit indicates an invalid format and should be resolved by contacting your software vendor.
10096	SUBSCRIBER INFO SEGMENT MISSING	SBR	The segment providing subscriber information for this claim is missing. This information is required on all DMERC claims.
10097	PAYER RESP CODE INVALID	SBR01	The qualifier indicating the responsibility of this payer (Medicare) in relation to other payers for this subscriber is invalid. *Valid Values:* P - Primary S - Secondary T - Tertiary
10098	SUBSCRIBER REL TO INSURED INVALID	SBR02	The qualifier indicating the subscriber's relation to the insured for this Payer (Medicare) is invalid. *Valid Value:* ***18 - Self***

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10099	MSP REASON CODE INVALID	SBR05	The qualifier identifying the type of Medicare secondary coverage for this subscriber is invalid. *Valid Values:* 12 - Medicare secondary working aged beneficiary or spouse with employer group health plan 13 - Medicare secondary end-stage renal disease beneficiary in the 12 month coordination period with an employer's group health plan 14 - Medicare secondary, no-fault insurance including auto is primary 15 - Medicare secondary worker's compensation 16 - Medicare secondary public health service or other federal agency 41 - Medicare secondary black lung 42 - Medicare secondary Veteran's Administration 43 - Medicare secondary disabled beneficiary under age 65 with large group health plan 47 - Medicare secondary, other liability insurance is primary *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10100	MSP COVERAGE TYPE CODE INVALID	SBR09	The qualifier identifying the type of Medicare coverage for this subscriber is invalid. *Valid Values:* 09 - Self-pay 10 - Central certification 1725 11 - Other non-federal programs 12 - Preferred Provider Organization (PPO) 13 - Point of Service (POS) 14 - Exclusive Provider Organization (EPO) 15 - Indemnity insurance 16 - Health Maintenance Organization (HMO) Medicare Risk AM - Automobile medical BL - BlueCross/Blue Shield CH - Champus CI - Commercial insurance company DS - Disability HM - Health Maintenance Organization LI - Liability LM - Liability medical MB - Medicare Part B MC - Medicaid OF - Other federal program VA - Veteran Administration plan WC - Workers' compensation health claim ZZ - Mutually defined unknown *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10101	SUBSCRIBER DT OF DEATH FMT QUAL INVALID	PAT05	The qualifier indicating the format used to report the patient's date of death for this claim is invalid. *Valid Value:* ***D8 - Date expressed in format CCYYMMDD***
10102	SUBSCRIBER DATE OF DEATH INVALID	PAT06	The patient's date of death entered is invalid for this claim. When entered, this information must be entered in a valid CCYYMMDD format.
10103	SUBSCRIBER DATE OF DEATH FUTURE DATE	PAT06	The patient's date of death entered is invalid for this claim. When entered, this information must not be greater than today's date.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10104	SUBSCRIBER WEIGHT MEA QUAL INVALID	PAT07	The code used to indicate the measurement of the patient's weight is invalid for this claim. This is used to report the subscriber's weight on DMERC CMN forms 2.03 and10.02. *Valid Value:* ***GR - Grams***
10105	SUBSCRIBER WEIGHT MISSING	PAT08	The patient's weight is missing for this claim. This information is required when reporting patient's weight for DMERC CMN forms 2.03 and 10.02.
10106	SUBSCRIBER PREG IND CODE INVALID	PAT09	The pregnancy indicator is invalid for this claim. *Valid Value:* Y - Indicating Patient is pregnant *This information is not used for DMERC.*
10107	SUBSCRIBER NAME SEGMENT MISSING	NM1	The segment providing name information for the subscriber of this claim is missing. *This information is required on all DMERC transactions.*
10108	SUBSCRIBER NAME QUAL INVALID	NM101	The qualifier identifying the subscriber for this transaction is invalid. *Valid Value:* ***IL - Insured or subscriber***
10109	SUBSCRIBER ENTITY TYPE QUAL INVALID	NM102	The qualifier identifying the subscriber type is invalid for this claim. *Valid Values:* ***1 - Person*** 2 - Non-person entity
10110	SUBSCRIBER LAST NAME MISSING	NM103	The last name or company name is missing for this transaction. If you have specified the subscriber type to be a person, this element must contain the last name of that person. If the subscriber was identified as a non-person entity, this element must contain the company name.
10111	SUBSCRIBER FIRST NAME MISSING	NM104	The first name of the subscriber is missing for this claim. If you have specified the subscriber type to be a person, this element must contain the first name of that person. If the subscriber was identified as a non-person entity, this element is not used.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10112	SUBSCRIBER ID NUMBER QUAL INVALID	NM108	The qualifier identifying the subscriber identification number for this claim is invalid. *Valid Values:* ***MI - Member Identification Number*** ZZ - Mutually Defined
10113	SUBSCRIBER HICN MISSING	NM109	The subscriber primary identification number is missing for this subscriber. The subscriber's HICN is required for all DMERC claims.
10114	SUBSCRIBER ADD NAME SEGMENT EXC MAX USE	N2	The segment providing additional subscriber name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10115	SUBSCRIBER ADR SEGMENT MISSING	N3	The segment providing the subscriber address for this claim is missing. The subscriber address must be submitted for each subscriber.
10116	SUBSCRIBER ADR SEGMENT EXC MAX USE	N3	The segment providing the subscriber address for this claim exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used.
10117	SUBSCRIBER C/S/Z SEGMENT MISSING	N4	The segment providing city, state, and zip code information for subscriber for this claim is missing. When reporting address information, the city, state, and zip code information must be included.
10118	SUBSCRIBER CITY MISSING	N401	The subscriber city is missing for this claim. When reporting address information, the city, state, and zip code information must be included.
10119	SUBSCRIBER STATE ABR MISSING	N402	The subscriber state abbreviation is missing for this claim. When reporting address information, the city, state, and zip code information must be included.
10120	SUBSCRIBER ZIP CODE MISSING	N403	The subscriber zip code is missing for this claim. When reporting address information, the city, state, and zip code information must be included.
10121	SUBSCRIBER DEMO INFORMATION MISSING	DMG	The segment providing the subscriber demographic information is missing for this claim. If the subscriber is the insured, the patient demographic segment is required.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10122	SUBSCRIBER DOB QUAL INVALID	DMG01	The qualifier indicating the format used to report the subscriber's date of birth is invalid for this claim. *Valid Value:* ***D8 - Date Expressed in Format CCYYMMDD***
10123	SUBSCRIBER SEX CODE INVALID	DMG03	The qualifier used to identify the subscriber's sex is invalid for this claim. *Valid Values:* ***F - Female*** ***M - Male*** U - Unknown
10124	ADD SUBSCRIBER ID SEGMENT EXC MAX USE	REF	The segment containing additional subscriber identification information exceeds maximum use. When this information is reported, only 4 occurrences per subscriber may be used. *This information is not used for DMERC.*
10125	SUBSCRIBER ID 2 QUAL INVALID	REF01	The qualifier for the subscriber secondary identification number information for this subscriber is invalid. *Valid Values:* 1W - Member identification number 23 - Client number IG - Insurance policy number SY - Social Security Number *This information is not used for DMERC.*
10126	SUBSCRIBER ID 2 = SUBSCRIBER ID 1	REF01	The qualifier used to indicate the primary identification number for this subscriber is duplicated as the secondary identifier for this subscriber. Valid Values: 1W - Member identification number 23 - Client number IG - Insurance policy number SY - Social Security Number *This information is not used for DMERC.*
10127	SUBSCRIBER ID 2 MISSING	REF02	The subscriber secondary identification number is missing for this subscriber. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10129	PAYER NAME SEGMENT MISSING	NM1	The segment providing name information for the payer of this transaction is missing. *This information is required on all DMERC transactions.*
10130	PAYER NAME QUAL INVALID	NM101	The qualifier identifying the payer for this transaction is invalid. *Valid Value:* ***PR - Payer***
10131	PAYER ENTITY TYPE QUAL INVALID	NM102	The qualifier identifying the payer type is invalid for this transaction. *Valid Value:* ***2 - Non-person entity***
10132	PAYER NAME MISSING	NM103	The company name is missing for this transaction. If the payer was identified as a non-person entity, this element must contain the company name.
10133	PAYER ID NBR QUAL INVALID	NM108	The qualifier identifying the payer identification number for this transaction is invalid. *Valid Values:* ***PI - Payer identification*** XV - Health Care Financing Administration National Plan Identifier
10134	PAYER ADD NAME SEGMENT EXC MAX USE	N2	The segment providing additional payer name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10135	PAYER ADR SEGMENT EXC MAX USE	N3	The segment providing the payer address for this claim exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10136	PAYER CITY MISSING	N401	The payer city is missing for this claim. When reporting address information, the city, state, and zip code information must be included. *This information is not used for DMERC.*
10137	PAYER STATE ABR MISSING	N402	The payer state abbreviation is missing for this transaction. When reporting address information, the city, state, and zip code information must be included. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10138	PAYER ZIP CODE MISSING	N403	The payer zip code is missing for this transaction. When reporting address information, the city, state, and zip code information must be included. *This information is not used for DMERC.*
10139	ADD PAYER ID SEGMENT EXC MAX USE	REF	The segment containing additional payer identification information exceeds maximum use. When this information is reported, only 3 occurrences per transaction may be used. *This information is not used for DMERC.*
10140	PAYER ID 2 QUAL INVALID	REF01	The qualifier for the payer secondary identification number information for this transaction is invalid. *Valid Values:* 2U - Payer identification number FY - Claim office number NF - National Association of Insurance Commissioners TJ - Federal taxpayer's identification number *This information is not used for DMERC.*
10141	PAYER ID 2 MISSING	REF02	The payer secondary identification number is missing for this transaction. *This information is not used for DMERC.*
10142	REP PAYEE NAME SEGMENT EXC MAX USE	NM1	The segment providing the responsible party name information for this transaction exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used.
10143	REP PAYEE NAME QUAL INVALID	NM101	The qualifier identifying the responsibility party for this claim is invalid. *Valid Value:* ***QD - Responsible Party***
10144	REP PAYEE ENTITY TYPE QUAL INVALID	NM102	The qualifier identifying the responsible party type is invalid for this claim. *Valid Values:* 1 - Person 2 - Non-person entity

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10145	REP PAYEE LAST/ORG NAME MISSING	NM103	The last name or company name is missing for this claim. If you have specified the responsible party type to be a person, this element must contain the last name of that person. If the responsible party was identified as a non-person entity, this element must contain the company name.
10146	REP PAYEE FIRST NAME MISSING	NM104	The first name of the responsible party is missing for this claim. If you have specified the responsible party type to be a person, this element must contain the first name of that person. If the responsible party was identified as a non-person entity, this element is not used.
10147	REP PAYEE ADD NAME SEGMENT EXC MAX USE	N2	The segment providing additional responsible party name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10148	REP PAYEE ADR SEGMENT EXC MAX USE	N3	The segment providing the responsible party address for this claim exceeds maximum use. When sending responsible party information, this information can be reported no more than one time.
10149	NOT USED		
10150	REP PAYEE CITY MISSING	N401	The responsible party's city is missing for this claim. When reporting address information, the city, state, and zip code information must be included.
10151	REP PAYEE STATE ABR MISSING	N402	The responsible party's state abbreviation is missing for this claim. When reporting address information, the city, state, and zip code information must be included.
10152	REP PAYEE ZIP CODE MISSING	N403	The responsible party's zip code is missing for this claim. When reporting address information, the city, state, and zip code information must be included.
10156	PAT HL PARENT CODE MISSING	HL02	The code identifying the hierarchical level that this HL relates to is missing. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10157	HL TYPE QUAL INVALID	HL03	The code identifying this hierarchical level is invalid. *Valid Value:* 23 - Patient This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC.*
10158	HL CHILD CODE INVALID	HL04	The hierarchical child code is invalid. *Valid Value:* 0 - No subordinate HL segment in this HL structure This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC.*
10159	PAT INFO SEGMENT MISSING	PAT	The segment providing patient information when different than the subscriber for this claim is missing. This information is required when the patient is not the subscriber. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10160	PAT REL TO INSURED CODE INVALID	PAT01	The qualifier indicating the patient's relationship to the insured is invalid for this subscriber. *Valid Values:* 01 - Spouse 04 - Grandfather or grandmother 05 - Grandson or granddaughter 07 - Nephew or niece 09 - Adopted child 10 - Foster child 15 - Ward 17 - Stepson or stepdaughter 19 - Child 20 - Employee 21 - Unknown 22 - Handicapped dependent 23 - Sponsored dependent 24 - Dependent of a minor dependent 29 - Significant other 32 - Mother 33 - Father 34 - Other adult 36 - Emancipated minor 39 - Organ donor 40 - Cadaver donor 41 - Injured plaintiff 43 - Child where insured has no financial responsibility 53 - Life partner G8 - Other relationship *This information is not used for DMERC.*
10161	PAT DATE OF DEATH FMT QUAL INVALID	PAT05	The qualifier indicating the format used to report the patient's date of death when the patient is not the subscriber for this claim is invalid. *Valid Value:* D8 - Date expressed in CCYYMMDD format *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10162	PAT DATE OF DEATH INVALID	PAT06	The patient's date of death, when the patient is not the subscriber, entered is invalid for this claim. When entered, this information must be entered in a valid CCYYMMDD format. *This information is not used for DMERC.*
10163	PAT DATE OF DEATH FUTURE DATE	PAT06	The patient's date of death, when the patient is not the subscriber, entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10164	PAT WEIGHT MEA QUAL INVALID	PAT07	The code used to indicate the measurement of the patient's weight when other than the subscriber is invalid for this claim. *Valid Value:* GR - Grams *This information is not used for DMERC.*
10165	PAT WEIGHT MISSING	PAT08	The patient's, when other than the subscriber, weight is missing for this claim. *This information is not used for DMERC.*
10166	PAT PREG IND CODE INVALID	PAT09	The pregnancy indicator, when the patient is other than the subscriber, is invalid for this claim. *Valid Value:* Y - Indicating patient is pregnant *This information is not used for DMERC.*
10167	PAT NAME SEGMENT EXC MAX USE	NM1	The segment providing name information for the patient, when other than insured, exceeds maximum use. *This information is not used for DMERC.*
10168	PAT NAME QUAL INVALID	NM101	The qualifier identifying the patient, when other than the subscriber, for this claim is invalid. *Valid Value:* QC - Patient *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10169	PAT ENTITY TYPE QUAL INVALID	NM102	The qualifier identifying the patient, when other than subscriber, type is invalid for this claim. *Valid Value:* 1 - Person *This information is not used for DMERC.*
10170	PAT LAST NAME MISSING	NM103	The last name is missing for this claim. If you have specified the patient, when other than the subscriber, type to be a person, this element must contain the last name of that person. *This information is not used for DMERC.*
10171	PAT FIRST NAME MISSING	NM104	The first name of the patient, when other than the subscriber, is missing for this claim. If you have specified the patient, when other than the subscriber, type to be a person, this element must contain the first name of that person. *This information is not used for DMERC.*
10172	PAT ID NUMBER QUAL INVALID	NM108	The qualifier identifying the patient, when other than the subscriber, identification number for this claim is invalid. *Valid Values:* MI - Member Identification Number ZZ - Mutually Defined *This information is not used for DMERC.*
10173	PAT ADD NAME SEGMENT EXC MAX USE	N2	The segment providing additional patient's, when other than subscriber, name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10174	PAT ADR SEGMENT EXC MAX USE	N3	The segment providing the patient, when other than the subscriber, address for this claim exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10175	PAT C/S/Z SEGMENT MISSING	N4	The segment providing city, state, and zip code information for the patient, when other than the subscriber, for this claim is missing. When reporting address information, the city, state, and zip code information must be included. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10176	PAT CITY MISSING	N401	The patient's, when other than the subscriber, city is missing for this claim. When reporting address information, the city, state, and zip code information must be included. *This information is not used for DMERC.*
10177	PAT STATE ABR MISSING	N402	The patient's, when other than the subscriber, state abbreviation is missing for this claim. When reporting address information, the city, state, and zip code information must be included. *This information is not used for DMERC.*
10178	PAT ZIP CODE MISSING	N403	The patient's, when other than subscriber, zip code is missing for this claim. When reporting address information, the city, state, and zip code information must be included. *This information is not used for DMERC.*
10179	PAT DEMO INFO SEGMENT MISSING	DMG	The segment providing the patient's demographic information for this claim, when other than the subscriber, is missing. This information is required when the patient is other than the insured. *This information is not used for DMERC.*
10180	PAT DOB QUAL INVALID	DMG01	The qualifier indicating the format used to report the patient's, when other than the subscriber, date of birth is invalid for this claim. *Valid Value:* D8 - Date expressed in CCYYMMDD format *This information is not used for DMERC.*
10181	PAT DOB INVALID	DMG02	The date entered for the patient's date of birth, when the patient is other than the subscriber, is invalid for this claim. When entered, this information must be entered in a valid CCYYMMDD format. *This information is not used for DMERC.*
10182	PAT DOB FUTURE DATE	DMG02	The date entered for the patient's date of birth, when the patient is other than the subscriber, is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10183	PAT SEX CODE INVALID	DMG03	The qualifier used to identify the patient's sex, when other than subscriber, is invalid for this claim. *Valid Values:* F - Female M - Male U - Unknown *This information is not used for DMERC.*
10184	ADD PAT ID SEGMENT EXC MAX USE	REF	The segment containing additional patient, when other than subscriber, identification information exceeds maximum use. When this information is reported, only 5 occurrences per claim may be used. *This information is not used for DMERC.*
10185	PAT ID 2 INVALID	REF01	The qualifier for the patient's, when other than subscriber, secondary identification number information for this claim is invalid. *Valid Values:* 1W - Member identification number 23 - Client number IG - Insurance policy number SY - Social Security Number *This information is not used for DMERC.*
10186	PAT ID 2 MISSING	REF02	The secondary ID for this patient when other than subscriber is missing for this patient. *This information is not used for DMERC.*
10187	INVALID CLM-11 VALUE	CLM11	The related causes code is invalid for this claim. *Valid Values:* AA – Auto Accident EM – Employment OA – Other Accident
10188	CLM SEGMENT MISSING	CLM	The segment containing claim information is missing. Each DMERC claim must contain a CLM segment. If over 100 claims are to be submitted, contact your software vendor for instruction.
10189	TOTAL CLAIM CHARGE AMOUNT NOT NUMERIC	CLM01	The value entered to indicate the total claim charge is invalid. The amount entered must contain numeric values only.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10190	TOTAL CLAIM CHARGE AMOUNT NOT > 0	CLM01	The value entered to indicate the total claim charge is invalid. The amount reported must be greater than zero.
10191	PLACE OF SERVICE CODE INVALID	CLM05-1	An invalid place of service has been submitted for this claim. *Valid Values:* 11 - Office ***12 - Home*** 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room – Hospital 24 - Ambulatory Surgical Center 25 - Birthing Center 26 - Military Treatment Facility ***31 - Skilled Nursing Facility*** ***32 - Nursing Facility*** ***33 - Custodial Care Facility*** 34 - Hospice 41 - Ambulance – Land 42 - Ambulance - Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center ***54 - Intermediate Care Facility/Mentally Retarded*** ***55 - Residential Substance Abuse Treatment Facility*** ***56 - Psychiatric Residential Treatment Center*** 50 - Federally Qualified Health Center 60 - Mass Immunization Center 61 - Comprehensive Inpatient Rehabilitation Facility 62 - Comprehensive Outpatient Rehabilitation Facility 65 - End Stage Renal Disease Treatment Facility 71 - State or Local Public Health Clinic 72 - Rural Health Clinic 81 - Independent Laboratory 99 - Other Unlisted Facility

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10192	CLM TYPE CODE INVALID	CLM05-3	The code indicating the type of claim being submitted is invalid for this claim. *Valid Values:* ***1 - Original*** 6 - Corrected 7 - Replacement 8 - Void
10193	SUP SIGN ON FILE INVALID	CLM06	The code indicating the supplier's signature is on file is invalid for this claim. *Valid Values:* Y - Yes N - No
10194	PROV ASSIGN IND INVALID	CLM07	The provider assignment indicator for this claim is invalid. *Valid Values:* A - Assigned B - Assignment accepted on clinical lab services only C - Not assigned P - Patient refuses to assign benefits
10195	PAT ASSIGN BENEFITS IND INVALID	CLM08	The patient assignment of benefits indicator is invalid for this claim. Use "Y" to indicate Insured authorizes benefits to be paid to the supplier. An "N" response indicates benefits have not been assigned to the supplier. *Valid Values:* N - No Y - Yes
10196	RELEASE OF INFO CODE INVALID	CLM09	The code specifying the type of release of information the patient has issued is invalid for this claim. *Valid Values:* A - Appropriate release of information on file at health care service provider or at utilization review organization I - Informed consent to release medical information for conditions or diagnoses regulated by federal statutes ***M - The provider has limited or restricted ability to release data related to a claim*** ***N - No, provider is not allowed to release data*** O - On file at payer or at plan sponsor ***Y - Yes, provider has a signed statement permitting release of medical billing data related to a claim***

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10197	PAT SIGN SOURCE CODE MISSING	CLM10	The code specifying the source of the patient's signature is missing for this claim. If you have indicated that a signature is on file to release any data, then you must provide a valid source of signature. *Valid Values:* B - Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file C - Signed HCFA-1500 Claim Form on file M - Signed signature authorization form for HCFA-1500 Claim Form block 13 on file P - Signature generated by provider because the patient was not physically present for services S - Signed signature authorization form for HCFA-1500 Claim Form block 12 on file
10198	PAT SIGN SOURCE CODE INVALID	CLM10	The code identifying the source of the patient's signature is invalid for this claim. *Valid Values:* B - Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file C - Signed HCFA-1500 Claim Form on file M - Signed signature authorization form for HCFA-1500 Claim Form block 13 on file P - Signature generated by provider because the patient was not physically present for services S - Signed signature authorization form for HCFA-1500 Claim Form block 12 on file
10199	RELATED CAUSE 2 CODE INVALID	CLM11-2	The second related cause indicator is invalid for this claim. If more than one related cause is indicated, the second occurrence of this indicator must be a valid value. *Valid Values:* AA - Auto accident AB - Abuse AP - Another party responsible EM - Employment OA - Other accident

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10200	RELATED CAUSE 3 CODE INVALID	CLM11-3	The third related cause indicator is invalid. If more than two related causes are indicated, the third occurrence of this indicator must be a valid value. *Valid Values:* AA - Auto Accident AB - Abuse AP - Another Party Responsible EM - Employment OA - Other Accident
10201	AUTO ACC STATE MISSING	CLM11-4	If you have indicated an auto accident as the cause for this claim, you must submit a valid state abbreviation for the state where the accident occurred.
10202	AUTO ACC COUNTRY INVALID	CLM11-5	If you have indicated an auto accident as the cause for this claim and the accident occurred outside of the United States, you must submit a country code.
10203	SPEC PROG IND INVALID	CLM12	The code indicating the special program under which the services rendered to the patient were performed is invalid for this claim. *Valid Values:* 01 - Early & Periodic Screening, Diagnosis and Treatment or Child Health Assessment Program 02 - Physically Handicapped Children's Program 03 - Special Federal Funding 05 - Disability 07 - Induced abortion, danger to life 08 - Induced abortion, rape or incest 09 - Second opinion or surgery *This information is not used for DMERC.*
10204	NON-PAR PAR AGMNT CODE INVALID	CLM16	The code indicating a non-participating provider has an agreement to submit this claim as participating is invalid. *Valid Value:* P - Participation Agreement *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10205	CLAIM DELAY REASON CODE INVALID	CLM20	The code indicating the reason for a delay in filing this claim is invalid. *Valid Values:* 1 - Proof of eligibility unknown or unavailable 2 - Litigation 3 - Authorization delays 4 - Delay in certifying provider 5 - Delay in supplying billing forms 6 - Delay in delivery of custom-made appliances 7 - Third party processing delay 8 - Delay in eligibility determination 9 - Original claim rejected or denied due to a reason unrelated to the billing limitation rules 10 - Administration delay in the prior approval process 11 - Other *This information is not used for DMERC.*
10206	ORDER DATE SEGMENT EXC MAX USE	DTP	The segment providing the order date for this claim exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10207	NOT USED		
10208	ORDER DATE FMT QUAL INVALID	DTP02	The qualifier indicating the format used to report the order date for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10209	ORDER DATE INVALID FMT	DTP03	The order date entered is invalid for this claim. When entered, this information must be entered in a valid CCYYMMDD format. *This information is not used for DMERC.*
10210	ORDER DATE FUTURE DATE	DTP03	The order date entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10211	INIT TREATMENT DT SEG EXC MAX USE	DTP	The segment providing the initial treatment date for this claim exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10212	NOT USED		
10213	INIT TREATMENT DT FMT Q INVALID	DTP02	The qualifier indicating the format used to report the initial treatment date for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10214	INIT TREATMENT DT INVALID FMT	DTP03	The initial treatment date entered is invalid for this claim. When entered, this information must be entered in a valid CCYYMMDD format. *This information is not used for DMERC.*
10215	INIT TREATMENT DT FUTURE DT	DTP03	The initial treatment date entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10216	REFERRAL DT SEG EXC MAX USE	DTP	The segment providing the referral date for this claim exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10217	NOT USED		
10218	REFERRAL DT FMT Q INVALID	DTP02	The qualifier indicating the format used to report the referral date for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10219	REFERRAL DT INVALID FMT	DTP03	The referral date entered is invalid for this claim. When entered, this information must be entered in a valid CCYYMMDD format. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10220	REFERRAL DT FUTURE DT	DTP03	The referral date entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10221	DT LAST SEEN SEG EXC MAX USE	DTP	The segment providing the date last seen for this claim exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10222	NOT USED		
10223	DT LAST SEEN FMT Q INVALID	DTP02	The qualifier indicating the format used to report the date last seen for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10224	DT LAST SEEN INVALID FMT	DTP03	The date last seen entered is invalid for this claim. When entered, this information must be entered in a valid CCYYMMDD format. *This information is not used for DMERC.*
10225	DT LAST SEEN FUTURE DT	DTP03	The date last seen entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10226	CURRENT ILL DT SEG EXC MAX USE	DTP	The segment providing the onset of current illness/symptom for this claim exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10227	NOT USED		
10228	CURRENT ILL DT FMT Q INVALID	DTP02	The qualifier indicating the format used to report the onset of current illness or symptom date for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10229	CURRENT ILL DT INVALID FMT	DTP03	The onset of current illness or symptom date entered is invalid for this claim. When entered, this information must be entered in a valid CCYYMMDD format. *This information is not used for DMERC.*
10230	CURRENT ILL DT FUTURE DT	DTP03	The onset of current illness date entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10231	ACUTE MAN DT SEG EXC MAX USE	DTP	The segment providing the acute manifestation for this claim exceeds maximum use. If this information is reported, only 5 occurrences per claim may be used. *This information is not used for DMERC.*
10232	ACUTE MAN DT SEG MISSING	DTP	The segment providing the acute manifestation for this claim is missing. When providing information for spinal manipulation, this information must be sent. *This information is not used for DMERC.*
10233	NOT USED		
10234	ACUTE MAN DT FMT Q INVALID	DTP02	The qualifier indicating the format used to report the acute manifestation date for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10235	ACUTE MAN DT INVALID FMT	DTP03	The acute manifestation date entered is invalid for this claim. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10236	ACUTE MAN DT FUTURE DT	DTP03	The acute manifestation date entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10237	SIMILAR ILL DT SEG EXC MAX USE	DTP	The segment providing the onset of similar illness or symptom date exceeds maximum use. If this information is reported, only 10 occurrences per claim may be used. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10238	NOT USED		
10239	SIMILAR ILL DT FMT Q INVALID	DTP02	The qualifier indicating the format used to report the onset of similar illness or symptom date for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10240	SIMILAR ILL DT INVALID FMT	DTP03	The onset of similar illness or symptom date entered is invalid for this claim. When entered, this information must be entered in a valid CCYYMMDD format. *This information is not used for DMERC.*
10241	SIMILAR ILL DT FUTURE DT	DTP03	The onset of similar illness or symptom date entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10242	ACC DATE SEGMENT EXC MAX USE	DTP	The segment providing the date of the accident for this claim exceeds maximum use. If this information is reported, only 10 occurrences per claim may be used.
10243	NOT USED		
10244	ACC DATE FMT QUAL INVALID	DTP02	The qualifier indicating the format used to report the accident date for this claim is invalid. *Valid Values:* D8 - Date expressed in format CCYYMMDD DT - Date and time expressed in format CCYYMMDDHHMM. Required if accident hour is known.
10245	ACC DATE INVALID FORMAT	DTP03	The accident date entered is invalid for this claim. When entered, this information must be entered in a CCYYMMDD format.
10246	ACC DATE FUTURE DATE	DTP03	The accident date entered is invalid for this claim. When entered, this information must not be greater than today's date.
10247	ACC DATE/TIME INVALID FMT	DTP03	The accident date and time combination entered is invalid for this claim. When entered, this information must be entered in a CCYYMMDDHHMM format.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10248	LMP DT SEG EXC MAX USE	DTP	The segment providing the date of last menstrual period for this claim exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10249	NOT USED		
10250	LMP DT FMT Q INVALID	DTP02	The qualifier indicating the format used to report the date of last menstrual period for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10251	LMP DT INVALID FMT	DTP03	The last menstrual period date entered is invalid for this claim. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10252	LMP DT FUTURE DT	DTP03	The last menstrual period date entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10253	LAST X-RAY DT SEG EXC MAX USE	DTP	The segment providing the last X-ray date for this claim exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10254	NOT USED		
10255	LAST X-RAY DT FMT Q INVALID	DTP02	The qualifier indicating the format used to report the X-ray date for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10256	LAST X-RAY DT INVALID FMT	DTP03	The last X-ray date entered is invalid for this claim. When entered, this information must be entered in a valid CCYYMMDD format. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10257	LAST X-RAY DT FUTURE DT	DTP03	The last X-ray date entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10258	EST DOB SEG EXC MAX USE	DTP	The segment providing the estimated date of birth for this claim exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10259	NOT USED		
10260	EST DOB FMT Q INVALID	DTP02	The qualifier indicating the format used to report the date of birth for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10261	EST DOB INVALID FMT	DTP03	The estimated date of birth entered is invalid for this claim. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10262	EST DOB FUTURE DT	DTP03	The estimated date of birth entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10263	HEAR/VIS RX DT SEG EXC MAX USE	DTP	The segment providing the hearing and vision prescription date for this claim exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10264	NOT USED		
10265	HEAR/VIS RX DT FMT Q INVALID	DTP02	The qualifier indicating the format used to report the hearing and vision prescription date for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10266	HEAR/VIS RX DT INVALID FMT	DTP03	The hearing and vision prescription date entered is invalid for this claim. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10267	HEAR/VIS RX DT FUTURE DT	DTP03	The hearing and vision prescription date entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10268	DIS BEGIN DT SEG EXC MAX USE	DTP	The segment providing the disability begin date for this claim exceeds maximum use. If this information is reported, only 5 occurrences per claim may be used. *This information is not used for DMERC.*
10269	NOT USED		
10270	DIS BEGIN DT FMT Q INVALID	DTP02	The qualifier indicating the format used to report the disability from date for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10271	DIS BEGIN DT INVALID FMT	DTP03	The disability from date entered is invalid for this claim. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10272	DIS BEGIN DT FUTURE DT	DTP03	The disability from date entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10273	DIS END DT SEG EXC MAX USE	DTP	The segment providing the disability end date for this claim exceeds maximum use. If this information is reported, only 5 occurrences per claim may be used. *This information is not used for DMERC.*
10274	NOT USED		

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10275	DIS END DT FMT Q INVALID	DTP02	The qualifier indicating the format used to report the disability end date for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10276	DIS END DT INVALID FMT	DTP03	The disability end date entered is invalid for this claim. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10277	DT LAST WORK SEG EXC MAX USE	DTP	The segment providing the date last worked for this claim exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10278	NOT USED		
10279	DT LAST WORK FMT Q INVALID	DTP02	The qualifier indicating the format used to report the date last worked for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10280	DT LAST WORK INVALID FMT	DTP03	The date last worked entered is invalid for this claim. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10281	DT LAST WORK FUTURE DT	DTP03	The date last worked entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10282	DT AUTH RET WORK SEG EXC MAX USE	DTP	The segment providing the date authorized to return to work for this claim exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10283	NOT USED		

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10284	DT AUTH RET WORK FMT Q INVALID	DTP02	The qualifier indicating the format used to report the authorized to return to work date for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10285	DT AUTH RET WORK INVALID FMT	DTP03	The date authorized to return to work entered is invalid for this claim. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10286	ADMISSION DT SEG EXC MAX USE	DTP	The segment providing the date of admission for this claim exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10287	NOT USED		
10288	ADMISSION DT FMT Q INVALID	DTP02	The qualifier indicating the format used to report the admission date for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMD *This information is not used for DMERC.*
10289	ADMISSION DT INVALID FMT	DTP03	The hospitalization admission date entered is invalid for this claim. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10290	ADMISSION DT FUTURE DT	DTP03	The hospitalization admission date entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10291	DISCHARGE DT SEG EXC MAX USE	DTP	The segment providing the date of discharge for this claim exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10292	NOT USED		

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10293	DISCHARGE DT FMT Q INVALID	DTP02	The qualifier indicating the format used to report the discharge date for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10294	DISCHARGE DT INVALID FMT	DTP03	The hospitalization discharge date entered is invalid for this claim. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10295	DISCHARGE DT FUTURE DT	DTP03	The hospitalization discharge date entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10296	RLINQ CARE DT SEG EXC MAX USE	DTP	The segment providing the date of assumed and relinquished care for this claim exceeds maximum use. If this information is reported, only 2 occurrences per claim may be used. *This information is not used for DMERC.*
10297	NOT USED		
10298	RLINQ CARE DT FMT Q INVALID	DTP02	The qualifier indicating the format used to report the assumed and relinquished care date for this claim is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10299	RLINQ CARE DT INVALID FMT	DTP03	The date assumed relinquished care entered is invalid for this claim. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10300	RLINQ CARE DT FUTURE DT	DTP03	The date assumed relinquished care entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10301	ATTACHMENT TYPE QUAL INVALID	PWK01	The qualifier specifying the type of attachment for this claim is invalid. *Valid Values:* 77 - Support data for verification AS - Admission summary B2 - Prescription B3 - Physician order B4 - Referral form CT - Certification DA - Dental models DG - Diagnostic report DS - Discharge summary EB - Explanation of benefits (coordination of benefits or Medicare secondary payer) MT - Models NN - Nursing notes OB - Operative note ***OZ - Support data for claim*** PN - Physical therapy notes PO - Prosthetics or orthotic certification PZ - Physical therapy certification RB - Radiology films RR - Radiology reports RT - Report of tests and analysis report
10302	ATTACHMENT TRANS MODE QUAL INVALID	PWK02	The qualifier indicating the mode of transmission for the documentation for this claim is invalid. *Valid Values:* ***AA - Available on request at provider site*** (This means that the paperwork is not being sent with the claim at this time. Instead, it is available to the payer (or appropriate entity) at their request.) BM - By mail EL - Electronically only (in a separate transaction) EM - E-mail FX - By fax

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10303	ATTACHMENT CONTROL NUMBER QUAL INVALID	PWK05	The qualifier indicating the attachment control number is invalid for this claim. *Valid Value:* AC - Attachment control number
10304	ATTACHMENT CONTROL NUMBER QUAL MISSING	PWK06	The qualifier indicating the attachment control number is missing for this claim. If indicating the support documentation is being sent by fax, e-mail, or electronically in a separate transaction, the attachment control number qualifier is required. *Valid Values:* AA - Available on request at provider site BM - By mail EL - Electronically only EM - E-mail FX - By fax
10305	ATTACHMENT CONTROL NUMBER INVALID	PWK06	The attachment control number is invalid for this claim
10307	ENCNTR CNTRCT TYPE CODE INVALID	CN101	The qualifier indicating the type of contract for encounter claims is invalid for this claim. *Valid Values:* 02 - Per diem 03 - Variable per diem 04 - Flat 05 - Capitated 06 - Percent 09 - Other *This information is not used for DMERC.*
10309	PAT PAID AMT SEGMENT EXC MAX USE	AMT	The segment providing the amount the patient paid exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used.
10310	NOT USED		
10311	PURCH SVC AMT SEGMENT EXC MAX USE	AMT	The segment providing the total purchased service amount exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10312	NOT USED		
10313	SVC AUTH CODE SEGMENT EXC MAX USE	REF	The segment containing the service authorization exception code information exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10314	NOT USED		
10315	SVC AUTH CODE REASON INVALID	REF02	The code specifying the reason for service authorization exception is invalid for this claim. *Valid Values:* 1 - Immediate/urgent care 2 - Services rendered in a retroactive period 3 - Emergency care 4 - Client as temporary Medicaid 5 - Request from county for second opinion to recipient can work 6 - Request for override pending 7 - Special handling *This information is not used for DMERC.*
10316	MED XOVER SEG EXC MAX USE	REF	The segment containing the mandatory Medicare crossover indicator information exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *This information is not used for DMERC.*
10317	NOT USED		

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10318	MED XOVER CODE INVALID	REF02	The mandatory Medicare crossover indicator is invalid for this claim. *Valid Values:* Y - 4081 *N - Regular Crossover* *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *This information is not used for DMERC.*
10319	MAM CERT SEG EXC MAX USE	REF	The segment containing the mammography certification information exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10320	NOT USED		
10321	MAM CERT NBR MISSING	REF02	The mammography certification number is missing for this claim. *This information is not used for DMERC.*
10322	PRIOR AUTH NBR SEG EXC MAX USE	REF	The segment containing the prior authorization or referral number information exceeds maximum use. When this information is reported, only 2 occurrences per claim may be used. *This information is not used for DMERC.*
10323	NOT USED		
10324	PRIOR AUTH NBR MISSING	REF02	The prior authorization or referral number is missing. *This information is not used for DMERC.*
10325	ORIG REF NBR SEG EXC MAX USE	REF	The segment containing the original reference number information exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10326	NOT USED		
10327	ORIG REF NBR MISSING	REF02	The original reference number is missing for this claim. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10328	CLIA NBR SEG EXC MAX USE	REF	The segment containing the Clinical Laboratory Improvement Amendment Number information exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10329	NOT USED		
10330	CLIA NBR MISSING	REF02	The Clinical Laboratory Improvement Amendment number is missing for this claim. *This information is not used for DMERC.*
10331	REPRICER CLM NBR SEG EXC MAX USE	REF	The segment containing the repriced claim number information exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10332	NOT USED		
10333	REPRICER CLM NBR MISSING	REF02	The repriced claim number is missing for this claim. *This information is not used for DMERC.*
10334	REPRICER ADJ CLM NBR SEG EXC MAX USE	REF	The segment containing the adjusted repriced claim number information exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10335	NOT USED		
10336	REPRICER ADJ CLM NBR MISSING	REF02	The adjusted repriced claim number is missing for this claim. *This information is not used for DMERC.*
10337	INV DVC NBR SEG EXC MAX USE	REF	The segment containing the investigational device exemption number information exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10338	NOT USED		
10339	INV DVC NBR MISSING	REF02	The investigational device exemption number is missing for this claim. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10340	CH CLM NBR SEG EXC MAX USE	REF	The segment containing the claim number for clearinghouses and other transmission intermediaries information exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10341	NOT USED		
10342	CH CLM NBR MISSING	REF02	The claim number for clearinghouses and other transmission intermediaries is missing for this claim. *This information is not used for DMERC.*
10343	APG NBR SEG EXC MAX USE	REF	The segment containing the ambulatory patient group number information exceeds maximum use. When this information is reported, only 4 occurrences per claim may be used. *This information is not used for DMERC.*
10344	NOT USED		
10345	APG NBR MISSING	REF02	The ambulatory patient group number is missing for this claim. *This information is not used for DMERC.*
10346	MEDICAL RCRD NBR SEG EXC MAX USE	REF	The segment containing the medical record number information exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10347	NOT USED		
10348	MEDICAL RCRD NBR MISSING	REF02	The medical record number is missing for this claim. *This information is not used for DMERC.*
10349	DEMO PROJ ID SEGMENT EXC MAX USE	REF	The segment containing the demonstration project identifier information exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for **Region D** DMERC.*
10350	NOT USED		

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10351	DEMO PROJ ID MISSING	REF02	The demonstration project identification code is missing from this claim. *This information is not used for **Region D** DMERC.*
10352	NARRATIVE SEGMENT EXC MAX USE	NTE	The segment providing additional narrative information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used.
10353	NARRATIVE TYPE QUAL INVALID	NTE01	The qualifier identifying the type of additional narrative information being sent with this claim is invalid. *Valid Values:* ***ADD - Additional information*** CER - Certification narrative DCP - Goals, rehabilitation potential, or discharge plans DGN - Diagnosis description PMT - Payment TPO - Third party organization notes
10354	AMBO PAT WEIGHT MEA Q INVALID	CR101	The code used to indicate the measurement of the patient's weight is invalid for this claim. This is only used when reporting information to justify extra ambulance services. *Valid Value:* LB - Pound *This information is not used for DMERC.*
10355	AMBO TRANSPORT CODE INVALID	CR103	The code used to indicate the type of ambulance transportation for this claim is invalid. *Valid Values:* I - Initial trip R - Return trip T - Transfer trip X - Round trip *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10356	AMBO REASON CODE INVALID	CR104	The code used to indicate the reason for the ambulance transport for this claim is invalid. *Valid Values:* A - Patient was transported to nearest facility for care of symptoms, complaints, or both. Can be used to indicate that the patient was transferred to a residential facility. B - Patient was transported for the benefit of a preferred physician C - Patient was transported for the nearness of family members D - Patient was transported for the care of a specialist or for availability of specialized equipment E - Patient transferred to rehabilitation facility *This information is not used for DMERC.*
10357	AMBO DIST MEA QUAL INVALID	CR105	The unit of measurement to indicate the distance the ambulance traveled for this claim is invalid. *Valid Value:* DH - Miles *This information is not used for DMERC.*
10358	AMBO RND TRIP NAR MISSING	CR109	This element is used to provide narrative information to indicate the purpose of the round trip ambulance service for this claim. This is a required element if the ambulance transport was a round trip. *This information is not used for DMERC.*
10359	NUMBER OF CHIRO SVC MISSING	CR201	The value representing the number of chiropractic service treatments in the series is missing from this claim. *This information is not used for DMERC.*
10360	NBR OF CHIRO TREATMNT MISSING	CR202	The value representing the total number of treatments ordered in this series is missing from this claim. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10361	LVL OF CHIRO SUBLX CODE 1 INVALID	CR203	The qualifier indicating the level of subluxation on chiropractic services is invalid for this claim. For claims involving subluxation, this information is required. *Valid Values:* C1 - Cervical 1 C2 - Cervical 2 C3 - Cervical 3 C4 - Cervical 4 C5 - Cervical 5 C6 - Cervical 6 C7 - Cervical 7 CO - Coccyx IL - Ilium L1 - Lumbar 1 L2 - Lumbar 2 L3 - Lumbar 3 L4 - Lumbar 4 L5 - Lumbar 5 OC - Occiput SA - Sacrum T1 - Thoracic 1 T10 - Thoracic 10 T11 - Thoracic 11 T12 - Thoracic 12 T2 - Thoracic 2 T3 - Thoracic 3 T4 - Thoracic 4 T5 - Thoracic 5 T6 - Thoracic 6 T7 - Thoracic 7 T8 - Thoracic 8 T9 - Thoracic 9 *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10362	LVL OF CHIRO SUBLX CODE 2 INVALID	CR204	The qualifier indicating the level of subluxation on chiropractic services is invalid for this claim. For claims involving subluxation, this information is required to indicate a range. *Valid Values:* C1 - Cervical 1 C2 - Cervical 2 C3 - Cervical 3 C4 - Cervical 4 C5 - Cervical 5 C6 - Cervical 6 C7 - Cervical 7 CO - Coccyx IL - Ilium L1 - Lumbar 1 L2 - Lumbar 2 L3 - Lumbar 3 L4 - Lumbar 4 L5 - Lumbar 5 OC - Occiput SA - Sacrum T1 - Thoracic 1 T10 - Thoracic 10 T11 - Thoracic 11 T12 - Thoracic 12 T2 - Thoracic 2 T3 - Thoracic 3 T4 - Thoracic 4 T5 - Thoracic 5 T6 - Thoracic 6 T7 - Thoracic 7 T8 - Thoracic 8 T9 - Thoracic 9 *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10363	CHIRO TREATMNT TIME Q INVALID	CR205	The qualifier indicating the length of time chiropractic treatment has been administered is invalid for this claim. *Valid Values:* DA - Days MO - Months WK - Week YR - Years *This information is not used for DMERC.*
10364	TREATMENT NUMBER IN MONTH MISSING	CR207	The value representing the number of chiropractic treatments rendered in the month for which this claim is being billed is missing. *This information is not used for DMERC.*
10365	CHIRO PAT COND CODE INVALID	CR208	The patient's condition code, indicating the need for spinal manipulation, is invalid for this claim. *Valid Values:* A - Acute condition C - Chronic condition D - Non-acute E - Non-life threatening F - Routine G - Symptomatic M - Acute manifestation of a chronic condition *This information is not used for DMERC.*
10366	CHIRO COMPL CODE INVALID	CR209	The value representing spinal manipulation complications is invalid for this claim. *Valid Values:* N - No Y - Yes *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10367	CHIRO X-RAY CODE INVALID	CR212	The qualifier indicating the X-ray availability for spinal manipulations is invalid for this claim. *Valid Values:* N - No, X-rays are not maintained and available for carrier review Y - Yes, X-rays are maintained and available for carrier review *This information is not used for DMERC.*
10368	AMBO CERT SEG EXC MAX USE	CRC	The segment containing ambulance certification information exceeds maximum use. If this information is reported, only 3 occurrences per claim may be used. *This information is not used for DMERC.*
10369	CLAIM INFORMATION QUAL INVALID	CRC01	The code used to indicate the type of certification that is being sent with this claim is invalid. *Valid Values:* 07 - Ambulance certification 75 – Functional limitations E1 – Spectacle lenses E2 – Contact lenses E3 – Spectacle frames *This information is not used for DMERC.*
10370	AMBO CERT COND CODE INVALID	CRC02	The ambulance certification condition code indicator is invalid for this claim. *Valid Values:* N – No Y - Yes *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10371	AMBO CERT COND REAS 1 INVALID	CRC03	The code indicating the patient's condition is invalid for this ambulance claim. *Valid Values:* 01 - Patient was admitted to a hospital 02 - Patient was bed confined before the ambulance service 03 - Patient was bed confined after the ambulance service 04 - Patient was moved by stretcher 05 - Patient was unconscious or in shock 06 - Patient was transported in an emergency situation 07 - Patient had to be physically restrained 08 - Patient had visible hemorrhaging 09 - Ambulance service was medically necessary 60 - Transportation was to the nearest facility *This information is not used for DMERC.*
10372	AMBO CERT COND REAS 2 INVALID	CRC04	The code indicating the patient's secondary condition is invalid for this ambulance claim. *Valid Values:* 01 - Patient was admitted to a hospital 02 - Patient was bed confined before the ambulance service 03 - Patient was bed confined after the ambulance service 04 - Patient was moved by stretcher 05 - Patient was unconscious or in shock 06 - Patient was transported in an emergency situation 07 - Patient had to be physically restrained 08 - Patient had visible hemorrhaging 09 - Ambulance service was medically necessary 60 - Transportation was to the nearest facility *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10373	AMBO CERT COND REAS 3 INVALID	CRC05	The code indicating the patient's third condition is invalid for this ambulance claim. *Valid Values:* 01 - Patient was admitted to a hospital 02 - Patient was bed confined before the ambulance service 03 - Patient was bed confined after the ambulance service 04 - Patient was moved by stretcher 05 - Patient was unconscious or in shock 06 - Patient was transported in an emergency situation 07 - Patient had to be physically restrained 08 - Patient had visible hemorrhaging 09 - Ambulance service was medically necessary 60 - Transportation was to the nearest facility *This information is not used for DMERC.*
10374	AMBO CERT COND REAS 4 INVALID	CRC06	The qualifier indicating the patient's fourth condition is invalid for this ambulance claim. *Valid Values:* 01 - Patient was admitted to a hospital 02 - Patient was bed confined before the ambulance service 03 - Patient was bed confined after the ambulance service 04 - Patient was moved by stretcher 05 - Patient was unconscious or in shock 06 - Patient was transported in an emergency situation 07 - Patient had to be physically restrained 08 - Patient had visible hemorrhaging 09 - Ambulance service was medically necessary 60 - Transportation was to the nearest facility *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10375	AMBO CERT COND REAS 5 INVALID	CRC07	The qualifier indicating the patient's fifth condition is invalid for this ambulance claim. *Valid Values:* 01 - Patient was admitted to a hospital 02 - Patient was bed confined before the ambulance service 03 - Patient was bed confined after the ambulance service 04 - Patient was moved by stretcher 05 - Patient was unconscious or in shock 06 - Patient was transported in an emergency situation 07 - Patient had to be physically restrained 08 - Patient had visible hemorrhaging 09 - Ambulance service was medically necessary 60 - Transportation was to the nearest facility *This information is not used for DMERC.*
10376	VIS SEG EXC MAX USE	CRC	The segment containing vision correction information exceeds maximum use. If this information is reported, only 3 occurrences per claim may be used. *This information is not used for DMERC.*
10377	NOT USED		
10378	VIS CERT COND CODE INVALID	CRC02	The vision certification condition code is invalid for this claim. *Valid Values:* N - No Y - Yes *This information is not used for DMERC.*
10379	VIS COND REAS 1 INVALID	CRC03	The code indicating the condition causing the need for replacement lenses or frames is invalid. *Valid Values:* L1 - General standard of 20 degree or .5 diopter sphere Or cylinder change met L2 - Replacement due to loss or theft L3 - Replacement due to breakage or damage L4 - Replacement due to patient preference L5 - Replacement due to medical reason *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10380	VIS COND REAS 2 INVALID	CRC04	The code indicating the secondary condition causing the need for replacement lenses or frames is invalid for this claim. *Valid Values:* L1 - General standard of 20 degree or .5 diopter sphere Or cylinder change met L2 - Replacement due to loss or theft L3 - Replacement due to breakage or damage L4 - Replacement due to patient preference L5 - Replacement due to medical reason *This information is not used for DMERC.*
10381	VIS COND REAS 3 INVALID	CRC05	The qualifier indicating the third condition causing the need for replacement lenses or frames is invalid for this claim. *Valid Values:* L1 - General standard of 20 degree or .5 diopter sphere Or cylinder change met L2 - Replacement due to loss or theft L3 - Replacement due to breakage or damage L4 - Replacement due to patient preference L5 - Replacement due to medical reason *This information is not used for DMERC.*
10382	VIS COND REAS 4 INVALID	CRC06	The qualifier indicating the fourth condition causing the need for replacement lenses or frames is invalid for this claim. *Valid Values:* L1 - General standard of 20 degree or .5 diopter sphere Or cylinder change met L2 - Replacement due to loss or theft L3 - Replacement due to breakage or damage L4 - Replacement due to patient preference L5 - Replacement due to medical reason *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10383	VIS COND REAS 5 INVALID	CRC07	The qualifier indicating the fifth condition causing the need for replacement lenses or frames is invalid for this claim. *Valid Values:* L1 - General standard of 20 degree or .5 diopter sphere Or cylinder change met L2 - Replacement due to loss or theft L3 - Replacement due to breakage or damage L4 - Replacement due to patient preference L5 - Replacement due to medical reason *This information is not used for DMERC.*
10384	HMBND TEST SEG EXC MAX USE	CRC	The segment containing information when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10385	NOT USED		
10386	HMBND COND CODE INVALID	CRC02	The homebound condition response code is invalid for this claim. *Valid Values:* Y - Yes N - No *This information is not used for DMERC.*
10387	HMBND COND REAS Q INVALID	CRC03	The qualifier indicating the patient is independent within their home is invalid for this claim. *Valid Value:* IH - Independent at home *This information is not used for DMERC.*
10388	DIAG CODE SEGMENT EXC MAX USE	HI	The segment providing the diagnosis information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used.
10389	DIAG CODE 1 QUAL INVALID	HI01-1	The qualifier identifying the type of diagnosis code being sent first with this claim is invalid. *Valid Value:* ***BK - Principal diagnosis – ICD-9 codes***

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10390	DIAG CODE 2 QUAL INVALID	HI02-1	The qualifier identifying the type of diagnosis code being sent second with this claim is invalid. *Valid Value:* ***BF - Diagnosis – ICD-9 codes***
10391	DIAG CODE 3 QUAL INVALID	HI03-1	The qualifier identifying the type of diagnosis code being sent third with this claim is invalid. *Valid Value:* ***BF - Diagnosis – ICD-9 codes***
10392	DIAG CODE 4 QUAL INVALID	HI04-1	The qualifier identifying the type of diagnosis code being sent fourth with this claim is invalid. *Valid Value:* ***BF - Diagnosis – ICD-9 codes***
10393	DIAG CODE 5 QUAL INVALID	HI05-1	The qualifier identifying the type of diagnosis code being sent fifth with this claim is invalid. *Valid Value:* BF - Diagnosis – ICD-9 codes *This information is not used for DMERC.*
10394	DIAG CODE 6 QUAL INVALID	HI06-1	The qualifier identifying the type of diagnosis code being sent sixth with this claim is invalid. *Valid Value:* BF - Diagnosis – ICD-9 codes *This information is not used for DMERC.*
10395	DIAG CODE 7 QUAL INVALID	HI07-1	The qualifier identifying the type of diagnosis code being sent seventh with this claim is invalid. *Valid Value:* BF - Diagnosis – ICD-9 codes *This information is not used for DMERC.*
10396	DIAG CODE 8 QUAL INVALID	HI08-1	The qualifier identifying the type of diagnosis code being sent eighth with this claim is invalid. *Valid Value:* BF - Diagnosis ICD-9 codes *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10397	REPRICER METHOD CODE INVALID	HCP01	The pricing methodology code used to indicate how this claim has been priced or repriced is invalid. *Valid Values:* 00 - Zero pricing (not covered under contract) 01 - Priced as billed at 100% 02 - Priced at the standard fee schedule 03 - Priced at a contractual percentage 04 - Bundled pricing 05 - Peer review pricing 07 - Flat rate pricing 08 - Combination pricing 09 - Maternity pricing 10 - Other pricing 11 - Lower of cost 12 - Ratio of cost 13 - Cost reimbursed 14 - Adjustment Pricing *This information is not used for DMERC.*
10398	REPRICER ALLOW AMT MISSING	HCP02	The repriced allowed amount for this claim is missing. *This information is not used for DMERC.*
10399	REPRICER REASON CODE INVALID	HCP13	The qualifier identifying the reason code for rejecting this service by the repricer is invalid for this claim. *Valid Values:* T1 - Cannot identify provider as TPO (Third Party Organization) participant T2 - Cannot identify payer as TPO (Third Party Organization) participant T3 - Cannot identify insured as TPO (Third Party Organization) participant T4 - Payer name or identifier missing T5 - Certification information missing T6 - Claim does not contain enough information for re-pricing *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10400	REPRICER CMPL CODE INVALID	HCP14	The repricer's policy compliance code is invalid for this claim. *Valid Values:* 1 - Procedure followed (compliance) 2 - Not followed – call not made (non-compliance call not made) 3 - Not medically necessary (non-compliance non-medically necessary) 4 - Not followed other (non-compliance other) 5 - Emergency admit to non-network hospital *This information is not used for DMERC.*
10401	REPRICER EXCEPT CODE INVALID	HCP15	The repricer's exception code is invalid for this claim. *Valid Values:* 1 - Non network professional provider in network hospital 2 - Emergency Care 3 - Services or specialist not in network 4 - Out of service area 5 - State mandates 6 - Other *This information is not used for DMERC.*
10402	HMHLTH CARE SEG EXE MAX	CR7	The segment reporting home health care plan information exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10403	DISCIPLINE TYPE CODE INVALID	CR701	The qualifier identifying the discipline type code for home health care plan information is invalid for this claim. *Valid Values:* AI - Home health aide MS - Medical social worker OT - Occupational therapy PT - Physical therapy SN - Skilled nursing ST - Speech therapy *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10404	HLTH CARE SER DEL SEG EXC MAX	HSD	The segment providing the health care services delivery information for this line exceeds maximum use. When this information is reported, only 3 occurrences per claim may be used. *This information is not used for DMERC.*
10405	QUANTITY QUALIFIER INVALID	HSD01	The qualifier specifying the type of services being reported for home health deliveries is not valid for this claim. *Valid Values:* ***VS - Visits*** *This information is not used for DMERC.*
10406	FREQUENCY PERIOD QUAL INVALID	HSD03	The qualifier specifying the frequency of services being reported for home health deliveries is not valid for this claim. *Valid Values:* DA - Days MO - Months Q1 - Quarter (time) WK - Week *This information is not used for DMERC.*
10407	DUR OF VISITS UNITS QUAL INVALID	HSD05	The qualifier specifying the duration of visits being reported for home health deliveries is not valid for this claim. *Valid Values:* 7 - Day 35 - Week *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10408	PATTERN CODE QUAL INVALID	HSD07	The qualifier indicating the pattern code for visits being reported for home health deliveries is not valid for this claim. *Valid Values:* SB - Tuesday through Saturday SC - Sunday, Wednesday, Thursday, Friday, Saturday SD - Monday, Wednesday, Thursday, Friday, Saturday SG - Tuesday through Friday SL - Monday, Tuesday, and Thursday SP - Monday, Tuesday, and Friday SX - Wednesday and Thursday SY - Monday, Wednesday, and Thursday SZ - Tuesday, Thursday, and Friday W - Whenever necessary *This information is not used for DMERC.*
10409	TIME CODE QUAL INVALID	HSD08	The qualifier indicating the time of visits being reported for home health deliveries is not valid for this claim. *Valid Values:* D - A.M. E - P.M. F - As directed *This information is not used for DMERC.*
10410	REF PROV NAME EXC MAX USE	NM1	The segment providing the referring provider name information for this claim exceeds maximum use. When this information is reported, only 2 occurrences per claim may be used. *This information is not used for DMERC.*
10411	REF PROV NAME QUAL INVALID	NM1	The segment providing the referring provider name information for this claim is invalid. If used, the first occurrence of the referring provider name segment at the claim level must contain information on the referring provider. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10412	REF PROV NAME QUAL INVALID	NM1	The segment providing the referring provider name information for this claim is invalid. If used, the second occurrence of the referring provider name segment at the claim level must contain information on the primary care provider. *This information is not used for DMERC.*
10413	NOT USED		.
10414	ENTITY TYPE QUALIFIER INVALID	NM102	The qualifier indicating the referring provider type is invalid for this claim. *Valid Values:* 1 - Person 2 - Non-person entity *This information is not used for DMERC.*
10415	REF PROV LAST NAME MISSING	NM103	The last name or company name is missing for this claim. If you have specified the referring provider type to be a person, this element must contain the last name of that person. If the referring provider was identified as a non-person entity, this element must contain the company name. *This information is not used for DMERC.*
10416	REF PROV FIRST NAME MISSING	NM104	The first name of the referring provider is missing for this claim. If you have specified the referring provider type to be a person, this element must contain the first name of that person. If the referring provider was identified as a non-person entity, this element is not used. *This information is not used for DMERC.*
10417	ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the referring provider identification number for this claim is invalid. *Valid Values:* 24 - Employer's Identification Number 34 - Social Security Number XX - Health Care Financing Administration National Provider Identifier *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10418	PROVIDER CODE INVALID	PRV01	The qualifier identifying the type of provider being reported for this claim is invalid. *Valid Value:* RF - Referring *This information is not used for DMERC.*
10419	REF ID QUALIFIER INVALID	PRV02	The qualifier identifying the type of identification number being reported for the referring provider is invalid for this claim. *Valid Value:* ZZ - Mutually defined *This information is not used for DMERC.*
10420	ADD REF PRO NAME INFO EXC MAX USE	N2	The segment providing additional Referring Provider name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10421	REF PROV SEC ID EXC MAX USE	REF	The segment containing additional referring provider identification information exceeds maximum use. When this information is reported, only 5 occurrences per claim may be used. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10422	REF ID QUALIFIER INVALID	REF01	The qualifier for the referring provider secondary identification number information for this claim is invalid. *Valid Values:* 0B - State license number 1B - Blue Shield provider number 1C - Medicare provider number 1D - Medicaid provider number ***1G - Provider UPIN number*** 1H - CHAMPUS identification number EI - Employer's Identification Number G2 - Provider commercial number LU - Location number N5 - Provider plan network identification number SY - Social Security Number, this may not be used for Medicare X5 - State industrial accident provider number *This information is not used for DMERC.*
10423	REF PROV SEC ID MISSING	REF02	The referring provider secondary identification is missing for this claim. *This information is not used for DMERC.*
10424	REND PROV NAME EXC MAX USE	NM1	The segment providing the rendering provider name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10425	ENTITY ID CODE QUAL INVALID	NM101	The qualifier identifying the rendering provider for this claim is invalid. *Valid Value:* ***82 - Rendering provider*** *This information is not used for DMERC.*
10426	ENTITY TYPE QUALIFIER INVALID	NM102	The qualifier identifying the rendering provider type is invalid for this claim. *Valid Values:* 1 - Person 2 - Non-person entity *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10427	REND PROV LAST OR ORG NAME MISSING	NM103	The last name or company name is missing for this claim. If you have specified the rendering provider type to be a person, this element must contain the last name of that person. If the rendering provider was identified as a non-person entity, this element must contain the company name. *This information is not used for DMERC.*
10428	REND PROV FIRST NAME MISSING	NM104	The first name of the rendering provider is missing for this claim. If you have specified the rendering provider type to be a person, this element must contain the first name of that person. If the rendering provider was identified as a non-person entity, this element is not used. *This information is not used for DMERC.*
10429	ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the rendering provider identification number for this transaction is invalid. *Valid Values:* 24 - Employer's Identification Number 34 - Social Security Number XX - Health Care Financing Administration National Provider Identifier *This information is not used for DMERC.*
10430	PROV CODE INVALID	PRV01	The qualifier identifying the type of provider being reported for this claim is invalid. *Valid Value:* ***PE - Performing*** *This information is not used for DMERC.*
10431	REF ID QUALIFIER INVALID	PRV02	The qualifier identifying the type of identification number being reported for the rendering provider is invalid for this claim. *Valid Value:* ***ZZ - Mutually Defined*** *This information is not used for DMERC.*
10432	ADD REND PROV NAME EXC MAX USE	N2	The segment providing additional rendering provider name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10433	REND PROV SEC ID EXC MAX USE	REF	The segment containing additional rendering provider identification information exceeds maximum use. When this information is reported, only 5 occurrences per claim may be used. *This information is not used for DMERC.*
10434	REF ID QUALIFIER INVALID	REF01	The qualifier for the rendering provider secondary identification number information for this claim is invalid. *Valid Values:* 0B - State license number 1B - Blue Shield provider number ***1C - Medicare provider number*** 1D - Medicaid provider number 1G - Provider UPIN number 1H - CHAMPUS identification number EI - Employer's Identification Number G2 - Provider commercial number LU - Location number N5 - Provider plan network identification number SY - Social Security Number X5 - State Industrial Accident Provider Number *This information is not used for DMERC.*
10435	REND PROV SEC ID MISSING	REF02	The rendering provider secondary identifier is missing for this claim. *This information is not used for DMERC.*
10436	PURCH SER PROV NAME EXC MAX USE	NM1	The segment providing the purchased service provider name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10437	ENTITY ID CODE INVALID	NM101	The qualifier identifying the purchased service provider for this claim is invalid. *Valid Value:* QB - Purchase service provider *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10438	ENTITY TYPE QUALIFIER INVALID	NM102	The qualifier identifying the purchased service provider type is invalid for this claim. *Valid Values:* 1 - Person 2 - Non-person entity *This information is not used for DMERC.*
10439	ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the purchased service provider identification number for this claim is invalid. *Valid Values:* 24 - Employers identification number 34 - Social Security Number XX - Health Care Financing Administration National Provider Identifier *This information is not used for DMERC.*
10440	PURSH SER PROV SEC ID EXC MAX USE	REF	The segment containing additional purchased service provider identification information exceeds maximum use. When this information is reported, only 5 occurrences per claim may be used. *This information is not used for DMERC.*
10441	REF ID QUALIFIER INVALID	REF01	The qualifier for the purchased service provider secondary identification number information for this claim is invalid. *Valid Values:* 0B - State license number 1B - Blue Shield provider number 1C - Medicare provider number 1D - Medicaid provider number 1G - Provider UPIN number 1H - CHAMPUS identification number EI - Employer's Identification Number G2 - Provider commercial number LU - Location number N5 - Provider plan network identification number SY - Social Security Number X5 - State industrial accident provider number *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10442	PURSH SER PROV SEC ID MISSING	REF02	The purchased service provider secondary identifier is missing for this claim. *This information is not used for DMERC.*
10443	SER FAC LOC EXC MAX USE	NM1	The segment providing the service facility location name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used.
10444	ENTITY ID CODE INVALID	NM101	The qualifier identifying the service facility location for this claim is invalid. *Valid Values:* 77 - Service location FA - Facility LI - Independent lab TL - Testing laboratory
10445	ENTITY TYPE QUALIFIER INVALID	NM102	The qualifier identifying the service facility location type is invalid for this claim. *Valid Value:* ***2 - Non-person entity***
10446	ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the service facility location identification number for this claim is invalid. *Valid Values:* 24 - Employer's Identification Number 34 - Social Security Number XX - Health Care financing Administration National Provider Identifier
10447	ADD SER FAC LOC NAME EXC MAX USE	N2	The segment providing additional service facility location name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10448	SER FAC LOC ADD EXC MAX USE	N3	The segment providing the service facility location address for this claim exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used.
10449	SER FAC LOC C/S/Z MISSING	N4	The segment providing city, state, and zip code information for the service facility location for this transaction is missing. When reporting address information, the city, state, and zip code information must be included.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10450	LAB/FAC CITY MISSING	N401	The service facility location city is missing for this claim. When reporting address information, the city, state, and zip code information must be included.
10451	LAB/FAC STATE MISSING	N402	The service facility location state abbreviation is missing for this claim. When reporting address information, the city, state, and zip code information must be included.
10452	LAB/FAC ZIP MISSING	N403	The service facility location zip code is missing for this claim. When reporting address information, the city, state, and zip code information must be included.
10453	SER FAC LOC SEC ID EXC MAX USE	REF	The segment containing additional service facility location identification information exceeds maximum use. When this information is reported, only 5 occurrences per claim may be used.
10454	REF ID QUALIFIER INVALID	REF01	The qualifier for the facility secondary identification number information for this claim is invalid. *Valid Values:* 0B - State license number 1A - Blue Cross provider number 1B - Blue Shield provider number ***1C - Medicare provider number*** 1D - Medicaid provider number ***1G - Provider UPIN Number*** 1H - CHAMPUS identification number G2 - Provider commercial number LU - Location number N5 - Provider plan network identification number TJ - Federal taxpayer's identification number X4 - Clinical Laboratory Improvement Amendment *Number* X5 - State industrial accident provider number
10455	SUPER PROV NAME EXC MAX USE	NM1	The segment providing the supervising provider name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10456	ENTITY ID CODE INVALID	NM101	The qualifier identifying the supervising provider for this claim is invalid. *Valid Value:* DQ - Supervising physician *This information is not used for DMERC.*
10457	ENTITY TYPE QUALIFIER INVALID	NM102	The qualifier identifying the supervising provider type is invalid for this claim. *Valid Value:* ***1 Person*** *This information is not used for DMERC.*
10458	SUPER PROV LAST NAME MISSING	NM103	The last name is missing for this claim. If you have specified the supervising provider type to be a person, this element must contain the last name of that person. *This information is not used for DMERC.*
10459	SUPER PROV FIRST NAME MISSING	NM104	The first name of the supervising provider is missing for this claim. If you have specified the supervising provider type to be a person, this element must contain the first name of that person. If the supervising provider was identified as a non-person entity, this element is not used. *This information is not used for DMERC.*
10460	ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the supervising provider identification number for this claim is invalid. *Valid Values:* 24 - Employer's Identification Number 34 - Social Security Number XX - National Provider Identifier *This information is not used for DMERC.*
10461	ADD SUPER PROV NAME EXC MAX USE	N2	The segment providing additional supervising provider name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10462	SUPER PROV SEC ID EXC MAX USE	REF	The segment containing additional supervising provider identification information exceeds maximum use. When this information is reported, only 5 occurrences per claim may be used. *This information is not used for DMERC.*
10463	REF ID QUALIFIER INVALID	REF01	The qualifier for the supervising provider secondary identification number information for this claim is invalid. *Valid Values:* 0B - State license number 1B - Blue Shield provider number ***1C - Medicare provider number*** 1D - Medicaid provider number ***1G - Provider UPIN number*** 1H - CHAMPUS identification number EI - Employer's Identification Number G2 - Provider commercial number LU - Location number N5 - Provider plan network identification number SY - Social Security Number X5 - State industrial accident provider number *This information is not used for DMERC.*
10464	SUPER PROV SEC ID MISSING	REF02	The supervising secondary identification number is missing for this claim. *This information is not used for DMERC.*
10465	PAYOR RESP SEQ CODE INVALID	SBR01	The qualifier indicating the responsibility of this payer (other payer) in relation to Medicare for this subscriber is invalid. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *Valid Values:* P - Primary S - Secondary T - Tertiary

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10466	IND REL CODE INVALID	SBR02	The qualifier indicating the patient's relation to the insured for this payer (other payer) is invalid. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *Valid Values:* 01 - Spouse 04 - Grandfather or grandmother 05 - Grandson or granddaughter 07 - Nephew or niece 10 - Foster child 15 - Ward 17 - Stepson or stepdaughter 18 - Self 19 - Child 20 - Employee 21 - Unknown 22 - Handicapped dependent 23 - Sponsored dependent 24 - Dependent of a minor dependent 29 - Significant other 32 - Mother 33 - Father 36 - Emancipated minor 39 - Organ donor 40 - Cadaver donor 41 - Injured plaintiff 43 - Child where insured has no financial responsibility 53 - Life partner G8 - Other relationship

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10467	INS TYPE CODE INVALID	SBR05	The qualifier identifying the type of insurance coverage primary to Medicare for this subscriber is invalid. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *Valid Values:* AP - Auto insurance policy C1 - Commercial CP - Medicare conditionally primary GP - Group policy HM - Health Maintenance Organization (HMO) IP - Individual policy LD - Long term policy LT - Litigation MB - Medicare Part B MC - Medicaid MI - Medigap Part B MP - Medicare Primary OT - Other PP - Personal payment (cash - no insurance) SP - Supplemental policy

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10468	CLM FILING IND CODE INVALID	SBR09	The qualifier identifying the other payer's insurance plan type for this subscriber is invalid for this claim. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *Valid Values:* 09 - Self-pay 10 - Central certification 11 - Other non-federal programs 12 - Preferred Provider Organization (PPO) 13 - Point of Service (POS) 14 - Exclusive Provider Organization (EPO) 15 - Indemnity insurance 16 - Health Maintenance Organization (HMO) Medicare Risk AM - Automobile medical BL - Blue Cross/Blue Shield CH - Champus CI - Commercial insurance co. DS - Disability HM - Health Maintenance Organization LI - Liability LM - Liability medical MB - Medicare Part B MC - Medicaid OF - Other federal program TV - Title V VA - Veteran Administration Plan WC - Workers' compensation health claim ZZ - Mutually defined/unknown
10469	CLM LEVEL ADJ EXC MAX USE	CAS	The segment reporting claim level adjustments exceeds maximum use. If this information is reported, only 5 occurrences per claim may be used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10470	CLM ADJ GRP CODE INVALID	CAS01	The qualifier specifying the claim adjustment group code for the adjustments being reported is invalid for this claim. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *Valid Values:* CO - Contractual obligation CR - Correction or reversal OA - Other adjustment PI - Payer initiated adjustment PR - Patient responsibility
10471	COB PAYER PD AMT EXC MAX USE	AMT	The segment providing the amount the primary payer paid exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10472	NOT USED		
10473	COB APP AMT EXC MAX USE	AMT	The segment providing the amount the primary payer approved exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10474	NOT USED		
10475	COB ALLOWED AMT EXC MAX USE	AMT	The segment providing the amount the primary payer allowed exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10476	NOT USED		

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10477	COB PAT RESP AMT EXC MAX USE	AMT	The segment providing the amount the patient is responsible for to the other payer exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.*
10478	NOT USED		
10479	COB COVERED AMT EXC MAX USE	AMT	The segment providing the amount the other payer covered exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.*
10480	NOT USED		
10481	COB DISCOIUNT AMT EXC MAX USE	AMT	The segment providing the amount the other payer discounted exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.*
10482	NOT USED		
10483	COB DAILY LMT AMT EXC MAX USE	AMT	The segment providing the daily limit amount for the other payer exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.*
10484	NOT USED		
10485	COB PAT PD AMT EXC MAX USE	AMT	The segment providing the amount paid by the other payer to the patient exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10486	NOT USED		

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10487	COB TAX AMT EXC MAX USE	AMT	The segment providing the other payer tax exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10488	NOT USED		
10489	COB TOT CLM BEFORE TAX EXC MAX USE	AMT	The segment providing the other payer total claim before taxes amount exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10490	NOT USED		
10491	SUB DEMOG INFO MISSING	DMG	The segment providing the other insured's demographic information is missing for this claim. This segment is required when patient is different than the insured for the primary payer. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
10492	DTE/TM/PER QUALIFIER INVALID	DMG01	The qualifier indicating the format used to report the insured's date of birth is invalid for this claim. This information is required when the patient is different than the insured for the primary payer. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.* *Valid Value:* ***D8 - Date expressed in CCYYMMDD format***

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10493	OTH INS BIRTH DT INVALID	DMG02	The date entered for the other payer's patient's date of birth is invalid for this line. When entered, this information must be entered in a valid CCYYMMDD format. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
10494	OTH INS BIRTH DT FUTURE DT	DMG02	The date entered for the other payer's patient's date of birth is invalid for this claim. When entered, this information must not be greater than today's date. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
10495	OTH INS GENDER INVALID	DMG03	The qualifier used to identify the other payer's patient's sex is invalid for this subscriber. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.* *Valid Values:* F - Female M - Male U - Unknown
10496	OTH INS COV INFOR MISSING	OI	The segment providing other insurance coverage information for this claim is missing. This information is required when information for the other subscriber is sent. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10497	BEN ASSIG CERT IND INVALID	OI03	The other insurance benefits assignment indicator is invalid for this claim. Use "Y" to indicate insured authorizes benefits to be paid to the supplier. An "N" response indicates benefits have not been assigned to the supplier. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.* *Valid Values:* N - No (benefits have not been assigned to the provider) Y - Yes (benefits have been assigned to the supplier)
10498	PAT SIG SOURCE MISSING	OI04	The code specifying the other insurance patient's signature is missing for this claim. If you have indicated that a signature is on file to release any data, then you must provide a valid source of signature. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.* *Valid Values:* B - Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file C - Signed HCFA-1500 Claim Form on file M - Signed signature authorization form for HCFA-1500 Claim Form block 13 on file P – Signature generated by provider because the patient was not physically present for services S - Signed signature authorization form for HCFA-1500 Claim Form block 12 on file

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10499	PAT SIG SOURCE INVALID	OI04	The code identifying the source of the other insurance patient's signature is invalid for this claim. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.* *Valid Values:* B - Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file C - Signed HCFA-1500 Claim Form on file M - Signed signature authorization form for HCFA-1500 Claim Form block 13 on file P – Signature generated by provider because the patient was not physically present for services S - Signed signature authorization form for HCFA-1500 Claim Form block 12 on file

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10500	REL INFO CODE INVALID	OI06	The code specifying the type of release of information the patient has issued for the other insurance is invalid for this claim. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.* *Valid Values:* A - Appropriate release of information on file at health care service provider or at utilization review organization I - Informed consent to release medical information for conditions or diagnoses regulated by federal statutes M - The provider has limited or restricted ability to release data related to a claim N - No, provider is not allowed to release data O - On file at payer or at plan sponsor Y - Yes, provider has a signed statement permitting release of medical billing data related to a claim
10501	OTH SUB NAME EXC MAX USE	NM1	The segment providing the other payer's subscriber name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
10502	ENTITY ID CODE INVALID	NM101	The qualifier identifying the other payer's subscriber Referring Provider for this claim is invalid. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.* *Valid Value:* ***IL - Insured or subscriber***

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10503	ENTITY TYPE QUALIFIER INVALID	NM102	The qualifier identifying the subscriber type is invalid for this claim. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.* *Valid Values:* 1 - Person 2 - Non-person entity
10504	OTH INS LAST NAME MISSING	NM103	The last name or company name is missing for this claim. If you have specified the other payer's insured type to be a person, this element must contain the last name of that person. If the other payer's insured has been identified as a non-person entity, this element must contain the company name. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
10505	OTH INS FIRST NAME MISSING	NM104	The first name of the other payer's insured is missing for this claim. If you have specified the other payer's insured type to be a person, this element must contain the first name of that person. If the other payer's insured was identified as a non-person entity, this element is not used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10506	ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the other subscriber identification number for this claim is invalid. *Valid Values:* MI - Member identification number ZZ - Mutually defined *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
10507	OTH SUB NAME INFO EXC MAX USE	N2	The segment providing additional other payer's subscriber name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10508	OTH SUB ADDRESS EXC MAX US	N3	The segment providing the other payer insured's address for this claim exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used by DMERC.*
10509	OTH INS STATE CODE INVALID	N402	The other payer's insured state abbreviation is missing for this claim. When reporting address information, the city, state, and zip code information must be included. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10510	REF ID QUALIFIER INVALID	REF01	The qualifier for the other insured secondary Identification number information for this claim is invalid. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *Valid Values:* 1W - Member identification number 23 - Client number IG - Insurance policy number SY - Social Security Number *This information is not used for DMERC.*
10511	OTH SUB SEC ID MISSING	REF02	The other insured's secondary identification number is missing for this claim. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*
10512	OTH PAYER NAME EXC MAX USE	NM1	The segment providing the other payer name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10513	ENTITY ID CODE INVALID	NM101	The qualifier identifying the other payer for this claim is invalid. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* OR *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.* *Valid Value:* ***PR - Payer***
10514	ENTITY TYPE QUALIFIER INVALID	NM102	The qualifier identifying the other payer type is invalid for this claim. *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.* OR *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *Valid Value:* ***2 - Non-person entity***
10515	OTH PAYER LAST NAME MISSING	NM103	The company name is missing for this claim. If the other payer was identified as a non-person entity, this element must contain the company name. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* OR *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10516	ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the other payer identification number for this line is invalid. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* OR *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.* *Valid Values:* PI - Payer identification XV - Health Care Financing Administration National Plan ID
10517	ADD OTH PAY NAME EXC MAX USE	N2	The segment providing additional other payer name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10518	CONTACT FUN CODE INVALID	PER01	The qualifier for the other payer contact information for this claim is invalid for this subscriber. *Valid Value:* IC - Information contact *This information is not used for DMERC.*
10519	OTH PAY CONT NAME MISSING	PER02	The other payer contact person's name is missing for this subscriber. A contact name for the other payer must be submitted when reporting other payer information *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* OR *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.* *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10520	COMM NUMBER QUALIFIER INVALID	PER03	The qualifier identifying the type of contact information being provided for the other payer is invalid for this subscriber. *Valid Values:* ED - Electronic data interchange access number EM - Electronic mail FX - Facsimile TE - Telephone *This information is not used for DMERC.*
10521	COMM NUMBER QUALIFIER INVALID	PER05	The qualifier identifying the second type of contact information being provided for the Other payer is invalid for this subscriber. *Valid Values:* ED - Electronic data interchange access number EM - Electronic mail EX - Telephone extension FX - Facsimile TE - Telephone *This information is not used for DMERC.*
10522	COMM NUMBER QUALIFIER INVALID	PER07	The qualifier identifying the third type of contact information being provided for the other payer is invalid for this subscriber. *Valid Values:* ED - Electronic data interchange access number EM - Electronic mail EX - Telephone extension FX - Facsimile TE - Telephone *This information is not used for DMERC.*
10523	CLM ADJ DATE EXC MAX USE	DTP	The segment providing the other payer claim adjudication date for this claim exceeds maximum use. If this information is reported, only 1 occurrence per claim may be used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10524	DATE TIME QUALIFIER INVALID	DTP01	The qualifier for the date claim paid for this claim is invalid. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *Valid Value:* ***573 - Date claim paid***
10525	DATE TIME PER FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the date the claim was paid is invalid. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *Valid Value:* ***D8 - Date expressed in format CCYYMMDD***
10526	ADJUD/PYMT DT INVALID	DTP03	The date claim paid entered is invalid for this claim. When entered, this information must be entered in a valid CCYYMMDD format. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10527	ADJUD/PYMT DT FUTURE DT	DTP03	The date claim paid entered is invalid for this claim. When entered, this information must not be greater than today's date. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10528	OTH PAYER SEC ID EXC MAX USE	REF	The segment containing additional other payer identification information exceeds maximum use. When this information is reported, only 2 occurrences per claim may be used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10529	REF ID QUALIFIER INVALID	REF01	The qualifier entered for the other payer's secondary identification information for this claim is invalid. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *Valid Values:* 2U - Payer identification number F8 - Original reference number FY - Claim office number NF - National Association of Insurance Commissioners (NAIC) code TJ - Federal taxpayer's identification number 9F – Referral number G1 – Prior authorization number T4 – Signal code
10530	OTH PAYER SEC ID INVALID	REF02	The other payer's secondary identification number is missing. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10531	OTH PAY PRI AUTH EXC MAX USE	REF	The segment containing the other payer prior authorization or referral number information exceeds maximum use. When this information is reported, only 2 occurrences per claim may be used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10532	OTH PAY SBR SEG MISSING OR EXC MAX USE	NM1	The loop containing other subscriber information for the other payer is missing or exceeds maximum use. If this information is reported, it can be reported no more than one time per claim. *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
10533	OTH PAYER PRIOR AUTH INVALID	REF02	The other payer's referral number or prior authorization number is missing for this claim. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10534	OTH PAY CLM ADJ EXC MAX USE	REF	The segment containing the other payer claim adjustment indicator information exceeds maximum use. When this information is reported, only 2 occurrences per transaction may be used. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.*
10535	NOT USED		
10536	OTH PAYER CLM ADJ MISSING	REF02	The other payer claim adjustment indicator is missing for this claim. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Value:* Y - Yes, the payer in this loop has previously adjudicated this claim and sent a record of that adjudication to the destination payer.
10537	OTH PAYER PAT INFO EXC MAX USE	NM1	The segment providing the other payer patient name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*
10538	ENTITY ID CODE INVALID	NM101	The qualifier identifying the other payer patient for this claim is invalid. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Value:* ***QC - Patient***

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10539	ENTITY TYPE QUALIFIER INVALID	NM102	The qualifier identifying the other payer patient type is invalid for this claim. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Value:* ***1 - Person***
10540	PATIENT LAST NAME MISSING	NM103	The last name is missing for this claim. If you have specified the other payer patient type to be a person, this element must contain the last name of that person. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.*
10541	ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the other payer's patient identification number for this claim is invalid. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Value:* ***MI - Member identification number***
10542	REF ID QUALIFIER INVALID	REF01	The qualifier for the other payer patient secondary identification number information for this claim is invalid. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Values:* 1W - Member identification number 23 - Client number IG - Insurance policy number SY - Social Security Number, this may not be used for Medicare
10543	OTH PAY PAT SEC ID MISSING	REF02	The other payer's patient secondary identification number is missing for this claim *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10544	OTH PAY REF PRO EXC MAX USE	NM1	The segment providing the other payer's referring provider name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.*
10545	ENTITY ID CODE INVALID	NM1	The segment providing the referring provider name information for this claim is invalid. If used, the first occurrence of the other payer referring provider name segment at the claim level must contain information on the referring provider. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.*
10546	ENTITY ID CODE INVALID	NM1	The segment providing the referring provider name information for this claim is invalid. If used, the second occurrence of the other payer referring provider name segment at the claim level must contain information on the primary care provider. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.*
10547	ENTITY TYPE QUALIFIER INVALID	NM102	The qualifier identifying the referring provider type is invalid for this claim. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Values:* 1 - Person 2 - Non-person entity
10548	REF PROV LAST NAME MISSING	NM103	The last name or company name is missing for this claim. If you have specified the other payer's referring physician type to be a person, this element must contain the last name of that person. If the other payer's referring physician was identified as a non-person entity, this element must contain the company name. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10549	OTH PAY REF PROV ID MISSING	REF	The segment containing additional other payer's referring provider identification information is missing. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.*
10550	REF ID QUALIFIER INVALID	REF01	The qualifier for the other payer's referring provider secondary identification number information for this claim is invalid. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Values:* 1B - Blue Shield provider number 1C - Medicare provider number 1D - Medicaid provider number EI - Employer's Identification Number G2 - Provider commercial number LU - Location number N5 - Provider plan network identification number
10551	OTH PAY REF PROV ID MISSING	REF02	The other payer referring provider secondary identification number is missing for this claim. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.*
10552	OTH PAY REND PRO EXC MAX USE	NM1	The segment providing the other payer rendering provider name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10553	ENTITY ID CODE INVALID	NM101	The qualifier identifying the other payer rendering provider for this claim is invalid. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Value:* 82 - Rendering provider *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10554	ENTITY TYPE QUALIFIER INVALID	NM102	The qualifier identifying the rendering provider type is invalid for this claim. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Values:* 1 - Person 2 - Non-person entity *This information is not used for DMERC.*
10555	REND PROV LAST NAME MISSING	NM103	The last name or company name is missing for this claim. If you have specified the other payer rendering provider type to be a person, this element must contain the last name of that person. If the other payer rendering provider was identified as a non-person entity, this element must contain the company name. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *This information is not used for DMERC.*
10556	OTH PAY REND PROV SEC EXC MAX USE	REF	The segment containing additional other payer rendering provider identification information is missing from this claim. *This information is not used for DMERC.*
10557	REF ID QUALIFIER INVALID	REF01	The qualifier for the other payer rendering provider secondary identification number information for this claim is invalid. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Values:* 1B - Blue Shield provider number 1C - Medicare provider number EI - Employer's Identification Number G2 - Provider commercial number LU - Location number N5 - Provider plan network identification number *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10558	OTH PAY REND PROV ID MISSING	REF02	The other payer rendering provider secondary identification number is missing for this claim *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *This information is not used for DMERC.*
10559	OTH PAY PUR SER PRO SEC EXC MAX USE	NM1	The segment providing the other payer purchased service provider name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *This information is not used for DMERC.*
10560	ENTITY ID CODE INVALID	NM101	The qualifier identifying the other payer purchased service provider for this claim is invalid. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Value:* QB - Purchased service provider *This information is not used for DMERC.*
10561	ENTITY TYPE QUALIFIER INVALID	NM102	The qualifier identifying the other payer purchased service provider type is invalid for this claim. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Values:* 1 - Person 2 - Non-person entity *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10562	PUR SER PROV LAST NAME MISSING	NM103	The last name or company name is missing for this claim. If you have specified the other payer purchased service provider type to be a person, this element must contain the last name of that person. If the other payer purchased service provider was identified as a non-person entity, this element must contain the company name. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *This information is not used for DMERC.*
10563	OTH PAY PUR SER PROV ID MISSING	REF	The segment containing additional other payer purchased service provider identification information is missing from this claim. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *This information is not used for DMERC.*
10564	REF ID QUALIFIER INVALID	REF01	The qualifier for the other payer purchased service provider secondary identification number information for this claim is invalid. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Values:* 1A - Blue Cross provider number 1B - Blue Shield provider number 1C - Medicare provider number EI - Employer's Identification Number G2 - Provider commercial number LU - Location number N5 - Provider plan network identification number *This information is not used for DMERC.*
10565	OTH PAY PUR SER PROV ID MISSING	REF02	The other payer purchased service provider secondary Identification number is missing for this claim. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10566	OTH PAY SER FAC SEC EXC MAX USE	NM1	The segment providing the other payer service facility name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10567	ENTITY ID CODE INVALID	NM101	The qualifier identifying the other payer service facility location for this claim is invalid. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Values:* 77 - Service location FA - Facility LI - Independent lab TL - Testing laboratory *This information is not used for DMERC.*
10568	ENTITY TYPE QUALIFIER INVALID	NM102	The qualifier identifying the other payer service facility type is invalid for this claim. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Value:* 2 - Non-person entity *This information is not used for DMERC.*
10569	SER FAC NAME MISSING	NM103	The last name or company name is missing for this claim. If you have specified the other payer service facility type to be a person, this element must contain the last name of that person. If the other payer service facility was identified as a non-person entity, this element must contain the company name. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10570	OTH PAY SER FAC ID MISSING	REF	The segment containing additional other payer service facility identification information is missing from this claim *This information is not used for DMERC.*
10571	REF ID QUALIFIER INVALID	REF01	The qualifier for the other payer service facility secondary identification number information for this claim is invalid. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Values:* 1A - Blue Cross provider number 1B - Blue Shield provider number 1C - Medicare provider number 1D - Medicaid provider number G2 - Provider commercial number LU - Location number N5 - Provider plan network identification number *This information is not used for DMERC.*
10572	OTH PAY SER FAC ID INVALID	REF02	The other payer service facility secondary identification number is missing for this claim. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *This information is not used for DMERC.*
10573	OTH PAY SUPER PROV SEC EXC MAX USE	NM1	The segment providing the other payer supervising provider name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
10574	ENTITY ID CODE INVALID	NM101	The qualifier identifying the other payer supervising provider for this claim is invalid. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Value:* DQ - Supervising physician *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10575	ENTITY TYPE QUALIFIER INVALID	NM102	The qualifier identifying the other payer supervising provider type is invalid for this claim. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Value:* 1 - Person *This information is not used for DMERC.*
10576	SUPER PROV LAST NAME MISSING	NM103	The last name is missing for this claim. If you have specified the other payer supervising provider type to be a person, this element must contain the last name of that person. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *This information is not used for DMERC.*
10577	OTH PAY SUPER PROV ID MISSING	REF	The segment containing additional other payer supervising provider identification information is missing from this claim. *This information is not used for DMERC.*
10578	REF ID QUALIFIER INVALID	REF01	The qualifier for the other payer supervising provider secondary identification number information for this claim is invalid. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *Valid Values:* 1B - Blue Shield provider number 1C - Medicare provider number 1D - Medicaid provider number EI - Employer's Identification Number G2 - Provider commercial number N5 - Provider plan network identification number *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10579	OTH PAY SUPER PROV ID MISSING	REF02	The other payer supervising provider secondary identification is missing for this line. *This information is used when a payer is submitting this claim to another payer and should not be submitted by the supplier.* *This information is not used for DMERC.*
10580	SERVICE LINE DOES NOT EXIST	LX	The segment providing the service line sequence information is missing. Each DMERC claim must contain at least one occurrence of this segment.
10581	SERVICE LINE EXC MAX USE	LX	The segment containing service line sequence information exceeds maximum use. Each DMERC claim can not exceed 50 occurrences of this segment.
10582	LINE COUNTER INVALID	LX01	The service line sequence counter is invalid. This element must contain only values 1 through 50.
10583	PROF SERVICE EXC MAX USE	SV1	The segment containing claim line specific information exceeds maximum use. When this information is reported, only 1 occurrence per line may be used.
10584	PROD/SER ID QUALIFIER INVALID	SV101-1	The qualifier indicating the type of product/service code used for this line is invalid. *Valid Values:* ***HC - Health Care Financing Administration Common Procedural Coding System Codes*** IV - Home Infusion EDI Coalition (HIEC) product/service code N1 - National drug code in 4-4-2 format N2 - National drug code in 5-3-2 format N3 - National drug code in 5-4-1 format ***N4 - National drug code in 5-4-2 format*** ZZ - Mutually defined
10585	LINE ITEM CHG AMT INVALID	SV102	The service line charges for this line item is missing. Each DMERC line item must contain a line charge.
10586	UNIT/BASE MEASURE CODE INVALID	SV103	The qualifier identifying the type of service units being reported is invalid for this line. *Valid Values:* F2 - International unit MJ - Minutes UN - Unit

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10587	PLACE OF SER INVALID	SV105	An invalid place of service has been submitted for this line. *Valid Values:* 11 - Office ***12 - Home*** 21 - Inpatient hospital 22 - Outpatient hospital 23 - Emergency room- hospital 24 - Ambulatory surgical center 25 - Birthing center 26 - Military treatment facility ***31 - Skilled nursing facility*** ***32 - Nursing facility*** ***33 - Custodial care facility*** 34 - Hospice 41 - Ambulance-land 42 - Ambulance-air or water 50 - Federally qualified health center 51 - Inpatient psychiatric facility 52 - Psychiatric facility partial hospitalization 53 - Community mental health center ***54 - Intermediate care facility/mentally retarded*** ***55 - Residential substance abuse treatment facility*** ***56 - Psychiatric residential treatment center*** 60 - Mass immunization center 61 - Comprehensive inpatient rehabilitation facility 62 - Comprehensive outpatient rehabilitation facility 65 - End stage renal disease treatment facility 71 - State or local public health clinic 72 - Rural health clinic 81 - Independent laboratory 99 - Other unlisted facility
10588	COMP DIAG CODE POINT MISSING	SV107	The diagnosis code pointer information is missing for this line. This information is required for all line items.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10589	DIAG CODE POINTER INVALID	SV107-1	The first diagnosis code pointer for this line item is invalid. Use this code to point back to the primary diagnosis on the claim. *Valid Values:* **1** **2** **3** **4** 5 6 7 8
10590	DIAG CODE POINTER INVALID	SV107-2	The second diagnosis code pointer for this line item is invalid. Use this code to point back to any secondary diagnosis on the claim. *Valid Values:* **1** **2** **3** **4** 5 6 7 8
10591	DIAG CODE POINTER INVALID	SV107-3	The third diagnosis code pointer for this line item is invalid. Use this code to point back to any secondary diagnosis on the claim. *Valid Values:* **1** **2** **3** **4** 5 6 7 8

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10592	DIAG CODE POINTER INVALID	SV107-4	The fourth diagnosis code pointer for this line item is invalid. Use this code to point back to any secondary diagnosis on the claim. *Valid Values:* **1** **2** **3** **4** 5 6 7 8
10593	EMERG IND INVALID	SV109	The qualifier indicating emergency services for this line is invalid *Valid Values:* N - No Y - Yes
10594	EPSDT IND INVALID	SV111	The qualifier indicating EPSDT services is invalid for this line. *Valid Values:* Y - Yes N - No *This information is not used for DMERC.*
10595	FAMILY PLAN IND INVALID	SV112	The qualifier indicating family planning services is invalid for this line. *Valid Values:* Y - Yes N - No *This information is not used for DMERC.*
10596	CO-PAY STAT INVALID	SV115	The qualifier indicting co-pay exemption status is invalid for this line. *Valid Value:* 0 - Co-pay exempt *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10597	DMERC CMN IND EXC MAX USE	PWK	The segment containing the DMERC CMN indicator information exceeds maximum use. When this information is reported, only 1 occurrence per line may be used.
10598	ATTACH RPT TYPE CODE INVALID	PWK01	The qualifier specifying the type of attachment for this line is invalid. *Valid Value:* ***CT - Certification***
10599	ATTACH TRANS CODE INVALID	PWK02	The qualifier indicating the mode of transmission for the documentation for this line is invalid. *Valid Values:* AB - Previously submitted to payer AD - Certification included in this claim AF - Narrative segment included in this claim AG - No documentation is required NS - Not specified

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10600	UNIT/BASIS MEASURE INVALID	CR101	The code used to indicate the measurement of the patient's weight is invalid for this line. This is only used when reporting information to justify extra ambulance services. *Valid Value:* LB - Pound *This information is not used for DMERC.*
10601	NOT USED		
10602	AMBU TRANS CODE INVALID	CR103	The code used to indicate the type of ambulance transportation for this line is invalid. *Valid Values:* I - Initial trip R - Return trip T - Transfer trip X - Round trip *This information is not used for DMERC.*
10603	AMBU TRANS REASON INVALID	CR104	The code used to indicate the reason for the ambulance transport for this line is invalid. *Valid Values:* A - Patient was transported to nearest facility for care of symptoms, complaints, or both B - Patient was transported for the benefit of a preferred physician C - Patient was transported for the nearness of family members D - Patient was transported for the care of a specialist or for availability of specialized equipment E - Patient transferred to rehabilitation facility *This information is not used for DMERC.*
10604	UNIT/BASIS MEASURE INVALID	CR105	The unit of measurement to indicate the distance the ambulance traveled for this line is invalid. *Valid Value:* DH - Miles *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10605	ROUND TRIP PUR MISSING	CR109	This element is used to provide narrative information to indicate the purpose of the round trip ambulance service for this line. This is a required element if the ambulance transport was a round trip. *This information is not used for DMERC.*
10606	TREATMNT NUMBER MISSING	CR201	The element containing the spinal manipulation treatment series number for this claim line is missing. *This information is not used for DMERC.*
10607	SUBLUX LVEL CODE INVALID	CR203	The qualifier indicating the level of subluxation on chiropractic services is invalid for this line. For lines involving subluxation, this information is required. *Valid Values:* C1 - Cervical 1 C2 - Cervical 2 C3 - Cervical 3 C4 - Cervical 4 C5 - Cervical 5 C6 - Cervical 6 C7 - Cervical 7 CO – Coccyx IL - Ilium L1 - Lumbar 1 L2 - Lumbar 2 L3 - Lumbar 3 L4 - Lumbar 4 L5 - Lumbar 5 OC - Occiput SA - Sacrum T1 - Thoracic 1 T10 - Thoracic 10 T11 - Thoracic 11 T12 - Thoracic 12 T2 - Thoracic 2 T3 - Thoracic 3 T4 - Thoracic 4 T5 - Thoracic 5 T6 - Thoracic 6 T7 - Thoracic 7 T8 - Thoracic 8 T9 - Thoracic 9

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
			This information is not used for DMERC.
10608	SUBLUX LEVEL CODE INVALID	CR204	The qualifier indicating the level of subluxation on chiropractic services is invalid for this line. For lines involving subluxation, this information is required to indicate a range. *Valid Values:* C1 - Cervical 1 C2 - Cervical 2 C3 - Cervical 3 C4 - Cervical 4 C5 - Cervical 5 C6 - Cervical 6 C7 - Cervical 7 CO - Coccyx IL - Ilium L1 - Lumbar 1 L2 - Lumbar 2 L3 - Lumbar 3 L4 - Lumbar 4 L5 - Lumbar 5 OC - Occiput SA - Sacrum T1 - Thoracic 1 T10 - Thoracic 10 T11 - Thoracic 11 T12 - Thoracic 12 T2 - Thoracic 2 T3 - Thoracic 3 T4 - Thoracic 4 T5 - Thoracic 5 T6 - Thoracic 6 T7 - Thoracic 7 T8 - Thoracic 8 T9 - Thoracic 9 *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10609	UNIT/BASIS MEASURE INVALID	CR205	The qualifier indicating the length of time chiropractic treatment has been administered is invalid for this line. *Valid Values:* DA - Days MO - Months WK - Week YR - Years *This information is not used for DMERC.*
10610	TREAT PER MISSING	CR207	The value representing the number of chiropractic treatments rendered in the month for which this line is being billed is missing. *This information is not used for DMERC.*
10611	PAT COND CODE INVALID	CR208	The patient's condition code, indicating the need for spinal manipulation, is invalid for this line. *Valid Values:* A - Acute condition C - Chronic condition D - Non-acute E - Non-life threatening F - Routine G - Symptomatic M - Acute manifestation of a chronic condition *This information is not used for DMERC.*
10612	COMP IND INVALID	CR209	The value representing spinal manipulation complications is invalid for this line. *Valid Values:* N - No Y - Yes *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10613	XRAY AVAIL IND INVALID	CR212	The qualifier indicating the X-ray availability for spinal manipulations is invalid for this line. *Valid Values:* N - No, X-rays are not maintained and available for carrier review Y - Yes, X-rays are maintained and available for carrier review *This information is not used for DMERC.*
10614	CERT TYPE CODE INVALID	CR301	The qualifier indicating the DMERC certification type is invalid for this line. This information is required on all DMERC claims requiring CMN's with the exception of CMN Form 484.2. *Valid Values:* I - Initial R - Renewal (Recertification) S - Revised
10615	DURATION QUALIFIER INVALID	CR302	The measurement qualifier for the CMN length of need is invalid for this line. This information is required on all DMERC claims requiring CMN's with the exception of CMN Form 484.2. *Valid Value:* ***MO - Months***
10616	CERT TYPE CODE INVALID	CR501	The qualifier indicating the oxygen certification type for CMN Form 484.2 is invalid for this line. This information is required on all DMERC claims requiring a CMN Form 484.2. *Valid Values:* I - Initial R - Renewal (Recertification) S - Revised
10617	LENG MED NECESS MISSING	CR502	Length of need for CMN Form 484.2 is missing for this line. This information is required on all DMERC claims requiring a CMN Form 484.2.
10618	ARTERIAL BLOOD GAD LEV MISSING	CR510	The arterial blood gas (ABG) test results are missing for this line. This information must be used to report the ABG for question number 1A on CMN Form 484.2.
10619	O2 SAT LEVEL MISSING	CR511	Oxygen saturation test results are missing for this line. This information must be used to report the oxygen saturation test for question number 1B on CMN Form 484.2.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10620	O2 TEST COND CODE INVALID	CR512	The condition under which the patient was tested in response to question 3 on CMN Form 484.2 is invalid for this line. *Valid Values:* E - Exercising R - At rest on room air S - Sleeping
10621	O2 TEST FINDINGS INVALID	CR513	The qualifier indicating the findings of oxygen tests performed on patient in response to question 8 on CMN form 484.2 is invalid for this line. *Valid Value:* ***1 - Dependant edema suggesting congestive heart failure***
10622	O2 TEST FINDINGS INVALID	CR514	The qualifier indicating the finding of oxygen tests performed on patient in response to question 9 on CMN Form 484.2 is invalid for this line. *Valid Value:* ***2 - "P" Pulmonale on electrocardiogram (EKG)***
10623	O2 TEST FINDINGS INVALID	CR515	The qualifier indicating the finding of oxygen tests performed on patient in response to question 10 on CMN Form 484.2 is invalid for this line. *Valid Value:* ***3 - Erythrocythemia with a hematocrit greater than 56 percent***
10624	CODE CATEGORY INVALID	CRC01	The code used to indicate the type of certification being sent with this ambulance line is invalid. *Valid Value:* 07 - Ambulance certification *This information is not used for DMERC.*
10625	CERT COND IND INVALID	CRC02	The ambulance certification condition code indicator is invalid for this line. *Valid Values:* N - No Y - Yes *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10626	COND CODE INVALID	CRC03	The code indicating the patient's condition is invalid for this ambulance line. *Valid Values:* 01 - Patient was admitted to a hospital 02 - Patient was bed confined before the ambulance service 03 - Patient was bed confined after the ambulance service 04 - Patient was moved by stretcher 05 - Patient was unconscious or in shock 06 - Patient was transported in an emergency situation 07 - Patient had to be physically restrained 08 - Patient had visible hemorrhaging 09 - Ambulance service was medically necessary 60 - Transportation was to the nearest facility *This information is not used for DMERC.*
10627	COND CODE INVALID	CRC04	The code indicating the patient's secondary condition is invalid for this ambulance line. *Valid Values:* 01 - Patient was admitted to a hospital 02 - Patient was bed confined before the ambulance service 03 - Patient was bed confined after the ambulance service 04 - Patient was moved by stretcher 05 - Patient was unconscious or in shock 06 - Patient was transported in an emergency situation 07 - Patient had to be physically restrained 08 - Patient had visible hemorrhaging 09 - Ambulance service was medically necessary 60 - Transportation was to the nearest facility *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10628	COND CODE INVALID	CRC05	The qualifier indicating the patient's third condition is invalid for this ambulance line. *Valid Values:* 01 - Patient was admitted to a hospital 02 - Patient was bed confined before the ambulance service 03 - Patient was bed confined after the ambulance service 04 - Patient was moved by stretcher 05 - Patient was unconscious or in shock 06 - Patient was transported in an emergency situation 07 - Patient had to be physically restrained 08 - Patient had visible hemorrhaging 09 - Ambulance service was medically necessary 60 - Transportation was to the nearest facility *This information is not used for DMERC.*
10629	COND CODE INVALID	CRC06	The qualifier indicating the patient's fourth condition is invalid for this ambulance line. *Valid Values:* 01 - Patient was admitted to a hospital 02 - Patient was bed confined before the ambulance service 03 - Patient was bed confined after the ambulance service 04 - Patient was moved by stretcher 05 - Patient was unconscious or in shock 06 - Patient was transported in an emergency situation 07 - Patient had to be physically restrained 08 - Patient had visible hemorrhaging 09 - Ambulance service was medically necessary 60 - Transportation was to the nearest facility *This information is not used for DMERC.*
10630	COND CODE INVALID	CRC07	The qualifier indicating the patient's fifth condition is invalid for this ambulance line. *Valid Values:* 01 - Patient was admitted to a hospital 02 - Patient was bed confined before the ambulance service 03 - Patient was bed confined after the ambulance service 04 - Patient was moved by stretcher 05 - Patient was unconscious or in shock 06 - Patient was transported in an emergency situation 07 - Patient had to be physically restrained 08 - Patient had visible hemorrhaging

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
			09 - Ambulance service was medically necessary 60 - Transportation was to the nearest facility *This information is not used for DMERC.*
10631	HOSPICE EMP IND EXC MAX USE	CRC	The segment containing hospice employee information exceeds maximum use. If this information is reported, only 1 occurrences per claim may be used. *This information is not used for DMERC.*
10632	NOT USED		.
10633	HOSPICE EMP PROV IND INVALID	CRC02	The qualifier indicating the provider is employed by a hospice is invalid for this line. *Valid Values:* N - No Y - Yes *This information is not used for DMERC.*
10634	COND IND INVALID	CRC03	The code indicating the provider is a hospice employee is invalid for this claim. *Valid Value:* 65 - Open *This information is not used for DMERC.*
10635	DMERC COND IND EXC MAX USE	CRC	The segment containing general DMERC CMN information exceeds maximum use. If this information is reported, only 2 occurrences per claim may be used.
10636	NOT USED		
10637	CERT COND IND INVALID	CRC02	The DMERC certification condition code indicator is invalid for this line. *Valid Values:* N - No Y - Yes

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10638	COND CODE INVALID	CRC03	The code indicating the patient's condition is invalid for this line. Use values 37, AL, and P1 for CMN form 484.2 and 38 for all DMERC CMN's including CMN form 484.2. *Valid Values:* 37 - Oxygen delivery equipment is stationary 38 - Certification signed by the physician is on file at the supplier's office AL - Ambulation limitations P1 - Patient was discharged from the first ZV - Replacement item
10639	COND CODE INVALID	CRC04	The code indicating the patient's secondary condition is invalid for this line. Use values 37, AL, and P1 for CMN form 484.2 and 38 for all DMERC CMN's including CMN form 484.2. *Valid Values:* 37 - Oxygen delivery equipment is stationary 38 - Certification signed by the physician is on file at the supplier's office AL - Ambulation limitations P1 - Patient was discharged from the first ZV - Replacement item
10640	COND CODE INVALID	CRC05	The qualifier indicating the patient's third condition is invalid for this line. Use values 37, AL, and P1 for CMN form 484.2 and 38 for all DMERC CMN's including CMN form 484.2. *Valid Values:* 37 - Oxygen delivery equipment is stationary 38 - Certification signed by the physician is on file at the supplier's office AL - Ambulation limitations P1 - Patient was discharged from the first ZV - Replacement item

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10641	COND CODE INVALID	CRC06	The qualifier indicating the patient's fourth condition is invalid for this line. Use values 37, AL, and P1 for CMN form 484.2 and 38 for all DMERC CMN's including CMN form 484.2. *Valid Values:* 37 - Oxygen delivery equipment is stationary 38 - Certification signed by the physician is on file at the supplier's office AL - Ambulation limitations P1 - Patient was discharged from the first ZV - Replacement item
10642	COND CODE INVALID	CRC07	The qualifier indicating the patient's fifth condition is invalid for this line. Use values 37, AL, and P1 for CMN form 484.2 and 38 for all DMERC CMN's including CMN form 484.2. *Valid Values:* 37 - Oxygen delivery equipment is stationary 38 - Certification signed by the physician is on file at the supplier's office AL - Ambulation limitations P1 - Patient was discharged from the first ZV - Replacement item
10643	SERVICE DATE EXC MAX USE	DTP	The segment providing the date of service for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used.
10644	NOT USED		
10645	DTE TIME PER FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the date(s) of service for this line is invalid. *Valid Values:* ***D8 - Date expressed in CCYYMMDD format*** ***RD8 - Range of dates expressed in CCYYMMDD-CCYYMMDD format***
10646	FROM DATE INVALID	DTP03	The date of service entered is invalid for this line. When entered, this information must be entered in a CCYYMMDD format.
10647	FROM DATE FUTURE DATE	DTP03	The date of service entered is invalid for this line. When entered, this information must not be greater than today's date.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10648	FROM/TO DATE INVALID	DTP03	The date of service entered is invalid for this line. When entered, this information must be entered in a CCYYMMDD-CYYMMDD format.
10649	FROM/TO DATE FUTURE DATE	DTP03	The date of service entered is invalid for this line. When entered, this information must not be greater than today's date.
10650	CERT REVISION DT MISSING	DTP	The segment providing the certification revision date for this line is missing. This information must be provided if a revised or recertification CMN is being sent.
10651	CERT REVISION DT EXC MAX USE	DTP	The segment providing the certification revision date for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used.
10652	NOT USED		
10653	DTE TIME PER FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the certification revision date for this line is invalid. *Valid Value:* ***D8 - Date expressed in format CCYYMMDD***
10654	REVISION DATE INVALID	DTP03	The certification revision date entered is invalid for this line. When entered, this information must be entered in a valid CCYYMMDD format.
10655	REVISION DATE FUTURE DATE	DTP03	The certification revision date entered is invalid for this line. When entered, this information must not be greater than today's date.
10656	REFERRAL DT EXC MAX USE	DTP	The segment providing the referral date for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10657	NOT USED		
10658	DTE TIME PER FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the referral date for this line is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10659	REFFERAL DATE INVALID	DTP03	The referral date entered is invalid for this line. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10660	REFFERAL DATE FUTURE DATE	DTP03	The referral date entered is invalid for this line. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10661	BEG THERAPY DT EXC MAX USE	DTP	The segment providing the begin therapy date (CMN initial date) for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used.
10662	NOT USED		
10663	DTE TIME PER FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the begin therapy (CMN initial date) date for this line is invalid. *Valid Value:* ***D8 - Date expressed in format CCYYMMDD***
10664	BEG THERAPY DATE INVALID	DTP03	The begin therapy (CMN initial date) date entered is invalid for this line. When entered, this information must be entered in a CCYYMMDD format.
10665	BEG THERAPY DATE FUTURE DATE	DTP03	The begin therapy (CMN initial date) date entered is invalid for this line. When entered, this information must not be greater than today's date.
10666	LAST CERT DT EXC MAX USE	DTP	The segment providing the last certification date (date the CMN was signed) for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used.
10667	NOT USED		
10668	DTE TIME PER FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the last certification date (date CMN was signed by the physician)for this line is invalid. *Valid Value:* ***D8 - Date expressed in format CCYYMMDD***
10669	LAST CERT DATE INVALID	DTP03	The last certification date (date CMN was signed by the physician) entered is invalid for this line. When entered, this information must be entered in a CCYYMMDD format.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10670	LAST CERT DATE FUTURE DATE	DTP03	The last certification date (date CMN was signed by the physician) entered is invalid for this line. When entered, this information must not be greater than today's date.
10671	ORDER DT EXC MAX USE	DTP	The segment providing the order date for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10672	NOT USED		
10673	DTE TIME PER FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the order date for this line is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10674	ORDER DATE INVALID	DTP03	The order date entered is invalid for this line. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10675	ORDER DATE FUTURE DATE	DTP03	The order date entered is invalid for this line. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10676	DTE LAST SEEN DT EXC MAX USE	DTP	The segment providing the date last seen for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10677	NOT USED		
10678	DTE TIME PER FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the date last seen for this line is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10679	LAST SEEN DATE INVALID	DTP03	The date last seen entered is invalid for this line. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10680	LAST SEEN DATE FUTURE DATE	DTP03	The date last seen entered is invalid for this line. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10681	TEST DT EXC MAX USE	DTP	The segment providing the hemoglobin/ hematocrit test date for this line exceeds maximum use. When this information is reported, only 2 occurrences per line may be used. *This information is not used for DMERC.*
10682	NOT USED		
10683	DTE TIME PER FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the hemoglobin/hematocrit test date for this line is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10684	TEST DATE INVALID	DTP03	The hemoglobin/hematocrit test date entered is invalid for this line. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10685	TEST DATE FUTURE DATE	DTP03	The hemoglobin/hematocrit test date entered is invalid for this line. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10686	O2 SAT ABG DT EXC MAX USE	DTP	The segment providing the oxygen saturation /arterial blood gas test date for this line exceeds maximum use. When this information is reported, only 3 occurrences per line may be used.
10687	NOT USED		
10688	DTE TIME PER FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the oxygen saturation/arterial blood gas test for this line is invalid. *Valid Value:* ***D8 - Date expressed in format CCYYMMDD***
10689	O2 SAT ABG DATE INVALID	DTP03	The oxygen saturation/arterial blood gas test date entered is invalid for this line. When entered, this information must be entered in a CCYYMMDD format.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10690	O2 SAT ABG DATE FUTURE DATE	DTP03	The oxygen saturation/arterial blood gas test date entered is invalid for this line. When entered, this information must not be greater than today's date.
10691	SHIPPED DT EXC MAX USE	DTP	The segment providing the shipped date for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10692	NOT USED		
10693	DTE TIME PER FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the date shipped for this line is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10694	SHIPPED DATE INVALID	DTP03	The shipped date entered is invalid for this line. When entered, this information must be entered in a valid CCYYMMDD format. *This information is not used for DMERC.*
10695	SHIPPED DATE FUTURE DATE	DTP03	The shipped date entered is invalid for this line. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10696	SYMPT/ILLNESS DT EXC MAX USE	DTP	The segment providing the onset of current symptom or illness date for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10697	NOT USED		
10698	DTE TIME PER FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the onset of current symptom or illness date for this line is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10699	SYMPT/ILLNESS DATE INVALID	DTP03	The onset of current symptom or illness date entered is invalid for this line. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10700	SYMPT/ILLNESS DATE FUTURE DATE	DTP03	The onset of current symptom or illness date entered is invalid for this line. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10701	LAST XRAY DT EXC MAX USE	DTP	The segment providing the last X-ray date for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10702	NOT USED		
10703	DTE TIME PER FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the last X-ray date for this line is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10704	LAST XRAY DATE INVALID	DTP03	The last X-ray date entered is invalid for this line. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10705	LAST XRAY DATE FUTURE DATE	DTP03	The last X-ray date entered is invalid for this line. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10706	ACUTE MANIF DT EXC MAX USE	DTP	The segment providing the acute manifestation for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10707	NOT USED		
10708	DTE TIME PER FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the acute manifestation date for this line is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10709	ACUTE MANIF DATE INVALID	DTP03	The acute manifestation date entered is invalid for this line. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10710	ACUTE MANIF DATE FUTURE DATE	DTP03	The acute manifestation date entered is invalid for this line. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10711	INITIAL TREAT DT EXC MAX USE	DTP	The segment providing the initial treatment date for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10712	NOT USED		
10713	DTE TIME PER FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the initial treatment date for this line is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10714	INT TREAT DATE INVALID	DTP03	The initial treatment date entered is invalid for this line. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10715	INT TREAT DATE FUTURE DATE	DTP03	The initial treatment date entered is invalid for this line. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10716	SIMI ILL/SYM ONSET DT EXC MAX USE	DTP	The segment providing the onset of similar illness or symptom date for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10717	NOT USED		

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10718	DTE TIME PER FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the onset of similar symptoms or Illness date for this line is invalid. *Valid Value:* D8 - Date expressed in format CCYYMMDD *This information is not used for DMERC.*
10719	SIMI ILL/SYM ONSET DATE INVALID	DTP03	The date of similar symptoms or illness entered is invalid for this line. When entered, this information must be entered in a CCYYMMDD format. *This information is not used for DMERC.*
10720	SIMI ILL/SYM ONSET DATE FUTURE DATE	DTP03	The date of similar symptoms or Illness entered is invalid for this line. When entered, this information must not be greater than today's date. *This information is not used for DMERC.*
10721	QUANTITY QUALIFIER INVALID	QTY01	The qualifier indicating anesthesia modifying units is invalid for this line. *Valid Values:* BF - Age modifying units EC - Use of extracorporeal circulation EM - Emergency modifying units HM - Use of hypothermnia HO - Use of hypotension HP - Use of hyperbaric pressurization P3 - Physical status III P4 - Physical status IV P5 - Physical status V SG - Swan-Ganz *This information is not used for DMERC.*
10722	ANESTH MOD UNITS MISSING	QTY02	The number of anesthesia modifying units is missing. You have indicated anesthesia units are being reported, however have not included any units with this line. *This information is not used for DMERC.*
10723	MEAS REF ID INVALID	MEA01	The qualifier indicating the measurement being reported for this line is invalid. *Valid Values:* OG - Original starting dosage ***TR - Test results***

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10724	MEAS QUALIFIER INVALID	MEA02	The qualifier identifying the test results or patient's height being reported for this line is invalid. *Valid Values:* ***CON - Concentration (used to report ABG test results when tested on 4 LPM for DMERC Form 484.2)*** GRA - Gas test rate ***HT - Height (Used to report the patient's height on all DMERC CMN's requiring patient's height to be reported)*** R1 - Hemoglobin R2 - Hematocrit R3 - Epoetin starting dosage R4 - Creatin ***ZO - Oxygen (used to report the oxygen saturation test results when tested on 4 LPM for DMERC Form 484.2)***
10725	TEAST RESULTS MISSING	MEA03	The test results or patient height being reported for this line is missing. This information is required to be sent for CMN form 484.2 and all DMERC CMN's requiring patient's height.
10726	CONTRACT TYPE INVALID	CN101	The qualifier indicating the type of contract for encounter claims is invalid for this line. *Valid Values:* 02 - Per diem 03 - Variable per diem 04 - Flat 05 - Capitated 06 - Percent 09 - Other *This information is not used for DMERC.*
10727	REPRICED LN ITEM REF NUM EXC MAX USE	REF	The segment containing the repriced line item reference number information exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10728	NOT USED		
10729	REPRICE LINE REF # MISSING	REF02	The repriced line item reference number is missing for this line. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10730	ADJ REPRICED LN ITEM REF NUM EXC MAX USE	REF	The segment containing the adjusted repriced line item reference information exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10731	NOT USED		
10732	ADJ REPRICE LINE REF # MISSING	REF02	The adjusted repriced line item reference number is missing for this line. *This information is not used for DMERC.*
10733	PRIOR AUTH/REFFERAL NUM EXC MAX USE	REF	The segment containing the prior authorization or referral number information exceeds maximum use. When this information is reported, only 1 occurrence per line may be used.
10734	NOT USED		
10735	PRIOR AUTH/REF # MISSING	REF02	The prior authorization or referral number is missing for this line.
10736	LINE ITEM CONT # EXC MAX USE	REF	The segment containing the line item control number information exceeds maximum use. When this information is reported, only 1 occurrence per line may be used.
10737	NOT USED		
10738	LINE ITEM CONT # MISSING	REF02	The line item control number is missing. *This information is not used for DMERC.*
10739	MAMMOG CERT # EXC MAX USE	REF	The segment containing the Mammography Certification Number information exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10740	NOT USED		
10741	MAMMOG CERT # MISSING	REF02	The mammography certification number is missing for this line. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10742	CLIN LAB IMP AM # EXC MAX USE	REF	The segment containing additional Clinical Laboratory Improvement Amendment (CLIA) Number information exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10743	NOT USED		
10744	CLIN LAB IMP AM # MISSING	REF02	The Clinical Laboratory Improvement Amendment (CLIA) number is missing for this line. *This information is not used for DMERC.*
10745	REF CLIA FAC ID EXC MAX USE	REF	The segment containing additional referring CLIA facility identification information exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10746	NOT USED		
10747	REF CLIA # MISSING	REF02	The referring CLIA facility identification number is missing for this line. *This information is not used for DMERC.*
10748	IMM BTCH # EXC MAX USE	REF	The segment containing the immunization batch number information exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10749	NOT USED		
10750	IMM BTCH # MISSING	REF02	The immunization batch number is missing for this line *This information is not used for DMERC.*
10751	AMBUL PAT GRP EXC MAX USE	REF	The segment containing the ambulatory patient group information exceeds maximum use. When this information is reported, only 4 occurrences per line may be used. *This information is not used for DMERC.*
10752	NOT USED		
10753	AMBUL PAT GRP MISSING	REF02	The ambulatory patient group number is missing for this line *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10754	O2 FLOW RATE EXC MAX USE	REF	The segment containing oxygen flow rate information exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used.
10755	NOT USED		
10756	O2 FLOW RATE INVALID	REF02	The oxygen flow rate is invalid for this line *Valid Values:* ***1 - 999*** ***X - if less than 1***
10757	UPN EXC MAX USE	REF	The segment containing universal product number information exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10758	NOT USED		
10759	UPN MISSING	REF02	The universal product number is missing for this line *This information is not used for DMERC.*
10760	SALES TAX AMT EXC MAX USE	AMT	The segment providing the sales tax amount exceeds maximum use. If this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10761	NOT USED		
10762	APPROV AMT EXC MAX USE	AMT	The segment providing the primary payer approved amount exceeds maximum use. If this information is reported, only 1 occurrence per line may be used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10763	NOT USED		
10764	PSTAGE CLMED AMT EXC MAX USE	AMT	The segment providing the postage amount exceeds maximum use for this line. If this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10765	NOT USED		

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10766	LINE NOTE EXC MAX USE	NTE	The segment providing additional narrative information for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used.
10767	NOTE REF INVALID	NTE01	The qualifier identifying the type of additional narrative information being sent with this line is invalid. *Valid Values:* ***ADD - Additional information*** DCP - Goals, rehabilitation potential, or discharge plans PMT - Payment TPO - Third party organization notes
10768	QUANTITY QUALIFIER INVALID	HSD01	The qualifier specifying the type of services being reported for home health deliveries is not valid for this line. *Valid Value:* VS - Visits *This information is not used for DMERC.*
10769	FREQ PERIOD INVALID	HSD03	The qualifier specifying the frequency of services being reported for home health deliveries is not valid for this line. *Valid Values:* DA - Days MO - Months Q1 - Quarter WK - Week *This information is not used for DMERC.*
10770	DUR OF VISITS/UNITS INVALID	HSD05	The qualifier specifying the duration of visits being reported for home health deliveries is not valid for this line. *Valid Values:* 7 - Day 34 - Month 35 - Week *This information is not used for DMERC.*
10771	DUR OF VIS/# UNITS MISSING	HSD06	The number of visits for home health deliveries is missing for this line. *This information is not used for DMERC.*
10772	PATTERN CODE INVALID	HSD07	The qualifier indicating the pattern code for visits being reported for home health deliveries is not valid for this line. *Valid Values:*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
			1 - 1st week of the month 2 - 2nd week of the month 3 - 3rd week of the month 4 - 4th week of the month 5 - 5th week of the month 6 - 1st & 3rd weeks of the month 7 - 2nd & 4th weeks of the month A - Monday through Friday B - Monday through Saturday C - Monday through Sunday D - Monday E - Tuesday F - Wednesday G - Thursday H - Friday J - Saturday K - Sunday L - Monday through Thursday N - As directed O - Daily Mon. through Fri. SA - Sunday, Monday, Thursday, Friday, Saturday SB - Tuesday through Saturday SC - Sunday, Wednesday, Thursday, Friday, Saturday SD - Monday, Wednesday, Thursday, Friday, Saturday SG - Tuesday through Friday SL - Monday, Tuesday and Thursday SP - Monday, Tuesday and Friday SX - Wednesday and Thursday SY - Monday, Wednesday and Thursday SZ - Tuesday, Thursday and Friday W - Whenever necessary *This information is not used for DMERC.*
10773	TIME CODE INVALID	HSD08	The qualifier indicating the time of visits being reported for home health deliveries is not valid for this line. *Valid Values:* D - A.M. E - P.M. F - As directed *This information is not used for DMERC.*
10774	PRICE/REPRIC E METH	HCP01	The pricing methodology code used to indicate how this line

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
	INVALID		has been priced or repriced is invalid. *Valid Values:* 00 - Zero pricing (not covered under contract) 01 - Priced as billed at 100% 02 - Priced at the standard fee schedule 03 - Priced at a contractual percentage 04 - Bundled pricing 05 - Peer review pricing 06 - Per diem pricing 07 - Flat rate pricing 08 - Combination pricing 09 - Maternity pricing 10 - Other pricing 11 - Lower of cost 12 - Ratio of cost 13 - Cost reimbursed 14 - Adjustment pricing *This information is not used for DMERC.*
10775	ALLOW AMT PRICE MISSING	HCP02	The repriced allowed amount for this line is missing. *This information is not used for DMERC.*
10776	PROD SER ID QUALIFIER INVALID	HCP09	The qualifier identifying the code format used by the repricer is invalid for this line. *Valid Values:* HC - HCPCS IV - HIEC ZZ - Mutually defined *This information is not used for DMERC.*
10777	UNIT/BASIS MEAS CODE INVALID	HCP11	The qualifier identifying the measurement used by the repricer for units of service is invalid for this line. *Valid Values:* DA - Days UN - Units *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10778	REJ REAS CODE INVALID	HCP13	The qualifier identifying the reason code for rejecting this service by the repricer for is invalid for this line *Valid Values:* T1 - Cannot identify provider as TPO (Third Party Organization) participant T2 - Cannot identify payer as TPO (Third Party Organization) participant T3 - Cannot identify insured as TPO (Third Party Organization) participant T4 - Payer name or identifier missing T5 - Certification information missing T6 - Claim does not contain enough information for re-pricing *This information is not used for DMERC.*
10779	POL COMP CODE INVALID	HCP14	The repricer's policy compliance code is invalid for this line. *Valid Values:* 1 - Procedure followed (compliance) 2 - Not followed - call not made (non-compliance call not made) 3 - Not medically necessary (non-compliance non-medically necessary) 4 - Not followed other (non-compliance other) 5 - Emergency admit to non-network hospital *This information is not used for DMERC.*
10780	EXCEP CODE INVAILD	HCP15	The repricer's exception code is invalid for this line. *Valid Values:* 1 - Non-network professional provider in network hospital 2 - Emergency care 3 - Services or specialist not in network 4 - Out-of-service area 5 - State mandates 6 - Other *This information is not used for DMERC.*
10781	REND PROV NAME EXC MAX USE	NM1	The segment providing the rendering provider name information for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10782	ENTITY ID CODE INVALID	NM101	The qualifier identifying the rendering provider for this line is invalid. *Valid Value:* 82 - Rendering provider *This information is not used for DMERC.*
10783	ENTITY TYPE QUALIFIER INVALID	NM102	The qualifier identifying the rendering provider type is invalid for this line. *Valid Values:* 1 - Person 2 - Non-person entity *This information is not used for DMERC.*
10784	REND PROV LAST NAME MISSING	NM103	The last name or company name is missing for this line. If you have specified the rendering provider type to be a person, this element must contain the last name of that person. If the rendering provider was identified as a non-person entity, this element must contain the company name. *This information is not used for DMERC.*
10785	REND PROV FIRST NAME MISSING	NM104	The first name of the rendering provider is missing for this line. If you have specified the rendering provider type to be a person, this element must contain the first name of that person. *This information is not used for DMERC.*
10786	ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the rendering provider identification number for this line is invalid. *Valid Values:* 24 - Employer's Identification Number 34 - Social Security Number XX - National Provider Identifier *This information is not used for DMERC.*
10787	REND PROV SPEC INFO MISSING	PRV	The segment providing rendering provider information for this line is missing. This information is required when a rendering provider is identified at the line level. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10788	PROV CODE INVALID	PRV01	The qualifier identifying the type of provider being reported for this line is invalid. *Valid Value:* PE - Performing *This information is not used for DMERC.*
10789	ID CODE QUALIFIER INVALID	PRV02	The qualifier identifying the type of identification number being reported for the rendering provider is invalid for this line. *Valid Value:* ZZ - Mutually Defined (Provider Taxonomy Code) *This information is not used for DMERC.*
10790	ADD REND PROV NAME INFO EXC MAX USE	N2	The segment providing additional rendering provider name information for this claim exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10791	REND PROV SEC ID EXC MAX USE	REF	The segment containing additional rendering provider Identification information exceeds maximum use. When this information is reported, only 5 occurrences per line may be used. *This information is not used for DMERC.*
10792	REF ID QUALIFIER INVALID	REF01	The qualifier for the rendering provider secondary identification number information for this line is invalid. *Valid Values:* 0B - State license number 1B - Blue Shield provider number 1C - Medicare Provider Number 1D - Medicaid provider number 1G - Provider UPIN number 1H - CHAMPUS identification number EI - Employer's Identification Number G2 - Provider commercial number LU - Location number N5 - Provider plan network identification number SY - Social Security Number X5 - State industrial accident provider number *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10793	REND PROV SEC ID MISSING	REF02	The rendering provider secondary identification number is missing for this line. *This information is not used for DMERC.*
10794	PUR SER PROV NAME EXC MAX USE	NM1	The segment providing the purchased service provider name information for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10795	ENTITY ID CODE INVALID	NM101	The qualifier identifying the purchased service provider for this line is invalid. *Valid Value:* QB - Purchase service provider *This information is not used for DMERC.*
10796	ENTITY TYPE QUALIFIER INVALID	NM102	The qualifier identifying the purchased service provider type is invalid for this line. *Valid Values:* 1 - Person 2 - Non-person entity *This information is not used for DMERC.*
10797	ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the purchased service provider identification number for this line is invalid. *Valid Values:* 24 - Employer's Identification Number 34 - Social Security Number XX - National Provider number *This information is not used for DMERC.*
10798	PUR SER PROV SEC ID EXC MAX USE	REF	The segment containing additional purchased service provider identification information exceeds maximum use. When this information is reported, only 5 occurrences per line may be used. *This information is not used for DMERC.*
10799	REF ID QUALIFIER INVALID	REF01	The qualifier for the purchased service provider secondary identification number information for this line is invalid. *Valid Values:* 0B - State license number 1B - Blue Shield provider number

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
			1C - Medicare provider number 1D - Medicaid provider number 1G - Provider UPIN number 1H - CHAMPUS identification number EI - Employer's Identification Number G2 - Provider commercial number LU - Location number N5 - Provider plan network identification number SY - Social Security Number U3 - Unique supplier identification number X5 - State industrial accident provider number *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10800	PUR SER PROV SEC ID MISSING	REF02	The purchased service provider secondary identification number is missing for this line. *This information is not used for DMERC.*
10801	CANNOT SEND >1 SVC FACILITY LOCATION	NM1	The segment providing the service facility location name or oxygen test facility name information for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used.
10802	SVC FACILITY ID CODE INVALID	NM101	The qualifier identifying the service facility location or oxygen test facility for this line is invalid. *Valid Values:* 77 - Service location FA - Facility LI - Independent lab TL - Testing laboratory
10803	SVC FACILITY TYPE QUALIFIER INVALID	NM102	The qualifier identifying the service facility location or oxygen test facility type is invalid for this line. *Valid Value:* ***2 - Non-person entity***
10804	SVC FACILITY NAME MISSING OR INVALID	NM103	The service facility name is missing or invalid for this line. Verify the first position of the service facility or oxygen test facility name does not contain a space and only contains alpha characters.
10805	SVC FACILITY ID QUALIFIER INVALID	NM108	The qualifier identifying the service facility location or oxygen test facility identification number for this line is invalid. *Valid Values:* 24 - Employer's Identification Number 34 - Social Security Number XX - Health Care Financing Administration National Provider Identifier
10806	CANNOT SEND >1 ADDTL SVC FACILITY NAME	N2	The segment providing additional service facility location or oxygen test facility name information for this line exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used.
10807	CANNOT SEND > 1 SVC FAC ADDRESS	N3	The segment providing the service facility location or oxygen test facility address for this line exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10808	SVC FACILITY C/S/Z SEGMENT MISSING	N4	The segment providing city, state, and zip code information for the service facility location or oxygen test facility for this line is missing. When reporting address information, the city, state, and zip code information must be included.
10809	SVC FACILITY CITY MISSING	N401	The service facility location or oxygen test facility city is missing for this line. When reporting address information, the city, state, and zip code information must be included.
10810	SVC FACILITY STATE MISSING	N402	The service facility location or oxygen test facility state abbreviation is missing for this claim. When reporting address information, the city, state, and zip code information must be included.
10811	SVC FACILITY ZIP MISSING	N403	The service facility location or oxygen test facility zip code is missing for this line. When reporting address information, the city, state, and zip code information must be included.
10812	CANNOT SEND >5 SVC FAC 2ND ID SEGMENTS	REF	The segment containing additional service facility location or oxygen test facility identification information exceeds maximum use. When this information is reported, only 5 occurrences per line may be used.
10813	SVC FAC LOC 2ND ID QUALIFIER INVALID	REF01	The qualifier for the service facility location or oxygen test facility secondary identification number information for this line is invalid. *Valid Values:* 0B - State license number 1A - Blue Cross provider number 1B - Blue Shield provider number 1C - Medicare provider number 1D - Medicaid provider number 1G - Provider UPIN number 1H - CHAMPUS identification number G2 - Provider commercial number LU - Location number N5 - Provider plan network identification number TJ - Federal taxpayer's identification number X4 - Clinical Laboratory Improvement Amendment (CLIA) number X5 - State industrial accident provider number
10814	FACILITY PROV NUMBER MISSING	REF02	The service facility location or oxygen test facility secondary identification code is missing for this line.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10815	CANNOT SEND >1 SPV PROV NAME SEGMENT	NM1	The segment providing the supervising provider name information for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC.*
10816	SPV PROV ID CODE INVALID	NM101	The qualifier identifying the supervising physician for this line is invalid. *Valid Value:* DQ - Supervising physician *This information is not used for DMERC.*
10817	SPV PROV NAME QUALIFIER INVALID	NM102	The qualifier identifying the supervising physician type is invalid for this line. *Valid Value:* 1 - Person *This information is not used for DMERC.*
10818	SPV PROV LAST NAME MISSING	NM103	The last name is missing for this line. If you have specified the supervising provider type to be a person, this element must contain the last name of that person. *This information is not used for DMERC.*
10819	SPV PROV FIRST NAME MISSING	NM104	The first name of the supervising provider is missing for this line. If you have specified the supervising provider type to be a person, this element must contain the first name of that person. *This information is not used for DMERC.*
10820	SPV PROV ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the supervising provider's identification number for this line is invalid. *Valid Values:* 24 - Employer's Identification Number 34 - Social Security Number XX - Health Care Financing Administration National Provider Identifier *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10821	CANNOT SEND >1 ADDTL SPV PROV NAME SEG	N2	The segment providing additional supervising provider's name information for this line exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10822	CANNOT SEND >5 SPV PROV 2ND ID SEGMENTS	REF	The segment containing additional supervising provider identification information exceeds maximum use. When this information is reported, only 5 occurrences per line may be used. *This information is not used for DMERC.*
10823	SPV PROV 2ND ID QUALIFIER INVALID	REF01	The qualifier for the supervising provider secondary identification number information for this transaction is invalid. *Valid Values:* 0B - State license number 1B - Blue Shield provider number 1C - Medicare provider number 1D - Medicaid provider number 1G - Provider UPIN number 1H - CHAMPUS identification number B3 - Preferred Provider Organization number EI - Employer's Identification Number G2 - Provider commercial number LU - Location number N5 - Provider plan network identification number SY - Social Security Number, this may not be used for Medicare. X5 - State industrial Accident provider number *This information is not used for DMERC.*
10824	SPV PROV UPIN MISSING	REF02	The supervising provider's secondary identification number is missing for this line *This information is not used for DMERC.*
10825	CANNOT SEND >1 ORD PROV NAME SEGMENT	NM1	The segment providing the ordering provider name information for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10826	ORD PROV ID CODE INVALID	NM101	The qualifier identifying the ordering physician for this line is invalid. *Valid Value:* ***DK - Ordering physician***
10827	ORD PROV QUALIFIER INVALID	NM102	The qualifier identifying the ordering physician type is invalid for this line. *Valid Value:* ***1 - Person***
10828	ORD PROV LAST NAME MISSING	NM103	The last name or company name is missing for this line. If you have specified the ordering physician type to be a person, this element must contain the last name of that person. If the ordering physician was identified as a non-person entity, this element must contain the company name.
10829	ORD PROV FIRST NAME MISSING	NM104	The first name of the ordering physician is missing for this line. If you have specified the ordering physician type to be a person, this element must contain the first name of that person.
10830	ORD PROV ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the ordering physician identification number for this line is invalid. *Valid Values:* 24 - Employer's Identification Number 34 - Social Security Number XX - Health Care Financing Administration National Provider Identifier *This information is not used for DMERC.*
10831	CANNOT SEND >1 ADDTL ORD PROV NAME SEG	N2	The segment providing additional ordering provider's name information for this line exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10832	CANNOT SEND >1 ORD PROV ADDR SEGMENT	N3	The segment providing the ordering provider address for this line exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10833	ORD PROV ADDR MISSING	N401	The ordering provider's city is missing for this line. When reporting address information, the city, state, and zip code information must be included. *This information is not used for DMERC.*
10834	ORD PROV STATE CODE MISSING	N402	The ordering provider's state abbreviation is missing for this line. When reporting address information, the city, state, and zip code information must be included. *This information is not used for DMERC.*
10835	ORD PROV ZIP CODE MISSING	N403	The ordering provider's zip code is missing for this line. When reporting address information, the city, state, and zip code information must be included. *This information is not used for DMERC.*
10836	CANNOT SEND >5 ORD PROV 2ND ID SEGMENTS	REF	The segment containing additional ordering provider Identification information exceeds maximum use. When this information is reported, only 5 occurrences per line may be used.
10837	ORD PROV REF ID QUALIFER INVALID	REF01	The qualifier for the ordering provider's secondary identification number information for this line is invalid. Qualifier used to indicate the identification number. *Valid Values:* 0B - State license number 1B - Blue Shield provider number 1C - Medicare provider number 1D - Medicaid provider number ***1G - Provider UPIN number*** 1H - CHAMPUS identification number EI - Employer's Identification Number G2 - Provider commercial number LU - Location number N5 - Provider plan network identification number SY - Social Security Number, this may not be used for Medicare. X5 - State industrial accident provider number
10838	ORD PROV UPIN MISSING	REF02	Ordering provider's secondary identification number (UPIN) is missing for this line.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10839	CANNOT SEND >1 ORD PROV CONT INFO SEG	PER	The segment containing ordering provider contact information exceeds maximum use. When this information is reported, only 1 occurrence per line may be used.
10840	CONTACT FUNCTION CODE INVALID	PER01	The qualifier for the ordering provider contact information for this line is invalid for this line. *Valid Value:* ***IC - Information contact***
10841	ORD PROV CONTACT NAME MISSING	PER02	The ordering provider's contact person's name is missing for this line. A contact name for the ordering provider's must be submitted when reporting ordering provider information for DMERC CMN's.
10842	ORD PROV COMM NBR QUALIFER INVALID	PER03	The qualifier identifying the type of contact information being provided for the ordering provider is invalid for this line. *Valid Values:* EM - Electronic mail FX - Facsimile ***TE - Telephone***
10843	ORD PROV PHONE NUMBER INVALID	PER05	The qualifier identifying the second type of contact information being provided for the ordering provider is invalid for this line. *Valid Values:* EM - Electronic mail EX - Telephone extension FX - Facsimile TE - Telephone
10844	ORD PROV COMM NBR QUALIFER INVALID	PER07	The qualifier identifying the third type of contact information being provided for the ordering provider is invalid for this line. *Valid Values:* EM - Electronic mail EX - Telephone extension FX - Facsimile TE - Telephone

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10845	CANNOT SEND >2 REF PROV NAME SEGMENTS	NM1	The segment providing the referring provider name information for this claim exceeds maximum use. When this information is reported, only 2 occurrences per line may be used. *This information is not used for DMERC.*
10846	DOES NOT EQUAL 'DN'	NM1	The segment providing the referring provider name information for this line is invalid. If used, the first occurrence of the name segment at the line level must contain information on the referring provider. *This information is not used for DMERC.*
10847	DOES NOT EQUAL 'P3'	NM1	The segment providing the referring provider name information for this line is invalid. If used, the second occurrence of the referring provider name segment at the line level must contain information on the primary care provider. *This information is not used for DMERC.*
10848	REF PROV ID CODE INVALID	NM101	The qualifier identifying the referring provider for this line is invalid. *Valid Values:* DN - Referring provider P3 - Primary care provider *This information is not used for DMERC.*
10849	REF PROV NAME QUALIFIER INVALID	NM102	The qualifier identifying the referring provider type is invalid for this line. *Valid Value:* 1 - Person *This information is not used for DMERC.*
10850	REF PROV LAST NAME MISSING	NM103	The last name is missing for this line. If you have specified the referring provider type to be a person, this element must contain the last name of that person. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10851	REF PROV FIRST NAME MISSING	NM104	The first name of the referring provider is missing for this line. If you have specified the referring provider type to be a person, this element must contain the first name of that person. If the referring provider was identified as a non-person entity, this element is not used . *This information is not used for DMERC.*
10852	REF PROV ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the referring provider identification number for this line is invalid. *Valid Values:* 24 - Employer's Identification Number 34 - Social Security Number XX - Health Care Financing Administration National Provider Identifier *This information is not used for DMERC.*
10853	REF PROV CODE MISSING/INVALID	PRV01	The qualifier identifying the type of provider being reported for this line is invalid. *Valid Value:* RF - Referring *This information is not used for DMERC.*
10854	REF PROV SPECIALITY QUALIFIER MISS/INV	PRV02	The qualifier identifying the type of identification number being reported for the referring provider is invalid for this line. *Valid Value:* ZZ - Mutually defined *This information is not used for DMERC.*
10855	CANNOT SEND >1 ADDTL REF PROV NAME SEG	N2	The segment providing additional referring provider name information for this line exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used. *This information is not used for DMERC.*
10856	CANNOT SEND >5 REF PROV 2ND INFO SEG	REF	The segment containing additional referring provider Identification information exceeds maximum use. When this information is reported, only 5 occurrences per line may be used. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10857	REF PROV ID QUALIFIER INVALID	REF01	The qualifier for the referring provider secondary identification number information for this line is invalid. *Valid Values:* 0B - State license number 1B - Blue Shield provider number 1C - Medicare provider number 1D - Medicaid provider number ***1G - Provider UPIN number*** 1H - CHAMPUS identification number EI - Employer's identification number G2 - Provider commercial number LU - Location number N5 - Provider plan network identification number SY - Social Security Number X5 - State industrial accident provider number *This information is not used for DMERC.*
10858	REFERRING PROV UPIN MISSING	REF02	The referring provider secondary identification number is missing for this line. *This information is not used for DMERC.*
10859	CANNOT SEND >4 2420G.NM1 SEGMENTS	NM1	The segment providing the other payer's, who issued the prior authorization or referral number, name information for this line exceeds maximum use. When this information is reported, only 4 occurrences per subscriber may be used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*
10860	ENTITY ID CODE INVALID	NM101	The qualifier identifying the other payer for this transaction is invalid. *Valid Value:* PR - Payer *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10861	OTHER PAY PRIOR AUTH/REFER QUAL INVALID	NM102	The qualifier identifying the other payer type who issued the prior authorization or referral number type is invalid for this line. *Valid Value:* 2 - Non-person entity *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*
10862	PAYOR NAME MISSING	NM103	The company name is missing for this line. If the other payer prior authorization or referral number was identified as a non-person entity, this element must contain the company name. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*
10863	OTHER PAYER ID QUALIFIER INVALID	NM108	The qualifier identifying the other payer prior authorization identification number for this line is invalid *Valid Values:* PI - Payer identification XV - Health Care Financing Administration National Plan Id *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*
10864	CANNOT SEND >2 2420G.REF SEGMENTS	REF	The segment containing the other payer prior authorization or referral number information exceeds maximum use. When this information is reported, only 2 occurrences per line may be used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10865	OTHER PAYER QUALIFIER INVALID	REF01	The qualifier for the other payer prior authorization or referral identification number information for this line is invalid. *Valid Values:* 9F –Referral number G1 - Prior authorization number *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*
10866	CANNOT SEND >25 LINE ADJUD INFO SEGMENTS	SVD	The segment providing the line adjudication information for this line exceeds maximum use. When this information is reported, only 25 occurrences per transaction may be used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10867	DOES NOT EQUAL 2330B.NM109	SVD01	The identification code for line adjudication information is invalid for this line. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10868	PROD/SVC ID QUALIFER INVALID	SVD03-1	The qualifier indicating the line adjudication product or service code is invalid for this line. *Valid Values:* HC - Health Care Financing Administration Common Procedural Coding System (HCPCS) codes IV - Home Infusion EDI Coalition (HIEC) product/service code N1 - National drug code in 4-4-2 format N2 - National drug code in 5-3-2 Format N3 - National drug code in 5-4-1 Format N4 - National drug code in 5-4-2 Format ZZ - Mutually defined *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10869	PAID SVC COUNT MISSING	SVD05	The line adjudication information paid service unit count is invalid for this line. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10870	GROUP ADJ REASON CODE INVALID	CAS01	The qualifier specifying the claim adjustment group code for the adjustments being reported is invalid for this line. *Valid Values:* CO - Contractual obligations CR - Correction and reversals OA - Other adjustments PI - Payer initiated reductions PR - Patient responsibility *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10871	CANNOT SEND >1 2430.DTP SEGMENT	DTP	The segment providing the line adjudication date for this line exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10872	DATE/TIME QUALIFIER INVALID	DTP01	The qualifier for the line adjudication date for this line is invalid. *Valid Value:* ***573 - Date claim paid*** *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10873	DTP FORMAT QUALIFIER INVALID	DTP02	The qualifier indicating the format used to report the line adjudication date for this line is invalid. *Valid Value:* ***D8 - Date expressed in format CCYYMMDD*** *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10874	ADJ OR PMT DATE INVALID	DTP03	The line adjudication or payment date entered is invalid for this line. When entered, this information must be entered in a CCYYMMDD format. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10875	ADJ OR PMT FUTURE DATE INVALID	DTP03	The line adjudication or payment date entered is invalid for this line. When entered, this information must not be greater than today's date. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10876	CANNOT SEND >5 2440.LQ SEGMENTS	LQ	The segment providing the CMN form identification number information for this line exceeds maximum use. When this information is reported, only 5 occurrences per claim may be used.
10877	FORM TYPE CODE INVALID	LQ01	The qualifier identifying the type of form identification code for this line is invalid. *Valid Values:* AS - Form type code ***UT - Health Care Financing Administration (HCFA) Durable Medical Equipment Regional Carrier (DMERC) Certificate of Medical Necessity (CMN) forms***
10878	CERTIFICATE NUMBER MISSING	LQ02	The CMN form identification code is missing for this line.
10879	INV RESPONSE. MUST BE Y, N, W OR BLANK	FRM02	The yes/no value used to respond to the questions requiring a yes/no response on all DMERC CMN's with the exception of CMN Form 484.2 is invalid for this line. *Valid Values:* N - No W - Not applicable Y - Yes
10880	SUPPORT DOC DATE INVALID	FRM04	The date value used to respond to the questions requiring a date response on all DMERC CMN's with the exception of CMN Form 484.2 is invalid for this line. When entered, this information must be entered in a CCYYMMDD format.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10881	SUPPORT DOC FUTURE DATE INVALID	FRM04	The date value used to respond to the questions requiring a date response on all DMERC CMN's with the exception of CMN Form 484.2 is invalid for this line. When entered, this information must not be greater than today's date.
10882	SE02 DOES NOT MATCH ST02	SE02	The ending control number for this transaction set does not match beginning control number for this transaction set. This edit indicates an invalid format and should be resolved by contacting your software vendor.
10883	GE02 DOES NOT MATCH GS02	GE02	The ending control number for this functional group does not match beginning control number for this functional group. This edit indicates an invalid format and should be resolved by contacting your software vendor.
10884	IEA02 DOES NOT MATCH ISA13	IEA02	The ending control number for this interchange does not match beginning control number for this interchange. This edit indicates an invalid format and should be resolved by contacting your software vendor.
10885	PT WEIGHT EXCEEDS MAXIMUM	PAT08	The value entered to indicate the patient weight is invalid. When reporting this value, it cannot exceed 10 positions.
10886	PT WEIGHT EXCEEDS MAX DECIMAL PLACES	PAT08	The value entered to indicate the patient weight is invalid. When this information is reported do not exceed the maximum number of positions to the right of the decimal point.
10887	PT WEIGHT EXCEEDS MAXIMUM	PAT08	The value representing the patient's weight exceeds two positions to the right of the decimal point.
10888	PT WEIGHT CANNOT BE >10 POSITIONS	PAT08	The value entered to indicate the patient weight is invalid. When reporting this value, it cannot exceed 10 positions.
10889	TOT CLM CHG EXCEEDS MAXIMUM	CLM02	The value representing the total claim charge amount exceeds 18 positions.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10890	TOT CLM CHG CANNOT HAVE >2 DEC PLACES	CLM02	The value representing the total claim charge amount exceeds two positions to the right of the decimal point.
10891	CONTRACT AMT EXCEEDS MAXIMUM	CN102	The value representing the contract information amount exceeds 18 positions. *This information is not used for DMERC.*
10892	CONTRACT AMT CANNOT HAVE >2 DEC PLACES	CN102	The value representing the contract Information amount exceeds two positions to the right of the decimal point. *This information is not used for DMERC.*
10893	TERMS DISC PERCENT EXCEEDS MAXIMUM	CN105	The value representing the contract terms discount percent amount exceeds six positions. *This information is not used for DMERC.*
10894	TERMS DISC % CANNOT HAVE >2 DEC PLACES	CN105	The value representing the contract terms discount percent amount exceeds two positions to the right of the decimal point. *This information is not used for DMERC.*
10897	PT PD AMT EXCEEDS MAXIMUM	AMT02	The value representing the patient paid amount for this claim exceeds 18 positions.
10898	PT PD AMT CANNOT HAVE >2 DEC PLACES	AMT02	The value representing the patient paid amount for this claim exceeds two positions to the right of the decimal point.
10899	TOT PURCH SVC AMT EXCEEDS MAXIMUM	AMT02	The value representing the total purchased service amount for this claim exceeds 18 positions.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10900	TOT PURCH SVC AMT CANNOT HAVE >2 DEC	AMT02	The value representing the patient paid amount for this claim exceeds two positions to the right of the decimal point.
10901	PT WEIGHT EXCEEDS MAXIMUM	CR102	The value representing the patient weight exceeds 10 positions. *This information is not used for DMERC.*
10902	PT WEIGHT EXCEEDS MAX DECIMAL PLACES	CR102	The value representing the patient weight exceeds two positions to the right of the decimal point *This information is not used for DMERC.*
10903	TRANSPORT DIST EXCEEDS MAXIMUM	CR106	The value representing the ambulance transport distance exceeds 15 positions. *This information is not used for DMERC.*
10904	TRANSPORT DIST CANNOT HAVE >1 DEC PLACES	CR106	The value representing the ambulance transport distance exceeds 1 position to the right of the decimal point. *This information is not used for DMERC.*
10905	TREATMENT SERIES # EXCEEDS MAXIMUM	CR201	The value representing the number of chiropractic service treatments in the series exceeds 9 positions. *This information is not used for DMERC.*
10906	TREATMENT SERIES # CANNOT HAVE DECIMAL	CR201	The value representing the number of chiropractic service treatments cannot contain a decimal point. *This information is not used for DMERC.*
10907	TREATMENT EXCEEDS MAXIMUM	CR202	The value representing the total number of treatments ordered in this series exceeds 15 positions. *This information is not used for DMERC.*
10908	TREATMENT CNT CANNOT HAVE DECIMAL	CR202	The value representing the total number of treatments ordered in this series cannot contain a decimal point. *This information is not used for DMERC.*
10909	TREATMENT PERIOD CNT EXCEEDS MAXIMUM	CR206	The value representing the treatment series period exceeds 15 positions. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10910	TREATMENT PERIOD CNT CANNOT HAVE DECIMAL	CR206	The value representing the treatment series period cannot contain a decimal point. *This information is not used for DMERC.*
10911	MONTHLY TREAT CNT CANNOT BE >15 POS	CR207	The value representing the spinal manipulation monthly treatment count exceeds 15 positions. *This information is not used for DMERC.*
10912	MONTHLY TREAT CNT CANNOT HAVE DECIMAL	CR207	The value representing the spinal manipulation monthly treatment count cannot contain a decimal. *This information is not used for DMERC.*
10913	ALLOW AMT PRICING EXCEEDS MAXIMUM	HCP02	The value representing the claim repricing allowed amount exceeds 18 positions. *This information is not used for DMERC.*
10914	ALLOW AMT PRICING CANNOT HAVE >2 DEC	HCP02	The value representing the claim repricing allowed amount exceeds two positions to the right of the decimal point. *This information is not used for DMERC.*
10915	SAVINGS AMT PRICING EXCEEDS MAXIMUM	HCP03	The value representing the claim repricing savings amount exceeds 18 positions. *This information is not used for DMERC.*
10916	SAVINGS AMT PRICING CANNOT HAVE >2 DEC	HCP03	The value representing the claim repricing savings amount exceeds two positions to the right of the decimal point. *This information is not used for DMERC.*
10917	PRICING RATE EXCEEDS MAXIMUM	HCP05	The value representing the claim repriced pricing rate exceeds 9 positions. *This information is not used for DMERC.*
10918	PRICING RATE CANNOT HAVE >2 DEC PLACES	HCP05	The value representing the claim repriced pricing rate exceeds two positions to the right of the decimal point. *This information is not used for DMERC.*
10919	APPR APG AMT PRICING EXCEEDS MAXIMUM	HCP07	The value representing the claim repriced approved APG amount exceeds 18 positions. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10920	APPR APG AMT PRICING CANNOT HAVE >2 DEC	HCP07	The value representing the claim repriced approved APG amount exceeds two positions to the right of the decimal point. *This information is not used for DMERC.*
10921	NUMBER OF VISITS EXCEEDS MAXIMUM	HSD02	The value representing the health care services delivery number of visits exceeds 15 positions. *This information is not used for DMERC.*
10922	NUMBER OF VISITS CANNOT HAVE DECIMAL	HSD02	The value representing the health care services delivery number of visits cannot contain a decimal point. *This information is not used for DMERC.*
10923	MODULUS AMT EXCEEDS MAXIMUM	HSD04	The value representing the health care services delivery sampling frequency exceeds six positions. *This information is not used for DMERC.*
10924	MODULUS AMT EXCEEDS MAX DECIMAL PLACES	HSD04	The value representing the health care services delivery sampling frequency exceeds the maximum number of positions to the right of the decimal point. *This information is not used for DMERC.*
10925	ADJ AMOUNT EXCEEDS MAXIMUM	CAS03	The value representing the claim level total adjustment amount exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10926	ADJ AMOUNT CANNOT HAVE >2 DEC PLACES	CAS03	The value representing the claim level total adjustment amount exceeds two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10927	ADJUSTED UNITS EXCEEDS MAXIMUM	CAS04	The value representing the claim level total adjusted units of service exceeds 15 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10928	ADJ UNITS EXCEEDS MAX DECIMAL PLACES	CAS04	The value representing the claim level total adjusted units of service exceeds the maximum number of positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10929	ADJ AMOUNT EXCEEDS MAXIMUM	CAS06	The value representing the claim level adjusted amount exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10930	ADJ AMOUNT CANNOT HAVE >2 DEC PLACES	CAS06	The value representing the claim level adjusted amount exceeds two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10931	ADJUSTED UNITS EXCEEDS MAXIMUM	CAS07	The value representing the claim level adjusted units of service exceeds 15 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10932	ADJ UNITS EXCEEDS MAX DECIMAL PLACES	CAS08	The value representing the claim level adjusted units of service exceeds the maximum number of positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10933	ADJ AMOUNT EXCEEDS MAXIMUM	CAS09	The value representing the claim level adjusted amount exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10934	ADJ AMOUNT CANNOT HAVE >2 DEC PLACES	CAS09	The value representing the claim level adjusted amount exceeds two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10935	ADJUSTED UNITS EXCEEDS MAXIMUM	CAS10	The value representing the claim level adjusted units of service exceeds 15 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10936	ADJ UNITS EXCEEDS MAX DECIMAL PLACES	CAS10	The value representing the claim level adjusted units of service exceeds the maximum number of positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10937	ADJ AMOUNT EXCEEDS MAXIMUM	CAS12	The value representing the claim level adjusted amount exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10938	ADJ AMOUNT CANNOT HAVE >2 DEC PLACES	CAS12	The value representing the claim level adjustment amount exceeds two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10939	ADJUSTED UNITS EXCEEDS MAXIMUM	CAS13	The value representing the claim level adjusted units of service exceeds 15 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10940	ADJ UNITS EXCEEDS MAX DECIMAL PLACES	CAS13	The value representing the Claim level adjusted units of service exceeds the maximum number of positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10941	ADJ AMOUNT EXCEEDS MAXIMUM	CAS15	The value representing the claim level adjusted amount exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10942	ADJ AMOUNT CANNOT HAVE >2 DEC PLACES	CAS15	The value representing the claim level adjusted amount exceeds two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10943	ADJUSTED UNITS EXCEEDS MAXIMUM	CAS16	The value representing the claim level adjusted units of service exceeds 15 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10944	ADJ UNITS EXCEEDS MAX DECIMAL PLACES	CAS16	The value representing the claim level adjusted units of service exceeds the maximum number of positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10945	ADJ AMOUNT EXCEEDS MAXIMUM	CAS18	The value representing the claim level adjusted amount exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10946	ADJ AMOUNT CANNOT HAVE >2 DEC PLACES	CAS18	The value representing the claim level adjusted amount exceeds two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10947	ADJUSTED UNITS EXCEEDS MAXIMUM	CAS19	The value representing the claim level adjusted units of service exceeds 15 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10948	ADJ UNITS EXCEEDS MAX DECIMAL PLACES	CAS19	The value representing the claim level adjusted units of service exceeds the maximum number of positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10949	COB PAYER PD AMT EXCEEDS MAXIMUM	AMT02	The value representing the primary payer paid amount exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10950	COB PAYER PD AMT CANNOT HAVE >2 DEC	AMT02	The value representing the primary payer paid amount exceeds two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10951	COB APPROVED AMT EXCEEDS MAXIMUM	AMT02	The value representing the primary payer approved amount exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10952	COB APPROVED AMT CANNOT HAVE >2 DEC	AMT02	The value representing the primary payer approved amount exceeds two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10953	COB ALLOWED AMT EXCEEDS MAXIMUM	AMT02	The value representing the primary payer allowed amount exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10954	COB ALLOWED AMT CANNOT HAVE >2 DEC	AMT02	The value representing the primary payer allowed amount exceeds two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10955	COB PT RESP AMT EXCEEDS MAXIMUM	AMT02	The value representing the primary payer's patient responsibility amount exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10956	COB PT RESP AMT CANNOT HAVE >2 DEC	AMT02	The value representing the primary payer's patient responsibility amount exceeds 2 positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10957	COB COVERED AMT EXCEEDS MAXIMUM	AMT02	The value representing the primary payer's covered amount exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10958	COB COVERED AMT CANNOT HAVE >2 DEC	AMT02	The value representing the primary payer's covered amount exceeds two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10959	COB DISCOUNT AMT EXCEEDS MAXIMUM	AMT02	The value representing the primary payer's discount amount exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10960	COB DISCOUNT AMT CANNOT HAVE >2 DEC	AMT02	The value representing the primary payer's discount amount exceeds two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10961	COB DAILY LIMIT AMT EXCEEDS MAXIMUM	AMT02	The value representing the primary payer's per day limit amount exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10962	COB DAILY LIMIT AMT CANNOT HAVE >2 DEC	AMT02	The value representing the primary payer's per day limit amount exceeds two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10963	COB PT PD AMT EXCEEDS MAXIMUM	AMT02	The value representing the primary payer's patient paid amount exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10964	COB PT PD AMT CANNOT HAVE >2 DEC	AMT02	The value representing the primary payer's patient paid amount exceeds two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10965	COB TAX AMT EXCEEDS MAXIMUM	AMT02	The value representing the primary payer's tax amount exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10966	COB TAX AMT CANNOT HAVE >2 DEC	AMT02	The value representing the primary payer's tax amount exceeds two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10967	COB TOT CLM B4 TAXES EXCEEDS MAXIMUM	AMT02	The value representing the primary payer's total claim before taxes amount exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10968	COB TOT CLM B4 TAXES CANNOT HAVE >2 DEC	AMT02	The value representing the primary payer's total claim before taxes amount exceeds two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10969	OUTPT REIMB RATE EXCEEDS MAXIMUM	MOA01	The value representing the Medicare outpatient reimbursement rate exceeds 18 positions. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10970	OUTPT REIMB RATE CANNOT HAVE >2 DEC	MOA01	The value representing the Medicare outpatient reimbursement rate exceeds two positions to the right of the decimal point. *This information is not used for DMERC.*
10971	HCPCS PAY AMT EXCEEDS MAXIMUM	MOA02	The value representing the payable amount for this HCPCS code exceeds 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10972	HCPCS PAY AMT CANNOT HAVE >2 DEC	MOA02	The value representing the payable amount for this HCPCS code exceeds two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
10973	ESRD PD AMT EXCEEDS MAXIMUM	MOA08	The value representing the end stage renal disease payment amount exceeds 18 positions. *This information is not used for DMERC.*
10974	ESRD PD AMT CANNOT HAVE >2 DEC	MOA08	The value representing the end stage renal disease payment amount exceeds two positions to the right of the decimal point. *This information is not used for DMERC.*
10975	PROF COMPONENT AMT EXCEEDS MAXIMUM	MOA09	The value representing the non-payable professional component billed amount exceeds 18 positions. *This information is not used for DMERC.*
10976	PROF COMPONENT AMT CANNOT HAVE >2 DEC	MOA09	The value representing the non-payable professional component billed amount exceeds two positions to the right of the decimal point. *This information is not used for DMERC.*
10977	SVC UNIT COUNT EXCEEDS MAXIMUM	SV104	The value representing the number of units exceeds 15 positions.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10978	SVC UNIT COUNT EXCEEDS MAX DECIMAL PLACES	SV104	The value representing the number of units exceeds the maximum number of positions to the right of the decimal point.
10979	PT WEIGHT EXCEEDS MAXIMUM	CR102	The value representing the patient weight for ambulance certification exceeds 10 positions. *This information is not used for DMERC.*
10980	PT WEIGHT EXCEEDS MAX DECIMAL PLACES	CR102	The value representing the ambulance transport distance exceeds two positions to the right of the decimal point. *This information is not used for DMERC.*
10981	TRANSPORT DIST EXCEEDS MAXIMUM	CR106	The value representing the ambulance transport distance exceeds 15 positions. *This information is not used for DMERC.*
10982	TRANSPORT DIST CANNOT HAVE >1 DEC PLACES	CR106	The value representing the ambulance transport distance exceeds 1 position to the right of the decimal point. *This information is not used for DMERC.*
10983	TREATMENT SERIES # EXCEEDS MAXIMUM	CR201	The value representing the chiropractic series treatment number exceeds nine positions. *This information is not used for DMERC.*
10984	TREATMENT SERIES # CANNOT HAVE DECIMAL	CR201	The value representing the chiropractic series treatment number cannot contain a decimal point. *This information is not used for DMERC.*
10985	TREATMENT CNT EXCEEDS MAXIMUM	CR202	The value representing the chiropractic treatment total count exceeds 15 positions. *This information is not used for DMERC.*
10986	TREATMENT CNT CANNOT HAVE DECIMAL	CR202	The value representing the chiropractic treatment total count cannot contain a decimal point. *This information is not used for DMERC.*
10987	TREATMENT PERIOD CNT EXCEEDS MAXIMUM	CR206	The value representing the chiropractic treatment period count exceeds 15 positions. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
10988	TREATMENT PERIOD CNT CANNOT HAVE DECIMAL	CR206	The value representing the chiropractic treatment period count cannot contain a decimal point. *This information is not used for DMERC.*
10989	MONTHLY TREAT CNT EXCEEDS MAXIMUM	CR207	The value representing the chiropractic monthly treatment count exceeds 15 positions. *This information is not used for DMERC.*
10990	MONTHLY TREAT CNT CANNOT HAVE DECIMAL	CR207	The value representing the chiropractic monthly treatment count cannot contain a decimal point. *This information is not used for DMERC.*
10991	MED NECESSITY LENGTH EXCEEDS MAXIMUM	CR303	The length of need as reported on the CMN for this line exceeds 15 positions.
10992	MED NECESSITY LENGTH CANNOT HAVE DEC	CR303	The length of need as reported on the CMN for this line cannot contain a decimal point.
10993	MED NECESSITY LENGTH EXCEEDS MAXIMUM	CR502	The length of need as reported on the oxygen certification form 484.2 exceeds 15 positions.
10994	MED NECESSITY LENGTH CANNOT HAVE DEC	CR502	The length of need as reported on the oxygen certification form 484.2 cannot contain a decimal point.
10995	ABG LEVEL EXCEEDS MAXIMUM	CR510	The value entered as the arterial blood gas quantity as reported on the oxygen certification form 484.2 exceeds 15 positions.
10996	ABG LEVEL CANNOT HAVE >2 DEC PLACES	CR510	The value entered as the arterial blood gas quantity as reported on the oxygen certification form 484.2 cannot exceed two positions to the right of the decimal point.
10997	OX SAT LEVEL EXCEEDS MAXIMUM	CR511	The value entered as the oxygen saturation quantity as reported on the oxygen certification form 484.2 exceeds 15 positions.

10998	OX SAT LEVEL CANNOT HAVE >2 DEC PLACES	CR511	The value entered as the oxygen saturation quantity as reported on the oxygen certification form 484.2 cannot exceed two positions to the right of the decimal point.
10999	ANESTH MODIFYING UNITS EXCEEDS MAXIMUM	QTY02	The value entered as the anesthesia modifying units cannot exceed 15 positions. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11000	ANESTH MODIFYING UNITS EXCEEDS MAX DEC	QTY02	The value entered as the anesthesia modifying units exceeds the maximum number of positions to the right of the decimal point. *This information is not used for DMERC.*
11001	TEST RESULT VALUE EXCEEDS MAXIMUM	MEA03	The test result entered for the ABG or oxygen saturation test as reported on the oxygen certification form 484.2, or the subscriber's height as reported on DMERC CMNs exceeds 20 positions.
11002	TEST RESULT VALUE EXCEEDS MAX DEC	MEA03	The test result entered for the ABG or oxygen saturation test as reported on the oxygen certification form 484.2, or the subscriber's height as reported on DMERC CMNs exceeds the maximum positions to the right of the decimal point.
11003	CONTRACT AMT EXCEEDS MAXIMUM	CN102	The contract amount information at the service line is invalid, this amount cannot exceed 18 positions. *This information is not used for DMERC.*
11004	CONTRACT AMT CANNOT HAVE >2 DEC PLACES	CN103	The contract amount Information at the service line is invalid. This amount cannot exceed two positions to the right of the decimal point. *This information is not used by DMERC.*
11005	TERMS DISC PERCENT EXCEEDS MAXIMUM	CN105	The contract terms discount percent information is invalid. If reported, this amount cannot exceed 6 positions. *This information is not used by DMERC.*
11006	TERMS DISC % CANNOT HAVE >2 DEC PLACES	CN105	The contract terms discount percent information is invalid. If reported, this amount cannot exceed two positions to the right of the decimal point. *This information is not used by DMERC.*
11007	SALES TAX AMT EXCEEDS MAXIMUM	AMT02	The sales tax amount is invalid. If reported, this amount cannot exceed 18 positions. *This information is not used for DMERC.*
11008	SALES TAX AMT CANNOT HAVE >2 DEC PLACES	AMT02	The sales tax amount is invalid. If reported this amount cannot exceed two positions to the right of the decimal point. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11009	APPROVED AMT EXCEEDS MAXIMUM	AMT02	The value entered as the approved amount is invalid. If reported, this amount cannot exceed 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11010	APPROVED AMT CANNOT HAVE >2 DEC PLACES	AMT02	The value entered as the approved amount is invalid. If reported, this amount cannot exceed two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11011	POSTAGE CLMD AMT EXCEEDS MAXIMUM	AMT02	The value entered as the postage claimed amount is invalid. If entered, this amount cannot exceed 18 positions. *This information is not used for DMERC.*
11012	POSTAGE CLMD AMT CANNOT BE >2 DEC	AMT02	The value entered as the postage claimed amount is invalid. If reported this amount cannot exceed two positions to the right of the decimal point. *This information is not used for DMERC.*
11013	PURCH SVC CHG AMT EXCEEDS MAXIMUM	PS102	The value entered as the purchased service charge amount is invalid. If reported, the amount cannot exceed 18 positions. *This information is not used by DMERC.*
11014	PURCH SVC CHG AMT CANNOT HAVE >2 DEC	PS102	The value entered as the purchased service charge amount is invalid. If reported, this amount cannot exceed two positions to the right of the decimal point. *This information is not used by DMERC*.
11015	NBR OF VISITS EXCEEDS MAXIMUM	HSD02	The value entered as the health care services delivery number of visits is invalid. If reported, this amount cannot exceed 15 positions. *This information is not used by DMERC.*
11016	NBR OF VISITS CANNOT HAVE DECIMAL	HSD02	The value entered as the health care services delivery number of visits is invalid. If entered, this amount cannot contain a decimal point. *This information is not used by DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11017	FREQUENCY CNT EXCEEDS MAXIMUM	HSD04	The value entered as the frequency count of the health care services delivery is invalid. If entered, this amount cannot exceed 6 positions. *This information is not used by DMERC.*
11018	FREQUENCY CNT CANNOT HAVE DECIMAL	HSD04	The value entered as the frequency count of the health care services delivery is invalid. If entered, this amount cannot contain a decimal point. *This information is not used by DMERC*.
11019	ALLOW AMT PRICING EXCEEDS MAXIMUM	HCP02	The value entered as the line pricing/repricing information allowed amount is invalid. If entered, this amount cannot exceed 18 positions. *This information is not used by DMERC.*
11020	ALLOW AMT PRICING CANNOT HAVE >2 DEC	HCP02	The value entered as the line pricing/repricing information allowed amount is invalid. If reported, this value cannot exceed two positions to the right of the decimal point. *This information is not used by DMERC.*
11021	SAVINGS AMT PRICING EXCEEDS MAXIMUM	HCP03	The value entered as the line pricing/repricing savings amount information is invalid. If reported, this amount cannot exceed 18 positions. *This information is not used by DMERC.*
11022	SAVINGS AMT PRICING CANNOT HAVE >2 DEC	HCP03	The value entered as the line pricing/repricing savings amount information is invalid. If reported this amount cannot exceed two positions to the right of the decimal point. *This information is not used by DMERC.*
11023	PRICING RATE EXCEEDS MAXIMUM	HCP05	The value entered as the line pricing/repricing rate information is invalid. If reported, this amount cannot exceed 9 positions. *This information is not used by DMERC.*
11024	PRICING RATE CANNOT HAVE >2 DEC PLACES	HCP05	The value entered as the line pricing/repricing rate information is invalid. If reported, this amount cannot exceed two positions to the right of the decimal point. *This information is not used by DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11025	APPR APG AMT PRICING EXCEEDS MAXIMUM	HCP07	The amount entered as the approved APG amount is invalid. If reported, this amount cannot exceed 18 positions. *This information is not used by DMERC.*
11026	APPR APG AMT PRICING CANNOT HAVE >2 DEC	HCP07	The amount entered as the approved APG amount is invalid. If reported, this amount cannot exceed two positions to the right of the decimal point. *This information is not used by DMERC.*
11027	VALUE EXCEEDS MAXIMUM	HCP12	The value entered as the pricing/repricing approved units or inpatient days is invalid. If reported, this amount cannot exceed 15 positions. *This information is not used by DMERC.*
11028	VALUE CANNOT CONTAIN DECIMAL	HCP12	The value entered as the pricing/repricing approved units or inpatient days is invalid. If reported, this amount cannot contain a decimal point. *This information is not used by DMERC.*
11029	SVC LINE PD AMT EXCEEDS MAXIMUM	SVD02	The value entered as the line adjudication service line paid amount is invalid. If reported, this amount cannot exceed 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11030	SVC LINE PD AMT CANNOT HAVE >2 DEC	SVD02	The value entered as the line adjudication service line paid amount is invalid. If reported this amount cannot exceed two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11031	PD SVC CTN EXCEEDS MAXIMUM	SVD05	The value entered as the line adjudication information paid service unit count amount is invalid. If reported, this amount cannot exceed 15 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11032	PD SVC CNT VALUE EXCEEDS MAX DEC PLACES	SVD05	The value entered as the line adjudication Information paid service unit count is invalid. If reported, do not exceed the maximum number of positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11033	ADJ AMOUNT EXCEEDS MAXIMUM	CAS03	The value entered as the line adjustment amount is invalid. If reported, this amount cannot exceed 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11034	ADJ AMOUNT CANNOT HAVE >2 DEC PLACES	CAS03	The value entered as the line adjustment amount is invalid. If reported, this amount cannot exceed two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11035	ADJUSTED UNITS EXCEEDS MAXIMUM	CAS04	The amount entered as the line adjusted unit claim level is invalid. If reported, this amount cannot exceed 15 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11036	ADJ UNITS EXCEEDS MAX DECIMAL PLACES	CAS04	The amount entered as the line adjusted unit claim level is invalid. If reported, do not exceed the maximum number of positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11037	ADJ AMOUNT EXCEEDS MAXIMUM	CAS06	The value entered as the line adjustment amount is invalid. If reported, this amount cannot exceed 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11038	ADJ AMOUNT CANNOT HAVE >2 DEC PLACES	CAS06	The value entered as the line adjustment amount is invalid. If reported, this value cannot exceed two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11039	ADJUSTED UNITS EXCEEDS MAXIMUM	CAS07	The value entered as the line adjustment, adjusted units claim level amount is invalid. If reported, this amount cannot exceed 15 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11040	ADJ UNITS EXCEEDS MAX DECIMAL PLACES	CAS07	The value entered as the line adjustment, adjusted units claim level is invalid. If reported, do not exceed the maximum number of positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11041	ADJ AMOUNT EXCEEDS MAXIMUM	CAS09	The value entered as the line adjustment amount is invalid. If reported, this amount cannot exceed 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11042	ADJ AMOUNT CANNOT HAVE >2 DEC PLACES	CAS09	The value entered as the line adjustment amount is invalid. If reported, this amount cannot exceed two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11043	ADJUSTED UNITS EXCEEDS MAXIMUM	CAS10	The value entered as the line adjustment, adjusted units claim level amount is invalid. If reported, this amount cannot exceed 15 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11044	ADJ UNITS EXCEEDS MAX DECIMAL PLACES	CAS10	The value entered as the line adjustment, adjusted units claim level amount is invalid. If reported, do not exceed the maximum number of positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*
11045	ADJ AMOUNT EXCEEDS MAXIMUM	CAS12	The value entered as the line adjustment amount is invalid. If reported the amount cannot exceed 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*
11046	ADJ AMOUNT CANNOT HAVE >2 DEC PLACES	CAS12	The value entered as the line adjustment amount is invalid. If reported, this amount cannot exceed two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*
11047	ADJUSTED UNITS EXCEEDS MAXIMUM	CAS13	The value entered as the line adjustment, the adjusted units claim level amount is invalid. If entered, this amount cannot exceed 15 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*
11048	ADJ UNITS EXCEEDS MAX DECIMAL PLACES	CAS13	The value entered as the line adjustment, the adjusted units claim level amount is invalid. If reported, do not exceed the maximum number of positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11049	ADJ AMOUNT EXCEEDS MAXIMUM	CAS15	The value entered as the line adjustment amount is invalid. If reported, this amount cannot exceed 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*
11050	ADJ AMOUNT CANNOT HAVE > 2 DEC PLACES	CAS15	The value entered as the line adjustment amount is invalid. If reported, this amount cannot exceed two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is not used for DMERC.*
11051	ADJUSTED UNITS EXCEEDS MAXIMUM	CAS16	The value entered as the line level adjusted units of service amount is invalid. If reported, this amount cannot exceed 15 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11052	ADJ UNITS EXCEEDS MAX DECIMAL PLACES	CAS16	The value entered as the line level adjusted units of service amount is invalid. If reported, do not exceed the maximum number of positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11053	ADJ AMOUNT EXCEEDS MAXIMUM	CAS18	The value entered as the line level adjusted amount is invalid. If reported, this amount cannot exceed 18 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11054	ADJ AMOUNT CANNOT HAVE >2 DEC PLACES	CAS18	The value entered as the line level adjusted amount is invalid. If reported, this amount cannot exceed two positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11055	ADJUSTED UNITS EXCEEDS MAXIMUM	CAS19	The value entered as the line level adjusted units of service is invalid. If reported, this amount cannot exceed 15 positions. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11056	ADJ UNITS EXCEEDS MAX DECIMAL PLACES	CAS19	The value entered as the line level adjusted units of service amount is invalid. If reported, do not exceed the maximum number of positions to the right of the decimal point. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11057	PERCENT EXCEEDS MAXIMUM	FRM05	The value entered as a percentage in response to a question on the CMN sent with this line is invalid. If reported, this amount cannot be greater than six positions.
11058	PERCENT VALUE EXCEEDS MAX DECIMAL PLACES	FRM05-1	The value entered as the line item charge is invalid. This amount cannot have greater than two positions to the right of the decimal.
11059	SVC FAC CITY STATE ZIP MISSING	CLM05-1	If a place of service other than 12-Home is used, the facility city, state, and zip information must be submitted for this claim.
11060	PLACE OF SERVICE ADDRESS MISSING	SV105	If a place of service other than 12-Home is used, the facility address information must be submitted for this line.
11061	FACILITY C/S/Z MISSING	SV105	If a place of service other than 12-Home is used, the facility city, state, and zip information must be submitted for this line.
11062	TRANSACTION /CREATION FUTURE DATE INV	BHT04	The creation date for this transaction set was submitted as a date greater than today's date. This edit indicates an invalid format and should be resolved by contacting your software vendor.
11063	CANNOT SEND >1 RECEIVER NAME SEGMENT	NM1	The segment providing the receiver name information for this transaction exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be sent.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11064	BILLING PROV ADDRESS SEGMENT MISSING	N3	The segment providing the billing provider address for this transaction is missing. When sending billing provider information, you must include address information.
11065	PAY TO PROV ADDR SEGMENT MISSING	N3	The segment providing the pay-to provider address for this transaction is missing. When sending pay-to provider information, you must include address information. *This information is not used for DMERC.*
11066	CANNOT SEND > 1 PAYER NAME SEGMENT	NM1	The segment providing the payer name information for this transaction exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used.
11067	RESP PARTY STREET ADDRESS SEG MISSING	N3	The segment providing the responsibility party address for this line exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used.
11068	RESP PARTY C/S/Z SEG MISSING	N4	Responsibility party city/state/zip segment is missing. If you have indicated the subscriber has a rep payee, this is a required segment.
11069	PATIENT NAME SEGMENT MISSING	NM1	The segment providing the patient's, when other than the subscriber, name information for this transaction exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC.*
11070	PT STREET ADDRESS SEGMENT MISSING	N3	The segment providing the patient, when other than the subscriber, address for this claim is missing. This information is required when reporting patient information when other than subscriber. *This information is not used for DMERC.*
11071	SERVICE FACILITY ADDRESS MISSING	N3	The segment providing the service facility address is missing. If the place of service is other than 12-home, this information is required.
11072	LINE ITEM CHG AMT EXCEEDS MAXIMUM	SV102	The value representing the line item charged amount exceeds 9 positions.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11073	SVCLINE ITEM CHG AMT CANNOT HAVE >2 DEC	SV102	The value entered as the line item charge is invalid. This amount cannot have greater than two positions to the right of the decimal point.
11074	CONTRACT % EXCEEDS MAX DECIMAL PLACES	CN103	The value representing the contract percentage amount is invalid. If reported, do not exceed the maximum number of positions to the right of the decimal point. *This information is not used for DMERC.*
11075	FRM SEGMENT REQUIRED IF CMN LOOP SENT	FRM	You have identified a CMN to be included with this claim line. The FRM segment is a required segment for claim lines that indicate a CMN is attached.
11076	CANNOT SEND >3 PT COND AMB SEGMENTS	CRC	This line exceeds 3 occurrences of the segment containing patient condition information for ambulance services. *This information is not used for DMERC.*
11077	OTHER SUBSCRIBER NAME SEGMENT MISSING	NM1	The segment containing the other subscriber name is missing. If you are sending other subscriber information, this segment is required. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
11078	OTHER PAYER NAME SEGMENT MISSING	NM1	The segment containing the other payer name information is missing for this claim. If you are sending other payer information, this segment is required. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
11079	SVC FACILITY ADDRESS MISSING	N3	The segment containing the service facility or oxygen test facility address is missing for this line. If a place of service other than 12-home was used, or if an oxygen test facility needs to be reported, this segment is required.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11080	OTHER PAYER PRIOR AUTH NUMBER MISSING	REF	The segment containing the other payer prior authorization or referral number is missing for this line. *This information is not used for DMERC.*
11081	LINE ADJUDICATION DATE MISSING	DTP	The line adjudication date segment is missing for this line. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
11082	CANNOT SEND >1 SUBMITTER NAME SEGMENT	NM1	The segment providing the submitter name information for the submitter of this transaction exceeds maximum use. When this information is reported, only 1 occurrence per transaction may be used.
11083	INVALID DATE QUALIFIER ON CLAIM	DTP01	The qualifier used to indicate the date being reported at the claim level is invalid.
11084	INVALID DATE QUALIFIER ON LINE	DTP01	The qualifier used to indicate the date being reported at the line level is invalid.
11085	SVC FACILITY ADDRESS MISSING	CLM05-1	The place of service reported at the claim level requires that a service facility address be included with this claim.
11086	CONTRACT % EXCEEDS MAXIMUM	CN103	Contract percent cannot be greater than 6 positions. *This information is not used for DMERC.*
11087	CONTRACT AMN > 2 DECIMALS	CN103	The value entered as the amount to be the contract amount in invalid. This amount cannot contain more than 2 positions to the right of the decimal point. *This information is not used for DMERC.*
11088	NOT USED		
11089	TOTAL CLAIM CHARGE AMOUNT MISSING	CLM02	The value representing the total claim charges for this claim is missing. This is required information on every DMERC claim.
11090	TRANSPORT DISTANCE MISSING	CR105	The value representing the ambulance transport distance is missing. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11091	TREATMENT PERIOD COUNT MISSING	CR207	The value representing the count of treatments in this period is missing from this claim *This information is not used for DMERC.*
11092	LINE ITEM CHARGE AMOUNT MISSING	SV102	The charge for this line item is missing. For DMERC claims, this is required information.
11093	SERVICE UNIT COUNT MISSING	SV104	The value representing the unit of service is missing for this line. For DMERC claims, this is required information.
11094	TRANSPORT DISTANCE MISSING	CR105	The value representing the ambulance transport distance is missing. *This information is not used for DMERC.*
11095	TREATMENT SERIES TOTAL MISSING	CR202	The total number of treatments in this chiropractic series is missing. *This information is not used for DMERC.*
11096	TREATMENT PERIOD COUNT MISSING	CR206	The time period involved in this chiropractic treatment series is missing. *This information is not used for DMERC.*
11097	MONTHLY TREATMENT COUNT MISSING	CR207	The number of chiropractic treatments rendered in the month of service is missing. *This information is not used for DMERC.*
11098	MEDICAL NECESSITY LENGTH MISSING	CR303	The value indicating the length of need for this line item is missing on this CMN.
11099	MEDICAL NECESSITY LENGTH MISSING	CR502	The value indicating the length of need for oxygen therapy is missing on the oxygen certification form.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11100	ANESTH MODIFYING UNITS MISSING	QTY02	The value representing the anesthesia modifying units is missing on this line. *This information is not used for DMERC.*
11101	TEST RESULT VALUE MISSING	MEA03	The value indicating the results of the oxygen saturation test or ABG test or the patient's height is missing from the CMN.
11102	ALLOW AMOUNT PRICING MISSING	HCP02	The allowed amount by the repricer of this line is missing. *This information is not used for DMERC.*
11103	NOT USED		
11104	CONTRACT % EXCEEDS MAX	CN103	The value entered as the contract percentage amount cannot be greater than 5 positions. *This information is not used for DMERC.*
11105	CONTRACT % EXCEEDS MAX DECIMALS	CN103	The value entered as the line item charge is invalid. This amount cannot have greater than two positions to the right of the decimal. *This information is not used for DMERC.*
11106	CLAIM LEVEL REF QUAL INVALID	REF01	A claim level error occurred due to invalid use of a qualifier identifying the use of a REF segment for this claim. If you receive this error, please contact your software vendor or refer to the 837 Implementation Guide for valid segments to use for this claim.
11107	LINE LEVEL REF QUAL INVALID	REF01	A line level error occurred due to invalid use of a qualifier identifying a REF segment for this line item. If you receive this error, please contact your software vendor or refer to the 837 Implementation Guide for valid REF segments to use for this line.
11108	CLAIM LEVEL AMT QUAL INVALID	AMT01	A claim level error occurred due to invalid use of a qualifier identifying an AMT segment for this claim. If you receive this error, please contact your software vendor or refer to the 837 Implementation Guide for valid AMT segments to use for this claim.
11109	LINE LEVEL AMT QUAL INVALID	AMT01	A line level error occurred due to invalid use of a qualifier identifying an AMT segment for this line. If you receive this error, please contact your software vendor or refer to the 387 Implementation Guide for valid AMT segments to use for this line.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11110	THE FIRST HL01 SEGMENT VALUE MUST = 1	HL01	The billing provider HL segment did not indicate the first HL of this file. If you receive this error, please contact your software vendor.
11111	THE 1ST POSITION OF HL01 MUST BE NUMERIC	HL01	The value entered in the HL element was not a numeric value. If you receive this error, please contact your software vendor.
11112	HL01 SEGMENT MUST BE INCREMENTED BY 1	HL01	The submitted file did not have the HL segments properly sequenced. When submitting the file, please make sure all information is complete. If you receive this error, please contact your software vendor.
11113	DATE OF SERVICE IS MISSING	DTP03	The date of service was missing for this line item. This information is required on every DMERC claim.
11114	INVALID COB AMOUNT QUALIFIER	AMT	A claim level error occurred due to invalid use of a qualifier identifying a COB AMT segment for this claim. If you receive this error, please contact your software vendor or refer to the 837 Implementation Guide for valid COB AMT segments to use for this claim.
11115	INVALID TEST / PROD INDICATOR	ISA15	The file submitted was designated as a production file, the submitter identified is not allowed to submit productions claims at this time.
11116	SERVICE LINE INFORMATION SEG MISSING	SV1	The service line for this claim is missing. A claim line is required for every DMERC claim.
11117	LX NOT INCREMENTED BY 1	LX	The line items submitted in this file were not correctly sequenced. If this error is received, please contact your software vendor.
11118	CREDIT/DEBIT CRDHOLDER NAME QUAL INVALID	NM101	The qualifier identifying the credit or debit cardholder's name for this transaction is invalid. *Valid Values:* AO – Account of *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11119	CREDIT/DEBIT NAME QUALIFIER INVALID	NM102	The qualifier identifying the credit/debit cardholder type is invalid for this transaction. *Valid Values:* 1 – Person 2 – Non Person entity *This information is not used for DMERC.*
11120	CREDIT/DEBIT LAST/ORG NAME MISSING	NM103	The last name or organization name is missing for this transaction. If you have identified the credit/debit cardholder to be a person, this element must contain the last name of that person. If you have identified the credit/debit cardholder to be a non-person entity, this element must contain the company name. *This information is not used for DMERC.*
11121	CREDIT/DEBIT FIRST NAME MISSING	NM104	The first name of the credit/debit cardholder is missing for this transaction. If you have specified the credit/debit cardholder to be a person, this element must contain the first name of that person. *This information is not used for DMERC.*
11122	CREDIT DEBIT ID CODE QUAL INVALID	NM108	The qualifier identifying the credit/debit cardholder's identification number is invalid for this transaction. *Valid Values:* MI – Member Identification Number *This information is not used for DMERC.*
11123	CREDIT/DEBIT NUMBER MISSING	NM109	The credit/debit cardholder's primary identification number is missing for this transaction. *This information is not used for DMERC.*
11124	ADD NAME INFO MISSING	N2	The segment containing additional name information for the credit/debit cardholder is missing. *This information is not used for DMERC.*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11125	ADD CREDIT/DEBIT ID QUAL INVALID	REF01	The qualifier for the credit/debit cardholder's secondary identification number information for this transaction is invalid. *Valid Values:* AB – Acceptable Source Purchaser ID BB – Authorization Number *This information is not used for DMERC.*
11126	AUTHORIZATION NUMBER MISSING	REF02	The secondary identification number for the credit/debit cardholder is missing. *This information is not used for DMERC.*
11127	CREDIT/DEBIT MAX AMT MISSING	AMT02	The value entered as the amount to be credited to the credit/debit account is not numeric. *This information is not used for DMERC.*
11128	DEBIT MAX AMT > 7 DIGITS	AMT02	The value entered as the amount to be credited to the credit/debit account is invalid. This amount cannot be greater than 7 positions. *This information is not used for DMERC.*
11129	DEBIT MAX AMT > 2 DECIMALS	AMT02	The value entered as the amount to be credited to the credit/debit account is invalid. This amount cannot contain more than 2 positions to the right of the decimal point. *This information is not used for DMERC.*
11130	ADMISSION DATE MISSING	DTP03	The admission date for this claim is missing. If you have indicated the place of service to be 21, or you are providing ambulance certification, this is a required element. *This information is not used for DMERC.*
11131	MISSING CLM-11 VALUE	CLM11-1	You have indicated this claim to have been related to an accident by including an accident date. When the accident date is submitted, the related causes code is a required element. *Valid Values:* AA – Auto Accident AP – Another Party Responsible EM – Employment OA – Other Accident

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11132	REND PROV TAXONOMY CODE MISSING	PRV	You have included a rendering provider loop with this claim. When this information is sent, you must included the PRV segment and include the provider's taxonomy code.
11133	PROVIDER SPECIALITY CODE INVALID	PRV03	The billing provider's taxonomy code indicated for this transaction is invalid. Verify the taxonomy code submitted against the taxonomy code list published by Washington Publishing Company. To obtain a copy of this list, visit their Web site at: *www.wpc-edi.com* *This information is not used for DMERC*
11134	RENDERING PROV SPECIALITY CODE INVALID	PRV03	The rendering provider's taxonomy code indicated for this claim is invalid. Verify the taxonomy code submitted against the taxonomy code list published by Washington Publishing Company. To obtain a copy of this list, visit their Web site at: *www.wpc-edi.com* *This information is not used for DMERC*
11135	REFERRING PROV SPECIALITY CODE INVALID	PRV03	The referring provider's taxonomy code indicated for this claim is invalid. Verify the taxonomy code submitted against the taxonomy code list published by Washington Publishing Company. To obtain a copy of this list, visit their Web site at: *www.wpc-edi.com* *This information is not used for DMERC*
11136	RENDERING PROVIDER SPECIALITY INVALID	PRV03	The rendering provider's taxonomy code indicated for this line is invalid. Verify the taxonomy code submitted against the taxonomy code list published by Washington Publishing Company. To obtain a copy of this list, visit their Web site at: *www.wpc-edi.com* *This information is not used for DMERC*
11137	REFERRING PROV SPECIALITY CODE INVALID	PRV03	The referring provider's taxonomy code indicated for this line is invalid. Verify the taxonomy code submitted against the taxonomy code list published by Washington Publishing Company. To obtain a copy of this list, visit their Web site at: *www.wpc-edi.com* *This information is not used for DMERC*
11138	N2 SEGMENT NOT ALLOWED IN X12 VERSION	N2	The segment providing additional name information for the payer of this transaction is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11139	N2 SEGMENT NOT ALLOWED IN X12 VERSION	N2	The segment providing additional name information for the responsible party for this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor.
11140	N2 SEGMENT NOT ALLOWED IN X12 VERSION	N2	The segment providing additional name information for the credit/debit card holder name for this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor.
11141	N2 SEGMENT NOT ALLOWED IN X12 VERSION	N2	The segment providing additional name information for the patient of this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11142	X-RAY AVAIL. IND MUST = Y, N, OR ‘ ‘	N2	The segment providing additional name information for the referring provider for this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11143	N2 SEGMENT NOT ALLOWED IN X12 VERSION	N2	The segment providing additional name information for the rendering provider for this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11144	N2 SEGMENT NOT ALLOWED IN X12 VERSION	N2	The segment providing additional name information for the service facility location for this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11145	N2 SEGMENT NOT ALLOWED IN X12 VERSION	N2	The segment providing additional name information for the supervising provider for this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11146	N2 SEGMENT NOT ALLOWED IN X12 VERSION	N2	The segment providing additional name information for the other subscriber for this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11147	N2 SEGMENT NOT ALLOWED IN X12 VERSION	N2	The segment providing additional name information for the other payer for this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor.
11148	N2 SEGMENT NOT ALLOWED IN X12 VERSION	N2	The segment providing additional name information for the rendering provider for this line is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11149	N2 SEGMENT NOT ALLOWED IN X12 VERSION	N2	The segment providing additional name information for the service facility location for this line is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor.
11150	N2 SEGMENT NOT ALLOWED IN X12 VERSION	N2	The segment providing additional name information for the supervising provider for this line is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11151	N2 SEGMENT NOT ALLOWED IN X12 VERSION	N2	The segment providing additional name information for the ordering provider for this line is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11152	N2 SEGMENT NOT ALLOWED IN X12 VERSION	N2	The segment providing additional name information for the referring provider for this line is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11153	SUBS. WEIGHT QUAL INVALID IN X12 VERSION	PAT07	The code used to indicate the measurement of the patient's weight is invalid for this claim. This is used to report the subscriber's weight on DMERC CMN forms 2.03 and 10.02. *Valid Value:* ***01 – Actual Pounds***
11154	WGT MEAS QUAL REQ WHEN WEIGHT PRESENT	PAT07	The code used to indicate the measurement of the patient's weight is missing for this claim. If the subscriber's weight is reported, this is a required element. *Valid Value:* ***01 – Actual Pounds***
11155	SUBSCRIBER WEIGHT MISSING	PAT08	The value entered to represent the subscriber's weight is invalid. When entered, this value must be a numeric value greater than 0.
11156	PAT. WEIGHT QUAL INVALID IN X12 VERSION	PAT07	The code used to indicate the measurement of the patient's weight is invalid for this claim. This is used to report the patient's weight on DMERC CMN forms 2.03 and 10.02. *Valid Value:* 01 – Actual Pounds *This information is not used for DMERC*
11157	WGT MEAS QUAL REQ WHEN WEIGHT PRESENT	PAT07	The code used to indicate the measurement of the patient's weight is missing for this claim. If the patient's weight is reported, this is a required element. *Valid Value:* 01 – Actual Pounds *This information is not used for DMERC*
11158	PATIENT WEIGHT MISSING	PAT08	The value entered as the patient's weight for this claim is invalid. When reported, this value must be numeric and greater than zero. *This information is not used for DMERC*
11159	DTP ORDER DATE NOT ALLOWED IN X12 VERSION	DTP	The segment providing the order date for this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11160	DTP REF DATE NOT ALLOWED IN X12 VERSION	DTP	The segment providing the referral date for this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor.
11161	DTP EST BIRTH DTE NOT ALLOWED IN X12 VER	DTP	The segment providing the estimated date of birth for this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor.
11164	RELATED CAUSE 2 CDE INVALID FOR X12 VERS	CLM11-2	The second related causes code entered for this claim is invalid. *Valid Values:* AA – Auto Accident AP – Another Party Responsible EM- Employment OA – Other Accident
11165	RELATED CAUSE 3 CDE INVALID FOR X12 VERS	CLM11-3	The third related causes code entered for this claim is invalid. *Valid Values:* AA – Auto Accident AP – Another Party Responsible EM- Employment OA – Other Accident
11166	REQ IF MODIFIER EQ RR NU OR UE-RENT/PRCH	SV5	You have included the durable medical equipment service segment and the procedure code for which payment is being requested does not contain a rental or purchase modifier (RR, NU, or UE). *This information is not used for DMERC*
11167	SPINAL MANIP TREAT # NOT USED IN X12 VER	CR201	The treatment service number included with this claim in invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11168	SPINL MANIP TREAT CNT NOT USD IN X12 VER	CR202	The spinal manipulation treatment count included with this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11169	SUBLUX LVL CODE 1 NOT USED IN X12 VERS	CR203	The subluxation level code included with this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11170	SUBLUX LVL CODE 2 NOT USED IN X12 VERS	CR204	The subluxation level code included with this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11171	CHIRO TREAT. TIME QUAL NOT USED X12 VERS	CR205	The unit or basis for measurement code with this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11172	TREAT PERIOD COUNT NOT USED IN X12 VERS	CR206	The treatment period count included for this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11173	MO NBR CHIRO TREAT NOT USED IN X12 VERS	CR207	The monthly treatment count included with this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11174	CHIRO COMPL CODE NOT USED IN X12 VERS	CR209	The complication indicator included with this claim is invalid. This edit indicates and invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11175	SPINAL MANIP TREAT # NOT USED IN X12 VERS	CR201	You have included a spinal manipulation service count for this line. This information is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11176	SPINL MANIP TREAT TOT NOT USED IN X12 VERS	CR202	You have included a spinal manipulation service quantity for this line. This information is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11177	SUBLUX LVL CODE 1 NOT USED IN X12 VERS	CR203	You have included a spinal manipulation subluxation level code for this line. This information is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11178	SUBLUX LVL CODE 2 NOT USED IN X12 VERS	CR204	You have included a spinal manipulation subluxation level code for this line. This information is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11179	CHIRO TREAT TIME QUAL NOT USED IN X12 VERS	CR205	You have included a spinal manipulation unit code for this line. This information is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11180	TREAT PERIOD COUNT NOT USED IN X12 ERS	CR206	You have included the time period involved in this chiropractic treatment series. This information is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11181	MO NBR CHIRO TREAT NOT USED IN X12 VERS	CR207	You have included the number of chiropractic treatments rendered in the month. This information is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11182	CHIRO COMPL CODE NOT USED IN X12 VERS	CR209	You have included the value representing spinal manipulation complications for this line. This information is invalid This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11184	EPSDT SEG EXC MAX USE	CRC	The segment containing Early and Periodic Screening , Diagnosis and Treatment (EPSDT) claims information exceeds maximum use. When this information is reported, only 1 occurrence per claim may be used. *This information is not used for DMERC*
11185	EPSDT COND CODE INVALID	CRC02	The qualifier indicating an EPSDT referral was given to the patient is invalid. *Valid Values:* N – No Y – Yes *This information is not used for DMERC.*
11186	EPSDT COND REAS 1 INVALID	CRC03	The qualifier indicating the type of EPSDT referral is invalid for this claim. *Valid Values:* AV – Available Not Used The patient refused referral NU – Not used This indicator must be used when the submitter answers “N” in CRC02 S2 – Under Treatment ST – New Services Requested *This information is not used for DMERC*
11187	COND IND MUST BE ‘NU’ WHEN NO REF. GIVEN	CRC03	You have indicated an EPSDT referral was not given to this patient, however the value used to indicate an EPSDT was not used is missing from this claim. *This information is not used for DMERC*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11188	EPSDT COND REAS 2 INVALID	CRC04	The qualifier indicating the type of EPSDT referral is invalid for this claim. *Valid Values:* AV – Available Not Used The patient refused referral NU – Not used This indicator must be used when the submitter answers "N" in CRC02 S2 – Under Treatment ST – New Services Requested *This information is not used for DMERC*
11189	EPSDT COND REAS 3 INVALID	CRC05	The qualifier indicating the type of EPSDT referral is invalid for this claim. *Valid Values:* AV – Available Not Used The patient refused referral NU – Not used This indicator must be used when the submitter answers "N" in CRC02 S2 – Under Treatment ST – New Services Requested *This information is not used for DMERC*
11190	SV4 SEGMENT NOT ALLOWED IN X12 VERSION	SV4	The segment providing drug service information for this line is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11191	PROD/SER ID QUALIFIER INVALID	SV501-1	The qualifier indicating the type of product/service code used for this line is invalid. *Valid Value:* HC – Health care Financing Administration Common Procedural Coding System (HCPCS) Codes *This information is not used for DMERC*
11192	SV5 PROC CODE NOT EQ TO SV101 PROC CODE	SV501-2	The HCPCS code listed in the durable medical equipment service segment does not match the HCPCS code listed in the professional service segment on this claim line. *This information is not used for DMERC*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11193	BASIS FOR MEASUREMENT CODE INVALID	SV502	The qualifier identifying the type of service units being reported is invalid for the durable medical equipment service segment. *Valid Value:* DA – Days *This information is not used for DMERC*
11195	DME RENTAL AND PURCH AMT MISSING	SV504	The DME rental price is missing from this Durable Medical Equipment segment. As a DME purchase price was not provided, this is a required element when this segment is used. *This information is not used for DMERC*
11196	DME RENT BILL FREQ MISSING RENTAL AMT	SV504	You have included a rental unit price indicator to indicate the frequency at which the rental equipment is billed, however, a DME rental price was not included in the Durable Medical Equipment segment. *This information is not used for DMERC*
11197	DMERENTAL AMOUNT INVALID	SV504	The DME Rental Price being reported is invalid. When used, this information must contain numeric values only. *This information is not used for DMERC*
11198	DME RENTAL PRICE EXCEEDS MAXIMUM	SV504	The value representing the DME Rental price reported amount exceeds 18 positions. *This information is not used for DMERC*
11199	DME RENT PRC CANNOT HAVE > 2 DEC PLACES	SV504	The value representing the DME rental price reported exceeds two positions to the right of the decimal point. *This information is not used for DMERC*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11200	DME PURCHASE AMOUNT INVALID	SV505	The DME purchase price being reported is invalid. When used, this information must contain numeric values only. *This information is not used for DMERC*
11201	DME PURCH PRICE EXCEEDS MAXIMUM	SV505	The value representing the DME purchase price reported exceeds 18 positions. *This information is not used for DMERC*
11202	DME PURCH PRC CANNOT HAVE >2 DEC PLACES	SV505	The value representing the DME purchase price reported exceeds two positions to the right of the decimal point. *This information is not used for DMERC*
11203	DME RENTAL FREQUENCY CODE INVALID	SV506	The qualifier used to indicate the rental unit price indicator for this line is invalid. *Valid Values:* 1 – Weekly 4 – Monthly 6 – Daily *This information is not used for DMERC*
11205	FIRST NAME REQ IF PRCH SER PRV IS PERSON	NM104	The first name of the Purchased Service Provider is missing for this claim. If you have specified the Purchased Service Provider to be a person, this element must contain the first name of that person. If the Purchases Service Provider was identified as a non-person entity, this element is not used. *This information is not used for DMERC*
11206	PAYOR LAST/ORG NAME NOT USED IN X12 VERS	NM103	You have included the other payer's referring provider last name or organization name with this claim. This information is invalid for this claim. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11207	PAYOR LAST/ORG NAME NOT USED IN X12 VERS	NM103	You have included the other payer's rendering provider last name or organization name with this claim. This information is invalid for this claim. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11208	PAYOR LAST/ORG NAME NOT USED IN X12 VERS	NM103	You have included the other payer's purchased service provider last name or organization name with this claim. This information is invalid for this claim. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11209	PAYOR LAST/ORG NAME NOT USED IN X12 VERS	NM103	You have included the other payer's service facility last name or organization name with this claim. This information is invalid for this claim. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11210	PAYOR LAST/ORG NAME NOT USED IN X12 VERS	NM103	You have included the other payer's supervising provider last name or organization name with this claim. This information is invalid for this claim. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11211	PROD/SER ID QUALIFIER INVALID	SV101-1	The qualifier indicating the type of product/service code used for this line is invalid. *Valid Values:* ***HC – Health Care Financing Administration Common Procedural coding System Codes*** ***ZZ – Mutually defined***
11212	EMERGENCY INDICATOR INVALID	SV109	The qualifier indicating emergency services for this line is invalid. *Valid Value:* ***Y – Yes***
11213	DTP ORDER DATE NOT ALLOWED IN X12 VERS	DTP	The segment providing the order date for this line is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11214	DTP REFERRAL DATE NOT ALLOWED IN X12 VER	DTP	The segment providing the referral date for this line is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11215	QTY SEGMENT NOT ALLOWED IN X12 VERSION	QTY	The segment providing the anesthesia modifying units for this line is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11216	MEASUREMENT QUALIFIER INVALID	MEA	The qualifier identifying the test results or patient's height being reported for this line is invalid. *Valid Values:* GRA – Gas test rate HT – Height R1 – Hemoglobin R2 – Hematocrit R3 – Epoetin starting dosage R4 – Creatin ZO – Oxygen (used to report the oxygen saturation test results when tested on 4 LPM for DMERC Form 484.2)
11217	PROD/SVC ID QUALIFIER MISSING/INVALID	SVD03-1	The qualifier indicating the line adjudication product or service code is invalid for this line. *Valid Values:* HC – Health Care Financing Administration Common Procedural Coding System (HCPCS) codes ZZ – Mutually defined
11218	SV5 SEGMENT EXCEEDS MAXIMUM USE	SV5	The segment providing durable medical equipment service information for this line exceeds maximum use. When this information is reported, only I occurrence per claim line may be used. *This information is not used for DMERC*
11219	2410-LIN INVALID FOR X12 VERSION	LIN	The segment providing drug identification information for this line is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11220	LIN DRUG ID SEGMENT EXC MAX USE	LIN	The segment providing the drug identification information exceeds maximum use. When this information is reported, when this information is reported, no more than 25 occurrences per claim line may be used.
11221	PROD/SER ID QUALIFIER INVALID	LIN02	The qualifier indicating the type of product/service code used for this line is invalid. *Valid Value:* ***N4 – National Drug Code in 5-4-2 format***
11222	PROD/SERVIC E ID MISSING	LIN03	The national drug code being reported in this segment is missing. When this segment is sent, this is a required element.
11223	2410-CTP INVALID FOR X12 VERSION	CTP	The segment providing the drug pricing information for this line is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11224	DRUG UNIT PRICE INVALID	CTP03	The drug unit price for this claim line is invalid. When reported, this element must contain a numeric value. *This information is not used for DMERC*
11225	DRUG UNIT PRICE EXCEED MAXIMUM	CTP03	The drug unit price for this claim line exceeds 18 positions. *This information is not used for DMERC*
11226	DRUG UNIT PRC CANNOT HAVE >2 DEC PLACES	CTP03	The drug unit price for this claim line exceeds two positions to the right of the decimal point. *This information is not used for DMERC*
11227	DRUG QUANTITY INVALID	CTP04	The national drug unit count amount submitted with this claim line is invalid. When reported, this element must contain a numeric value. *This information is not used for DMERC*
11228	DRUG QUANTITY EXCEEDS MAXIMUM	CTP04	The national drug unit count amount exceeds15 positions. *This information is not used for DMERC*

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11229	DRUG QUANTITY INVALID DECIMAL FORMAT	CTP04	The national drug unit count amount exceeds two positions to the right of the decimal point. *This information is not used for DMERC*
11230	UNIT/MEASUREMENT QUALIFIER INVALID	CTP05-1	The qualifier identifying the type of service units being reported is invalid for this claim line. *Valid Values:* F2 – International unit GR – Gram ML – Milliliter UN – Unit *This information is not used for DMERC.*
11231	DRUG LOOP 2410 REF ID QUALIFIER INVALID	REF01	The qualifier indicating the type of prescription number for this claim line is invalid. *Valid Value:* XZ – Pharmacy Prescription Number *This information is not used for DMERC*
11232	REFERENCE IDENTIFICATION MISSING	REF02	The prescription number is missing for this claim line. When the prescription number segment is used, this is a required element. *This information is not used for DMERC*
11236	2410-REF INVALID FOR X12 VERSION	REF	The segment providing the prescription number for this line is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor. *This information is not used for DMERC*
11247	REF SEGMENT EXCEEDS MAXIMUM USE	REF	The segment containing prescription number information exceeds maximum use. When this information is reported, only 1 occurrence per line may be used. *This information is not used for DMERC*
11255	N2 SEGMENT NOT ALLOWED IN X12 VERSION	N2	The segment providing additional name information for the pay-to-provider of this transaction in invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor.

Edit Number	Edit Description	Element/ Segment ID	Edit Explanation
11256	N2 SEGMENT NOT ALLOWED IN X12 VERSION	N2	The segment providing additional name information for the subscriber for this claim is invalid. This edit indicates an invalid format and should be resolved by contacting your software vendor.
11257	LENGTH MEDICAL NECESS EXCEEDS MAXIMUM	SV503	The value representing the number of days being reported as the length of medical necessity exceeds 15 positions. *This information is not used for DMERC*
11258	LENGTH MED NECESSITY INV DECIMAL FORMAT	SV503	The value representing the number of days being reported as the length of medical necessity exceeds the maximum number of positions to the right of the decimal point. *This information is not used for DMERC*
11259	NDC CODE MISSING	LIN	You have indicated this claim line to have a National Drug Code (NDC) associated with it, however the segment used to provide the NDC is missing.

Chapter Eight:

Front-End Edits – Medicare

Introduction

Front-end edits are broken down into three categories or levels. It is important to understand the differences between these levels to determine error resolution. In addition to Medicare specific and DMERC specific edits, CMS has required us to add Implementation Guide (IG) edits, to ensure electronic files meet the HIPAA standard. The IG edits and descriptions are contained in Chapter 7. The Medicare edits are included in this chapter and the DMERC-specific edits and descriptions are contained in Chapter 9.

To allow you to quickly identify the level in which the error occurred, the edits are numbered as follows:

10XXX - **Implementation Guide edits**

20XXX - **Medicare-specific edits**

40XXX - **DMERC-specific edits**

The Medicare edits are designed to make sure that valid Medicare data is being transmitted in order to properly adjudicate the electronic claims. These edits will only perform data validation to ensure we have the data required to process a Medicare claim.

Since this level of editing is validating against the Medicare data requirements, we have listed all valid Medicare values under the valid value section of each edit. In an effort to prevent future edits from occurring at the DMERC level, we have ***bolded and italicized*** the valid DMERC values that may be used for that element.

For your convenience, we have indicated data elements in this section that are not used for DMERC. If you receive an edit on data that is not used for DMERC, and the information is not needed for another payer, please remove the erroneous data and resubmit the file. If the data is needed for another payer, please correct the claim and retransmit.

We have also noted those elements that contain data specific to Medicare Secondary Payer, Medigap, and Payer-to-Payer transactions. These elements should not be used unless the specific condition is met. Payer-to-Payer elements should never be submitted to DMERC by a supplier.

Key to Manual:

NOT USED = These edits are currently not used but may be added at a later date.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20001	INTERCHANGE ID QUALIFIER INVALID	ISA07	The qualifier indicating the receiver of this interchange is invalid. *Valid Values:* ***27 - Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)***
20002	INTERCHANGE RECEIVER ID INVALID	ISA08	The Interchange Control Receiver number is invalid. This must be a valid Carrier ID assigned by the Health Care Financing Administration (HCFA). *Valid DMERC Carrier Code:* 05655 - Region D
20003	TEST/PRODUCTION INDICATOR INVALID	ISA15	The test/production indicator for this interchange is invalid. *Valid Values:* P - Production T - Test
20004	SUBMITTER ID INVALID	NM109	The submitter identification number indicated for this transaction is invalid. Verify the submitter identification number reported is the number you were assigned by the EDI Department and not the National Supplier Clearinghouse or the Provider Enrollment Department.
20005	PROVIDER SPECIALTY CODE INVALID	PRV03	The billing provider's taxonomy code indicated for this transaction is invalid. Verify the taxonomy code submitted against the taxonomy code list published by Washington Publishing Company. To obtain a copy of this list visit their Web site at: *www.wpc-edi.com*.
20006	BILLING PROVIDER STATE INVALID	N402	The state abbreviation, indicated in this transaction for the billing provider state, is not a valid two character state abbreviation code.
20007	BILLING PROVIDER ZIP CODE INVALID	N403	The zip code indicated in this transaction for the billing provider's address was reported in an invalid format. Verify the zip code contains only numeric data and is not all zeros or all nines and is either five or nine digits in length.
20008	BILLING PROVIDER COUNTRY CODE INVALID	N404	The country code indicated in this transaction for the billing provider's address is not a valid country code.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20009	BILLING PROVIDER MEDICARE ID MISSING	REF01	The qualifier for the billing provider's secondary identification number (supplier number) information for this transaction is missing. *Valid Value:* ***1C - Medicare provider number***
20010	BILLING PROVIDER SECONDARY ID INVALID	REF02	The secondary identification number indicated in this transaction for the billing provider is invalid. Verify the number entered is a valid supplier number as assigned by the National Supplier Clearinghouse.
20011	BILLING PROVIDER SECONDARY ID INVALID	REF02	The supplier number indicated in this transaction for the billing provider is not currently authorized to bill electronically and/or we do not have an EDI Enrollment form on file.
20012	PAY-TO PROVIDER STATE CODE INVALID	N402	The state abbreviation indicated in this transaction for the pay-to provider, state is not a valid two character state abbreviation code. *This information is not used for DMERC.*
20013	PAY-TO PROVIDER ZIP CODE INVALID	N403	The zip code indicated in this transaction for pay-to provider address was reported in an invalid format. Verify the zip code contains only numeric data and is not all zeros or all nines and is either five or nine digits in length. *This information is not used for DMERC.*
20014	PAY-TO PROVIDER COUNTRY CODE INVALID	N404	The country code indicated in this transaction for the pay-to provider's address is not a valid country code. *This information is not used for DMERC.*
20015	PAY-TO PROV. ID CODE QUALIFIER INVALID	REF01	The qualifier for the pay-to provider's secondary identification number information for this transaction is invalid. *Valid Value:* 1C - Medicare provider number *This information is not used for DMERC*
20016	PAY-TO PROVIDER SECONDARY ID INVALID	REF02	The secondary identification number indicated in this transaction for the pay-to provider is invalid. Verify the number entered is a valid supplier number as assigned by the National Supplier Clearinghouse. *This information is not used for DMERC*

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20017	PAY-TO PROVIDER SECONDARY ID INVALID	REF02	The secondary identification number indicated in this transaction for the pay-to provider is not currently authorized to bill electronically and/or we do not have an EDI Enrollment form on file. *This information is not used for DMERC*
20018	SUBSCRIBER INSURED GROUP NAME MISSING	SBR04	You have indicated there is a primary payer other than Medicare for this subscriber by entering a group or policy number and leaving the group or plan name blank. You must include a group or plan name when reporting this information.
20019	CLAIM FILLING INDICATOR CODE INVALID	SBR09	The qualifier used to identify the claim filing indicator for this subscriber is invalid. *Valid Value:* ***MB - Medicare Part B***
20020	PATIENT WEIGHT INVALID	PAT08	The amount entered for the patient weight for this subscriber is invalid
20021	SUBSCRIBER LAST NAME INVALID	NM103	The subscriber's last name was entered in an invalid format. Verify the first position of the subscriber's last name is an alpha character and does not contain spaces. Make sure the first three positions of the subscriber's last name are not any of the following: MR., MR, DR, DR., JR or JR..
20022	SUBSCRIBER FIRST NAME INVALID	NM104	The subscriber's first name was entered in an invalid format. Verify the first position of the subscriber's first name does not contain a space and the name only contains alpha characters.
20023	SUBSCRIBER MIDDLE NAME INVALID	NM105	The subscriber's middle name was entered in an invalid format. Verify only alpha characters are present.
20024	SUBSCRIBER ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the subscriber identification number for this claim is invalid. *Valid Value:* ***MI - Member Identification Number***

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20025	SUBSCRIBER ID CODE INVALID	NM109	The subscriber's Health Insurance Claim Number (HICN) indicated for this claim was entered in an invalid format. Verify the HICN was entered exactly as it appears on the Medicare beneficiary's red, white and blue Medicare card.
20026	SUBSCRIBER ADDRESS1 INVALID	N301	The subscriber's address listed on this claim was entered in an invalid format. Verify the first position of the address information does not contain a space.
20027	SUBSCRIBER ADDRESS2 INVALID	N302	The subscriber's additional address information listed on this claim was entered in an invalid format. Verify the first position of the additional address information does not contain a space.
20028	SUBSCRIBER CITY NAME INVALD	N401	The city indicated on this claim for the subscriber's city is invalid. Verify the first position of the name of the city does not contain a space.
20029	SUBSCRIBER STATE CODE INVALID	N402	The state abbreviation indicated on this claim for the subscriber state is not a valid two character state abbreviation code.
20030	SUBSCRIBER ZIP CODE INVALID	N403	The zip code indicated on this claim for the subscriber's address was reported in an invalid format. Verify the zip code contains only numeric data and is not all zeros or all nines and is either five or nine digits in length.
20031	SUBSCRIBER COUNTRY CODE INVALID	N404	The country code indicated on this claim for the subscriber's address is not a valid country code.
20032	SUBSCRIBER BIRTH DATE INVALID	DMG02	The subscriber's date of birth indicated on this claim is invalid. Verify the date is not greater than today's date and that the century was entered as either 18, 19, or 20.
20033	SUBSCRIBER GENDER CODE INVALID	DMG03	The subscriber's sex code indicated on this claim is invalid. *Valid Values:* M - Male F - Female
20034	PAYOR ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the payer's identification number for this claim is invalid. *Valid Value:* ***PI - Payor Identification***

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20035	PAYOR ADDRESS1 INVALID	N301	The payer's address listed on this claim was entered in an invalid format. Verify the first position of the address information does not contain a space.
20036	PAYOR STATE CODE INVALID	N402	The state abbreviation indicated on this claim for the payer's state is not a valid two character state abbreviation code.
20037	PAYOR ZIP CODE INVALID	N403	The zip code indicated on this claim for the payer's address was reported in an invalid format. Verify the zip code contains only numeric data and is not all zeros or all nines and is either five or nine digits in length.
20038	PAYOR COUNTRY CODE INVALID	N404	The country code indicated on this claim for the payer's address is not a valid country code.
20039	RESPONSIBLE PARTY LAST NAME INVALID	NM103	The responsible party's last name was entered in an invalid format. Verify the first position of the responsible party's last name is an alpha character and does not contain spaces. Make sure the first three positions of the responsible party's last name are not any of the following: MR, MR., DR, DR., JR or JR..
20040	RESPONSIBLE PARTY FIRST NAME INVALID	NM104	The responsible party's first name was entered in an invalid format. Verify the first position of the responsible party's first name does not contain a space and the name only contains alpha characters.
20041	RESPONSIBLE PARTY MIDDLE NAME INVALID	NM105	The responsible party's middle name was entered in an invalid format. Verify only alpha characters are present.
20042	RESPONSIBLE PARTY ADDESS1 INVALID	N301	The responsible party's address listed on this claim was entered in an invalid format. Verify the first position of the address information does not contain a space.
20043	RESPONSIBLE PARTY ADDRESS2 INVALID	N302	The responsible party's additional address information listed on this claim was entered in an invalid format. Verify the first position of the address information does not contain a space.
20044	RESONSIBLE PARTY CITY NAME INVALID	N401	The city indicated on this claim for the responsible party's city is invalid. Verify the first position of the name of the city does not contain a space.
20045	RESPONSIBLE PARTY STATE CODE INVALID	N402	The state abbreviation, indicated on this claim, for the responsible party state is not a valid two character state abbreviation code.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20046	RESPONSIBLE PARTY ZIP CODE INVALID	N403	The zip code indicated on this claim for the responsible party's address was reported in an invalid format. Verify the zip code contains only numeric data and is not all zeros or all nines and is either five or nine digits in length.
20047	RESPONSIBLE PARTY COUNTRY CODE INVALID	N404	The country code indicated on this claim for the responsible party's address is not a valid country code.
20048	PATIENT WEIGHT INVALID	PAT08	The amount entered for the patient, when other than the subscriber, weight is invalid. *This information is not used for DMERC.*
20049	PATIENT STATE CODE INVALID	N402	The state abbreviation indicated on this claim for the patient is not a valid two character state abbreviation code.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20050	PATIENT COUNTRY CODE INVALID	N404	The country code indicated on this claim for the patient's address is not a valid country code.
20051	TOTAL CLAIM CHARGE AMOUNT INVALID	CLM02	The total claim charge amount is invalid. Verify the sum of all line item charges equal the total claim charge submitted with this claim.
20052	CLAIM FREQUENCY TYPE CODE INVALID	CLM05-3	The type of claim being sent is invalid. *Valid Values:* ***1 - Original*** 7 - Replacement
20053	AUTO ACCIDENT STATE CODE INVALID	CLM11-4	The state abbreviation indicated on this claim for the auto accident state is not a valid two character state abbreviation code.
20054	COUNTRY CODE INVALID	CLM11-5	The auto accident country code is invalid.
20055	ACCIDENT DATE MISSING	DTP	This claim indicates there was an automobile accident, abuse, another responsible party or some other accident involved and the date of that occurrence was not reported.
20056	PATIENT AMOUNT PAID INVALID	AMT02	The amount entered on this claim as the amount the patient paid is invalid. Verify the amount that was entered as what the patient paid does not exceed the total amount of the claim.
20057	DIAGNOSIS 1 INVALID	HI01-2	The first diagnosis code indicated on this claim is invalid. Verify the diagnosis code submitted on this claim is a valid ICD-9 diagnosis code.
20058	DIAGNOSIS 2 INVALID	HI02-2	The second diagnosis code indicated on this claim is invalid. Verify the diagnosis code submitted on this claim is a valid ICD-9 diagnosis code.
20059	DIAGNOSIS 3 INVALID	HI03-2	The third diagnosis code indicated on this claim is invalid. Verify the diagnosis code submitted on this claim is a valid ICD-9 diagnosis code.
20060	DIAGNOSIS 4 INVALID	HI04-2	The fourth diagnosis code indicated on this claim is invalid. Verify the diagnosis code submitted on this claim is a valid ICD-9 diagnosis code.
20061	DIAGNOSIS 5 INVALID	HI05-2	The fifth diagnosis code indicated on this claim is invalid. Verify the diagnosis code submitted on this claim is a valid ICD-9 diagnosis code. *This information is not used for DMERC.*

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20062	DIAGNOSIS 6 INVALID	HI06-2	The sixth diagnosis code indicated on this claim is invalid. Verify the diagnosis code submitted on this claim is a valid ICD-9 diagnosis code. *This information is not used for DMERC.*
20063	DIAGNOSIS 7 INVALID	HI07-2	The seventh diagnosis code indicated on this claim is invalid. Verify the diagnosis code submitted on this claim is a valid ICD-9 diagnosis code. *This information is not used for DMERC.*
20064	DIAGNOSIS 8 INVALID	HI08-2	The eighth diagnosis code indicated on this claim is invalid. Verify the diagnosis code submitted on this claim is a valid ICD-9 diagnosis code. *This information is not used for DMERC.*
20065	REFERRING PROV. SPECIALTY CODE INVALID	PRV03	The referring provider's taxonomy code indicated for this claim is invalid. Verify the taxonomy code submitted against the taxonomy code list published by Washington Publishing Company. To obtain a copy of this list visit their Web site at: *www.wpc-edi.com*. *This information is not used for DMERC.*
20066	RENDERING PROV/ORG. NAME INVALID	NM103	The rendering provider's last name was entered in an invalid format. Verify the first position of the rendering provider's last name is an alpha character and does not contain spaces. Make sure the first three positions of the rendering provider's last name are not any of the following: MR, MR., DR, DR., JR or JR.. *This information is not used for DMERC.*
20067	RENDERING PROVIDER FIRST NAME INVALID	NM104	The rendering provider's first name for this claim was entered in an invalid format. Verify the first position of the rendering provider's first name does not contain a space and the name only contains alpha characters. *This information is not used for DMERC.*
20068	RENDERING PROVIDER MIDDLE NAME INVALID	NM105	The rendering provider's middle name was entered in an invalid format for this claim. Verify only alpha characters are present. *This information is not used for DMERC.*

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20069	RENDERING PROV. SPECIALTY CODE INVALID	PRV03	The rendering provider's taxonomy code indicated for this claim is invalid. Verify the taxonomy code submitted against the taxonomy code list published by Washington Publishing Company. To obtain a copy of this list visit their Web site at: *www.wpc-edi.com*. *This information is not used for DMERC.*
20070	RENDERING PROV ID QUALIFIER INVALID	REF01	The qualifier for the rendering provider's secondary identification number information for this claim is invalid. *Valid Value:* ***1C - Medicare provider number*** *This information is not used for DMERC.*
20071	RENDERING PROV. ID INVALID	REF02	The provider number indicated on this claim for the rendering provider is invalid. Verify the number entered is a valid supplier number as assigned by the National Supplier Clearinghouse. *This information is not used for DMERC.*
20072	PURCHASE SERV PROV ID QUALIFIER INVALID	REF01	The qualifier for the purchased service provider's secondary identification number for this claim is invalid. *Valid Value:* 1C - Medicare provider number 1G - Provider UPIN number *This information is not used for DMERC*
20073	PURCHASE SERV. PROVIDER ID INVALID	REF02	The secondary identification number indicated on this claim for the purchased service provider is invalid. Verify the number entered is a valid supplier number as assigned by the National Supplier Clearinghouse. *This information is not used for DMERC*
20074	SERVICE FACILITY/LAB NAME INVALID	NM103	The service facility location or oxygen test facility name was entered in an invalid format. Verify the first position of the service facility location or oxygen test facility is an alpha character and does not contain spaces.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20075	SERVICE FACILITY/LAB ADDDRESS1 INVALID	N301	The service facility location or oxygen test facility's address listed on this claim was entered in an invalid format. Verify the first position of the address information does not contain a space.
20076	SERVICE FACILITY/LAB ADDDRESS2 INVALID	N302	The service facility location or oxygen test facility additional address information listed on this claim was entered in an invalid format. Verify the first position of the address information does not contain a space.
20077	SERVICE FACILITY/LAB CITY NAME INVALID	N401	The city indicated on this claim for the service facility location or the oxygen test facility city is invalid. Verify the first position of the name of the city does not contain a space.
20078	SERVICE FACILITY/LAB STATE CODE INVALID	N402	The state abbreviation indicated on this claim for the service facility or oxygen test facility state is not a valid two character state abbreviation code.
20079	SERVICE FACILITY/LAB ZIP CODE INVALID	N403	The zip code indicated on this claim for the service facility or oxygen test facility zip code was reported in an invalid format. Verify the zip code contains only numeric data and is not all zeros or all nines and is either five or nine digits in length.
20080	SERVICE FACILITY/LAB COUNTRY INVALID	N404	The country code indicated on this claim for the service facility or oxygen test facility country is not a valid country code.
20081	SERVICE FACILITY REF ID QUALIFIER INVALID	REF01	The qualifier for the service facility location or oxygen test facility's secondary identification number information for this claim is invalid. *Valid Value:* ***1C - Medicare provider number***
20082	SERVICE FACILITY/LAB ID INVALID	REF02	The provider number indicated on this claim for the service facility location or oxygen test facility is invalid. Verify the number entered is a valid supplier number as assigned by the National Supplier Clearinghouse.
20083	SUPER PROV REF ID QUALIFIER INVALID	REF01	The qualifier for the supervising provider's secondary identification number information for this claim is invalid. *Valid Values:* ***1C - Medicare provider number*** 1G - Provider UPIN number *This information is not used for DMERC*

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20084	SUPERVISING PROVIDER ID INVALID	REF02	The secondary identification number indicated on this claim for the supervising provider is invalid. Verify the number entered is a valid supplier number as assigned by the National Supplier Clearinghouse. *This information is not used for DMERC*
20085	CLAIM LEVEL ADJUSTMENT INVALID	CAS	The total claim level adjustment amounts indicated on this claim do not equal the total for all submitted charges for this claim. *This information is used for Medicare Secondary Payor claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20086	ADJUSTMENT REASON CODE1 INVALID	CAS02	The claim adjustment reason code, indicated on this claim, is invalid. Verify the claim adjustment reason code was entered as it appears on the explanation of benefits from the primary payer. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20087	ADJUSTMENT REASON CODE2 INVALID	CAS05	The claim adjustment reason code, indicated on this claim, is invalid. Verify the claim adjustment reason code was entered as it appears on the explanation of benefits from the primary payer. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20088	ADJUSTMENT REASON CODE3 INVALID	CAS09	The claim adjustment reason code, indicated on this claim, is invalid. Verify the claim adjustment reason code was entered as it appears on the explanation of benefits from the primary payer. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20089	ADJUSTMENT REASON CODE4 INVALID	CAS11	The claim adjustment reason code, indicated on this claim, is invalid. Verify the claim adjustment reason code was entered as it appears on the explanation of benefits from the primary payer. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20090	ADJUSTMENT REASON CODE5 INVALID	CAS14	The claim adjustment reason code, indicated on this claim, is invalid. Verify the claim adjustment reason code was entered as it appears on the explanation of benefits from the primary payer. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20091	ADJUSTMENT REASON CODE6 INVALID	CAS17	The claim adjustment reason code, indicated on this claim, is invalid. Verify the claim adjustment reason code was entered as it appears on the explanation of benefits from the primary payer. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20092	SUBSCRIBER DATE OF BIRTH INVALID	DMG02	The other insured's date of birth indicated on this claim is invalid. Verify the century was entered as either 18, 19, or 20. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
20093	REMARK CODE1 INVALID	MOA03	The remark code indicated on this claim is invalid. Verify the correct code was entered off of the primary payer's electronic remittance advice. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20094	REMARK CODE2 INVALID	MOA04	The remark code indicated on this claim is invalid. Verify the correct code was entered off of the primary payer's electronic remittance advice. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20095	REMARK CODE3 INVALID	MOA05	The remark code indicated on this claim is invalid. Verify the correct code was entered off of the primary payer's electronic remittance advice. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20096	REMARK CODE 4 INVALID	MOA06	The remark code indicated on this claim is invalid. Verify the correct code was entered off of the primary payer's electronic remittance advice. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20097	REMARK CODE 5 INVALID	MOA07	The remark code indicated on this claim is invalid. Verify the correct code was entered off of the primary payer's electronic remittance advice. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20098	SUBSCRIBER LNAME OR ORG NAME INVALID	NM103	The other insured's last name was entered in an invalid format. Verify the first position of the insured's last name is an alpha character and does not contain spaces. Make sure the first three positions of the other insured's last name are not any of the following: MR., MR, DR, DR., JR or JR.. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20099	SUBSCRIBER FIRST NAME INVALID	NM104	The other insured's first name was entered in an invalid format. Verify the first position of the insured's first name does not contain a space and the name only contains alpha characters. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20100	SUBSCRIBER MIDDLE NAME INVALID	NM105	The other insured's middle name was entered in an invalid format. Verify only alpha characters are present. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
20101	IDENTIFICATION CODE QUALIFIER INVALID	NM108	The qualifier identifying the other insured's identification number for this claim is invalid. *Valid Value:* ***MI - Member identification number*** *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
20102	OTHER SUBSCRIBER ADDRESS1 INVALID	N301	The other insured's address listed on this claim was entered in an invalid format. Verify the first position of the address information does not contain a space. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20103	OTHER SUBSCRIBER ADDRESS2 INVALID	N302	The other insured's additional address information listed on this claim was entered in an invalid format. Verify the first position of the address information does not contain a space. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
20104	OTHER SUBSCRIBER CITY NAME INVALID	N401	The city indicated on this claim for the other insured's city is invalid. Verify the first position of the name of the city does not contain a space. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
20105	OTHER SUBSCRIBER STATE CODE INVALID	N402	The state abbreviation, indicated on this claim, for the other insured's state is not a valid two character state abbreviation code. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20106	OTHER SUBSCRIBER ZIP CODE INVALID	N403	The zip code indicated on this claim for the other insured's address was reported in an invalid format. Verify the zip code contains only numeric data and is not all zeros or all nines and is either five or nine digits in length. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
20107	OTHER SUBSCRIBER COUNTRY CODE INVALID	N404	The country code indicated on this claim for the other insured's address is not a valid country code. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
20108	OTHER PAYOR ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the other payer's identification number for this claim is invalid. *Valid Value:* ***PI - Payor identification*** *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
20109	PRODUCT/SERVICE ID QUALIFIER INVALID	SV101-1	The qualifier indicating the type of procedure code being submitted used for this line is invalid. *Valid Values:* ***HC - HCPCS Codes*** ***N4 - NDC***

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20110	PROCEDURE CODE INVALID	SV101-2	The HCPCS or NDC code indicated on this claim line is not a valid code.
20111	PROCEDURE MODIFIER1 INVALID	SV101-3	The first modifier appended to the HCPCS code for this line is invalid. Verify correct modifier usage in the DMERC Region D Supplier Manual.
20112	PROCEDURE MODIFIER1 INVALID	SV101-3	The modifier and HCPCS code combination reported for this line item is invalid. Verify the correct modifier usage in the DMERC Region D Supplier Manual.
20113	PROCEDURE MODIFIER2 INVALID	SV101-4	The second modifier appended to the HCPCS code for this line is invalid. Verify correct modifier usage in the DMERC Region D Supplier Manual.
20114	PROCEDURE MODIFIER2 INVALID	SV101-4	The second modifier and HCPCS code combination reported for this line item is invalid. Verify the correct modifier usage in the DMERC Region D Supplier Manual.
20115	PROCEDURE MODIFIER3 INVALID	SV101-5	The third modifier appended to the HCPCS code for this line is invalid. Verify correct modifier usage in the DMERC Region D Supplier Manual.
20116	PROCEDURE MODIFIER3 INVALID	SV101-5	The third modifier and HCPCS code combination reported for this line item is invalid. Verify the correct modifier usage in the DMERC Region D Supplier Manual.
20117	PROCEDURE MODIFIER4 INVALID	SV101-6	The fourth modifier appended to the HCPCS code for this line is invalid. Verify correct modifier usage in the DMERC Region D Supplier Manual.
20118	PROCEDURE MODIFIER4 INVALID	SV101-6	The fourth modifier and HCPCS code combination reported for this line item is invalid. Verify the correct modifier usage in the DMERC Region D Supplier Manual.
20119	LINE ITEM CHANGE AMOUNT INVALID	SV102	The charge submitted for this line item is invalid. Verify the charge was entered correctly and is not all zeros.
20120	DIAGNOSIS CODE POINTER 1 INVALID	SV107-1	The diagnosis code pointer for this line item is invalid. *Valid Values:* ***1*** ***2*** ***3*** ***4***

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20121	DIAGNOSIS CODE POINTER 2 INVALID	SV107-2	The diagnosis code pointer for this line item is invalid. *Valid Values:* ***1*** ***2*** ***3*** ***4***
20122	DIAGNOSIS CODE POINTER 3 INVALID	SV107-3	The diagnosis code pointer for this line item is invalid. *Valid Values:* ***1*** ***2*** ***3*** ***4***
20123	DIAGNOSIS CODE POINTER 4 INVALID	SV107-4	The diagnosis code pointer for this line item is invalid. *Valid Values:* ***1*** ***2*** ***3*** ***4***
20124	SERVICE DATE INVALID	DTP03	The date of service entered for this line item is invalid. Verify the date of service is greater than 19811231 and if you are reporting a span date range that the to date is not a future date.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20125	RENDERING PROV LNAME OR ORG INVALID	NM103	The rendering provider's last name was entered in an invalid format. Verify the first position of the rendering provider's last name is an alpha character and does not contain spaces. Make sure the first three positions of the other insured's last name are not any of the following: MR., MR, DR, DR., JR or JR.. *This information is not used for DMERC*
20126	RENDERING PROVIDER FIRST NAME INVALID	NM104	The rendering provider's first name for this claim line was entered in an invalid format. Verify the first position of the rendering provider's first name does not contain a space and the name only contains alpha characters. *This information is not used for DMERC*
20127	RENDERING PROVIDER MIDDLE NAME INVALID	NM105	The rendering provider's middle name was entered in an invalid format for this line. Verify only alpha characters are present. *This information is not used for DMERC*
20128	RENDERING PROVIDER SPECIALTY INVALID	PRV03	The rendering provider's taxonomy code indicated for this line item is invalid. Verify the taxonomy code submitted against the taxonomy code list published by Washington Publishing Company. To obtain a copy of this list visit their Web site at: *www.wpc-edi.com*. *This information is not used for DMERC*
20129	RENDERING PROV REF ID QUALIFIER INVALID	REF01	The qualifier for the rendering provider's supplier number information for this line item is invalid. *Valid Value:* 1C - Medicare provider number *This information is not used for DMERC*
20130	RENDERING PROV SECONDARY ID INVALID	REF02	The supplier number indicated on this line item for the rendering provider is invalid. Verify the number entered is a valid supplier number as assigned by the National Supplier Clearinghouse. *This information is not used for DMERC*

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20131	PURCH SERV PROV REF ID QUALIFIER INVALID	REF01	The qualifier for the purchased service provider's secondary identification number information for this line item is invalid. *Valid Values:* 1C - Medicare provider number 1G - Provider UPIN number *This information is not used for DMERC*
20132	PURCH SERV PROV SECONDARY ID INVALID	REF02	The secondary identification number indicated on this claim for the purchased service provider for this line item is invalid. If a Medicare provider number was reported, it must be a valid supplier number assigned by the National Supplier Clearinghouse. If a provider UPIN was reported, it must be a valid UPIN Number. *This information is not used for DMERC*
20133	SERVICE FACILITY LOCATION STATE INVALID	N402	The state abbreviation, indicated on this line item for the service facility or oxygen test facility state, is not a valid two character state abbreviation code.
20134	SERV FACILITY LOCATION ZIP CODE INVALID	N403	The zip code, indicated on this line item for the service facility or oxygen test facility address, was reported in an invalid format. Verify the zip code contains only numeric data and is not all zeros or all nines and is either five or nine digits in length.
20135	LAB/FACILITY COUNTRY CODE INVALID	N404	The country code indicated on this line item for the service facility or oxygen test facility address is not a valid country code.
20136	SERV FAC LOC REF ID QUALIFIER INVALID	REF01	The qualifier for the service facility location or oxygen test facility's secondary identification number information for this line item is invalid. *Valid Value:* ***1C - Medicare provider number***
20137	SERV FAC LOC SECONDARY ID INVALID	REF02	The secondary identification number indicated on this claim for the service facility or oxygen test facility for this line item is invalid. If a Medicare provider number was reported, it must be a valid supplier number assigned by the National Supplier Clearinghouse.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20138	SUPER PROV ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the supervising provider's identification number for this claim is invalid. *Valid Values:* 24 - Employer's identification number 34 - Social Security Number – not used for Medicare XX - Health Care Financing Administration National Provider Identifier *This information is not used for DMERC*
20139	ORDERING PROVIDER STATE CODE INVALID	N402	The state abbreviation, indicated on this line item for the ordering provider state, is not a valid two character state abbreviation code.
20140	ORDERING PROVIDER ZIP CODE INVALID	N403	The zip code, indicated on this line item for the ordering provider address, was reported in an invalid format. Verify the zip code contains only numeric data and is not all zeros or all nines and is either five or nine digits in length.
20141	ORDERING PROVIDER COUNTRY CODE INVALID	N404	The country code indicated on this line item for the ordering provider is not a valid country code.
20142	ORDER PROV SECOND REF ID QUAL INVALID	REF01	The qualifier for the ordering provider's secondary identification number information for this line item is invalid. *Valid Value:* ***1G - Provider UPIN number***
20143	ORDERING PROVIDER SECONDARY ID INVALID	REF02	The secondary identification number indicated on this claim for the ordering provider for this line item is invalid. The provider UPIN reported, must be a valid UPIN Number.
20144	REFERING PROVIDER SPECIALTY CODE INVALID	PRV03	The referring provider's taxonomy code indicated for this line item is invalid. Verify the taxonomy code submitted against the taxonomy code list published by Washington Publishing Company. To obtain a copy of this list visit their Web site at: *www.wpc-edi.com*. *This information is not used for DMERC*

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20145	PRIOR AUTH ID CODE QUALIFIER INVALID	NM108	The qualifier identifying the identification number other payer who issued the prior authorization or referral number is invalid. *Valid Value:* ***PI - Payor identification*** *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20146	PRODUCE/SERVICE ID QUALIFIER INVALID	SVD03-1	The qualifier indicating the other payer's type code for this line is invalid *Valid Values:* HC - HCPCS code N4 - NDC code *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20147	PATIENT LAST NAME INVALID	NM103	The patient's last name was entered in an invalid format. Verify the first position of the patient's last name is not a space and only contains alpha characters. *This information is not used for DMERC.*
20148	LINE ADJUSTMENT INVALID	CAS	The total line level adjustment amounts indicated for this line do not equal the line charge. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20149	LINE ADJUSTMENT REASON CODE1 INVALID	CAS02	The line level claim adjustment reason code, indicated on this claim, is invalid. Verify the claim adjustment reason code was entered as it appears on the explanation of benefits from the primary payer. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20150	LINE ADJUSTMENT REASON CODE2 INVALID	CAS05	The line level claim adjustment reason code, indicated on this claim, is invalid. Verify the claim adjustment reason code was entered as it appears on the explanation of benefits from the primary payer. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20151	LINE ADJUSTMENT REASON CODE3 INVALID	CAS08	The line level claim adjustment reason code, indicated on this claim, is invalid. Verify the claim adjustment reason code was entered as it appears on the explanation of benefits from the primary payer. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20152	LINE ADJUSTMENT REASON CODE4 INVALID	CAS11	The line level claim adjustment reason code, indicated on this claim, is invalid. Verify the claim adjustment reason code was entered as it appears on the explanation of benefits from the primary payer. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20153	LINE ADJUSTMENT REASON CODE5 INVALID	CAS14	The line level claim adjustment reason code, indicated on this claim, is invalid. Verify the claim adjustment reason code was entered as it appears on the explanation of benefits from the primary payer. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*
20154	LINE ADJUSTMENT REASON CODE6 INVALID	CAS17	The line level claim adjustment reason code, indicated on this claim, is invalid. Verify the claim adjustment reason code was entered as it appears on the explanation of benefits from the primary payer. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.*

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20155	SPV PRV LAST NAME INVALID	NM103	The supervising provider's last name was entered in an invalid format. Verify the first position of the supervising provider's last name is not a space and only contains alpha characters. *This information is not used for DMERC.*
20156	DATE TIME QUALIFIER INVALID	DTP01	The code used to indicate the date of receipt is invalid. *Valid Value:* ***RC - Receipt date*** If you receive this edit contact the DMERC EDI Department.
20157	DATE TIME PERIOD FORMAT QUAL INVALID	DTP02	The code used to indicate the format the date was entered to indicate the date of receipt is invalid. *Valid Value:* ***D8 - Date expressed in CCYYMMDD format*** If you receive this edit contact the DMERC EDI Department.
20158	CLAIM RECEIPT DATE INVALID	DTP03	The date entered as the claim date of receipt was entered in an invalid format. Verify the date is a valid calendar date and not a date greater than today's date. If you receive this edit contact the DMERC EDI Department.
20159	CLAIM SOURCE INVALID	REF	The segment containing the claim source code segment is missing. If you receive this edit contact the DMERC EDI Department.
20160	CLAIM SOURCE REF ID QUALIFIER INVALID	REF01	The code indicating the claim source code is invalid. *Valid Value:* PR - Payer If you receive this edit contact the DMERC EDI Department.
20161	CLAIM SOURCE CODE INVALID	REF02	The value used to indicate the type of claim submitted is invalid. *Valid Value:* ***E - EMC***

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20162	OTH PAYER PATIENT LAST NAME INVALID	NM103	The other payer's patient's last name was entered in an invalid format. Verify the first position of the other payer's patient's last name is not a space and only contains alpha characters. *This information is used for Medicare Secondary Payer claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.* *This information is used for Medigap secondary to Medicare claims and should not be submitted unless there is an approved Medigap policy held by this subscriber.*
20163	DEMO PROJECT ID INVALID	REF02	You have indicated this is a demonstration project claim and you did not submit the demonstration project identifier code. *Valid Value:* ***00803 - Region C***
20164	OTH PAYER SPV PRV LAST NAME INV	NM103	The other payer's supervising provider's last name was entered in an invalid format. Verify the first position of the other payer's supervising provider's last name is not a space and only contains alpha characters. *This information is not used for DMERC.*
20165	SPV PRV LAST NAME INVALID	NM103	The supervising provider's last name was entered in an invalid format. Verify the first position of the supervising provider's last name is not a space and only contains alpha characters. *This information is not used for DMERC.*
20166	CLAIM CONTROL NUMBER INVALID	REF02	If you receive this edit, please contact the DMERC EDI Department.
20167	LINE ITEM CHANGE AMOUNT INVALID	SV102	The amount entered for this line item charge was 0 and the code submitted requires a charge be entered.
20168	ORDERING PROVIDER LAST NAME INVALID	NM103	The ordering provider's last name was entered in an invalid format. Verify the first position of the ordering provider's last name is not a space and only contains alpha characters.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20169	REFERRING PROVIDER LAST NAME INVALID	NM103	The referring provider's last name was entered in an invalid format. Verify the first position of the referring provider's last name is not a space and only contains alpha characters. *This information is not used for DMERC.*
20171	TOTAL CLAIM CHARGE > $99,999.99	CLM02	The value entered as the total claim charges is invalid. The total claim charges cannot exceed $99,999.99
20172	LINE CHARGE > $99,999.99	SV102	The amount entered for this line item charge exceeds $99,999.99.
20173	TOTAL CLM CHARGE AMT MISSING	CLM02	The total claim charge amount is missing on this claim. This is a required element on each claim and must equal the sum of all service line charges.
20174	SVC LINE CHARGE AMT MISSING	SV102	The service line charge amount is missing on this line. This is a required element on each service line.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20175	BILLING PROV ID QUAL INVALID	NM108	The qualifier used to indicate the billing provider's primary identification number is invalid. Valid values: **24 – Employer's identification number** 34 – Social Security Number XX – National Provider Identifier
20176	PAY TO PROV ID QUAL INVALID	NM108	The qualifier used to indicate the pay-to provider's primary identification number is invalid. Valid values: **24 – Employer's identification number** 34 – Social Security Number XX – National Provider Identifier *This information is not used for DMERC.*
20177	REF PROV ID QUAL INVALID	NM108	The qualifier used to indicate the referring provider's primary identification number is invalid. Valid values: **24 – Employer's identification number** 34 – Social Security Number XX – National Provider Identifier *This information is not used for DMERC.*
20178	REND PROV ID QUAL INVALID	NM108	The qualifier used to indicate the rendering provider's primary identification number is invalid. Valid values: **24 – Employer's identification number** 34 – Social Security Number XX – National Provider Identifier *This information is not used for DMERC.*
20179	PURCH SERV PROV ID QUAL INVALID	NM108	The qualifier used to indicate the purchased service provider's primary identification number is invalid. Valid values: **24 – Employer's identification number** 34 – Social Security Number XX – National Provider Identifier *This information is not used for DMERC.*

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20180	SERVICE FACILITY ID QUAL INVALID	NM108	The qualifier used to indicate the service facility's primary identification number is invalid. Valid values: **24 – Employer's identification number** 34 – Social Security Number XX – National Provider Identifier
20181	SUPERVISING PROV ID QUAL INVALID	NM108	The qualifier used to indicate the supervising provider's primary identification number is invalid. Valid values: **24 – Employer's identification number** 34 – Social Security Number XX – National Provider Identifier *This information is not used for DMERC.*
20182	REND PROV ID QUAL INVALID	NM108	The qualifier used to indicate the rendering provider's primary identification number for this line is invalid. Valid values: **24 – Employer's identification number** 34 – Social Security Number XX – National Provider Identifier *This information is not used for DMERC.*
20183	PURCH SERV PROV ID QUAL INVALID	NM108	The qualifier used to indicate the purchased service provider's primary identification number for this line is invalid. Valid values: **24 – Employer's identification number** 34 – Social Security Number XX – National Provider Identifier *This information is not used for DMERC.*
20184	SERVICE FACILITY ID QUAL INVALID	NM108	The qualifier used to indicate the service facility's primary identification number for this line is invalid. Valid values: **24 – Employer's identification number** 34 – Social Security Number XX – National Provider Identifier

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20185	ORDERING PROV ID QUAL INVALID	NM108	The qualifier used to indicate the ordering provider's primary identification number for this line is invalid. Valid values: **24 – Employer's identification number** 34 – Social Security Number XX – National Provider Identifier
20186	REF PROV ID QUAL INVALID	NM108	The qualifier used to indicate the referring provider's primary identification number for this line is invalid. Valid values: **24 – Employer's identification number** 34 – Social Security Number XX – National Provider Identifier *This information is not used for DMERC.*
20187	SUPPLIER CREDIT/DEBIT INFOR NOT USED	REF	The loop containing the secondary identification number for the credit/debit card billing information was sent with this transaction. This information cannot be sent to Medicare.
20188	CREDIT/DEBIT NAME INFO NOT USED	NM1	The loop containing the credit/debit cardholder information was sent with this claim. This information is not to be sent to Medicare
20189	SUBSCRIBER CREDIT/DEBIT INFO NOT USED	AMT	The segment containing the amount to be credited to the credit/debit card account was submitted with this claim. This information cannot be sent to Medicare. *This information is not used for DMERC.*
20190	SPEC PROG IND INVALID	CLM12	The code indicating the special program under which the services rendered to the patient were performed is invalid for this claim Valid values: 01 – Early & Periodic Screening, Diagnosis and Treatment or Child Health Assessment Program 02 – Physically Handicapped Children's Program. *This information is not used for DMERC*

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
20191	PROD/SER ID QUALIFIER INVALID	SVD03-1	The code used to indicate the type of procedure code being reported in the line adjudication segment for this claim line is invalid. Valid value: **HC – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** *This information is not used for DMERC*
20192	PROD/SER ID QUALIFIER INVALID	SV101-2	The code indicating the type of procedure code entered for this line is invalid. Valid values: **HC – Health Care Financing Administration common Procedural Coding System** **ZZ – Mutually Defined**

Chapter Nine:

Front-End Edits – DMERC

Introduction

Front-end edits are broken down into three categories or levels. It is important to understand the differences between these levels to determine error resolution. In addition to Medicare specific and DMERC specific edits, CMS has required us to add Implementation Guide (IG) edits, to ensure electronic files meet the HIPAA standard. The IG edits and descriptions are contained in Chapter 7. The Medicare edits are in Chapter 8 and the DMERC-specific edits and descriptions are included in this chapter.

To allow you to quickly identify the level in which the error occurred, the edits are numbered as follows:

10XXX - **Implementation Guide edits**

20XXX - **Medicare-specific edits**

40XXX - **DMERC-specific edits**

The DMERC-specific edits will validate data requirements specific to DMERC, such as DMERC HCPCS/NDC codes, proper dates, places of service, and CMN data requirements. Since our system processes both DMERC and Part B Medicare claims, a separate level for editing DMERC requirements has been developed.

For your convenience, we have indicated data elements in this section that are not used for DMERC. If you receive an edit on data that is not used for DMERC, and the information is not needed for another payer, please remove the erroneous data and resubmit the file. If the data is needed for another payer, please correct the claim and retransmit.

Key to Manual:

NOT USED = These edits are currently not used but may be added at a later date.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
40001	PATIENT DATE OF DEATH INVALID	PAT06	The date entered as the subscriber's date of death is invalid. Verify the date entered is greater than the subscriber's date of birth and the date is not greater than today's date.
40002	PATIENT WEIGHT INVALID	PAT08	The amount entered as the subscriber's weight is invalid. Verify the value entered is numeric.
40003	PATIENT WEIGHT INVALID	PAT08	The amount entered as the subscriber's weight equals less than 1 pound.
40004	NOT USED		
40005	PATIENT ZIP CODE INVALID	N403	The zip code indicated for the subscriber's address was reported in an invalid format. Verify the zip code contains only numeric data and is not all zeros or all nines and is either five or nine digits in length.
40007	PATIENT WEIGHT INVALID	PAT08	The amount entered as the patient's weight is invalid. Verify the value entered is numeric and is greater than 0. This information should only be reported if the patient is not the same as the subscriber.
40008	PATIENT WEIGHT INVALID	PAT08	The amount entered as the patient's weight equals less than 1 pound. This information should only be reported if the patient is not the same as the subscriber.
40009	INSURED STATE CODE INVALID	N402	The state abbreviation for the patient state is not a valid two character state abbreviation code. This information should only be reported if the patient is not the same as the subscriber.
40010	INSURED ZIP CODE INVALID	N403	The zip code indicated for the patient's address was reported in an invalid format. Verify the zip code contains only numeric data and is not all zeros or all nines and is either five or nine digits in length. This information should only be reported if the patient is not the same as the subscriber.
40011	RELEASE OF INFO INDICATOR INVALID	CLM09	The release of information indicator entered for this claim is not a valid value. *Valid Values:* ***M - The provider has limited or restricted ability to release data related to a claim.*** ***N - No, provider is not allowed to release data.*** ***Y - Yes, provider has a signed statement permitting release of medical billing data related to a claim.***
40012	AMOUNT PAID BY BENE NOT NUMERIC	AMT02	The amount entered as the patient paid amount was not entered in a numeric format.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
40013	NOT USED		
40014	ORDERING PROV INFO MISSING	NM1	The loop containing the ordering provider information is missing. This loop must be present for each service line of a DMERC claim.
40021	CAPPED RENTAL K MODIFIER MISSING	SV101-2	The procedure code indicated on this line is a capped rental item. This code requires one of the following modifiers be appended to the code: KH, KI, or KJ.
40022	PROCEDURE CODE/MODIFIER INVALID	SV101-2	The procedure code indicated on this line is invalid. Verify the first position is not a space.
40023	NUMBER OF SERVICES INVALID	SV104	The units of service entered for this line is invalid for the procedure code submitted. If the procedure code submitted is a capped rental item, the unit of service must be equal to one unless the procedure code has both the RT and LT modifiers appended. In that instance, the unit of service may be equal to two.
40024	CMN INFORMATION MISSING	CR3	You have indicated there is a CMN included with this claim, however, the segment containing the durable medical equipment certification did not accompany this claim.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
40025	CMN LENGTH OF NEED INVALID	CR303	The length of need reported on the durable medical equipment CMN is invalid. Verify the length of need was reported as numeric data and does not equal all zeros.
40026	OXYGEN CMN INFORMATION MISSING	CR5	You have indicated there is a CMN included with this claim, however, the segment containing the oxygen certification form did not accompany this claim.
40027	OXYGEN CMN LENGTH OF NEED INVALID	CR502	The length of need reported on the oxygen certification form is invalid. Verify the length of need was reported as numeric data and does not equal all zeros or is greater than 100.
40028	ABG RESULTS INVALID	CR510	The value entered as the arterial blood gas test result (question 1A on the oxygen certification form) is not numeric.
40029	OXIMETRY INVALID	CR511	The value entered as the oxygen saturation test result (question 1B on the oxygen certification form) is not numeric.
40030	CRC SEGMENT MISSING FOR CMN	CRC	The segment containing information on conditions as indicated on the durable medical equipment CMN or oxygen certification form is missing.
40031	SERVICE FROM DATE MISSING	DTP03	The service from date is missing on this line.
40032	SERVICE FROM DATE INVALID	DTP03	The date entered to indicate the service from date was entered in an invalid format. Verity the date is a valid date, contains 19 or 20 as the century, and was entered in a CCYYMMDD format.
40033	SERVICE TO DATE MISSING	DTP03	The service to date is missing on this line.
40034	SERVICE TO DATE INVALID	DTP03	The date entered to indicate the service to date was entered in an invalid format. Verity the date is a valid date, contains 19 or 20 as the century, and was entered in a CCYYMMDD format.
40035	SERVICE TO DATE LESS THAN FROM DATE	DTP03	The to date is prior to the from date. The to date must be equal to or greater than the from date.
40036	SERVICE FROM DATE DOES NOT EQUAL TO DATE	DTP03	The procedure code submitted for this line does not allow for spanned dates of service. Verify the from and to dates for this line are equal.
40037	SERVICE DATE GREATER THAN RECEIPT DATE	DTP03	The date entered to indicate the service from date is greater than the date this claim was received by CIGNA DMERC.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
40038	SERVICE FROM DATE LESS THAN PATIENT DOB	DTP03	The date entered to indicate the service from date is greater than the subscriber's date of birth.
40039	FROM DATE = TO DATE AND UNITS > 1	DTP03	The date of service entered for this line is invalid. Verify if the HCPCS code has an RR modifier appended to it, the service from date and the service to date are equal and the unit of service is equal to 1.
40040	CERTIFICATION TYPE INVALID	CRC01	The value used to indicate the type of certification being sent with this line is invalid. *Valid Values:* ***09 - Durable Medicare Equipment Certification*** ***11 - Oxygen Therapy Certification***
40041	CMN RECERT/REVISED DATE INVALID	DTP03	The date entered to indicate the CMN recertification or revision date is equal to the date entered to indicate the initial date on the CMN.
40042	CMN RECERT/REVISED DATE INVALID	DTP03	The date entered to indicate the CMN recertification or revision date is greater than 60 days into the future.
40043	CMN INITIAL DATE MISSING	DTP	The segment containing the CMN initial date is missing. If a CMN is being sent with this claim, this is a required segment.
40044	CMN CERTIFICATOIN DATE MISSING	DTP	The segment containing the date the physician signed the CMN is missing. If a CMN is being sent with this claim, this is a required segment.
40046	OXYGEN SATURATION/ABG TEST DATE MISSING	DTP	The segment containing the oxygen saturation/arterial blood gas test date is missing. If an oxygen certification form is being sent with this claim, this is a required segment.
40047	MEASUREMENTS INVALID	MEA	The segment containing the results of the oxygen saturation /arterial blood gas test (question 7 on the oxygen certification form) is missing or invalid. You have indicated greater than 4 LPM is being prescribed and the test results were not provided.
40048	PATIENTS HEIGHT INVALID	MEA03	The subscriber's height was entered in an invalid format. Verify the height was entered using numeric data only.
40049	FORM 484 – QUESTION 7A INVALID	MEA03	The response to question 7A on the oxygen certification form was entered in an invalid format. Verify the response is equal to spaces, zeros, or is numeric.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
40050	FORM 484 – QUESTION 7B INVALID	MEA03	The response to question 7B on the oxygen certification form was entered in an invalid format. Verify the response is equal to spaces, zeros, or is numeric.
40051	OXYGEN FLOW RATE MISSING	REF	The segment containing the oxygen flow rate information is missing. If an oxygen certification form is being sent with this claim, this is a required segment.
40052	NOTE MISSING	NTE	The segment containing narrative information for this line is missing. The procedure code submitted requires narrative information be sent.
40053	SERVICE FACILITY LOCATION MISSING	NM1	The segment containing the service facility location information is missing. If an oxygen certification form is being sent with this line, this is a required segment.
40054	ORDERING PROVIDER LAST NAME INVALID	NM103	The ordering provider's last name was entered in an invalid format. Verify the first two positions of the ordering provider's last name are alpha characters and do not contain spaces. Make sure the first three positions of the ordering provider's last name are not any of the following: MR., MR, DR, DR., JR or JR..
40055	ORDERING PROVIDER FIRST NAME INVALID	NM104	The ordering provider's first name was entered in an invalid format. Verify the first position of the ordering provider's first name is an alpha character and does not contain spaces. Make sure the first three positions of the ordering provider's last name are not any of the following: MR., MR, DR, DR., JR or JR..
40056	ORDERING PROVIDER MIDDLE NAME INVALID	NM105	The ordering provider's middle name was entered in an invalid format. Verify only alpha characters are present.
40057	ORDERING PROVIDER ADDRESS1 INVALLID	N301	The ordering provider's address listed on this claim was entered in an invalid format. Verify the first position of the address information does not contain a space.
40058	ORDERING PROVIDER ADDRESS2 INVALID	N302	The ordering provider's additional address information listed on this claim was entered in an invalid format. Verify the first position of the additional address information does not contain a space.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
40066	INVALID / UNNECESSARY CMN SUBMITTED	LQ02	The DMERC CMN form number entered is not a valid form number for the HCPCS code submitted on this line. Verify the CMN form number is entered as it appears on the CMN. Do not include the alpha character. *Valid Values:* ***01.02*** ***02.03*** ***03.02*** ***04.03*** ***06.02*** ***07.02*** ***08.02*** ***09.02*** ***10.02***
40067	INVALID / UNNECESSARY CMN VERSION SUBMITTED	LQ02	The DMERC CMN version number entered is not a valid version number for the HCPCS code submitted on this line. Verify the version number is entered as it appears on the CMN. Do not include the alpha character. *Valid Values:* ***01.02*** ***02.03*** ***03.02*** ***04.03*** ***06.02*** ***07.02*** ***08.02*** ***09.02*** ***10.02***
40068	QUESTION NUMBER/LETTER INVALID	FRM01	The question number entered is not valid for the DMERC CMN form being sent with this claim line.
40069	NOT USED		
40070	QUESTION RESPONSE INVALID	FRM03	The question response for this CMN was entered in an invalid format. If you have indicated the question is to be answered using a text response, the first position of the response cannot contain a space.
40071	QUESTION RESPONSE INVALID - DATE	FRM04	The date entered on this CMN is invalid. Verify the date is an actual date, has 19 or 20 as the century and is entered in a CCYYMMDD format.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
40072	QUESTION RESPONSE INVALID - PERCENT	FRM05	The percentage amount entered is invalid. Verify information submitted is numeric and is not greater than 99.99.
40073	DATES OF SERVICE EXCEED MPR DATES	DTP03	The date of service entered for this line is invalid. Verify the HCPCS or NDC is effective for the date of service submitted for this line.
40074	CMN INITIAL DATE INVALID	DTP03	The date entered as the initial date on the CMN submitted with this line is invalid. Verify the date entered as the initial date is not greater than today's date.

Edit Number	EDIT DESCRIPTION	Element ID	Edit Explanation
40075	CMN INDICATOR MISSING	PWK	The segment containing the CMN indicator is missing. This is a required segment for all lines containing a CMN.
40076	CMN FORM IDENTIFIER MISSING	LQ	The segment containing the CMN form number is missing. This is a required segment for all lines containing a CMN.
40077	CMN FORM RESPONSES MISSING	FRM	The segment containing the responses to the questions on the CMN is missing. This is a required segment for all lines containing a CMN.
40078	TOTAL CLAIM CHARGE AMOUNT MISSING	CLM02	The total claim charges for this claim was not submitted. Please make sure you have entered your total claim charges and that it is equal to the total of all submitted line charges.
40079	NUMBE OF SERVICES MISSING	SV104	The number of services for this line was not submitted.
40080	PATIENT HEIGHT MISSING	MEA03	The subscriber's height was not included for this CMN. CMN forms 2.03 and 10.02 require the height to be reported.
40081	CMN LENGTH OF NEED MISSING	CR303	The CMN for this line did not have a length of need submitted. For all DMERC CMN's, except form 8.02, a length of need must be reported.
40082	OXYGEN LENGTH OF NEED MISSING	CR502	The oxygen certification from (484.2) was submitted without a length of need reported. All oxygen certification forms require a length of need.
40083	BILLING PROV INFO MISSING	PRV	The loop containing the billing provider information is missing. Please make sure your supplier information is submitted for each transaction.
40085	SVC DATES NOT WITHIN NDC RNG	DTP	The National Drug Code (NDC) submitted on this line for the date of service provided is invalid. The NDC is not effective for this date.
40086	NDC CODE INVALID	LIN03	The National Drug Code (NDC) submitted is invalid. Verify the NDC was entered correctly.
40087	NDC SERVICE DATES NOT WITHIN RANGE	LIN03	The National Drug Code (NDC) submitted is not valid based on the service date entered. Please verify the NDC was entered correctly and is effective for the service date entered.

Chapter Ten:

Contact Information

NEW Supplier Resource Sheet

The ***Supplier Resource Sheet*** contains key resources for common inquiries. Refer to the resource sheet before contacting a customer service agent, who is responsible for addressing complex inquiries that can not be handled through other means identified on this document.

Use the ***Supplier Resource Sheet*** as your first point of reference. For your convenience, the resource sheet is included in this chapter, and is also accessible via the CIGNA Medicare Web site at *www.cignamedicare.com*. If after referring to the resource sheet you are still unable to obtain the necessary information, please see additional Region D DMERC contact information below.

Additional Region D DMERC Contacts

NEW Call the Interactive Voice Response (IVR) Unit at 877.320.0390 (toll-free) for questions regarding:

- Status of a claim (electronic or paper)
- Outstanding checks
- Annual deductible
- Eligibility status
- Legislation issues
- Fee schedules
- Ordering payment reports
- Ordering publications
- Appeal rights

NEW To speak with a **Customer Service Agent**, located in Nashville, Tennessee, call 866.243.7272 (toll-free) for questions regarding:

- Action codes
- Verification of claim information
- How a claim was processed (paid or denied)
- Error messages (rejections)
- EMC claim edits
- Biller Purged Claim Reports
- Electronic Funds Transfer (EFT)

Call the **Customer Support Center's Electronic Commerce Helpdesk**, located in Bloomfield, Connecticut at 800.810.3388 (toll-free) for questions regarding:

- Stratus password and inactive user ID support

Call the **EDI Department**, located in Boise, Idaho, at 866.224.3094 (toll-free), option 1 for questions about:

- Electronic reports
- Transmission assistance and support
- Getting started billing electronically
- Electronic Remittance Notices (ERNs)
- *DMACS-837*
- Testing electronic billing formats (ANSI/NSF)
- Beneficiary eligibility support
- Claim Status Inquiry (CSI) support

EDI Department *(cont.)*

- EDI Enrollment Form
- EDI application requests
- EDI application status
- Name or address changes
- Activation status
- Software or matrix requests
- ID numbers and passwords
- *ANSI 837 Approved Vendor List* request

Contact the **Provider Education and Training (PET) Department**, located in Boise, Idaho, at 866.224.3094 (toll-free), option 3 for questions regarding:

- Educational seminars, Webinars and other educational outreach
- Provider/supplier training
- Complex claim issues that have not been resolved through normal channels

When contacting the PET department, please leave a message and briefly explain the purpose of your inquiry. A PET representative will respond to you within 24-48 hours of your call.

Other DMERCs

Region A
HealthNow, NY, Inc.
PO Box 6800
Wilkes-Barre, PA 18733-6800
Phone: 866.419.9458 (toll-free)
EDI: 570.735.9429
www.umd.nycpic.com

Region B
AdminaStar Federal, Inc.
PO Box 7078
Indianapolis, IN 46207-7078
Phone: 877.299.7900 (toll-free)
EDI: 800.470.9630 (toll-free)
www.adminastar.com

Region C
Palmetto GBA (Medicare DMERC)
PO Box 100141
Columbia, SC 29202-3141
Phone: 866.238.9650 (toll-free)
EDI: 866.749.4301 (toll-free)
www.palmettogba.com

Other Contacts

Statistical Analysis DMERC (SADMERC)
PO Box 100143
Columbia SC 29202-3143
Phone: 877.735.1326 (toll-free)
www.palmettogba.com (select "Other Medicare Partners")

Centers for Medicare & Medicaid Services (CMS)
www.cms.gov

National Supplier Clearinghouse (NSC)
PO Box 100142
Columbia SC 29202-3142
Phone: 866.238.9652 (toll-free)
www.palmettogba.com
(select "Other Medicare Partners")

Social Security Administration
Phone: 800.772.1213
www.ssa.gov

Medicare
www.medicare.gov

HOW DO I FIND INFORMATION ON...

	REGION D DMERC WEB SITE	LISTSERV (EXPRESS NOTIFICATION)	CMS WEB SITE	PET (PROVIDER EDUCATION & TRAINING)	REGION D DMERC SUPPLIER MANUAL	REGION D DMERC DIALOGUE	VENDOR GAZETTE	EDI EDGE	CSI SOFTWARE (CLAIM STATUS)	REMIT NOTICE	IVR (INTERACTIVE VOICE RESPONSE)
CLAIM STATUS									◆	◆	◆
OUTSTANDING CHECKS											◆
ANNUAL DEDUCTIBLE										◆	◆
ELIGIBILITY STATUS											◆
FEE SCHEDULE	◆	◆	◆			◆					◆
ORDER PAYMENT REPORTS											◆
ORDER PUBLICATIONS	◆	◆	◆			◆					◆
UPDATED PUBLICATIONS	◆	◆									
LEGISLATION ISSUES			◆								◆
SEMINARS/WEBINARS	◆	◆		◆		◆	◆	◆			
REVIEW REQUEST FORMS	◆		◆			◆					
APPEAL RIGHTS	◆				◆	◆				◆	◆
FREQUENTLY ASKED QUESTIONS	◆			◆		◆					
PHYSICIAN INFORMATION PACKET	◆										
ELECTRONIC FUNDS TRANSFER	◆				◆	◆					
DMERC FORMS	◆		◆		◆	◆					
REGION D SUPPLIER MANUAL	◆	◆			◆						
LOCAL MEDICAL REVIEW POLICIES	◆	◆	◆		◆	◆					
REGION D DMERC DIALOGUES	◆	◆				◆					
UPIN DIRECTORY	◆		◆								
HELPFUL RESOURCES TO EXTERNAL ENTITIES	◆		◆			◆					
HIPAA	◆		◆			◆	◆	◆			
REGION D DMERC CONTACTS	◆		◆		◆	◆				◆	

DMERC REGION D
SUPPLIER RESOURCE SHEET

SEE BACK OF SHEET FOR DETAILED DESCRIPTIONS OF RESOURCES.

WHAT IS WHAT & WHERE TO GO...

CIGNA MEDICARE WEB SITE (DMERC) - http://www.cignamedicare.com/dmerc

LISTSERV (EXPRESS E-MAIL NOTIFICATION SYSTEM) - By joining the CIGNA Medicare electronic mailing list, you can get immediate updates on DMERC Dialogues, Supplier Manuals, Workshops, Medical Review and other information. http://www.cignamedicare.com/mailer/subscribe.asp

CMS WEB SITE - http://www.cms.hhs.gov

PET - The Provider Education and Training department, located in Boise, Idaho, provides education to Durable Medical Equipment suppliers by means of face-to-face meetings or Webinars, which are interactive web-based training sessions. www.cignamedicare.com/wrkshp/dm

SEMINARS/WEBINARS - In addition to our on-site seminars, Region D DMERC also provides Webinars, web-based seminars, for more convenient access to Medicare education. http://www.cignamedicare.com/wrkshp/dm/index.html

REGION D DMERC SUPPLIER MANUAL - http://www.cignamedicare.com/dmerc/dmsm/index.html#toc

REGION D DMERC DIALOGUE - The *DMERC Dialogue* is a service of CIGNA HealthCare Medicare Administration. Together with occasional special releases, the *DMERC Dialogue* serves as legal notice to suppliers concerning responsibilities and requirements imposed upon them by Medicare law, regulations and guidelines. http://www.cignamedicare.com/dmerc/dlog/index.asp

DMERC VENDOR GAZETTE - The *Vendor Gazette* has been developed especially for software vendors. The *Vendor Gazette*, together with occasional special releases, serves as legal notice to vendors concerning the responsibilities and requirements imposed upon them by Medicare law, regulations and guidelines. http://www.cignamedicare.com/edi/gazette/index.html

DMERC EDI EDGE - The purpose of the *EDI Edge* is to provide you with the information which will allow you to take full advantage of all the benefits of electronic billing. Additionally, the *EDI Edge* contains vital information that will help you avoid common billing pitfalls which may delay payment. http://www.cignamedicare.com/dmerc/edge/index.html

CSI SOFTWARE (CLAIM STATUS INQUIRY) - The Claim Status Inquiry software (CSI) allows you to quickly check the status of your claims after they have been received by our system and assigned a Claim Control Number (CCN). http://www.cignamedicare.com/edi/Products_and_Services/index.html#

REMIT NOTICE - A paper or electronic payment report, which lists claims that have been paid and/or denied.

IVR (INTERACTIVE VOICE RESPONSE) - The IVR is a toll-free automated phone service that provides many different options to suppliers such as claim status, Medicare beneficiary eligibility information, allowables, and much more! It is available for supplier usage as long as our mainframe is up and running, and is available beyond the Customer Service hours of 8:00am to 6:00pm (Central Standard Time). Also, there is no limit to the number of claims you can check in the IVR!

FREQUENTLY ASKED QUESTIONS...

CIGNA Medicare contracts with the Centers for Medicare & Medicaid Services (CMS) to process Medicare claims and answer calls from providers and beneficiaries. Due to a 163% increase in our call volume from 2002, callers are frequently receiving a busy signal on the current toll-free line. Those who need to speak to a Customer Service Agent are having a hard time getting through.

As a result, CIGNA Medicare and CMS have developed a plan to add an additional toll-free number to help alleviate busy signals and allow those with more complex inquiries to speak directly to an agent. The existing toll-free line (877) 320-0390 will be devoted to inquiries that can be conducted entirely through the Interactive Voice Response Unit (IVR). Complex inquiries that cannot be resolved through the IVR can be made to the new toll-free number, (866) 243-7272, where Customer Service Agents will be available to assist you.

When will this new plan go into effect ? I noticed Palmetto GBA, Region C is implementing the same plan in March 2003?
CIGNA Medicare will go "live" with the new toll-free line in April 14, 2003.

When should I call the IVR line versus the customer service line?
The customer service line is reserved for complex issues that cannot be resolved by using the IVR. Inquiries that must be made to the IVR line include:

- Claim Status - pending, denied, paid and/or applied to deductible
- Outstanding Check Information
- Current Deductible Information (available to participating suppliers)
- Medicare Beneficiary Eligibility Information
- Allowable Information
- Duplicate Payment Reports
- Ordering Publications
- New Legislation, Supplier Issues and Educational Seminar Information
- Information About Appeal Rights

If I contact a Customer Service Agent with an issue that can be handled through the IVR, will they still be able to assist me?
Suppliers contacting the Customer Service Agents with inquiries that can be handled through the IVR will be advised to disconnect and call the IVR toll-free number, (877) 320-0390. Suppliers calling on the beneficiary toll-free line will also be instructed to disconnect and call the appropriate number.

Can we "opt out" for a Customer Service Agent when using the IVR?
Unfortunately, when accessing the toll-free IVR number, suppliers will not have the capability to transfer directly to an agent.

Will I still be able to speak to a Customer Service Agent?
Yes, however suppliers should first seek out information from the various resources listed on the Resource Sheet. If you can not obtain information from one of these avenues, at that time, you may contact a Customer Service Agent.

I don't like using the IVR. Do you have any plans to make it more user friendly?
CIGNA Medicare is always looking for ways to improve our IVR! Several changes have already been put in place to make our IVR more user friendly. CIGNA Medicare is constantly monitoring and updating the features of the IVR as needed. Your comments, suggestions, or questions about using the IVR may be directed to any of our Customer Service Agents.

How do I obtain the most current DMERC Dialogue or any other CIGNA Medicare publication?
CIGNA Medicare's Web site has DMERC Dialogues from March 1997 to current as well as the Region D Supplier Manual. If you would like to order publications from CIGNA Medicare's Office Services, an order form can be accessed from the following link:
http://www.cignamedicare.com/dmerc/resource.html

Appendix

- **DMERC Region D – Companion Document/Trading Partner Agreement** *(updated 05/22/02)*

a HealthCare
Medicare Administration

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

DMERC Region D –
Companion Document/Trading Partner Agreement

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI X12N 837 implementation guides have been established as the standards of compliance for claim transactions. The implementation guides for each transaction are available electronically at *www.wpc-edi.com.*

The following information is intended to serve only as a companion document to the HIPAA ANSI X12N 837 implementation guides. The use of this document is solely for the purpose of clarification.

The information describes specific requirements to be used for processing data in the ViPS Medicare processing system of CIGNA Healthcare Medicare Administration (CIGNA Medicare) Contractor number 05655. The information in this document is subject to change. Changes will be communicated in the standard *DMERC Dialogue* and *EDI Edge* quarterly news bulletins and on CIGNA Medicare's Web site: *www.cignamedicare.com.* This companion document supplements, but does not contradict any requirements in the X12N 837 Professional implementation guide. Additional companion documents/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

- Negative values submitted in the following fields will not be processed and will result in the claim being rejected: Total Claim Charge Amount (2300 Loop, CLM02), Patient Amount Paid (2300 Loop, AMT02), Patient Weight (2300 and 2400 Loop, CR102), Transport Distance (2300 and 2400 Loop, CR106), Payer Paid Amount (2320 Loop, AMT02), Allowed Amount (2320 Loop, AMT02), Line Item Charge Amount (2400 Loop, SV102), Service Unit Count (2400 Loop, SV104), Total Purchased Service Amount (2300 Loop, AMT02), and Purchased Service Charge Amount (2400 Loop, PS102).
- The only valid values for CLM05-3 (Claim Frequency Type Code) are '1' (ORIGINAL) and '7' (REPLACEMENT). Claims with a value of '7' will be processed as original claims and will result in duplicate claim rejection. The claims processing system does not process electronic replacements.
- The maximum number of characters to be submitted in the dollar amount field is seven characters. Claims in excess of 99,999.99 will be rejected.
- Claims that contain percentage amounts submitted with values in excess of 99.99 will be rejected.
- Claims that contain percentage amounts submitted with more than two positions to the left or the right of the decimal will be rejected.
- Data submitted in CLM20 (Delay Reason Code) will not be used for processing.
- CIGNA Medicare will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.

- You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Professional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set will cause the interchange (transmission) to be rejected at the carrier translator.
- The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.
- Currency code (CUR02) must equal 'USA'.
- Diagnosis codes have a maximum size of five (5). Medicare does not accept decimal points in diagnosis codes.
- Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102).
- Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).
- Service unit counts (units or minutes) cannot exceed 999.9 (SV104).
- For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MB). The Patient Hierarchical Level (2000C loop) is not used.
- The incoming 837 transactions utilize delimiters from the following list: >, *, ~, ^, |, and: Submitting delimiters not supported within this list may cause an interchange (transmission) to be rejected.
- Only loops, segments, and data elements valid for the HIPAA Institutional or Professional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.
- Only loops, segments, and data elements valid for the HIPAA Institutional or Professional Implementation Guides will be translated. Non-implementation guide data will not be sent for processing consideration.
- All dates that are submitted on an incoming 837 claim transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the applicable interchange (transmission).
- Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).
- Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE).
- CIGNA Medicare will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange).
- CIGNA Medicare will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Institutional or Professional Implementation Guides.
- CIGNA Medicare will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.

- CIGNA Medicare will reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the carrier definition.
- CIGNA Medicare will reject an interchange (transmission) that is not submitted with a valid carrier code. Each individual Contractor determines this code.
- CIGNA Medicare will reject an interchange (transmission) submitted with more than 9,999 loops.
- CIGNA Medicare will reject an interchange (transmission) submitted with more than 9,999 segments per loop.
- CIGNA Medicare will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) may cause the transaction to be rejected.
- CIGNA Medicare will only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).
- CIGNA Medicare will reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.
- You may send up to eight diagnosis codes per claim; however, the last four diagnosis codes will not be considered in processing.
- Only valid qualifiers for Medicare should be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicare processing not defined for use in Medicare billing will cause the claim or the transaction to be rejected.
- You may send up to four modifiers; however, the last modifier may not be considered. The CIGNA Medicare processing system may only use the first three modifiers for adjudication and payment determination of claims.
- CIGNA Medicare will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997.
- We suggest retrieval of the ANSI 997 functional acknowledgment files on or before the first business day after the claim file is submitted, but no later than five days after the file submission.
- Compression of files is not supported for transmissions between the submitter and CIGNA Medicare.

Glossary

- A -

ANSI: American National Standards Institute – The highest level national standards organization that coordinates voluntary standards in the United States. Does not develop standards, but approves a standard when the sanctioned development organizations prove substantial agreement from those affected by the proposed standard.

American National Standards Institute (ANSI) Format: Stream file format that uses transactions, segments, elements, identifiers, and delimiters. All data lengths are variable in this format. Specifications for the HIPAA-compliant ANSI X12N version 4010 implementation guides are available on the Washington Publishing Company Web site at *www.wpc-edi.com.*

AT&T Global Services Network: The network, formerly IBM Global Services Network, utilized by users of AT&T Passport for Windows communications software in order to utilize Claim Status Inquiry (CSI).

AT&T Passport for Windows: Communications software used to access Claim Status Inquiry (CSI).

- B -

Beneficiary Eligibility: A feature that enables participating providers/suppliers to electronically access information regarding the eligibility data of beneficiaries.

Billing Provider: The entity submitting electronic claims. This will be the provider of medical services who is requesting adjudication of the claim.

Billing Service: An entity that provides claims services to providers/suppliers. It compiles medical information to build and transmit claims. They will collect claim information from a provider/supplier electronically or on paper and will bill the appropriate insurance payer. Note: You are responsible for verifying that claims are being transmitted electronically, and for the accuracy of claims that a billing service or clearinghouse sends to CIGNA Medicare on your behalf.

- C -

Claim Control Number (CCN): A tracking number assigned by CIGNA Medicare to claims that were accepted into its claims processing system.

Certificates of Medical Necessity (CMN) Reject Report: A report that lists all CMNs that were rejected after the claim was accepted into the CIGNA Medicare system. This report will accompany the Electronic Receipt Listing (ERL), for DMERC only.

Claim Status Inquiry (CSI): A feature that allows providers/suppliers to electronically check the status of production claims. This allows EMC providers/suppliers to electronically access information displaying the receipt and payment status of their pending or assigned claims.

Claim File: Once claim data is entered into your Medicare billing software, the billing software then compiles the data and develops an electronic file in the ANSI format. This file is then transmitted electronically to CIGNA Medicare.

Clean Claim: A claim that does not require investigation or development outside the Medicare operation on a prepayment basis.

Clearinghouse: An entity that transfers or moves EDI transactions for a provider/supplier. A clearinghouse accepts multiple types of claims and sends them to various payers, including Medicare. **Note:** You are responsible for verifying that claims are being transmitted electronically, and for the accuracy of claims that a billing service or clearinghouse sends to CIGNA Medicare on your behalf.

Code Set: A group of codes with pre-defined meanings. A code set may be controlled by X12 or by an independent industry group. Only values from a named code set may be used in specific data elements.

Communications Software: The software that enables one to send or receive information from one computer to another.

- D -

DMERC Medicare Automated Claims System (DMACS32) Software: The computer software provided by CIGNA Medicare that allows suppliers to create Medicare claim files. Note: DMACS32 is a stand-alone program and cannot be integrated with any existing medical management software program.

- E -

Electronic Data Interchange (EDI): The computer-to-computer electronic exchange of business documents using standard formats.

EDI Enrollment Form: A HCFA (now CMS) agreement stating that the provider/supplier is responsible for the Medicare claims sent by itself, its employees, or its agents. Each provider of health care services, physician, or supplier that intends to submit electronic media claims (EMC) must execute the agreement. The EDI Enrollment Form must be completed prior to submitting EMC to Medicare. The signed original form must be on file for each Medicare carrier that processes your claims before production claims may be transmitted.

Electronic Funds Transfer (EFT): Automatically transferring payment to a provider's or supplier's bank account.

Electronic Media Claims (EMC): Transmitting claims by computer rather than submitting them on paper.

Electronic Receipt Listing (ERL) and Standardized Error Report: A report that lists all claims received by CIGNA Medicare. The standardized error report will list all of the claims that were rejected and did not get into the system.

Electronic Remittance Notice (ERN): An electronic payment report, which lists claims that have been paid and/or denied. The ERN process may permit the provider/supplier to utilize automatic posting capability if they use a practice management system.

Element: The smallest named unit of information in the ASC X12 standards. An element is almost always defined as variable length with specified minimum and maximum requirements. Elements do not repeat and may be optional or mandatory within the segment.

- F -

Functional Acknowledgment (997): An EDI message sent in response to the receipt of an electronic transaction used to notify the sender that the information was received. It acknowledges receipt only and does not imply agreement with acceptance of the content of the transaction.

- I -

Implementation Guide: Set of standards developed by the ANSI X12N sub-committee to specify format and data requirements to be used for the electronic transactions named in the HIPAA Transactions and Code Sets Final Rule. These guides are available to download, free-of-charge, at *www.wpc-edi.com.*

- L -

Loop: The largest named unit of information in a transaction set. A loop contains logically related segments in a defined sequence in order to group related information together. Loops may repeat up to a specified number of times and may be optional or mandatory based on the usage of the first segment of that loop.

- O -

Ordering Provider: The individual whom ordered supplies for the subscriber. The Ordering Provider is the physician who provided the order to the subscriber or completed the DMERC CMN.

- P -

Patient: The individual for whom a health insurance claim is being submitted if different from the subscriber. For Medicare claim purposes this will not apply because the patient (beneficiary) will always be the subscriber.

Payer: The entity from which payment is being requested.

Payment Floor: The minimum amount of time a claim must be held before payment can be released. EMC claims must remain on the payment floor 13 days before payment is released. Paper claims must remain on the payment floor for 26 days before payment is released.

Pay-to Provider: The entity receiving payment for the claims being sent in this transaction. This provider information would only be used if the pay-to provider is different from the billing provider. This information is not used for DMERC claim processing because the billing provider represents the company whom provided the services for this claim.

Proprietary Software: This software is written or developed in-house for a company, and tailored to the specific needs of that company. Specifications for the HIPAA compliant ANSI X12N version 4010 implementation guides are available on the Washington Publishing Company Web Site at *www.wpc-edi.com.*

- Q -

Qualifier: A code from an approved code list used to define the data contained in the element following the qualifier.

- R -

Reader (Program): A software program which is designed for the purpose of converting raw data to a recognizable format for interpretation.

- S -

Segment: An intermediate unit of information in a transaction set. A segment contains logically related data elements in a defined sequence which can be used in one or more business transactions; it consists of a segment identifier (which is not a data element), one or more data elements delimited by a data element separator, and a segment terminator. The data segment is always defined as variable length, with the exception of the very first segment within the transaction. Segments may repeat up to a specified number of times and may be optional or mandatory within the transaction set.

Stratus: An asynchronous transmission mailbox system that allows users to dial directly into CIGNA Medicare's Gateway Service. This network is used to transmit claims and download reports.

Submitter ID: An identification number assigned by the DMERC Electronic Data Interchange department to identify electronic billers. DMERC billers will be issued one Submitter ID that may be used to transmit claims to any of the four DMERCs.

Subscriber: The individual for whom the Medicare claim is being submitted. This individual is also referred to as the Medicare beneficiary. For Medicare claim purposes, the beneficiary is always the subscriber.

- T -

Taxonomy Code: A code that identifies the provider's specialization, a segment of the population that a health care provider chooses to service, a specific medical service, a specialization in treating a specific disease, or any other descriptive characteristic about the providers practice relating to the services rendered.

Trading Partner: Any entity conducting electronic transactions with another entity.

Trading Partner Agreement: An agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement.

Transaction Set: The culmination of data that represents the information exchange between trading partners for a specified business process.

- V -

Vendor: An entity that provides hardware, software, and/or ongoing technical support for providers/suppliers.

Vendor Software: Software written or developed by a third party entity (vendor) so that providers/suppliers might submit claims to CIGNA Medicare. If you already use vendor software to manage your practice, contact the vendor to see if they offer a feature for submitting claims to Medicare.

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Legend: 1.1 = Chapter 1.Page 1

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