Chapter 1: Overview

National Government Services, the Common Electronic Data Interchange (CEDI) returns all electronic front-end reports directly to Durable Medical Equipment Medicare Administrative Contractor (DME MAC) electronic trading partners/submitters. CEDI creates the TA1, TRN, 997, and GenResponse reports that are received by the DME MAC electronic submitters. Additional electronic reports are created by the DME MAC Jurisdictions and delivered by CEDI. This manual provides a description of all CEDI reports, instructions on what to do when the report is received and report examples.

The following reports are included in this manual:

- TA1 Report
- TRN Report
- 997 Report
- GenResponse Report
- DME MAC Front-End Report

List of CEDI Acronyms

ABG	Arterial blood gas
ANSI	American National Standards Institute
APG	Approved patient group
ASCA	Administrative Simplification Compliance Act
CCN	Claim control number Number assigned to claims accepted by CEDI to be used to track claims processed by the DME MACs Also referred to as internal control number (ICN)
CEDI	Common Electronic Data Interchange Electronic gateway for submitting Medicare DME claims
CLIA	Clinical Laboratory Improvement Amendment
CMN	Certificate of Medical Necessity A certificate that supports the need of a DME item
CMS	Centers for Medicare & Medicaid Services
DIF	DME Information Form
DME	Durable medical equipment Medical equipment used at the patient's place of residence that contributes to a better quality of life and can be used over an extended period of time
DME MAC	Durable medical equipment Medicare administrative contractor
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
EDI	Electronic data interchange
EIN	Employer Identification Number
EPSDT	Early and periodic screening, diagnosis and treatment
GENRPT	GenResponse Report A CEDI processed report identifying all front-end rejections as well as claims accepted to Medicare by providing an ICN
HCPCS	Healthcare Common Procedure Coding System
HICN (HIC)	Health Insurance Claim number
HIEC	Home Infusion EDI Coalition
HIPAA	Health Insurance Portability and Accountability Act Requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers
IDE	Investigational device exemption
ICD-9	International Classification of Diseases, Clinical Modification, 9th Revision A free list of Diagnosis and HCPCS codes are listed on the ICD-9 Web site at www.icd9data.com
ICN	Internal control number Heading for the claim control number (CCN) on the GENRPT produced by CEDI
LPM	Liters per minute
MAC	Medicare administrative contractor

MSP	Medicare Secondary Payer
NDC	National drug code
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System Assigns unique identifiers for health care providers and health plans as mandated by HIPAA (NPI)
NSC	National Supplier Clearinghouse Assigns unique numbers that identifies the applicant as a supplier of DMEPOS (Provider Transaction Access Number [PTAN]/NSC number)
NUBC	National Uniform Billing Committee
PECOS	Provider Enrollment, Chain and Ownership System
PTAN	Provider Transaction Access Number Unique supplier number assigned by the NSC
SSN	Social Security Number
TP	Trading partner Submitter who exchanges electronic transactions with CEDI; Also referred to as a submitter or sender
TP ID	Trading partner identifier Unique identifier used by the trading partner (submitter/sender) assigned by CEDI
TRN	Transaction Acknowledgement Report A validation report showing that a valid file has been received by CEDI for processing

TA1 Rejection Codes and Descriptions

000 No error
001 The interchange control number in the header and trailer do not match. The value from the header is used in the acknowledgement.
002 This standard as noted in the control standards identifier is not supported
003 This version of the controls is not supported
004 The segment terminator is invalid
005 Invalid interchange id qualifier for sender
006 Invalid interchange sender ID
007 Invalid interchange id qualifier for receiver
008 Invalid interchange receiver ID
009 Unknown interchange receiver ID
010 Invalid authorization information qualifier value
011 Invalid authorization information value
012 Invalid security information qualifier value
013 Invalid security information value
014 Invalid interchange date value
015 Invalid interchange time value
016 Invalid interchange standards identifier value
017 Invalid interchange version id value
018 Invalid interchange control number value
019 Invalid acknowledgement requested value
020 Invalid test indicator value
021 Invalid number of included groups value
022 Invalid control structure
023 Improper (premature) end-of-file (transmission)
024 Invalid interchange content (e.g., invalid GS segment)
025 Duplicate interchange control number
026 Invalid data element separator
027 Invalid component element separator
028 Invalid delivery date in deferred delivery request
029 Invalid delivery time in deferred delivery request
030 Invalid delivery time code in deferred delivery request
031 Invalid grade of service code

Chapter 5: GenResponse Report

The GenResponse Report (GENRPT) explains the status of a trading partner's American National Standards Institute (ANSI) electronic claims file (837). Edits for electronic data interchange (EDI) enrollment, ANSI 837 v4010.A1 *Implementation Guide*, edits and business level edits will occur on the GENRPT.

All electronic front-end claim editing is done through CEDI and all front-end rejections are returned on the CEDI GENRPT Report. Claims accepted on the GENRPT Report are assigned a CCN/internal claim number (ICN). These are indicated on the GENRPT Report that is returned to the trading partner from CEDI. This CCN/ICN is attached to the claim as it enters the appropriate DME MAC for processing.

Claims accepted on the Common Electronic Data Interchange (CEDI) GENRPT will be delivered to the appropriate durable medical equipment Medicare administrative contractor (DME MAC) Jurisdiction, based on the beneficiary's two letter state abbreviation code submitted on the claim.

Claims that reject on the GENRPT will **not** be delivered to the appropriate DME MAC Jurisdiction. It is the trading partner's responsibility to monitor the GENRPT for rejected claims, correct the claims that rejected and resubmit them to CEDI.

- Trading partners will continue to receive the Level II reports from the DME MACs. However, this report will no longer receive Front-end rejections. The CCN/ICN numbers listed on the report will be the same as the ones assigned on the GENRPT Report.
- DME MACs will continue to produce the CMN Reject and this report will be returned to trading partners through CEDI on the DME MAC RPT Level II Reports.

Report Name: The report name is "GENRPT*filename*.sequence number.sequence number" (the "*filename*" is the name of the submitted claims file).

Timeframe: The GENRPT is typically delivered back to the trading partner within 30 minutes; however, the size of the claims file will determine how long it takes to produce the GENRPT. If the GENRPT is not received within four hours, contact the CEDI Help Desk at 866-311-9184.

Field	Description
	batch or file errors.
Total Rejected	The sum of claims with errors or other rejected.
Accepted	The total number and dollar amount of claims passed for further processing.
Total Claims	Sum of claims and sum of dollars of total claims transmitted.
Destination Summary	Name of this portion of the report.
Destination	The names of where the accepted claims will go for further processing. – Jurisdiction A – MB16003P (T = test, P = production) Jurisdiction B – MB17003P (T = test, P = production) Jurisdiction C – MB18003P (T = test, P = production) Jurisdiction D – MB19003P (T = test, P = production)
Number of Claims	The number of claims accepted for this destination.
Total Charges	Total dollar of the accepted claims by destination.
Total Number of Claims	Total number of accepted claims.
Total Charges	Total dollar amount of all accepted claims.

Field	Description
	the heading "GenReponse Report Error Codes and Descriptions."

Field	Description
Value	The value sent that is incorrect.
Desc	The error code description. See the error code listing in this chapter under the heading "GenReponse Report Error Codes and Descriptions."

Field	Description
Field	The field within a record that contains the error.
Seq	This field may be populated with a '0' or may contain the segment position within a logical portion of the file.
Code	The Warning code. See the error code listing beginning on page 20.
Value	The value sent that is incorrect.
Desc	The error code description. See the error code listing beginning on page 20.

Important: If a claim has just a warning with no rejections, and thus is accepted by CEDI, it will have a claim control number in the "ICN" field. Also, if a claim has no claim level errors but does not have a claim control number in the "ICN" field, check for batch/provider level errors for rejection.

Field	Description
Payer ID	The Payer's Identification Number: – Jurisdiction A – 16003 – Jurisdiction B – 17003 – Jurisdiction C – 18003 – Jurisdiction D – 19003
Source of Pay	Code used to identify the payer: MA = Medicare A, MB = Medicare B (DME MAC)
ICN	Internal claim numbers (ICN), also known as claim control numbers (CCN) are assigned by CEDI and included in this field.
Loop	The loop where the error occurred.
Segment	The record or the segment where the error occurred.
Field	The field within a record that contains the error.
Seq	This field may be populated with a '0' or may contain the segment position within a logical portion of the file.
Error Code	The error code. See the GenReponse Report Error Codes and Descriptions on the next page.
Value	The value sent that is incorrect.
Desc	The error code description. See the GenReponse Report Error Codes and Descriptions on the next page.

Important: If a claim has no claim level errors but does not have a claim control number in the "ICN" field, check for batch/provider level errors for rejection.

GenReponse Report Error Codes and Descriptions

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
A002	Security Information Invalid	ISA04		The security information is missing for this interchange. If it was indicated that security information is present, this element must be filled with ten alpha/numeric characters. If it was indicated no security information is submitted, this must be spaces. This edit should be resolved by contacting your software vendor.
A003	Interchange Date can't be a future date	ISA09		The creation date is a future date. This cannot be greater than the claim's submission date. This edit should be resolved by contacting your software vendor.
A005	Creation Date can't be a future date	GS04		The functional group creation date is a future date. This cannot be greater than today's date. This edit should be resolved by contacting your software vendor.
A006	Transaction Set Create Date can't be future date	BHT04		The creation date for this transaction set was submitted as a date greater than the claim's submission date. This edit should be resolved by contacting your software vendor.
A008	Submitter Last Name is Invalid	1000A	NM103	The submitter last name or organization name is invalid. The first position cannot be a space.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				If NM102 = 1 (person), NM103 (last name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space. If NM102 = 2 (non-person), NM103 (company name) may contain only ‘A’–‘Z’, ‘a’–‘z’, ‘0’–‘9’, dash/hyphen (-), slash (/), period (.), comma (,), ampersand (&), single quotation/apostrophe (‘), double quotation (“) or space character values and the first position must contain an ‘A’–‘Z’, ‘a’–‘z’ or ‘0’–‘9’ character value.
A009	Submitter First Name is missing	1000A	NM104	The first name of the submitter is missing for this transaction. If the submitter type was 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.
A010	Submitter First Name is Invalid	1000A	NM104	The submitter first name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM104 (first name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
A011	Submitter Middle Name is invalid	1000A	NM105	The submitter middle name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM105 (middle name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
A013	Receiver Name is invalid	1000B	NM103	The receiver organization name is invalid. The first position cannot be a space. NM102 must = 2 (nonperson) NM103 (company name) may contain only 'A'–'Z', 'a'–'z', '0'–'9', dash/hyphen (-), slash (/), period (.), comma (,), ampersand (&), single quotation/apostrophe ('), double quotation (") or space character values and the first position must contain an 'A'–'Z', 'a'–'z' or '0'–'9' character value.
A014	Billing/Pay-To Prov Specialty code invalid	2000A	PRV03	The billing provider taxonomy code is invalid. Verify the taxonomy code submitted is valid according to the taxonomy code list published by Washington Publishing Company. To obtain a copy of the taxonomy code list, visit their Web site a www.wpc-edi.com.
A015	Currency Country Code Invalid	2000A	CUR02	The country code is invalid. A foreign currency billing provider and currency code were submitted; however, the country code is invalid.
A018	Billing Provider Last Name is invalid	2010AA	NM103	The billing provider last name or organization name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM103 (last name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe ('), or a space. If NM102 = 2 (non-person), NM103

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				(company name) may contain only 'A'–'Z', 'a'–'z', '0'–'9', dash/hyphen (-), slash (/), period (.), comma (,), ampersand (&), single quotation/apostrophe ('), double quotation (") or space character values and the first position must contain an 'A'–'Z', 'a'–'z' or '0'–'9' character value.
A019	Billing Provider First Name is Missing	2010AA	NM104	The first name of the billing provider is missing. If the billing provider type was 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.
A020	Billing Provider First Name is invalid	2010AA	NM104	The billing provider first name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM104 (first name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe ('), or a space.
A021	Billing Provider Middle Name is invalid	2010AA	NM105	The billing provider middle name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM105 (middle name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe ('), or a space.
A022	Billing Provider City is invalid	2010AA	N401	The billing provider city is invalid. The first position cannot be a space.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				May contain only 'A'–'Z', 'a'–'z', dash/hyphen (-), period (.), or space character values and the first position must contain an 'A'–'Z' or 'a'– z' character value.
A023	Billing Provider State is invalid	2010AA	N402	The billing provider state is invalid. This must be a valid two-character state abbreviation code. CEDI requires that both letters in the state abbreviation code be capitalized.
A024	Billing Provider Zip code is invalid	2010AA	N403	The billing provider is missing or invalid. The ZIP code must be a valid US Postal Service Code. The ZIP code must be numeric. The ZIP code must not be all zeroes and/or all nines.
A025	Billing Provider Country is invalid	2010AA	N404	The billing provider country code is not valid. This error can be caused by an invalid state abbreviation code.
A026	Tax ID or SSN Number is Required	2010AA	REF01	The billing provider's Employer Identification Number (EIN) or Social Security Number (SSN) was not submitted on the claim.
A026	Tax ID or SSN Number is Required	2010AB	REF01	The pay-to provider's Employer Identification Number (EIN) or Social Security Number (SSN) was not submitted on the claim.
A027	Qualifier Code Exceeds Max Use	2300	AMT (Qualifier F5)	The patient paid amount segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	AMT (Qualifier NE)	The total purchased service amount segment cannot occur more than one time on a claim.
A027	Qualifier Code	2320	AMT	The amount the primary payer paid

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	Exceeds Max Use		(Qualifier D)	segment cannot occur more than one time on a claim. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A027	Qualifier Code Exceeds Max Use	2320	AMT (Qualifier AAE)	The amount the primary payer approved segment cannot occur more than one time on a claim. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A027	Qualifier Code Exceeds Max Use	2320	AMT (Qualifier B6)	The amount the primary payer allowed segment cannot occur more than one time on a claim. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A027	Qualifier Code Exceeds Max Use	2320	AMT (Qualifier F2)	The amount the patient is responsible for to the other payer segment cannot occur more than one time on a claim. This information is used when a payer is submitting this claim to another payer and should not be submitted by the provider/supplier.
A027	Qualifier Code Exceeds Max Use	2320	AMT (Qualifier AU)	The amount the other payer covered segment cannot occur more than one time on a claim. This information is used when a payer is submitting this claim to another

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				payer and should not be submitted by the provider/supplier.
A027	Qualifier Code Exceeds Max Use	2320	AMT (Qualifier D8)	The amount the other payer discounted segment cannot occur more than one time on a claim. This information is used when a payer is submitting this claim to another payer and should not be submitted by the provider/supplier.
A027	Qualifier Code Exceeds Max Use	2320	AMT (Qualifier DY)	The daily limit amount for the other payer segment cannot occur more than one time on a claim. This information is used when a payer is submitting this claim to another payer and should not be submitted by the provider/supplier.
A027	Qualifier Code Exceeds Max Use	2320	AMT (Qualifier F5)	The amount paid by the other payer to the patient segment cannot occur more than one time on a claim. This information is used when a payer is submitting this claim to another payer and should not be submitted by the provider/supplier.
A027	Qualifier Code Exceeds Max Use	2320	AMT (Qualifier T)	The other payer tax segment cannot occur more than one time on a claim. This information is used when a payer is submitting this claim to another payer and should not be submitted by the provider/supplier.
A027	Qualifier Code Exceeds Max Use	2320	AMT (Qualifier T2)	The other payer total claim before taxes amount segment cannot occur more than one time on a claim. This information is used when a payer is submitting this claim to another payer and should not be submitted by

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				the provider/supplier.
A027	Qualifier Code Exceeds Max Use	2400	AMT (Qualifier F4)	The postage amount segment cannot occur more than one time on a charge line.
A027	Qualifier Code Exceeds Max Use	2300	CRC (Qualifier 07)	The ambulance certification segment cannot occur more than three times on a claim.
A027	Qualifier Code Exceeds Max Use	2300	CRC (QualifiersE1, E2, E3)	The vision correction segment cannot occur more than three times on a claim.
A027	Qualifier Code Exceeds Max Use	2300	CRC (Qualifier 75)	The homebound segment, used to report information when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient, cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	CRC (Qualifier ZZ)	The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2400	CRC (Qualifier 70)	The hospice employee segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	DTP (Qualifier 454)	The initial treatment date segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	DTP (Qualifier 304)	The date last seen segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	DTP (Qualifier 431)	The current illness/symptom date segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	DTP (Qualifier 453)	The acute manifestation segment cannot occur more than five times on a claim.
A027	Qualifier Code Exceeds Max Use	2300	DTP (Qualifier 438)	The onset of similar illness/symptoms date segment cannot occur more than ten times on a claim.
A027	Qualifier Code Exceeds Max Use	2300	DTP (Qualifier 439)	The date of the accident segment cannot occur more than ten times on a claim.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
A027	Qualifier Code Exceeds Max Use	2300	DTP (Qualifier 484)	The last menstrual period date segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	DTP (Qualifier 455)	The last x-ray date segment cannot repeat more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	DTP (Qualifier 471)	The hearing and vision prescription date segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	DTP (Qualifier 360)	The disability "begin" date segment cannot occur more than five times on claim.
A027	Qualifier Code Exceeds Max Use	2300	DTP (Qualifier 361)	The disability "end" date segment cannot occur more than five times on a claim.
A027	Qualifier Code Exceeds Max Use	2300	DTP (Qualifier 297)	The date last worked segment cannot occur more than one time per claim.
A027	Qualifier Code Exceeds Max Use	2300	DTP (Qualifier 296)	The date authorized to return to work segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	DTP (Qualifier 435)	The date of admission segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	DTP (Qualifier 096)	The date of discharge segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	DTP (Qualifiers90, 091)	The date of assumed and relinquished care segment cannot occur more than two times on a claim.
A027	Qualifier Code Exceeds Max Use	2400	DTP (Qualifier 472)	The date of service segment cannot occur more than one time on a charge line.
A027	Qualifier Code Exceeds Max Use	2400	DTP (Qualifier 607)	The CMN revision/recertification date segment cannot occur more than one time on a charge line.
A027	Qualifier Code Exceeds Max Use	2400	DTP (Qualifier 463)	The "begin" therapy date (CMN initial date) segment cannot occur more than one time on a charge line.
A027	Qualifier Code Exceeds Max Use	2400	DTP (Qualifier 461)	The last certification date (date the CMN was signed by the physician) cannot occur more than one time on a claim.
A027	Qualifier Code	2400	DTP	The date last seen segment cannot

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	Exceeds Max Use		(Qualifier 304)	occur more than one time on a charge line.
A027	Qualifier Code Exceeds Max Use	2400	DTP (Qualifier 011)	The shipped date segment cannot occur more than one time on a charge line.
A027	Qualifier Code Exceeds Max Use	2400	DTP (Qualifier 431)	The onset of current symptom or illness date segment cannot occur more than one time on a charge line
A027	Qualifier Code Exceeds Max Use	2400	DTP (Qualifier 455)	The last x-ray date segment cannot occur more than one time on a charge line.
A027	Qualifier Code Exceeds Max Use	2400	DTP (Qualifier 453)	The acute manifestation date segment cannot occur more than one time on a charge line.
A027	Qualifier Code Exceeds Max Use	2400	DTP (Qualifier 454)	The initial treatment date segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2400	DTP (Qualifier 438)	The onset of similar illness or symptom date segment cannot occur more than one time on a charge line.
A027	Qualifier Code Exceeds Max Use	2300	REF (Qualifier 4N)	The service authorization exception code segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	REF (Qualifier F5)	The mandatory Medicare crossover indicator segment cannot occur more than one time on a claim. This information is used when a payer is submitting this claim to another payer and should not be submitted by the provider/supplier.
A027	Qualifier Code Exceeds Max Use	2300	REF (Qualifier EW)	The mammography certification segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	REF (Qualifiers 9F, G1)	The prior authorization or referral number segment cannot occur more than two times on a claim.
A027	Qualifier Code Exceeds Max Use	2300	REF (Qualifier F8)	The original reference number segment cannot occur more than one time on a claim.
A027	Qualifier Code	2300	REF	The Clinical Laboratory Improvement

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	Exceeds Max Use		(Qualifier X4)	Amendment (CLIA) number segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	REF (Qualifier 9A)	The re-priced claim number segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	REF (Qualifier 9C)	The adjusted re-priced claim number segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	REF (Qualifier LX)	The investigational device exemption number (IDE) segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	REF (Qualifier D9)	The claim identification number for clearinghouse and other transmission intermediaries segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	REF (Qualifier 1S)	The ambulatory patient group number segment cannot occur more than four times on a claim.
A027	Qualifier Code Exceeds Max Use	2300	REF (Qualifier EA)	The medical record number segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2300	REF (Qualifier P4)	The demonstration project identifier segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2400	REF (Qualifier 9B)	The re-priced line item reference number information segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2400	REF (Qualifier 9D)	The adjusted re-priced line item reference number segment cannot occur more than one time on a charge line.
A027	Qualifier Code Exceeds Max Use	2400	REF (Qualifiers 9F, G1)	The prior authorization or referral number segment cannot occur more than one time on a charge line.
A027	Qualifier Code Exceeds Max Use	2400	REF (Qualifier 6R)	The line item control number segment cannot occur more than one time on a charge line.
A027	Qualifier Code Exceeds Max Use	2400	REF (Qualifier EW)	The mammography certification segment cannot occur more than one

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				time on a charge line.
A027	Qualifier Code Exceeds Max Use	2400	REF (Qualifier X4)	The Clinical Laboratory Improvement Amendment (CLIA) number segment cannot occur more than one time on a charge line.
A027	Qualifier Code Exceeds Max Use	2400	REF (Qualifier F4)	The Clinical Laboratory Improvement Amendment (CLIA) facility identification segment cannot occur more than one time on a charge line.
A027	Qualifier Code Exceeds Max Use	2400	REF (Qualifier BT)	The immunization batch number segment cannot occur more than one time on a charge line.
A027	Qualifier Code Exceeds Max Use	2400	REF (Qualifier 1S)	The ambulatory patient group segment cannot occur more than four times on a charge line.
A027	Qualifier Code Exceeds Max Use	2400	REF (Qualifier TP)	The oxygen flow rate segment cannot occur more than one time on a claim.
A027	Qualifier Code Exceeds Max Use	2400	REF (Qualifiers OZ, VP)	The universal product number segment cannot occur more than one time on a charge line.
A029	Pay to Provider First Name is Missing	2010AB	NM104	The first name of the pay to provider is missing. If the pay to provider type was 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.
A030	Pay to Provider First Name is invalid	2010AB	NM104	The pay to provider first name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM104 (first name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
A031	Pay to Provider	2010AB	NM105	The pay to provider middle name is

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	Middle Name is Invalid			invalid. The first position cannot be a space. If NM102 = 1 (person), NM105 (middle name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
A032	Pay to Provider City is invalid	2010AB	N401	The pay to provider city is invalid. The first position cannot be a space. May contain only ‘A’–‘Z’, ‘a’–‘z’, dash/hyphen (-), period (.), or space character values and the first position must contain an ‘A’–‘Z’ or ‘a’–‘z’ character value.
A033	Pay to Provider State Code is invalid	2010AB	N402	The pay to provider state is not a valid two-letter state abbreviation code. CEDI requires that both letters in the state abbreviation code be capitalized.
A034	Pay to Provider Zip Code is invalid	2010AB	N403	The pay to provider ZIP code is missing or invalid. The ZIP code must be a valid US Postal Service Code. The ZIP code must be numeric. The ZIP code must not be all zeroes and/or all nines.
A035	Pay to Provider country code is invalid	2010AB	N404	The pay to provider country code is valid. This error can be caused by an invalid state abbreviation code.
A036	Subscriber HL Child Code must =0	2000B	HL04	For Medicare claims, the 2000B.HL04 must = “0” indicating no subordinate information is present.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
A037	Relationship Code must = 18 (self)	2000B	SBR02	The subscriber relationship to insured qualifier is invalid. Valid Value: 18 – Self
A038	Relationship Code must = spaces	2000B	SBR02	If 2000B.HL04 = "1" to indicate subordinate information is present), the relationship code in the 2000B.SBR02 cannot be present. **Note:** For Medicare, the Subscriber must be the same as the Patient (SBR02=18).
A039	Patient Information can not be present	2000B	PAT	If 2000B.SBR02 is not present indicating the patient is not subscriber, an occurrence of the 2000B.PAT (Patient Information) segment may not be present. **Note:** For Medicare, the Subscriber must be the same as the Patient (SBR02=18).
A040	Date of Death is a future date	2000B 2000C	PAT06	The subscriber date of death is a future date. This cannot be greater than the claim's submission date.
A041	Patient Weight is invalid	2300 2400	CR102	The patient weight is invalid. This cannot be greater than three positions. This cannot contain a decimal point.
A041	Patient Weight is invalid	2000B	PAT08	The subscriber weight is invalid. This must be numeric and greater than zero. This cannot be greater than six positions to the left of the implied or explicit decimal point. This cannot contain more than two

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				positions to the right of the implied or explicit decimal point.
A042	Subscriber Last Name is invalid	2010BC	NM103	The subscriber's last name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM103 (last name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space and NM104 (first name) must be present following the same rules. If NM102 = 2 (non-person), NM103 (company name) may contain only ‘A’–‘Z’, ‘a’–‘z’, ‘0’–‘9’, dash/hyphen (-), slash (/), period (.), comma (,), ampersand (&), single quotation/apostrophe (‘), double quotation (“) or space character values and the first position must contain an ‘A’–‘Z’, ‘a’–‘z’ or ‘0’–‘9’ character value. The first three positions cannot be any of the following: MR, MR., DR, DR., JR or JR.
A042	Subscriber Last Name is invalid	2330A	NM103	The other insured subscriber's last name invalid. The first position cannot be a space. If NM102 = 1 (person), NM103 (last name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space. If NM102 = 2 (non-person), NM103 (company name) may contain only ‘A’–‘Z’, ‘a’–‘z’, ‘0’ – ‘9’, dash/hyphen (-), slash (/), period (.), comma (,), ampersand (&), single quotation/apostrophe (‘), double quotation (“) or space character values and the first position must contain an

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				'A'–'Z', 'a'–'z' or '0'–'9' character value. The first three positions cannot be any of the following: MR, MR., DR, DR., JR or JR. This information is used for MSP and Medigap secondary claims. MSP claims should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. Medigap secondary claims should not be submitted unless there is an approved Medigap policy held by this subscriber.
A043	Subscriber First Name is missing	2010BA	NM104	The subscriber's first name is missing for this claim. If the subscriber type was a person (NM102=1), this element must contain the first name of that person. If the subscriber was identified as a non-person entity (NM102=2), this element is not used.
A043	Subscriber First Name is missing	2330A	NM104	The other payer subscriber's first name is missing. If the other payer-insured type was a person, this must contain the first name of that person. If the other payer insured was identified as a non-person entity, this is not used. This information is used for MSP and Medigap secondary claims. MSP claims should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. Claims with Medigap information should not be submitted unless there is an approved Medigap policy held by this

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				subscriber.
A044	Subscriber First Name is invalid	2010BA	NM104	The subscriber's first name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM104 may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
A044	Subscriber First Name is invalid	2330A	NM104	The other insured subscriber's first name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM104 (first name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space. This information is used for MSP and Medigap secondary claims. MSP claims should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. Medigap secondary claims should not be submitted unless there is an approved Medigap policy held by this subscriber.
A045	Subscriber Middle Name is invalid	2010BA	NM105	The subscriber's middle name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM105 may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
A045	Subscriber Middle Name is invalid	2330A	NM105	The other insured subscriber's middle name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM105 (middle name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				This information is used for MSP and Medigap secondary claims. MSP claims should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. Medigap secondary claims should not be submitted unless there is an approved Medigap policy held by this subscriber.
A047	ID qualifier invalid for this payer	2010BA	NM108	The subscriber's identification number qualifier invalid. Valid Value: MI – Member Identification Number
A047	ID qualifier invalid for this payer	2330A	NM108	The other insured subscriber's identification number qualifier is invalid. Valid Value: MI – Member identification number This information is used for MSP and Medigap secondary claims. MSP claims should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. Medigap secondary claims should not be submitted unless there is an approved Medigap policy held by this subscriber.
A047	ID qualifier invalid for this payer	2400	SV101-1	The type of product/service qualifier is invalid. Valid Values: HC – HCPCS Codes ZZ – Mutually defined
A047	ID qualifier invalid for this payer	2430	SVD03-1	The type of product/service qualifier is invalid. Valid Values: HC – HCPCS Codes

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				ZZ – Mutually defined
A048	Subscriber ID contains invalid values	2010BA	NM109	The subscriber's primary identifier is invalid. This may only contain the characters 'A-Z', 'a-z', or '0-9'
A049	Subscriber City is invalid	2010BA	N401	The subscriber's city is invalid. The first position cannot be a space. May contain only 'A'–'Z', 'a'–'z', dash/hyphen (-), period (.), or space character values and the first position must contain an 'A'–'Z' or 'a'–'z' character value.
A049	Subscriber City is invalid	2330A	N401	The other insured subscriber's city is invalid. The first position cannot be a space. May contain only 'A'–'Z', 'a'–'z', dash/hyphen (-), period (.), or space character values and the first position must contain an 'A'–'Z' or 'a'–'z' character value. This information is used for MSP and Medigap secondary claims. MSP claims should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. Medigap secondary claims should not be submitted unless there is an approved Medigap policy held by this subscriber.
A050	Subscriber State Code is invalid	2010BA	N402	The subscriber's state code is invalid. This must be a valid two-letter state abbreviation code. CEDI requires that both letters in the state abbreviation code be capitalized.
A050	Subscriber State Code is invalid	2330A	N402	The other insured subscriber's state code is invalid.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				This must be a valid two-character state abbreviation code. CEDI requires that both letters in the state abbreviation code be capitalized. This information is used for MSP and Medigap secondary claims. MSP claims should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. Medigap secondary claims should not be submitted unless there is an approved Medigap policy held by this subscriber.
A051	Subscriber postal ZIP code is invalid	2010BA	N403	The subscriber's ZIP code is missing or invalid. The ZIP code must be a valid US Postal Service Code. The ZIP code must be numeric. The ZIP code must not be all zeroes and/or all nines.
A051	Subscriber postal ZIP code is invalid	2330A	N403	The other insured subscriber's ZIP code is missing or invalid. The ZIP code must be a valid US Postal Service Code. The ZIP code must be numeric. The ZIP code must not be all zeroes and/or all nines.
A052	Subscriber Country Code is invalid	2010BA	N404	The subscriber's country code is invalid. This error can be caused by an invalid state abbreviation code.
A052	Subscriber Country	2330A	N404	The other insured subscriber's country

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	Code is invalid			code is invalid. This error can be caused by an invalid state abbreviation code.
A053	Subscriber Date of Birth is a future Date	2010BA	DMG02	The subscriber's date of birth is in an invalid format. Verify the date is not greater than the claim's submission date and that the century was entered as 18, 19, or 20.
A053	Subscriber Date of Birth is a future Date	2320	DMG02	The other insured subscriber's date of birth is a future date. This cannot be greater than the claim's submission date. This information is used for MSP and Medigap secondary claims. MSP claims should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. Claims with Medigap information should not be submitted unless there is an approved Medigap policy held by this subscriber.
A054	Service Date cannot be < Subscriber DOB	2400	DTP03	The service start/from date is less than the patient date of birth. This must be greater than the patient date of birth.
A055	Value of "1W" cannot be used	2010BA	REF01	The subscriber's secondary identifier is a duplicate of the primary identifier. Valid Values: 23 – Client number IG – Insurance policy number SY – Social Security Number
A056	Payer Name is invalid	2010BB	NM103	The payer organization name is invalid.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				The first position cannot be a space. If NM102 must = 2 (non-person) and NM103 (company name) may contain only 'A'–'Z', 'a'–'z', '0'–'9', dash/hyphen (-), slash (/), period (.), comma (,), ampersand (&), single quotation/apostrophe ('), double quotation (") or space character values and the first position must contain an 'A'–'Z', 'a'–'z' or '0'–'9' character value.
A056	Payer Name is invalid	2330B 2420G	NM103	The other payer organization name is invalid. The first position cannot be a space. If NM102 must = 2 (non-person) and NM103 (company name) may contain only 'A'–'Z', 'a'–'z', '0'–'9', dash/hyphen (-), slash (/), period (.), comma (,), ampersand (&), single quotation/apostrophe ('), double quotation (") or space character values and the first position must contain an 'A'–'Z', 'a'–'z' or '0'–'9' character value.
A057	Value of "PI" must be used	2010BB	NM108	The payer identification qualifier is invalid. Valid Value: PI – Payer Identification
A057	Value of "PI" must be used	2330B	NM108	The other payer identification number qualifier is invalid. Valid Value: PI – Payer Identification This information is used for MSP and Medigap secondary claims. MSP claims should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. Medigap secondary claims should not be

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				submitted unless there is an approved Medigap policy held by this subscriber.
A057	Value of "PI" must be used	2420G	NM108	The prior authorization or referral number qualifier is invalid. Valid Value: PI – Payer Identification This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A058	Payer City is invalid	2010BB	N401	The payer city is invalid. The first position cannot be a space. May contain only 'A'–'Z', 'a'–'z', dash/hyphen (-), period (.), or space character values and the first position must contain an 'A'–'Z' or 'a'–'z' character value.
A059	Payer State Code is invalid	2010BB	N402	The state code submitted is invalid. This must be a valid two-character state abbreviation code.
A060	Payer ZIP code is invalid	2010BB	N403	The payer ZIP code is missing or invalid. The ZIP code must be a valid US Postal Service Code. The ZIP code must be numeric. The ZIP code must not be all zeroes and/or all nines.
A061	Payer Country Code is invalid	2010BB	N404	The payer's country code submitted is invalid. This error can be caused by an invalid state abbreviation code.
A063	Responsible Party	2010BC	NM104	The first name of the responsible party

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	First Name is missing			is missing. If the responsible party type was a person (NM102=1), this element must contain the first name of that person. If the responsible party was identified as a non-person entity (NM102=2), this element is not used.
A064	Responsible Party First Name is invalid	2010BC	NM104	The responsible party first name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM104 may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
A065	Responsible Party Middle Name is invalid	2010BC	NM105	The responsible party middle name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM105 may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
A066	Responsible Party City is invalid	2010BC	N401	The responsible party city is invalid. The first position cannot be a space. May contain only ‘A’–‘Z’, ‘a’–‘z’, dash/hyphen (-), period (.), or space character values and the first position must contain an ‘A’–‘Z’ or ‘a’–‘z’ character value.
A067	Responsible Party State is invalid	2010BC	N402	The responsible party state is invalid. This must be a valid two-character state abbreviation code.
A068	Responsible Party Zip Code is invalid	2010BC	N403	The responsible payee ZIP code is missing or invalid. The ZIP code must be a valid US Postal Service Code.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				The ZIP code must be numeric. The ZIP code must not be all zeroes and/or all nines.
A069	Responsible Party country is invalid	2010BC	N404	The responsible party country code is invalid. This error can be caused by an invalid state abbreviation code.
A074	Patient HL cannot be present	2000B	HL04	When 2000B.HL04 = "0" indicating no subordinate information is present, an occurrence of the 2000C.HL (Patient) segment cannot be present on this claim.
A075	Patient HL must be present	2000B	HL04	If the 2000B.HL04 is "1", there must be a 2000C loop.
A076	Patient Last Name is invalid	2010CA	NM103	The purchased service provider last name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM103 (last name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
A077	Patient First Name is missing	2010CA	NM104	The patient first name is missing.
A078	Patient First Name is invalid	2010CA	NM104	The patient first name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM104 (first name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.◎
A079	Patient Middle Name is invalid	2010CA	NM105	The patient middle name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM105 (middle name) may only contain alpha

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
A080	Patient City must be A-Z and no space in 1st char	2010CA	N401	The patient city is invalid. The first position cannot be a space. May contain only ‘A’–‘Z’, ‘a’–‘z’, dash/hyphen (-), period (.), or space character values and the first position must contain an ‘A’–‘Z’ or ‘a’–‘z’ character value.
A081	Patient State Code is invalid	2010CA	N402	The patient state code is invalid. This must be a valid two-character state abbreviation code.
A082	Patient Zip Code is invalid	2010CA	N403	The patient ZIP code is missing or invalid. The ZIP code must be a valid US Postal Service Code. The ZIP code must be numeric. The ZIP code must not be all zeroes and/or all nines.
A083	Patient Country Code is invalid	2010CA	N404	The patient country code is invalid. This error can be caused by an invalid state abbreviation code.
A084	Patient Date of Birth can't be a future date	2010CA	DMG02	The patient date of birth is invalid. This must be in a valid CCYYMMDD format.
A086	Total claim charge amount is invalid	2300	CLM02	The total claim charge amount in invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot be greater than two

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				positions to the right of the implied or explicit decimal point.
A087	Total Claim Charges not = to sum of services lines	2300	CLM02	The total claim charge amount is invalid. Verify the sum of all line item charges (SV102) equal the total claim charge (CLM02) submitted with this claim.
A088	Claim Postal State Code is invalid	2300	CLM11-4	The auto accident state code is invalid. This must be a valid two-character state abbreviation code.
A089	Claim Country Code is invalid	2300	CLM11-5	The auto accident country code is invalid. This error can be caused by an invalid state abbreviation code.
A091	Initial Treatment date can't be a future date	2300 2400	DTP03	The initial treatment date is a future date. This cannot be greater than the claim's submission date.
A093	Date Last Seen can't be a future date	2300 2400	DTP03	The date last seen is a future date. This cannot be greater than the claim's submission date.
A094	Current Illness/Symptom Date can't be a future date	2300 2400	DTP03	The onset of current illness date entered is a future date. This cannot be greater than the claim's submission date.
A095	Date required when patient condition is acute	2300	DTP (Qualifier 453)	The acute manifestation date segment is missing. If the Patient Condition Code is A (Acute) or M (Acute Manifestation), the Acute Manifestation Date in the 2300 Loop with Qualifier 453 (Acute Manifestation Date) must be present.
A096	Acute	2300	DTP03	The acute manifestation date is a future

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	manifestation can't be a future date	2400		date. This cannot be greater than the claim's submission date.
A097	Similar Illness/Symptom can't be a future date	2300 2400	DTP03	The onset of similar illness or symptoms date is invalid. This cannot be greater than the claim's submission date.
A098	Accident Date can't be a future date	2300	DTP03	The accident date is a future date. This cannot be greater than the claim's submission date.
A099	Last Menstrual Period can't be a future date	2300	DTP03	The last menstrual period date is future date. This cannot be greater than the claim's submission date.
A100	Last X-ray Date can't be a future date	2300 2400	DTP03	The last x-ray date is a future date. This cannot be greater than the claim's submission date.
A101	Hearing/Vision RX Date can't be a future date	2300	DTP03	The hearing and vision prescription date entered is a future date. This cannot be greater than the claim's submission date.
A102	Date Last Worked can't be a future date	2300	DTP03	The date last worked is a future date. This cannot be greater than the claim's submission date.
A103	Admission Date can't be a future date	2300	DTP03	The admission date is a future date. This cannot be greater than the claim's submission date.
A104	Admit Date required with discharge date	2300	DTP01	The discharge date is required when the admission date is submitted.
A105	Discharge Date can't be a future date	2300	DTP03	The discharge date is a future date. This cannot be greater than the claim's

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				submission date.
A106	Discharge Date can't be prior to admit date	2300	DTP03	The discharge date submitted on the claim is prior to the admission date.
A107	Assumed/Relinquished Date > File Create Date	2300	DTP03	The assumed and relinquished care date is a future date. The date must not be greater than the file's creation date.
A108	Attachment control number qualifier missing	2300	PWK05	The attachment control number qualifier is missing. If indicating the support documentation is sent by fax, e-mail, or electronically in a separate transaction, the attachment control number qualifier is required. Valid Value: AC – Attachment control number
A109	Attachment control number missing	2300	PWK06	The attachment control number is missing.
A110	Contract amount is invalid	2300 2400	CN102	The contract information amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
A111	Contract Percentage is invalid	2300 2400	CN103	The contract percent is invalid. This cannot be greater than two positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
A112	Terms Discount	2300	CN105	This cannot be greater than two

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	Percent is invalid	2400		positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
A114	Patient amount paid is > claim total charge	2300	AMT02	The patient paid amount is invalid. The patient paid amount cannot exceed the total amount of the claim.
A115	Patient amount paid is invalid	2300	AMT02	The patient paid amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
A116	Total purchased service is invalid	2300	AMT02	The total purchased service amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
A117	Ambulance mileage is invalid	2300 2400	CR106	The ambulance transport distance is invalid. This cannot be greater than four positions. This cannot contain a decimal point.
A118	Purpose of round trip required is type transport = X	2400	CR109	The ambulance round trip narrative is missing or invalid. This is required if the ambulance

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				transport was a round trip.
A122	Qualifier Code can occur only three times	2300	CRC	The ambulance certification segment cannot occur more than three times on a claim.
A124	A 3rd Diagnosis submitted w/o a 2nd Diagnosis	2300	HI02	A third diagnosis code was submitted but the second diagnosis code is missing.
A125	Repriced Allowed amount is invalid	2300 2400	HCP02	The claim re-pricing allowed amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
A126	Repriced Savings amount is invalid	2300 2400	HCP03	The claim re-pricing savings amount is invalid. This cannot be greater than five positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
A127	Repricing Flat Rate Amount is invalid	2300 2400	HCP05	The claim re-priced pricing rate amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
A128	Repriced Approved Patient Group Amt. is invalid	2300 2400	HCP07	The claim re-priced Approved Patient Group (APG) amount is invalid.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
A129	Home Health Care # of visits is invalid	2305	HSD02	The health care services delivery number of visits is invalid. This cannot be greater than three positions. This cannot contain a decimal point.
A130	Home Health Care Frequency count is invalid	2305	HSD04	The health care services delivery sampling frequency count is invalid. This cannot be greater than two positions to the left of the implied or explicit decimal point. This cannot contain more than one position to the right of the implied or explicit decimal point.
A131	Referring Provider Last Name invalid	2310A	NM103	The referring provider's last name or organization name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM103 (last name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space. If NM102 = 2 (non-person), NM103 (company name) may contain only ‘A’–‘Z’, ‘a’–‘z’, ‘0’–‘9’, dash/hyphen (-), slash (/), period (.), comma (,), ampersand (&), single quotation/apostrophe (‘), double

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				quotation (") or space character values and the first position must contain an 'A'–'Z', 'a'–'z' or '0'–'9' character value.
A131	Referring Provider Last Name invalid	2420F	NM103	The referring provider's last name is invalid. The first position cannot be a space. NM102 must = 1 (person) and NM103 (last name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe ('), or a space.
A132	Referring Provider First Name Missing	2310A 2420F	NM104	The referring provider's first name is missing. If the referring provider type was a person, this must contain the first name of that person. If the referring provider was identified as a non-person entity, this is not used.
A133	Referring Provider First Name invalid	2310A 2420F	NM104	The referring provider first name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM104 (first name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe ('), or a space.
A134	Referring Provider Middle Name invalid	2310A 2420F	NM105	The referring provider middle name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM105 (middle name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe ('), or a space.
A135	Referring Provider Specialty code is	2310A 2420F	PRV03	The referring provider taxonomy code is invalid.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	invalid			Verify the taxonomy code submitted is valid according to the taxonomy code list published by Washington Publishing Company. To obtain a copy of the taxonomy code list, visit their Web site at www.wpc-edi.com.
A136	Rendering Provider Name cannot be present	2310B	NM1	If a taxonomy code is submitted for a billing provider, rendering provider information cannot be submitted. Technical Information: If the Billing Provider 2000A.PRV segment is submitted, the Rendering Provider 2310B.NM1 segment cannot be sent.
A138	Rendering Provider Last Name invalid	2310B 2420A	NM103	The rendering provider last name or organization name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM103 (last name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space and NM104 (first name) must be present following the same rules. If NM102 = 2 (non-person), NM103 (company name) may contain only ‘A’–‘Z’, ‘a’–‘z’, ‘0’–‘9’, dash/hyphen (-), slash (/), period (.), comma (,), ampersand (&), single quotation/apostrophe (‘), double quotation (“) or space character values and the first position must contain an ‘A’–‘Z’, ‘a’–‘z’ or ‘0’–‘9‘ character value.
A139	Rendering Provider First Name missing	2310B 2420A	NM104	The rendering provider first name is missing or invalid.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				If the rendering provider type was a person, this must contain the first name of that person. If the rendering provider was identified as a non-person entity, this is not used.
A140	Rendering Provider First Name invalid	2310B 2420A	NM104	The rendering provider first name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM104 may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
A141	Rendering Provider Middle Name invalid	2301B 2420A	NM105	The rendering provider middle name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM105 may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
A142	Rendering Provider specialty code is invalid	2310B 2420A	PRV03	The rendering provider taxonomy code is invalid. Verify the taxonomy code submitted is valid according to the taxonomy code list published by Washington Publishing Company. To obtain a copy of the taxonomy code list, visit their Web site at www.wpc-edi.com.
A146	Subscriber Information Required	2010BA 2320	DMG	The other insured demographic segment is missing. This segment is required when patient is different than the insured for the

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				primary payer. This information is used for MSP and Medigap secondary claims. MSP claims should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. Claims with Medigap information should not be submitted unless there is an approved Medigap policy held by this subscriber.
A146	Subscriber Information Required	2010BA	N3 N4	The subscriber's address segment is missing. The subscriber's city, state, and ZIP code segment is missing.
A147	Service Facility Name is invalid	2310D 2420C	NM103	The service facility name is invalid. The first position cannot be a space. NM102 must = 2 (non-person) and NM103 may contain only 'A'–'Z', 'a'–'z', '0'–'9', dash/hyphen (-), slash (/), period (.), comma (,), ampersand (&), single quotation/apostrophe ('), double quotation (") or space character values and the first position must contain an 'A'–'Z', 'a'–'z' or '0'–'9' character value.
A150	Service Facility City is invalid	2310D 2420C	N401	The service facility city is invalid. The first position cannot be a space. May contain only 'A'–'Z', 'a'–'z', dash/hyphen (-), period (.), or space character values and the first position must contain an 'A'–'Z' or 'a'–'z' character value.
A153	Service Facility State Code invalid	2310D 2420C	N402	The service facility (2310D and/or 2420C) or oxygen test facility (2420C) state is not a valid two-character state

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				abbreviation code.
A154	Service Facility Postal Zip Code invalid	2310D 2420C	N403	The service facility (2310D and/or 2420C) or oxygen test facility (2420C) ZIP code is missing or invalid. The ZIP code must be a valid US Postal Service Code. The ZIP code must be numeric. The ZIP code must not be all zeroes and/or all nines.
A155	Service Facility Country Code is invalid	2310D 2420C	N404	The service facility (2310D and/or 2420C) or oxygen test facility (2420C) country code is invalid. This error can be caused by an invalid state abbreviation code.
A156	Supervising Provider Last Name is invalid	2310E 2420D	NM103	The supervising provider's last name is invalid. The first position cannot be a space. NM102 must = 1 (person) and NM103 (last name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
A157	Supervising Provider First Name is missing	2310E 2420D	NM104	The supervising provider's first name is missing. If the supervising provider type was a person, this must contain the first name of that person. If the supervising provider was identified as a non-person entity, this is not used.
A158	Supervising Provider First Name is invalid	2310E 2420D	NM104	The supervising provider's first name is invalid.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				The first position cannot be a space. If NM102 = 1 (person), NM104 (first name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
A159	Supervising Provider Middle Name is invalid	2310E 2420D	NM105	The supervising provider’s middle name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM105 (middle name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
A160	Insurance type code of MP invalid in sequence	2320	SBR05	The insurance type code is invalid. If the other subscriber sequence number is “S” or “T” (Secondary or Tertiary Payer), the insurance type code in the 2320.SBR05 cannot be “MP” (Medicare Primary).
A161	Claim Level Adjustment Amount is invalid	2320	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	The claim level total adjustment amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A162	Claim Level Adjustment Quantity is invalid	2320	CAS04 CAS07 CAS10 CAS13	The claim level total adjusted unit of service is invalid. This cannot be greater than seven

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
			CAS16 CAS19	positions. This cannot contain a decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A164	Approved Amount Invalid (COB)	2320	AMT02	The primary payer approved amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A165	Allowed Amount is invalid (COB)	2320	AMT02	The primary payer allowed amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
A166	Patient Responsibility Amount invalid (COB)	2320	AMT02	The primary payer patient responsibility amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A167	Covered Amount is invalid (COB)	2320	AMT02	The primary payer covered amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A168	Discount Amount is invalid (COB)	2320	AMT02	The primary payer discount amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				positions to the right of the implied or explicit decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A169	Per Day Limit Amount is invalid (COB)	2320	AMT02	The primary payer per day limit amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A170	Patient Paid Amount is invalid (COB)	2320	AMT02	The primary payer patient paid amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
A171	Tax amount is invalid (COB)	2320	AMT02	The primary payer tax amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A172	Total Claim Before Taxes Amount invalid (COB)	2320	AMT02	The primary payer total claim before taxes amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A173	Patient signature source code invalid	2320	OI04	The source of the other insurance patient signature code is invalid. Valid Values: B – Signed signature authorization form or forms for both CMS-1500 Claim Form block 12 and block 13 are on file

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				C – Signed CMS-1500 Claim Form on file M – Signed signature authorization form for CMS-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 CMS-1500 Claim Form block 12 on file This information is used for MSP and Medigap secondary claims. MSP claims should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. Claims with Medigap information should not be submitted unless there is an approved Medigap policy held by this subscriber.
A174	Outpatient Reimbursement Rate invalid	2320	MOA01	The Medicare outpatient reimbursement rate is invalid. This cannot be greater than three positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A175	HCPCS Payable Amount invalid	2320	MOA02	The payable amount for this HCPCS/CPT code is invalid. This cannot be greater than seven

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A176	ESRD Paid amount is invalid	2320	MOA08	The end stage renal disease payment amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
A177	Non-payable Prof. Component Billed Amt invalid	2320	MOA09	The non-payable professional component-billed amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
A178	Claim Adjudication > File Created Date	2330B	DTP03	The other payer claim paid date is a future date. This cannot be greater than today's date. This information is used for MSP claims and should not be submitted

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				unless another payer adjudicated this claim prior to being submitted to Medicare.
A179	Pay to Provider Name is invalid	2010AB	NM103	The pay to provider's last name or organization name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM103 (last name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space. If NM102 = 2 (non-person), NM103 (company name) may contain only ‘A’–‘Z’, ‘a’–‘z’, ‘0’–‘9’, dash/hyphen (-), slash (/), period (.), comma (,), ampersand (&), single quotation/apostrophe (‘), double quotation (“) or space character values and the first position must contain an ‘A’–‘Z’, ‘a’–‘z’ or ‘0’–‘9’ character value.
A180	Purchased Service Provider Name is invalid	2310C	NM103	The purchased service provider's last name or organization name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM103 (last name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space. If NM102 = 2 (non-person), NM103 (company name) may contain only ‘A’–‘Z’, ‘a’–‘z’, ‘0–‘9’, dash/hyphen (-), slash (/), period (.), comma (,), ampersand (&), single quotation/apostrophe (‘), double quotation (“) or space character values and the first position must contain an ‘A’–‘Z’, ‘a’–‘z’ or ‘0’–‘9’ character value.
A183	Invalid Procedure	2400	SV101-3	The first, second, third and/or fourth

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	Modifier		SV101-4 SV101-5 SV101-6	modifier appended to the HCPCS/CPT code is invalid. Verify correct modifier usage. Questions regarding the correct modifier to submit on a claim should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
A184	Line Item Charge Amount Invalid	2400	SV102	The line item charge amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
A185	Units of Service submitted invalid	2410	CTP04	The NDC unit count amount is invalid. The count submitted exceeds the number of allowed positions to the left or right of the implied or explicit decimal point. When CTP05 = UN: When the qualifier is "UN" (Unit), the maximum allowed is "999.9". When CTP05 = F2 When the qualifier is "F2" (International Unit), the maximum allowed is "9999999.999". When CTP05 = ML or GR When the qualifier is "ML" (Milliliter) or "GR" (Gram), the maximum allowed

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				is "99.99".
A185	Units of Service submitted invalid	2400	SV104	The number of units is invalid. The count submitted exceeds the number of allowed positions to the left or right of the implied or explicit decimal point. The maximum units allowed is "999.9".
A186	Minutes submitted invalid	2400	SV104	The number of minutes is invalid. When SV103 = MJ: This cannot be greater than four positions. This cannot contain a decimal point.
A187	Line Level Dx Code Pointer must be present	2400	SV107	The diagnosis code pointer is missing.
A188	Claim Level Dx Code must be present	2400	SV107-1	The diagnosis code pointer on the claim charge line is pointing to a blank diagnosis code.
A189	Diagnosis Pointer points to blank Dx code	2400	SV107-1 SV107-2 SV107-3 SV107-4	A diagnosis code pointer on the claim charge line is pointing to a blank diagnosis code.
A190	Durable Medical Equipment Duration is invalid	2400	CR303	The length of need as reported on the CMN is invalid. This cannot be greater than two positions. This cannot contain a decimal point.
A191	Home Oxygen Therapy Cert. period invalid	2400	CR502	The length of need for the oxygen CMN (Form 484.03) is invalid. This cannot be greater than two positions. This cannot contain a decimal point.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
A192	Arterial Blood Gas quantity is invalid	2400	CR510	The arterial blood gas quantity for the oxygen CMN (Form 484.03) is invalid. This cannot be greater than two positions to the left of the implied or explicit decimal point. This cannot contain more than one position to the right of the implied or explicit decimal point.
A193	Oxygen Saturation quantity is invalid	2400	CR511	The oxygen saturation quantity for the oxygen CMN (Form 484.03) is invalid. This cannot be greater than two positions to the left of the implied or explicit decimal point. This cannot contain more than one position to the right of the implied or explicit decimal point.
A194	Hospice Employed Provider must be Y or N	2400	CRC	The hospice employed provider indicator (Y or N) is missing or invalid. If the place of service submitted on the claim is "34" for Hospice, at least one occurrence of the 2400. CRC with qualifier "70" and the indicator must be submitted.
A195	Date of Death can't be > service date	2000C	PAT06	Date of service cannot be greater than patient's date of death. Note: For Medicare, the Subscriber must be the same as the Patient (SBR02=18) and this loop should not be used.
A196	Service Date can not be < Patient DOB	2010CA	DMG02	Patient's Date of Birth must be less than or equal Date of Service. **Note:** For Medicare, the Subscriber must be the same as the Patient

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				(SBR02=18) and this loop should not be used.
A197	Current Illness/Symptom date can't be > DOS	2400	DTP03	The onset of current illness/symptom date value must be less than or equal to the date of service.
A198	Accident Date can not be > date of service	2400	DTP03	The accident date must be less than or equal to the date of service.
A199	Last Menstrual Period can not be > DOS	2300	DTP03	The last menstrual period date must be less than or equal to the date of service.
A201	POS = 21, Admission date must be present.	2300	DTP03	The admission date is missing.
A202	Date of Service greater than File Create Date	2400	DTP03	The "from" date of service or the range of dates of service is a future date. This cannot be greater than the Transaction Set Creation Date reported in the BHT04. This must be in a CCYYMMDD format when DTP02=D8. This must be in the CCYYMMDD-CCYYMMDD format when the DTP02=RD8.
A204	Service From Date is greater than to date	2400	DTP03	The date of service is in an invalid format. Verify the date of service is greater than 12-31-1981 and if a span date range is reported that the “to” date is the same as the “from” date or is a future date. The end/to date is prior to the start/from date. The end/to date must be equal to or

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				greater than the start/from date.
A205	Purchased Service Information Required	2400	PS1	The purchased service information is missing. If the purchased service provider was submitted, the purchased service information is required.
A207	Begin Therapy Date > File Receive Date	2400	DTP03	The begin therapy/CMN initial date (DTP*463) is invalid. This cannot be greater than the file's creation date.
A208	Last Certification Date > File Receive Date	2400	DTP03	The last certification date (CMN was signed by the physician) is a future date. This cannot be greater than the claim's submission date.
A209	Test Date > File Receive Date	2400	DTP03	The test date is a future date. This cannot be greater than the claim's submission date.
A210	Oxygen Blood Gas Test Dt > File Receive Date	2400	DTP03	The oxygen saturation/arterial blood gas test date is a future date. This cannot be greater than the claim's submission date.
A211	Shipped Date > File Receive Date	2400	DTP03	The shipped date is a future date. This cannot be greater than the claim's submission date.
A213	Test Results is invalid	2400	MEA03	The Arterial Blood Gas (ABG) or oxygen saturation test result for the oxygen CMN (Form 484.03) or the patient height for DME MAC CMNs is missing OR The ABG or oxygen saturation test

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				result for the oxygen CMN (Form 484.03) or the patient height as reported on DME MAC CMNs exceeds the maximum positions to the right of the decimal point.
A214	CLIA number submitted is invalid	2300	REF02	The CLIA number is invalid. The fourth position of the CLIA number cannot be the alpha letter "O".
A215	Oxygen Flow Rate is invalid	2400	REF02 (Qualifier TP)	The oxygen flow rate is invalid. Valid Values: 1 – 999 X
A216	Sales Tax Amount is invalid	2400	AMT02	The sales tax amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
A217	Approved Amount Invalid	2400	AMT02	The approved amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A218	Postage Claimed Amount is invalid	2400	AMT02	The postage claimed amount is invalid. This cannot be greater than seven positions to the left of the implied or

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
A219	Purchased Service Charge Amount is invalid	2400	PS102	The purchased service charge amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
A220	Health Care Services # of visits is invalid	2400	HSD02	The health care services delivery number of visits is invalid. This cannot be greater than three positions. This cannot contain a decimal point.
A221	Health Care Srv. Frequency count is invalid	2400	HSD04	The frequency count of the health care services delivery is invalid. This cannot be greater than two positions to the left of the implied or explicit decimal point. This cannot contain more than one position to the right of the implied or explicit decimal point.
A222	Re-priced Approved unit count is invalid	2400	HCP12	The pricing/re-pricing approved units or inpatient days are invalid. When HCP11 = DA This cannot be greater than three positions to the left of the implied or explicit decimal point.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				This cannot contain a decimal point. When HCP11 = UN This cannot be greater than three positions to the left of the implied or explicit decimal point. This cannot contain more than one position to the right of the implied or explicit decimal point.
A224	Purchased Service Provider Name is Required	2300	AMT01	Purchased Service Provider (2310C) is required when Purchased Service Amount is reported (AMT01=NE).
A224	Purchased Service Provider Name is Required	2400 2310C 2420	PS1 NM101 NM101	This rejection is received when the Purchased Service Information (2400.PS1) is sent without the Purchased Service Amount 2300.AMT (Qualifier "NE") or when the Purchased Service Information (2400.PS1) and the Purchased Service Amount Qualifier NE (2300.AMT01) is entered without the Purchased Service Provider Name in either the 2310C.NM1 or the 2420.NM1 with a "QB" qualifier.
A225	Ordering Provider Last Name is invalid	2420R	NM103	The ordering provider's last name is invalid. The first position cannot be a space. NM102 must = 1 (person) and NM103 (last name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe ('), or a space. The first three positions cannot be any of the following: MR, MR., DR, DR., JR or JR..
A226	Ordering Provider First Name missing	2420E	NM104	The ordering provider's first name is missing.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				If the ordering physician type was a person (NM102=1), this must contain the first name of that person.
A227	Ordering Provider First Name invalid	2420E	NM104	The ordering provider's first name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM104 (first name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
A228	Ordering Provider Middle Name invalid	2420E	NM105	The ordering provider's middle name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM105 (middle name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
A229	Ordering Provider City is invalid	2420E	N401	The ordering provider's city is invalid. The first position cannot be a space. May contain only ‘A’–‘Z’, ‘a’–‘z’, dash/hyphen (-), period (.), or space character values and the first position must contain an ‘A’–‘Z’ or ‘a’–‘z’ character value.
A230	Ordering Provider state code is invalid	2420E	N402	The ordering provider's state is not a valid two-letter state abbreviation.
A231	Ordering Provider ZIP code is invalid	2420E	N403	The ordering provider ZIP code is missing or invalid. The ZIP code must be a valid US Postal Service Code. The ZIP code must be numeric. The ZIP code must not be all zeroes and/or all nines.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
A232	Ordering Provider country code is invalid	2420E	N404	The ordering provider's country code is invalid. This error can be caused by an invalid state abbreviation code.
A233	Service Line Paid amount is invalid	2430	SVD02	The line adjudication service line paid amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A235	Line Level Adjusted Amount is invalid	2430	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	The line adjustment amount is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A236	Line Level Adjusted Units is invalid	2430	CAS04 CAS07 CAS10 CAS13	The line adjusted unit claim level is invalid. This cannot be greater than seven

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
			CAS16 CAS19	positions. This cannot contain a decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A237	Line Adjustment Date > File Create Date	2430	DTP03	The line adjudication or payment date is a future date. This cannot be greater than the claim's submission date. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A238	Question Response Percent is invalid	2440	FRM05	The percentage in response to a question on the CMN is invalid. This cannot be greater than three positions to the left of the implied or explicit decimal point. This cannot contain more than one position to the right of the implied or explicit decimal point. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A239	Purchased Service Provider # invalid	2400	PS101	The purchased service provider identifier is invalid. This may contain only 'A'–'Z', 'a'-'z', '-', or '0'-'9' values.
A240	Medicare	2000B	SBR05	Medicare is secondary or tertiary on

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	Secondary Payer Ins Type Code required			this claim; however, the insurance type code is missing.
A241	Insured Group/Policy Number cannot be present	2000B	SBR03	The Insured Group/Policy Number was submitted but is not allowed when Medicare is primary.
A242	Subscriber ID Qualifier is missing	2010BA	NM108	The subscriber ID qualifier is invalid. Valid Values: MI – Member Identification Number ZZ – Mutually Defined
A243	Subscriber ID Number is missing	2010BA	NM109	The subscriber identification number is missing. Verify the HICN was entered on the claim.
A247	Facility Type code is invalid	2300	CLM05-1	The place of service code is invalid. Valid Values: 01 – Pharmacy 04 – Homeless Shelter 05 – Indian Health Service Free-Standing Facility ** 06 – Indian Health Service Provider-Based Facility ** 07 – Tribal 638 Free-Standing Facility ** 08 – Tribal 638 Provider-Based Facility ** 11 – Office 12 – Home 13 – Assisted Living Facility 14 – Group Home 15 – Mobile Unit 20 – Urgent Care Facility 21 – Inpatient Hospital 22 – Outpatient Hospital 23 – Emergency Room – Hospital 24 – Ambulatory Surgical Center 25 – Birthing Center

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				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 49 – Independent Clinic 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 57 – Non-Residential Substance Abuse Treatment Facility 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 ** Place of Service codes 05, 06, 07 and 08 are valid for submission but not for adjudication of Medicare claims.
A248	Claim Frequency Type Code invalid	2300	CLM05-3	The claim frequency type code is invalid as defined in Code Source 235 from the NUBC.
A351	Submitter Contact # contains invalid	1000A	PER04 PER06	The communication number must be exactly ten digits.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	values		PER08	
A352	Credit Card Information can't be present	2300	AMT	The credit/debit card maximum amount loop cannot be sent to Medicare.
A352	Credit Card Information can't be present	2010BD	NM1	The credit/debit cardholder name loop cannot be sent to Medicare.
A352	Credit Card Information can't be present	2010AA	REF	The credit/debit card billing information loop cannot be sent to Medicare.
A352	Credit Card Information can't be present	2010BD	REF	The credit/debit authorization number cannot be sent to Medicare.
A353	Billing Provider Contact # contain invalid values	2010AA	PER04 PER06 PER08	The communication number must be all numeric when qualifier is TE, FX or EX. If TE or FX, the communication number must be exactly 10 numeric digits.
A354	Group Number cannot = Subscriber ID	2010BA	NM109	The group number submitted cannot be the same as the subscriber number.
A355	Claim indicates accident -accident date missing	2300	DTP (Qualifier 439)	This accident date is missing and an accident was indicated on the claim (in CLM11-1, -2, or -3).
A356	Accident Dt present - Accident indicator missing	2300	DTP01	The accident date is missing (CLM11-1, -2, or -3). This is required if the accident date is submitted.
A358	First Referring Provider Qualifier must = DN	2310A	NM1	The referring provider name qualifier is invalid. If used, the first occurrence of the referring provider name segment at the claim level must contain information on the referring provider.
A359	Second Referring Provider Qualifier must = P3	2310A	NM1	The referring provider name qualifier is invalid. If used, the second occurrence of the

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				referring provider name segment at the claim level must contain information on the primary care provider.
A360	Adjustment Reason Code is invalid	2320	CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	The claim adjustment reason code is invalid. Verify the claim adjustment reason code entered is valid for the date the primary payer adjudicated the claim. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A360	Adjustment Reason Code is invalid	2430	CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	The line level claim adjustment reason code is invalid. Verify the claim adjustment reason code entered is valid for the date the primary payer adjudicated the claim. This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A361	Remittance Remark Code is invalid	2320	MOA03 MOA04 MOA05 MOA06 MOA07	The remark code is invalid. Verify the correct code was entered from the primary payer electronic remittance advice. This information is used for MSP and Medigap secondary claims. MSP claims should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. Medigap secondary claims should not be submitted unless there is an approved Medigap policy held by this subscriber.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
A362	National Plan ID is invalid	2010BB 2330B 2420G	NM109	The National Plan ID submitted is invalid
A363	Other Payer Contact # contains invalid values	2330B	PER04 PER06 PER08	The communication number must be exactly ten digits.
A364	HIEC code is invalid	2400	HCP10	The HIEC code submitted is invalid.
A366	Place of Service Code is invalid	2400	SV105	The place of service code is invalid. Valid Values: 01 – Pharmacy 04 – Homeless Shelter 05 – Indian Health Service Free-Standing Facility ** 06 – Indian Health Service Provider-Based Facility ** 07 – Tribal 638 Free-Standing Facility ** 08 – Tribal 638 Provider-Based Facility ** 11 – Office 12 – Home 13 – Assisted Living Facility 14 – Group Home 15 – Mobile Unit 20 – Urgent Care Facility 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 49 – Independent Clinic 50 – Federally Qualified Health Center

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				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 57 – Non-Residential Substance Abuse Treatment Facility 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 ** Place of Service codes 05, 06, 07 and 08 are valid for submission but not for adjudication of Medicare claims.
A367	Ordering Provider Contact # contain invalid values	2420E	PER04 PER06 PER08	The communication number must be exactly ten digits.
A374	Invalid Claim Adjustment Indicator value	2330B	REF02	The other payer claim adjustment indicator is missing.
A385	Subscriber LOB not = Billing Provider LOB	2000B	SBR09	If 2000B-SBR09 = 'CH', one (1) occurrence of the 2010AA-REF segment must contain the value of '1H' in 2010AA-REF01.
A386	Entity Type Code must = 1 w/claim filing ind	2010BA	NM102	The subscriber's name qualifier is invalid. Valid Value:

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				1 – Person
A387	Clearinghouse Trace Number > 20 digits	2300	REF02	The clearinghouse trace number is invalid. This cannot be greater than 20 positions.
A388	Referring Provider Secondary ID Missing	2310A	REF	If 2310A-NM108 is not present and 2310A-NM109 is not present, one (1) occurrence of 2310A-REF segment must be present.
A389	Primary Payer info missing	2320	SBR	The primary payer information is missing on the Medicare Secondary Payer (MSP) claim.
A390	Primary or Secondary Payer info missing	2320	SBR	The primary and secondary payer information is missing on the Medicare tertiary payer claim.
A391	Certification Revision Date missing	2400	DTP (Qualifier 607)	The CMN revision/recertification date segment is missing.
A392	Other Payer Claim Adjudication Date missing	2430	SVD	The other payer claim adjudication date is missing.
A397	Patient Signature Source Code missing	2300	CLM10	The patient signature source code is missing. If a signature on file was specified to release any data, a valid source of signature must be provided. Valid Values: B – Signed signature authorization form or forms for both CMS-1500 Claim Form block 12 and block 13 are on file C – Signed CMS-1500 Claim Form on file M – Signed signature authorization form for CMS-1500 Claim Form block 13 on file P – Signature generated by provider

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				because the patient was not physically present for services S – Signed signature authorization form for CMS-1500 Claim Form block 12 on file
A398	Ambulance Admission, Admission Date missing	2300	DTP (Qualifier 435)	The admission date is missing.
A399	A 4th Diagnosis submitted w/o a 3rd Diagnosis	2300	HI03	A fourth diagnosis code was submitted but the third diagnosis code is missing.
A400	A 5th Diagnosis submitted w/o a 4th Diagnosis	2300	HI04	A fifth diagnosis code was submitted but the fourth diagnosis code is missing.
A401	A 6th Diagnosis submitted w/o a 5th Diagnosis	2300	HI05	A sixth diagnosis code was submitted but the fifth diagnosis code is missing.
A402	A 7th Diagnosis submitted w/o a 6th Diagnosis	2300	HI06	A seventh diagnosis code was submitted but the sixth diagnosis code is missing.
A403	An 8th Diagnosis submitted w/o a 7th Diagnosis	2300	HI07	An eighth diagnosis code was submitted but the seventh diagnosis code is missing.
A468	Claim Filing Indicator Code must be present	2320	SBR09	The other payer insurance plan type is invalid. This cannot be spaces. 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

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				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 This information is required if other payers are known to potentially be involved in paying on this claim. If 2010BB-NM101 ='PR' and 2010BB-NM108 = 'PI', 2000B-SBR09 must be present.
A486	Subscriber ID Number is required	2010BA	NM109	The subscriber identification number is missing. Verify the HICN was entered on the claim.
A487	Purchased Service First Name is missing	2310C	NM104	The purchased service provider first name is missing.
A488	HCPCS Code values are not the same	2400	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 (SV101-2).
A508	EPSDT Referral Condition Code not 'NU'	2300	CRC03	The EPSDT condition indicator is missing. The condition reason must be "NU" when no ESPDT referral is given.
A512	Qualifier 'ZZ' not	2330A	NM108	The other insured identification

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	yet mandated, may not use			number qualifier is invalid. Valid Values: MI – Member identification number This information is used for MSP and Medigap secondary claims. MSP claims should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. Medigap secondary claims should not be submitted unless there is an approved Medigap policy held by this subscriber.
A512	Qualifier 'ZZ' not yet mandated, may not use	2010BA 2010CA 2330B	NM108	The subscriber identifier qualifier is invalid. The qualifier "ZZ" (HIPAA Individual Identifier) cannot be submitted.
A513	Qualifier 'XV' not yet mandated, may not use	2010BB	NM108	The payer identification qualifier is invalid. The qualifier "XV" (National Plan ID) cannot be submitted.
A514	Purchased Service Amount required	2310C	NM1	The purchased service amount is missing. This is required when a purchased service provider is submitted.
A514	Purchased Service Amount required	2400 2300 2310C 2320B	PS1 AMT01 NM101 NM101	The purchased service amount is missing. This rejection is received when the Purchased Service Information (2400.PS1) is sent without the Purchased Service Amount 2300.AMT (Qualifier "NE") or when the Purchased Service Information (2400.PS1) and the Purchased Service Amount Qualifier NE (2300.AMT01) is entered without the Purchased Service Provider Name in either the

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				2310C.NM1 or the 2420.NM1 with a "QB" qualifier.
A515	CLM11-1='AA', CLM11-4 & CLM11-5 missing	2300	CLM11-4	The auto accident state is missing or invalid. If an auto accident has been indicated on this claim, a valid state abbreviation must be submitted for the state where the accident occurred. CEDI requires that both letters in the state abbreviation code be capitalized.
A516	CLM11-2='AA', CLM11-4 & CLM11-5 missing	2300	CLM11-4	The auto accident state is missing or invalid. If an auto accident has been indicated on this claim, a valid state abbreviation must be submitted for the state where the accident occurred. CEDI requires that both letters in the state abbreviation code be capitalized.
A517	CLM11-3='AA', CLM11-4 & CLM11-5 missing	2300	CLM11-4	The auto accident state is missing or invalid. If an auto accident has been indicated on this claim, a valid state abbreviation must be submitted for the state where the accident occurred. CEDI requires that both letters in the state abbreviation code be capitalized.
A518	1 occurrence of the 2320-SBR loop is required	2320	SBR	The other subscriber information loop is missing. This is required when the other payer identification code is submitted in the line adjudication information loop.
A519	2430-SVD01 needs an occurrence of	2430	SVD01	The line adjudication information identification code is invalid.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	2330B-NM109			This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
A521	2320-DMG segment is required	2320	DMG03	The other subscriber demographic information is missing.
A522	PAT~(~ = seg separator) is not a valid segment	2000B	PAT	The patient information segment was submitted; however, the patient date of death, patient weight, or the pregnancy indicator was not submitted.
A523	Country Code = US and State Code not present	2300	CLM11-5	The auto accident country is missing. If auto accident has been indicated as the cause for this claim and the accident occurred outside of the United States, a country code must be submitted.
A524	Submitted Code valid only for Medicaid	2300	CLM12	The special program code is invalid. Valid Values: 01 – Early & periodic Screening, Diagnosis and Treatment or Child Health Assessment Program 02 – Physically Handicapped Children Program
A525	2310D-NM103 is required	2310D	NM103	The service facility name is missing. The first position cannot be a space. NM102 must = 2 (non-person) and NM103 may contain any only 'A'–'Z', 'a'–'z', '0'–'9', dash/hyphen (-), slash (/), period (.), comma (,), ampersand (&), single quotation/apostrophe ('), double quotation (") or space character values and the first position must contain an 'A'–'Z', 'a'–'z' or '0'–'9' character value.
A531	Acceptable pointer	2400	SV107-1	The diagnosis code pointer is invalid.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	values are 1–8, inclusive		SV107-2 SV107-3 SV107-4	Valid Values: 1, 2, 3, 4, 5, 6, 7, 8
A534	Subscriber Last Name is invalid	2010BA	NM103	The subscriber last name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM103 (last name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space. And NM104 (first name) must be used following the same rules. If NM102 = 2 (non-person), NM103 (company name) may contain only ‘A’–‘Z’, ‘a’–‘z’, ‘0’–‘9’, dash/hyphen (-), slash (/), period (.), comma (,), ampersand (&), single quotation/apostrophe (‘), double quotation (“) or space character values and the first position must contain an ‘A’–‘Z’, ‘a’–‘z’ or ‘0’–‘9’ character value and NM104 must be blank. The first three positions cannot be any of the following: MR, MR., DR, DR., JR, or JR..
A535	CAS required when 2320-AMT02 NE 2300-CLM02	2320	CAS	The claim level adjustment segment is missing. This error occurs when Medicare is the secondary payer and the primary paid amount does not equal the claim charges.
A536	CAS required when 2320-AMT02 NE 2300-CLM02	2320	CAS	The claim level adjustment segment is missing. This error occurs when Medicare is the tertiary payer and the primary paid amount does not equal the claim charges.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
A537	CAS required when 2320-AMT02 NE 2300-CLM02	2320	CAS	The claim level adjustment segment is missing. This error occurs when Medicare is the tertiary payer and the secondary paid amount does not equal the claim charges.
A540	Modifier 2 is present but Modifier 1 is not	2400	SV101-4	The first modifier is missing and the second modifier is present.
A541	Modifier 3 is present but Modifier 2 is not	2400	SV101-5	The second modifier is missing and the third modifier is present.
A542	Modifier 4 is present but Modifier 3 is not	2400	SV101-6	The third modifier is missing and the fourth modifier is present.
A543	Length of NPI value is invalid	2010AA 2010AB 2310A 2310B 2310C 2310D 2310E 2420A 2420B 2420C 2420D 2420E 2420F	NM109	Invalid NPI number. NPI number must be ten digits. NPI number must be all numeric. NPI number must begin with 1, 2, 3, or 4
A544	NPI value contains a non numeric value	2010AA 2010AB 2310B 2310C 2310D 2310E 2420A 2420B 2420C 2420D 2420E	NM109	Invalid NPI number. NPI number must be all numeric. NPI number must be ten digits. NPI number must begin with 1, 2, 3, or 4

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
		2420F		
A545	1st digit of NPI value not 1, 2, 3, or 4	2010AA 2010AB 2310A 2310B 2310C 2310D 2310E 2420A 2420B 2420C 2420D 2420E	NM109	Invalid NPI number. NPI number must be all numeric. NPI number must be ten digits. NPI number must begin with 1, 2, 3, or 4
A547	2430-CAS required when 2430-SVD NE 2400-SV102	2430	DTP (Qualifier 573)	The line adjustment information is missing. This error occurs when the line level DTP01=573 (Line Adjudication Date) is present with line level MSP Information and the Payer Paid amount does not equal the service line charges, but there is not a CAS (Line Level Adjustment) sent on the service line.
A549	MB MSP w/o prior payer adjudication information	2320B	SBR	The primary payer information is missing. This error occurs when Medicare is indicated as secondary but there is not any primary payer adjudication information.
A550	MB MSP w/o prior payer adjudication information	2320B	SBR	The primary payer information is missing. This error occurs when Medicare is indicated as tertiary but there is not any primary payer adjudication.
A552	Postal State Code value required	2010AA 2010AB 2010BA	N404	The state code is missing. The value must be a valid two-

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
		2010BB 2010BC 2010CA 2310D 2330A 2420C		character state abbreviation code. CEDI requires that both letters in the state abbreviation code be capitalized.
B108	Billing provider not authorized for submitter	2010AA	NM109	The billing provider's Provider ID supplied is not a valid ID. The Trading Partner/Submitter ID is not authorized to submit claims for the supplier. If this error is received, the supplier must complete and sign the appropriate form on the CEDI Web site (www.ngscedi.com) and return to CEDI for processing. Suppliers who use a third party (e.g. a clearinghouse or billing service) must complete the Supplier Authorization Form. Suppliers who submit their own claims and do not use a third party biller must complete the CMS EDI Enrollment Agreement.
B108	Billing provider not authorized for submitter	2010AB	NM109	The pay to provider's Secondary ID supplied is not a valid ID. The Trading Partner/Submitter ID is not authorized to submit claims for the supplier. If this error is received, the supplier must complete and sign the appropriate form on the CEDI Web site (www.ngscedi.com) and return to CEDI for processing.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				Suppliers who use a third party (e.g. a clearinghouse or billing service) must complete the Supplier Authorization Form. Suppliers who submit their own claims and do not use a third party biller must complete the CMS EDI Enrollment Agreement.
C001	Foreign Currency Not Allowed	1000A	CUR	The foreign currency segment is not valid for Medicare claims and should not be sent.
C002	Billing Provider ID Qualifier Invalid	2010AA	NM108	The billing provider identifier is invalid. Valid Value: XX – NPI
C003	Billing NPI Not on Crosswalk	2010AA	NM109	The billing provider NPI is not found on the crosswalk. Go to the NPPES Web site and verify the following information matches what you are submitting. The NPPES Web site can be accessed at: https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart: Verify that all information for your NPI number is accurate including the name, address and Employer Identification Number (EIN). Verify that your PTAN (Supplier/NSC number) is listed in the Medicare NSC field in the "Other Provider Identifier" record. Verify that the "Entity Type" is correct. **Note:** An organization has an Entity

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				type of 2. Individual/sole proprietorship has an Entity type of 1. **Note:** Any information updated with NPPES will reflect on NPPES Web site immediately, but it will take up to 10 business days for the updates to occur in the DME MACs processing system. Please allow at least 10 business days after making a change to NPPES before resubmitting your claims.
C004	Billing NPI Invalid Check Digit	2010AA	NM109	The billing provider NPI number has an invalid check digit.
C005	Billing Address 1 Invalid	2010AA	N301	The billing provider address line one is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set.
C006	Billing Address 2 Invalid	2010AA	N302	The billing provider address line two is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set.
C007	Secondary ID Invalid	2010AA	REF01	The billing provider secondary identifier is invalid. Only the Employer Identification Number (EIN) or Social Security Number (SSN) and its qualifier are allowed. Valid Values: EI – Employer's Identification Number SY – Social Security Number
C008	EIN/SSN Not On File w/ NPI	2010AA	REF02	The SSN/EIN submitted for the NPI is not matched on the crosswalk.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				Go to the NPPES Web site and verify the following information matches what you are submitting. The NPPES Web site can be accessed at: https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart: Verify that all information for your NPI number is accurate including the name, address and Employer Identification Number (EIN). Verify that your PTAN (Supplier/NSC number) is listed in the Medicare NSC field in the "Other Provider Identifier" record. Verify that the "Entity Type" is correct. **Note:** An organization has an Entity type of 2. Individual/sole proprietorship has an Entity type of 1. **Note:** Any information updated with NPPES will reflect on NPPES Web site immediately, but it will take up to 10 business days for the updates to occur in the DME MACs processing system. Please allow at least 10 business days after making a change to NPPES before resubmitting your claims.
C009	EIN/SSN Invalid Format	2010AA	REF02	Employer's Identification Number (EIN) or Social Security Number (SSN) must be 9 numeric digits.
C010	Pay-To Provider ID Qualifier Invalid	2010AB	NM108	The pay-to provider identifier is invalid. Valid Value: XX – NPI
C011	Pay-To NPI Not on	2010AB	NM109	The pay-to provider NPI was not found

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	Crosswalk			on the NSC (Provider ID) crosswalk. Go to the NPPES Web site and verify the following information matches what you are submitting. The NPPES Web site can be accessed at https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart: Verify that all information for your NPI number is accurate including the name, address and Employer Identification Number (EIN). Verify that your PTAN (Supplier/NSC number) is listed in the Medicare NSC field in the "Other Provider Identifier" record. Verify that the "Entity Type" is correct. Note: An organization has an Entity type of 2. Individual/sole proprietorship has an Entity type of 1. **Note:** Any information updated with NPPES will reflect on NPPES Web site immediately, but it will take up to 10 business days for the updates to occur in the DME MACs processing system. Please allow at least 10 business days after making a change to NPPES before resubmitting your claims.
C012	Pay-To NPI Invalid Check Digit	2010AB	NM109	The pay-to provider NPI number has an invalid check digit.
C013	Pay-To Address 1 Invalid	2010AB	N301	The pay to provider address line one is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				character set.
C014	Pay-To Address 2 Invalid	2010AB	N302	The pay to provider address line two is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set.
C015	Secondary ID Invalid	2010AB	REF01	The pay-to provider secondary identifier is invalid. Only the Employer Identification Number (EIN) or Social Security Number (SSN) and its qualifier are allowed. Valid Values: EI – Employer's Identification Number SY – Social Security Number
C016	EIN/SSN Invalid Format	2010AB	REF02	Employer's Identification Number (EIN) or Social Security Number (SSN) must be 9 numeric digits.
C017	EIN/SSN Not On File w/ NPI	2010AB	REF02	The SSN/EIN submitted for the NPI is not matched on the crosswalk. Go to the NPPES Web site and verify the following information matches what you are submitting. The NPPES Web site can be accessed at https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart: Verify that all information for your NPI number is accurate including the name, address and Employer Identification Number (EIN). Verify that your PTAN (Supplier/NSC number) is listed in the Medicare NSC field in the "Other Provider Identifier"

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				record. Verify that the "Entity Type" is correct. **Note:** An organization has an Entity type of 2. Individual/sole proprietorship has an Entity type of 1. **Note:** Any information updated with NPPES will reflect on NPPES Web site immediately, but it will take up to 10 business days for the updates to occur in the DME MACs processing system. Please allow at least 10 business days after making a change to NPPES before resubmitting your claims.
C018	Subscriber Insured Group Name Missing	2000B	SBR04	The insured group name is missing. If a primary payer other than Medicare is indicated by entering a group or policy number, the group name must be included. If claim is a Medicare Primary, this location must be blank.
C019	Claim Filing Indicator Code Invalid	2000B	SBR09	The claim filing indicator code is invalid. Valid Value: MB – Medicare Part B
C020	Patient Date Of Death Invalid	2000B	PAT06	The patient date of death is invalid. Verify the date entered is greater than the subscriber's date of birth and is not greater than the claim's submission date.
C021	Patient Weight Invalid	2000B	PAT07	The patient weight qualifier is missing. Valid Value: 01 – Actual Pounds

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
C022	Patient Weight Required EPO	2000B 2000C	PAT08	The patient weight is required in either the 2000B or 2000C Loop for the following procedure codes: J0881 Q9920 – Q9940 J0882 Q4054 J0885 Q4055 J0886 Q4081
C023	Subscriber Address 1 Invalid	2010BA	N301	The subscriber address line one is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set.
C024	Subscriber Address 2 Invalid	2010BA	N302	The subscriber address line two is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set.
C025	Subscriber Gender Invalid	2010BA	DMG03	The subscriber's gender code is invalid. Valid Values: M – Male F – Female
C026	Payer Address 1 Invalid	2010BB	N301	The payer address line one is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set.
C027	Payer Address 2 Invalid	2010BB	N302	The payer address line two is invalid. The first position cannot be a space.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				May contain any characters from both the basic character set and extended character set.
C028	Responsible Party Address 1 Invalid	2010BC	N301	The responsible party address line one is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set.
C028	Responsible Party Address 1 Invalid	2010BC	N302	The responsible party address line two is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set.
C030	Patient Weight Invalid	2000C	PAT08	The patient weight is invalid. The weight must be greater than zero.
C031	Patient Address 1 Invalid	2010CA	N301	The patient address line one is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set.
C032	Patient Address 2 Invalid	2010CA	N302	The patient address line two is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set.
C033	Total Claim Charge Equals Zero	2300	CLM02	The total claim charge must be greater than zero.
C034	Total Claim Charge	2300	CLM02	The total claim charge is invalid.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	Invalid			The total claim charges cannot be greater than $99,999.99
C035	Claim Frequency Code Invalid (REF=F8)	2300	CLM05-3	The claim frequency code is invalid. This must be "7" when the 2300.REF01 = F8 (original reference number).
C036	Claim Frequency Code Invalid	2300	CLM05-3	The type of claim is invalid. Valid Values: 1 – Original 7 – Replacement
C037	Release of Information Code Invalid	2300. CLM09	CLM09	The release of information indicator is invalid. 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.
C038	Patient Weight Invalid	2000B	PAT08	The patient's weight is missing or invalid. The weight may contain only numbers. This is a required element for some CMNs.
C038	Patient Weight Invalid	2000B	PAT08	The patient's weight is less than one pound.
C039	Disability Begin Date Invalid - Future	2300	DTP03	The disability "from" date is a future date. This cannot be greater than the claim's submission date.
C040	Original Reference Number Missing	2300	REF (Qualifier F8)	The original reference number segment is missing.
C041	Demonstration	2300	REF02	The demonstration project identifier is

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	Project ID Invalid			invalid. This value must be a valid eight numeric digit clinical trial registry number.
C042	Round Trip Not Indicated	2300	CR109	The ambulance round trip indicator is missing. This is required when the ambulance round trip description is submitted on the claim.
C043	Ambulance Certification Required	2300	CRC (Qualifier 07)	The ambulance certification is missing. This is required when the ambulance transport information is sent.
C044	Subscriber Primary ID Invalid	2010BA	NM109	The subscriber HICN is invalid. Verify the HICN is entered exactly as it appears on the beneficiary's red, white and blue Medicare card.
C045	Diagnosis Code Invalid for DOS	2300	HI01-2	The first diagnosis code is not pointed to by any claim line and the effective dates of the diagnosis code falls entirely outside the claim's dates of service. Questions regarding the effective dates of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C046	Diagnosis Code Invalid for DOS	2300	HI02-2	The second diagnosis code is not pointed to by any claim line and the effective dates of the diagnosis code falls entirely outside the claim's dates of service. Questions regarding the effective dates of a diagnosis code should be directed

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C047	Diagnosis Code Invalid for DOS	2300	HI03-2	The third diagnosis code is not pointed to by any claim line and the effective dates of the diagnosis code falls entirely outside the claim's dates of service. Questions regarding the effective dates of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C048	Diagnosis Code Invalid for DOS	2300	HI04-2	The fourth diagnosis code is not pointed to by any claim line and the effective dates of the diagnosis code falls entirely outside the claim's dates of service. Questions regarding the effective dates of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C049	Diagnosis Code Invalid for DOS	2300	HI05-2	The fifth diagnosis code is not pointed to by any claim line and the effective dates of the diagnosis code falls entirely outside the claim's dates of service. Questions regarding the effective dates of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
C050	Diagnosis Code Invalid for DOS	2300	HI06-2	The sixth diagnosis code is not pointed to by any claim line and the effective dates of the diagnosis code falls entirely outside the claim's dates of service. Questions regarding the effective dates of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C051	Diagnosis Code Invalid for DOS	2300	HI07-2	The seventh diagnosis code is not pointed to by any claim line and the effective dates of the diagnosis code falls entirely outside the claim's dates of service. Questions regarding the effective dates of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C052	Diagnosis Code Invalid for DOS	2300	HI08-2	The eighth diagnosis code is not pointed to by any claim line and the effective dates of the diagnosis code falls entirely outside the claim's dates of service. Questions regarding the effective dates of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C053	Referring Provider ID Qualifier Invalid	2310A	NM108	The referring provider identifier is invalid. Valid Value: XX – NPI

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
C054	Invalid NPI Check Digit	2310A	NM109	The referring provider NPI number has an invalid check digit.
C055	Secondary ID Invalid	2310A	REF01	The referring provider secondary identifier is invalid. Only the Employer Identification Number (EIN) or Social Security Number (SSN) and its qualifier are allowed. Valid Values: EI – Employer's Identification Number SY – Social Security Number
C056	EIN/SSN Invalid Format	2310A	REF02	The Employer's Identification Number (EIN) or Social Security Number (SSN) must be nine numeric digits.
C057	Referring Provider ID Qualifier Invalid	2310B	NM108	The referring provider identifier is invalid. Valid Value: XX – NPI
C058	Invalid NPI Check Digit	2310B	NM109	The rendering provider NPI number has an invalid check digit.
C059	EIN/SSN Invalid Format	2310B	REF02	The rendering provider's Employer's Identification Number (EIN) or Social Security Number (SSN) must be nine numeric digits.
C060	Secondary ID Invalid	2310B	REF01	The rendering provider Secondary ID is invalid. The rendering provider information is used primarily for Medicare Part B claims to indicate a physician within a group. DME MAC suppliers can do either of the following: Do not submit any information in the Rendering Provider loops. If submitting the Rendering Provider

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				information, make sure the Rendering Provider (2310B) and Billing Provider (2010AA) loops are identical. The REF segments in these loops should not be sent and should be removed from the electronic file. The NPI must be reported in the NM109 only, with an "XX" qualifier in the NM108. This would apply to all loops with a REF segment for DME MAC electronic claims. **Note:** Prior to May 23, 2008, the REF segment was used to report legacy identification numbers.
C061	Purch Svc Provider First Name Invalid	2310C	NM104	The purchased service provider first name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM104 (first name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
C062	Purch Svc Provider Middle Name Invalid	2310C	NM105	The purchased service provider middle name is invalid. The first position cannot be a space. If NM102 = 1 (person), NM105 (middle name) may only contain alpha characters (A–Z), period (.), hyphen (-), apostrophe (‘), or a space.
C063	Purchased Service Provider ID Qualifier Invalid	2310C	NM108	The purchased service provider identifier is invalid. Valid Value: XX – NPI
C064	Invalid NPI Check Digit	2310C	NM109	The purchased service provider NPI number has an invalid check digit.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
C065	Secondary ID Invalid	2310C	REF01	The purchased service provider secondary ID is invalid. Only the Employer Identification Number (EIN) or Social Security Number (SSN) and its qualifier are allowed. Valid Values: EI – Employer's Identification Number SY – Social Security Number
C066	EIN/SSN Invalid Format	2310C	REF02	Employer's Identification Number (EIN) or Social Security Number (SSN) must be 9 numeric digits.
C067	Service Facility Not Allowed For POS	2400	SV105	Facility information cannot be submitted with Place of Service 12 (Home).
C068	Service Facility ID Qualifier Invalid	2310D	NM108	The service facility location identifier is invalid. Valid Value: XX –– NPI
C069	Invalid NPI Check Digit	2310D	NM109	The service facility location NPI number has an invalid check digit.
C070	Service Facility Address 1 Invalid	2310D	N301	The service facility address 1 is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set.
C071	Service Facility Address 2 Invalid	2310D	N302	The service facility address 2 is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set.
C072	Secondary ID Invalid	2310D	REF01	The service facility location secondary identifier is invalid.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				Only the Federal Taxpayer ID Number and its qualifier are allowed. Valid Value: TJ – Federal Taxpayer's Identification Number
C073	Invalid Taxpayer ID	2310D	REF02	The service facility location taxpayer identification number is invalid.
C074	Supervising Provider ID Qualifier Invalid	2310E	NM108	The supervising provider identifier is invalid. Valid Value: XX – NPI
C075	Invalid NPI Check Digit	2310E	NM109	The supervising provider NPI number has an invalid check digit.
C076	EIN/SSN Invalid Format	2310E	REF02	The supervising provider Employer's Identification Number (EIN) or Social Security Number (SSN) must be 9 numeric digits.
C077	Secondary ID Invalid	2310E	REF01	The supervising provider secondary ID is invalid. Only the Employer Identification Number (EIN) or Social Security Number (SSN) and its qualifier are allowed. Valid Values: EI – Employer's Identification Number SY – Social Security Number
C078	Claim Level Adjustments Not Balanced	2320	CAS	The total claim level adjustment amounts plus the primary paid amount does not equal the total for all submitted charges. TECHNICAL INFORMATION: When 2320.SBR01 = P, and a 2320.CAS segment is submitted, and 2320.AMT01 = D, then the sum of all 2320.CAS03 +

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				2320.CAS06 + 2320.CAS09 + 2320.CAS12 + 2320.CAS15 + 2320.CAS18 + 2430.CAS03 + 2430.CAS06 + 2430.CAS09 + 2430.CAS12 + 2430.CAS15 + 2430.CAS18 + 2320.AMT02, must = 2300.CLM02. —OR— When 2320.SBR01 = P, and a 2320.CAS segment is submitted, and 2320.AMT01 is not = D, then the sum of all 2320.CAS03 + 2320.CAS06 + 2320.CAS09 + 2320.CAS12 + 2320.CAS15 + 2320.CAS18 + 2430.CAS03 + 2430.CAS06 + 2430.CAS09 + 2430.CAS12 + 2430.CAS15 + 2430.CAS18 + 2330.SVD02, must = 2300.CLM02
C079	Multiple Payers Not Allowed	2320	AMT01	The claim submitted included two or more occurrences of the 2320 loop with an AMT01 = "D" (Payer Paid Amount).
C080	Other Subscriber Date of Birth Invalid	2320	DMG02	The other insured date of birth is in an invalid format. Verify the century was entered as 18, 19, or 20. This information is used for MSP and Medigap secondary claims. MSP claims should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. Medigap secondary claims should not be submitted unless there is an approved Medigap policy held by this subscriber.
C081	Other Subscriber Address 1 Invalid	2330A	N301	The other insured address line one is invalid.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				The first position cannot be a space. May contain any characters from both the basic character set and extended character set. This information is used for MSP and Medigap secondary claims. MSP claims should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. Medigap secondary claims should not be submitted unless there is an approved Medigap policy held by this subscriber.
C082	Other Subscriber Address 2 Invalid	2330A	N302	The other insured address line two is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set. This information is used for MSP and Medigap secondary claims. MSP claims should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare. Medigap secondary claims should not be submitted unless there is an approved Medigap policy held by this subscriber.
C083	Other Payer Paid Date Required	2330B	DTP (Qualifier 573)	The primary payer paid date is missing.
C084	First/Only Occurrence Must Be Referring	2330D	NM1	The other payer referring provider name segment 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.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				This information is used when a payer is submitting this claim to another payer and should not be submitted by the provider/supplier.
C085	Second Occurrence Must Be Primary Care	2330D	NM1	The other payer referring provider name segment is invalid. If used, the second 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 provider/supplier.
C086	Secondary ID Invalid	2330D	REF01	The other payer referring provider secondary identifier is invalid. Only the Employer Identification Number (EIN) and its qualifier are allowed. Valid Value: EI – Employer's Identification Number
C087	Secondary ID Invalid	2330E	REF01	The other payer rendering provider secondary identifier is invalid. Only the Employer Identification Number (EIN) and its qualifier are allowed. Valid Value: EI – Employer's Identification Number
C088	Secondary ID Invalid	2330F	REF01	The other payer purchased service provider secondary identifier is invalid. Only the Employer Identification Number (EIN) and its qualifier are allowed.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				Valid Value: EI – Employer's Identification Number
C089	Secondary ID Invalid	2330G	REF01	The other payer service facility location secondary identifier is not allowed.
C090	Secondary ID Invalid	2330H	REF01	The other payer supervising provider secondary identifier is invalid. Only the Employer Identification Number (EIN) and its qualifier are allowed. Valid Value: EI – Employer's Identification Number
C091	Modifier EY must be present on all lines	2400	SV101	If any of the four procedure code modifiers on one or more claim lines equals EY (No physician or other licensed health care provider order for this item or service), all lines must contain the EY modifier. Questions regarding the correct modifier to submit on a claim should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C092	Line Item Charge Amt Invalid	2400	SV102	The line item charge amount is invalid. Verify the charge was entered correctly and is not all zeros.
C093	Line Item Charge Amt Invalid	2400	SV102	The line item charge is invalid. This cannot be greater than $99,999.99.
C094	Basis For Measurement Invalid for Procedure	2400	SV103	The basis of measurement qualifier is invalid. Valid Value: UN – Unit
C095	Diagnosis Code Invalid - Pointer 1	2400	SV107-1	The diagnosis code pointed to by diagnosis code pointer 1 (SV107-1) is

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				invalid for the claim line date of service. Questions regarding the effective dates of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C096	Diagnosis Code Invalid - Pointer 2	2400	SV107-2	The diagnosis code pointed to by diagnosis code pointer 2 (SV107-2) is invalid for the claim line date of service. Questions regarding the effective dates of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C097	Diagnosis Code Invalid - Pointer 3	2400	SV107-3	The diagnosis code pointed to by diagnosis code pointer 3 (SV107-3) is invalid for the claim line date of service. Questions regarding the effective dates of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C098	Diagnosis Code Invalid - Pointer 4	2400	SV107-4	The diagnosis code pointed to by diagnosis code pointer 4 (SV107-4) is invalid for the claim line date of service. Questions regarding the effective dates of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				patient's state code in the address provided on the claim.
C099	EPSDT Referral Required (2300 CRC)	2400	SV111	The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) segment is missing.
C100	Required Modifier RR, NU, UE not Present	2400	SV501-2	A rental or purchase modifier is missing for the durable medical equipment service segment and the procedure code for which payment is being requested. Valid Codes: RR NU UE Questions regarding the correct procedure code and/or modifier to submit on a claim should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim. If the procedure code does not have a valid modifier combination that includes RR, NU, or UE, the SV5 segment cannot be submitted to CEDI.
C101	CMN Indicator Missing (2400 PWK)	2400	PWK	The CMN indicator is missing.
C102	Oxygen Treatment Period Invalid	2400	CR502	The length of need reported on the oxygen CMN form is invalid. Verify the length of need was a number greater than zero.
C103	Oxygen ABG Results Missing	2400	CR510	If question 1a on Oxygen CMN 484.03 is answered with a value between 55 and 60, then at least one of Questions 7 through 9 on Oxygen CMN 484.03 must be answered "Yes".

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
C104	ABG Results Missing/Invalid	2400	CR510	An ABG test date was submitted in the 2400.DTP (Qualifier = 480); however, the ABG Level was missing in the 2400.CR510.
C105	Oxygen SAT Results Missing	2400	CR511	If Question 1b on Oxygen CMN 484.03 is answered with a value above 88%, then at least one of Questions 7 through 9 must be answered "Yes". If the paper CMN from the ordering physician meets the criteria to require Questions 7–9 to have at least one "Yes" response, but no "Yes" response was provided, this claim will need to be filed on paper. This is a known paper claims exception and the supplier must contact DME MAC Jurisdiction that will process the claims to make sure an ASCA waiver is on file for this condition before the paper claim is submitted.
C106	Oxygen SAT Results Missing/Invalid	2400	CR511	An Oxygen Saturation test date was submitted in the 2400.DTP (Qualifier = 481); however, the Oxygen Saturation Level was missing in the 2400.CR511.
C107	DMERC Condition Indicator (CRC) Required	2400	CRC	The segment containing information on conditions (CRC) as indicated on the Certificate of Medical Necessity (CMN) is missing.
C108	Signed/Filed CMN Indicator Required	2400	CRC01	The CMN was not indicated to have been signed by a physician.
C109	Service From Date Invalid	2400	DTP03	The service start/from date is invalid. Verify the date is a valid date, contains 19 or 20 as the century and was entered in a CCYYMMDD format.
C110	Service To Date Invalid	2400	DTP03	The service end/to date is invalid. Verify the date is a valid date, contains 19 or 20 as the century and was entered

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				in a CCYYMMDD format.
C111	Invalid Service Count - RR Modifier	2400	DTP03	The number of services entered for this line is invalid. Rentals can only have one unit of service. Questions regarding the correct modifier to submit on a claim should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C112	CMN Revision Date Invalid - Future	2400	DTP03	The CMN revision/recertification date is a future date. This cannot be greater than the claim's submission date.
C113	CMN Recert/Revise Date Invalid	2400	DTP03	The CMN recertification or revision date (DTP*607) is equal to or less than the initial date on the CMN.
C114	Begin Therapy Date Required	2400	DTP (Qualifier 463)	The CMN initial date is missing.
C115	CMN Certification Date Required	2400	DTP (Qualifier 461)	The date the physician signed the CMN is missing.
C116	Oxygen Sat/ABG Date Required	2400	DTP (Qualifier 480 or Qualifier 481)	The oxygen saturation or arterial blood gas test date is missing.
C117	Test Result Invalid	2400	MEA03	The response to question 6A on the oxygen CMN form is invalid. The response must be equal to spaces, zeros, or numeric.
C118	Test Result Invalid	2400	MEA03	The response to question 6B on the oxygen CMN form is invalid. The response must be equal to a number between 1 and 99.
C119	Oxygen Flow Rate	2400	REF	The oxygen flow rate is missing.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	Required		(Qualifier TP)	
C120	NDC Code Required	2410	LIN03	The NDC segment is missing.
C121	Rendering Provider ID Qualifier Invalid	2420A	NM108	The rendering provider identifier is invalid. Valid Value: XX – NPI
C122	Rendering NPI Not on Crosswalk	2420A	NM109	The rendering provider NPI was not found on the crosswalk. Go to the NPPES Web site and verify the following information matches what you are submitting. The NPPES Web site can be accessed at https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart: Verify that all information for your NPI number is accurate including the name, address and Employer Identification Number (EIN). Verify that your PTAN (Supplier/NSC number) is listed in the Medicare NSC field in the "Other Provider Identifier" record. Verify that the "Entity Type" is correct. **Note:** An organization has an Entity type of 2. Individual/sole proprietorship has an Entity type of 1. **Note:** Any information updated with NPPES will reflect on NPPES Web site immediately, but it will take up to 10 business days for the updates to occur in the DME MACs processing system. Please allow at least 10 business days after making a change to NPPES before

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				resubmitting your claims.
C123	Invalid NPI Check Digit	2420A	NM109	The rendering provider NPI number has an invalid check digit.
C124	EIN/SSN Not On File w/ NPI	2420A	REF02	The rendering provider SSN/EIN submitted for the NPI is not matched. Go to the NPPES Web site and verify the following information matches what you are submitting. The NPPES Web site can be accessed at: https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart: Verify that all information for your NPI number is accurate including the name, address and Employer Identification Number (EIN). Verify that your PTAN (supplier/NSC number) is listed in the Medicare NSC field in the "Other Provider Identifier" record. Verify that the "Entity Type" is correct. **Note:** An organization has an Entity type of 2. Individual/sole proprietorship has an entity type of 1. **Note:** Any information updated with NPPES will reflect on NPPES Web site immediately, but it will take up to 10 business days for the updates to occur in the DME MACs processing system. Please allow at least 10 business days after making a change to NPPES before resubmitting your claims.
C125	Secondary ID Invalid	2420A	REF01	The rendering provider secondary identifier is invalid. Only the Employer Identification Number (EIN) or Social Security

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				Number (SSN) and its qualifier are allowed. Valid Values: EI – Employer's Identification Number SY – Social Security Number
C126	EIN/SSN Invalid Format	2420A	REF02	The rendering provider Employer's Identification Number (EIN) or Social Security Number (SSN) must be 9 numeric digits.
C127	Purchased Service Amount/Provider Required	2420B	NM101	This error occurs when there is a line level Purchased Service Provider (2420B) but no claim level Purchased Service Provider in 2310C. —OR— There is a not a Purchased Service Amount reported (AMT01=NE).
C128	Referring Provider ID Qualifier Invalid	2420B	NM108	The referring provider identifier is invalid. Valid Value: XX – NPI
C129	Invalid NPI Check Digit	2420B	NM109	The purchased service provider NPI number has an invalid check digit.
C130	Multiple Purchased Service Providers Invalid	2420B	NM109	The NPI submitted in the 2420B NM109 must equal the identifier submitted in 2400.PS101.
C131	Secondary ID Invalid	2420B	REF01	The purchased service provider secondary identifier is invalid. Only the Employer Identification Number (EIN) or Social Security Number (SSN) and its qualifier are allowed. Valid Values: EI – Employer's Identification Number SY – Social Security Number

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
C132	EIN/SSN Invalid Format	2420B	REF02	The purchased service provider Employer's Identification Number (EIN) or Social Security Number (SSN) must be 9 numeric digits.
C133	Service Facility ID Qualifier Invalid	2420C	NM108	The service facility qualifier is invalid. Valid Value: XX –– NPI
C134	Invalid NPI Check Digit	2420C	NM109	The service facility location NPI number has an invalid check digit.
C135	Service Facility Address 1 Invalid	2420C	N301	The service facility address line one is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set.
C136	Service Facility Address 2 Invalid	2420C	N302	The service facility address line two is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set.
C137	Secondary ID Invalid	2420C	REF01	The service facility location secondary identifier is invalid. Only the Federal Taxpayer ID Number and its qualifier are allowed. Valid Value: TJ – Federal Taxpayer's Identification Number
C138	Invalid Taxpayer ID	2420C	REF02	The service facility location taxpayer identification number is invalid.
C139	Supervising Provider ID Qualifier Invalid	2420D	NM108	The supervising provider identifier is invalid. Valid Value: XX – NPI

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
C140	Invalid NPI Check Digit	2420D	NM109	The supervising provider NPI number has an invalid check digit.
C141	Secondary ID Invalid	2420D	REF01	The supervising provider secondary identifier is invalid. Only the Employer Identification Number (EIN) or Social Security Number (SSN) and its qualifier are allowed. Valid Values: EI – Employer's Identification Number SY – Social Security Number
C142	EIN/SSN Invalid Format	2420D	REF02	The supervising provider Employer's Identification Number (EIN) or Social Security Number (SSN) must be 9 numeric digits.
C143	Ordering Provider ID Qualifier Invalid	2420E	NM108	The ordering provider identifier is invalid. Valid Value: XX – NPI
C144	Invalid NPI Check Digit	2420E	NM109	The ordering provider NPI number has an invalid check digit.
C145	Ordering Provider Address 1 Invalid	2420E	N301	The ordering provider address line one is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set.
C146	Ordering Provider Address 2 Invalid	2420E	N302	The ordering provider address line two is invalid. The first position cannot be a space. May contain any characters from both the basic character set and extended character set.
C147	Secondary ID Invalid	2420E	REF01	The ordering provider secondary identifier is invalid.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				This REF segment should not be sent and should be removed from the electronic file. The NPI for the ordering provider must be reported in the NM109 only, with an "XX" qualifier in the NM108. This would apply to all loops with a REF segment for DME MAC electronic claims. **Note:** Prior to May 23, 2008, the REF segment was used to report legacy identification numbers.
C148	EIN/SSN Invalid Format	2420E	REF02	The ordering provider Employer's Identification Number (EIN) or Social Security Number (SSN) must be 9 numeric digits. This REF segment should not be sent and should be removed from the electronic file. The NPI for the ordering provider must be reported in the NM109 only, with an "XX" qualifier in the NM108. This would apply to all loops with a REF segment for DME MAC electronic claims. **Note:** Prior to May 23, 2008, the REF segment was used to report legacy identification numbers.
C149	Ordering Provider Contact Required	2420E	PER	The ordering provider contact information is missing. This segment must be submitted when the Home Oxygen Therapy Information segment (2400.CR5) is present.
C150	First/Only Occurrence Must Be Referring	2420F	NM1	If this segment is used, at least one occurrence must be for the referring provider.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
C151	Second Occurrence Must Be Primary Care	2420F	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.
C152	Referring Provider ID Qualifier Invalid	2420F	NM108	The referring provider identifier is invalid. Valid Value: XX – NPI
C153	Invalid NPI Check Digit	2420F	NM109	The referring provider NPI number has an invalid check digit.
C154	Secondary ID Invalid	2420F	REF01	The referring provider secondary identifier is invalid. Only the Employer Identification Number (EIN) or Social Security Number (SSN) and its qualifier are allowed. Valid Values: EI – Employer's Identification Number SY – Social Security Number
C155	EIN/SSN Invalid Format	2420F	REF02	The referring provider Employer's Identification Number (EIN) or Social Security Number (SSN) must be 9 numeric digits.
C156	Product/Service ID Invalid	2430	SVD03-1	The procedure code qualifier is invalid. Valid Value: HC – HCPCS/CPT Codes
C157	Line Level Adjustments Not Balanced	2430	CAS	The total line level adjustment amounts indicated for this line plus the primary paid amount does not equal the line charge. TECHNICAL INFORMATION:

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				When 2430.SVD01 = 2330B.NM109 (Primary Payer), then the sum of 2430.SVD02 + 2430.CAS03 + 2430.CAS06 + 2430.CAS09 + 2430.CAS12 + 2430.CAS15 + 2430.CAS18, must = 2400.SV102 This information is used for MSP claims and should not be submitted unless another payer adjudicated this claim prior to being submitted to Medicare.
C158	CMN Form Identifier Required	2440	LQ02	The CMN form number segment is missing.
C159	Question Response Missing	2440	FRM01	The answer to an indicated CMN question is missing. Check the CMN and verify all relevant questions were answered.
C160	Question Response Date Invalid - Future	2440	FRM04	The response to the DME MAC CMN questions requiring a date is a future date. This cannot be greater than the claim's submission date.
C161	Question Response Invalid Date	2440	FRM04	The date 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.
C162	Patient Weight Invalid	2000C	PAT08	The patient's weight is invalid. Verify the value entered is numeric and is greater than zero. This information should only be reported if the patient is not the same as the subscriber.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
C162	Patient Weight Invalid	2000C	PAT08	The patient's weight is less than one pound. This information should only be reported if the patient is not the same as the subscriber.
C163	Diagnosis Code 1 Invalid	2300	HI01-2	The ICD-9 code is invalid. The decimal point cannot be submitted in the diagnosis code. Questions regarding the correct diagnosis code or the effective date of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C164	Diagnosis Code 2 Invalid	2300	HI02-2	The ICD-9 code is invalid. The decimal point cannot be submitted in the diagnosis code. Questions regarding the correct diagnosis code or the effective date of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C165	Diagnosis Code 3 Invalid	2300	HI03-2	The ICD-9 code is invalid. The decimal point cannot be submitted in the diagnosis code. Questions regarding the correct diagnosis code or the effective date of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				state code in the address provided on the claim.
C166	Diagnosis Code 4 Invalid	2300	HI04-2	The ICD-9 code is invalid. The decimal point cannot be submitted in the diagnosis code. Questions regarding the correct diagnosis code or the effective date of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C167	Diagnosis Code 5 Invalid	2300	HI05-2	The ICD-9 code is invalid. The decimal point cannot be submitted in the diagnosis code. Questions regarding the correct diagnosis code or the effective date of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C168	Diagnosis Code 6 Invalid	2300	HI06-2	The ICD-9 code is invalid. The decimal point cannot be submitted in the diagnosis code. Questions regarding the correct diagnosis code or the effective date of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C169	Diagnosis Code 7 Invalid	2300	HI07-2	The ICD-9 code is invalid.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				The decimal point cannot be submitted in the diagnosis code. Questions regarding the correct diagnosis code or the effective date of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C170	Diagnosis Code 7 Invalid	2300	HI08-2	The ICD-9 code is invalid. The decimal point cannot be submitted in the diagnosis code. Questions regarding the correct diagnosis code or the effective date of a diagnosis code should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C171	Capped Rental – Modifier Missing	2400	SV101-2	A capped rental modifier is required for this capped rental procedure code. Valid Values: KH KI KJ Questions regarding the correct modifier to submit on a claim should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C172	Invalid Procedure Code and/or Modifier	2400	SV101-2	The procedure code or modifier is invalid. Verify the HCPCS and modifier

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				combination is valid. Verify the first position does not contain a space. Questions regarding the correct procedure code and/or modifier to submit on a claim should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim. Helpful Tips to verify a Procedure Code/HCPCS and modifier combination: Check the validity of the procedure code/modifier combination by using the Pricing, Data Analysis and Coding (PDAC) Web site www.dmepdac.com. Check the Local Coverage Determination (LCD) at the DME MACs for guidelines on procedure codes and modifier usage for that LCD. Reference the supplier manual at the DME MAC Jurisdiction(s). Contact the Customer Service/Contact Center department at the appropriate Jurisdiction: Jurisdiction A: 866-590-6731 Jurisdiction B: 866-590-6727 Jurisdiction C: 866-270-4909 Jurisdiction D: 866-243-7272
C173	Number of Services Invalid	2400	SV104	The unit of service is invalid. The unit of service for most capped rental item procedure codes must be

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				equal to one.
C175	Non-Oxygen CMN Missing Required Data	2400	CR3	When DMEPOS category is not oxygen (5) and any of the following conditions are present, then all of the conditions are required: PWK02 = AD (Certification included in this Claim) CR3 (DME Certification) DTP*461 (Date CMN signed by physician) DTP*463 (Begin Therapy Date) CRC01 = 09 (DME Certification) LQ = (Form Identification) FRM (Supporting Documentation) When CR301 = R or S, DTP607 (Certification Revision) must be present. When DTP607 (Certification Revision) is present, CR301 must = R or S
C176	Invalid CMN Length of Need	2400	CR303	The length of need reported on CMN is invalid. Verify the length of need was a number greater than zero.
C178	Oxygen CMN Missing Required Data	2400	CR5	When DMEPOS category is oxygen (5) and ANY of the following conditions are present, then ALL of the conditions are required: PWK02 = AD (Certification included in this Claim) CR5 = (Home Oxygen Therapy Info) DTP*461= (Date CMN signed by Physician) DTP*463 = (Oxygen Therapy Start Date) CRC01 = 11 (Oxygen Therapy

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				Certification) REF01 = TP (Oxygen Flow Rate) >4, MEA and DTP*119 must be present (4 LPM test date and test results). DTP*480 (Date of Arterial Blood Gas Test) or DTP*481 (Date of Oxygen Sat Test) When CR501 = R or S, DTP*607 (Certification Revision) must be present. When DTP*607 (Certification Revision) is present, CR501 must = R or S.
C179	Service From/To Dates Not Equal	2400	DTP03	The procedure code submitted for this line does not allow for spanned dates of service. Verify the start/from and end/to dates for this line are equal.
C180	Service Date Greater than Receipt Date	2400	DTP03	The service start/from date is greater than the date this claim was received.
C181	Date of Service Invalid for Procedure	2400	DTP03	The HCPCS or NDC is not valid for the date of service. Check effective dates of HCPCS/NDC vs. dates of service on claim. Questions regarding the HCPCS and/or NDC code to submit on a claim should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C183	Required Note Missing	2400	NTE	The narrative information is missing. The procedure code submitted requires narrative information.
C184	Invalid NDC Code	2410	LIN03	The NDC is invalid for the dates of

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				service. Questions regarding the NDC code to submit on a claim should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C185	NDC Not Valid for Service Date	2410	LIN03	The NDC submitted is not valid for the dates of service on this claim. Questions regarding the NDC code to submit on a claim should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C186	HCPCS Code Required	2410	LIN03	An NDC code was submitted for an item that is not an oral anti-cancer drug. Only oral anti-cancer drugs should be submitted with NDC codes in ANSI. Non-oral anti-cancer drugs should either be billed with the corresponding HCPCS code (from the NDC-HCPCS crosswalk) if they are to be submitted in ANSI or should be submitted in the NCPDP format if your pharmacy is required to bill via that format. Questions regarding the HCPCS and/or NDC code to submit on a claim should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C187	Service Facility Required -Oxygen	2420C	NM1	The service facility or the oxygen testing location is missing.
C188	Invalid/Unnecessar	2440	LQ02	This error code indicates either

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
	y CMN Submitted			A) The CMN (or DIF) submitted is not appropriate for the procedure code to which it is attached. B) A CMN is not required at all, or C) The combination of modifiers attached to the procedure code is causing the CMN to read as invalid or unnecessary. Situation C is a possibility if error code C172 was generated for the same charge line or if procedure code E0776 was submitted. Questions regarding whether a procedure code requires a CMN should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C189	Invalid/Unnecessary CMN Submitted	2440	LQ02	The DME MAC CMN (or DIF) form number entered is not valid for the HCPCS code. Verify the CMN form number is entered as it appears on the CMN and is still valid for the date of submission. The alpha character is not needed but can be submitted at the end of the CMN or DIF valid value. Valid Values: 01.02 (Expires Jan 1, 2007) 02.03 (Expires Jan 1, 2007) 03.02 (Expires Jan 1, 2007) 04.03 (Expires Jan 1, 2007) 06.02 (Expires Jan 1, 2007) 07.02 (Expires Jan 1, 2007) 08.02 (Expires Jan 1, 2007)

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				09.02 (Expires Jan 1, 2007) 10.02 (Expires Jan 1, 2007) 04.04 (Valid for dates of service starting Oct 1, 2006) 06.03 (Valid for dates of service starting Oct 1, 2006) 07.03 (Valid for dates of service starting Oct 1, 2006) 09.03 (Valid for dates of service starting Oct 1, 2006) 10.03 (Valid for dates of service starting Oct 1, 2006) 484.3 (Valid for dates of service starting Oct 1, 2006) Questions regarding whether a procedure code requires a CMN should be directed to the DME MAC where the claim would be processed based on the patient's state code in the address provided on the claim.
C190	Invalid CMN Question Number	2440	FRM01	The CMN (or DIF) question number in element FRM01 is not appropriate for the CMN indicated in element LQ02. If the question number includes a letter, make sure that letter is capitalized.
C191	Question Response Invalid	2440	FRM03	The question response for this CMN is invalid. If the question is to be answered using a text response, the first position of the response cannot contain a space.
C192	Question Response Invalid Percent	2440	FRM05	The percentage amount is invalid. This must be numeric and cannot be greater than 99.99.
C193	Length of Medical Necessity Invalid	2400	SV503	The quantity for the length of medical necessity is invalid.

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				This cannot be greater than three positions. This cannot contain a decimal point.
C194	DME Rental Price Invalid	2400	SV504	The DME rental price is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
C195	DME Purchase Price Invalid	2400	SV505	The DME purchase price is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
C196	Drug Unit Price Invalid	2410	CTP03	The drug pricing quantity is invalid. This cannot be greater than seven positions to the left of the implied or explicit decimal point. This cannot contain more than two positions to the right of the implied or explicit decimal point.
C199	DME MAC code category invalid	2400	CRC	The type of certification is invalid. Valid Values: 09 - Durable Medicare Equipment Certification 11 - Oxygen Therapy Certification
C200	Referring provider not authorized	2310A	NM103 NM104 NM109	C200 is a warning edit. It will not stop claims from being sent to Medicare until it becomes a rejection. CMS will

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				send out notification prior to the code changing to a rejection. The submitted NPI (NM1-09) and name (NM1-03/04) are not found on the CMS supplied file of Providers/Suppliers who are authorized to Order/Refer services for Medicare. Contact the ordering/referring provider to verify their eligibility with PECOS. More information can be found at http://www.cms.hhs.gov/MLNMatters Articles/downloads/MM6421.pdf
C201	Referring provider not authorized	2420F	NM103 NM104 NM109	C201 is a warning edit. It will not stop claims from being sent to Medicare until it becomes a rejection. CMS will send out notification prior to the code changing to a rejection. The submitted NPI (NM1-09) and name (NM1-03/04) are not found on the CMS supplied file of Providers/Suppliers who are authorized to Order/Refer services for Medicare. Contact the ordering/referring provider to verify their eligibility with PECOS. More information can be found at http://www.cms.hhs.gov/MLNMatters Articles/downloads/MM6421.pdf
C202	Ordering provider not authorized	2420E	NM103 NM104 NM109	C202 is a warning edit. It will not stop claims from being sent to Medicare until it becomes a rejection. CMS will send out notification prior to the code changing to a rejection. The submitted NPI (NM1-09) and name (NM1-03/04) are not found on the CMS supplied file of Providers/Suppliers

Edit Code	Edit Code Message	Loop	Segment/ Field	Description/Logic
				who are authorized to Order/Refer services for Medicare. Contact the ordering/referring provider to verify their eligibility with PECOS. More information can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6421.pdf
NGS005	Sender ID =/= To Trading Partner ID	ISA06		The value in the ISA06 must equal the Login ID used to submit the file.
NGS006	Interchange Sender ID =/= Application Sender ID	ISA06		The Sender/Trading Partner ID in the ISA06 must match the Sender/Trading Partner ID in the GS02
NGS008	Submitter ID (ETIN) =/= To Trading Partner ID	1000A	NM109	The Submitter/Trading Partner ID in the 1000A.NM109 must match the Login ID used to submit the file.

General Translation Errors

The following errors report problems with the inbound file. These errors are not predefined for a specific loop, segment, or element and may appear at any level. These errors may appear along with other predefined CEDI edits on the GENRPT and may require the submitter/trading partner to contact their software vendor to determine the cause of the issue.

Segment Errors

Segment errors represent structural errors in the file. These errors are caused by missing mandatory segments or exceeding the maximum number of occurrences of a segment or a loop.

Error Code: 1000

Error Description: Input data segment failed matching
This error occurs if the matching criteria for the segment do not match the data.

Error Code: 1001

Error Description: Required loop not found
This error occurs if a required loop is not found.

Error Code: 1004

Error Description: Maximum loop repeat exceeded
This error occurs if the maximum number of loops in the file is exceeded, whether the loop is required or optional.

Error Code: 1005

Error Description: Maximum segment occurs exceeded
This error occurs if a segment is repeated more than the maximum allowed per the X12 definition.

Error Code: 1006

Error Description: Required segment not found
This error occurs if a segment is required per the X12 definition and was not submitted.

Data Errors

Data errors represent field level errors of the inbound file. These are caused by exceeding the maximum field lengths, submitting characters in numeric fields, and/or invalid format types (e.g. invalid dates).

Error Code: 2000

Error Description: Required data field not present in input
This error occurs if a required fixed length data element per the X12 is not present.

Error Code: 2001

Error Description: Required data field zero length in input
This error occurs if a required variable length data element per the X12 is zero bytes long.

Error Code: 2002

Error Description: Required group not present in input
This error occurs if a required group element per the X12 is not present.

Error Code: 2003

Error Description: Group exceeds maximum allowed occurrences
This error occurs if a group element occurs more than the maximum number of times per the X12 definition.

Error Code: 2004

Error Description: Validation offset + length point past actual field data
This error occurs if the validation of an element occurs in a position within a field that does not exist in the submitted element.
Example: If the validation is to occur in the fifth byte of an element and the element submitted is only three bytes long, this error will occur.

Error Code: 2005

Error Description: Validation check of Value List failed
This error s if the submitted value is not valid for an element occur.
Example: If an element can only contain the values "1","2" or "3" and the value submitted is "4", this error will occur.

Error Code: 2006

Error Description: Input data length less then minimum defined
A data element is less than the minimum length defined.
Example: If an element is defined as a minimum of five bytes and the submitted element only contains three bytes, this error will occur.

Error Code: 2007

Error Description: Field contents failed data type check
A data element fails data type check.
Example: If a data element is defined as numeric and the submitted element contains an alpha character, this error will occur.

Error Code: 2008

Error Description: Failed relationship check

A data element fails a relationship check. A relationship check is a validation of the relational condition that can exist among two or more data elements within a data segment.

Error Code: 2009

Error Description: Validation check of value string failed
This error occurs if the submitted string of values is not valid for an element.
Example: If an element can only contain the value "ABC" and the value submitted is "XYZ", this error will occur.

Error Code: 2010

Error Description: Validation check against global value failed
A validation check against a global value fails. Global values are temporary stored values, such as counters, accumulators, or checks against element values from elements within different segments.

Error Code: 2011

Error Description: Validation check against code table failed
This error occurs if the submitted code is not valid against the defined code table.

Error Code: 2012

Error Description: Field contents failed data format check
This error occurs if a data element fails the data format check.
Example: If a data field is coded for the format "mmddyy" and the submitted value is formatted as "yymmdd", this error will occur.

Error Code: 2013

Error Description: Input data length greater then maximum defined
This error will occur if the length of a data element is greater than the maximum length defined.

Delivery Errors

Error Code: 3001

Error Description: Unable to Determine Route
This error occurs when the destination payer is unable to be determined. For CEDI, this error may occur when the beneficiary information (2010BA) is or missing or invalid.

Error Code: 3001

Error Description: Duplicate file found – File not processed
This error occurs when a duplicate file has been submitted to CEDI. A duplicate file is determined by the following:

- Claim count

- Service line count
- Record count
- Total charge amount
- First and last patients listed in the claim file

Error Code: 3001

Error Description: Dup Error – Missing Required Data in Input
This error occurs when a file is submitted that is missing required information to run the duplicate file check. This includes information missing for the first name, last name, or HICN for the first and last patients listed in the claim file.

Chapter 6: DME MAC Front-end Report

The DME MAC Front-End Report (RPT) is a set of reports that provide specific information as it relates to each claim transmitted. These reports will list the total number of claims accepted into the Medicare system for processing. This section identifies and describes each of the reports that are generated. Although there are multiple reports, every report may not be received when the electronic Front-end report is downloaded. The reports are referenced by report number. The report numbers are located in the upper left-hand corner of each page of the reports.

Example:

- CONTRACTOR: 16003 – Jurisdiction A
  17003 – Jurisdiction B
  18003 – Jurisdiction C
  19003 – Jurisdiction D
- PROGRAM: X837I600
- REPORT: 7I6001

The reports included in the RPT file are:

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

Reports 7I6001, 7I6002 and 7I6004 will be included in every electronic report package and delivered to the CEDI bulletin board as part of the RPT file. The 7I6006 report will be included if there are errors in the Certificate of Medical Necessity (CMN) claim file submitted to the DME MAC.

The next few pages provide a description and a DME MAC example of each report included in the electronic report package electronic report package.

Note: Claims that receive a CMN rejection are still sent to the DME MAC and will be processed against the CMN on file.

Report Name: The report name is "RPT.ccyymmdd.sequence number.txt"
(ccyymmdd = century, year, month, day)

Timeframe: The RPT typically returns within 24-48 business hours after the claims file has been submitted to CEDI.

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 the DME MAC.
- The date and time the file was transmitted.
- The submitter ID and contact person.
- The submitter name and address.
- The Interchange Sender ID as included in the ANSI X12N 837 transaction.
- The type of file transmitted based on data sent in the ANSI X12N 837 transaction.
  - T = Test
  - P = Production
- Contact information for the entity that transmitted the file.

Report 7I6002 – Received Claims Listing

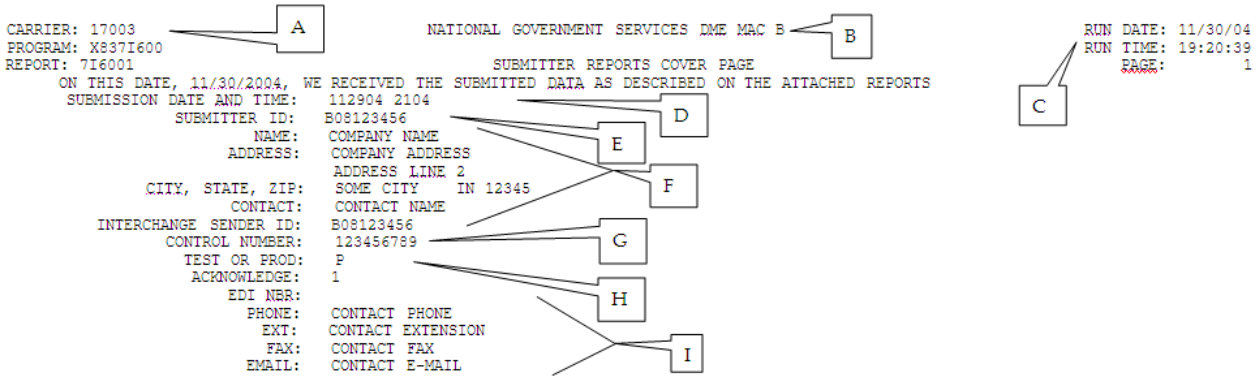
The Received Claims listing report is included with every electronic report package and will follow the Submitter Reports Cover Page (Report 7I6001). This report will provide Claim Control Numbers (CCNs) assigned by the DME MACs for claims accepted into the claims processing system. The CCNs listed on this report will reflect the Internal Control Numbers (ICNs) provided on the GenResponse Report.

This report will be organized by the billing provider's National Provider Identifier (NPI). This is beneficial for billing services or large companies that bill multiple DME suppliers in a single transaction. Rather than locating a particular provider's claims among the total claims transmitted, a separate Received Claims listing report will be generated for each provider/supplier.

The information contained on the Received Claims Listing report includes:

- The patient HICN (Medicare number)
- The name of the beneficiary
- The patient account number
- The date of service
- The Claim Control Number (CCN)
- The amount billed
- The status of the claim
  - A = Accepted for processing

Note: All claims listed on this report will be accepted into the Medicare system for processing. All rejected claims will be listed on the GenResponse report provided by CEDI.



A	Contractor code for the Jurisdiction generating this report	F	Submitter information, pulled from EDI records.
B	Name of the Jurisdiction generating this report	G	ISA13 control number from original 837
C	Date and time this report was created by the EDI systems	H	Test or Production indicator from original 837, ISA15
D	Date and time original 837 was built by submitter's system	I	Contact information from original 837, 1000A.PER segment
E	Submitter ID from the original 837, 1000A.NM109		

Report 7I6004 – Submission Summary

The Submission Summary report is included with every electronic report package and is an excellent tool for balancing claim totals. This report summarizes the number and dollar amounts of assigned and/or non-assigned claims received by the DME MAC for each transaction transmitted for a particular run date.

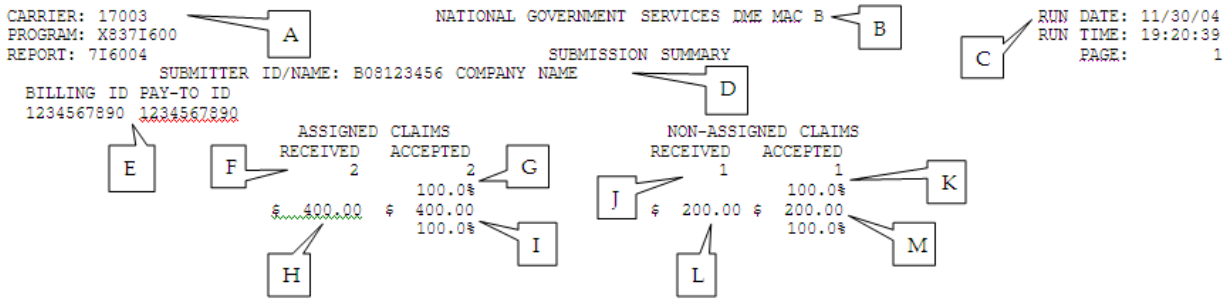
The information contained in this report includes:

Assigned claims information

- The total number of assigned claims received and accepted by the DME MAC.
- The percentage of assigned claims that were accepted in relation to the total number of assigned claims received.
- The total dollar amount of assigned claims received and accepted.
- The percentage in dollar amount of assigned claims accepted as that dollar amount relates to the dollar amount of received, assigned claims.

Nonassigned claims information

- The total number of nonassigned claims received and accepted by the DME MAC.
- The percentage of nonassigned claims that were accepted in relation to the total number of nonassigned claims received.
- The total dollar amount of non-assigned claims received and accepted.
- The percentage in dollar amount of nonassigned claims accepted as that dollar amount relates to the dollar amount of received, nonassigned claims.



A	Contractor Code of the Jurisdiction generating this report	H	Total dollar amount received for assigned claims
B	Name of the Jurisdiction generating this report	I	Dollar amount for accepted assigned claims and percentage of total assigned claims received
C	Date and time report was created by EDI systems	J	Total Non-assigned claims received
D	Submitter ID information from original 837	K	Accepted Non-assigned claims and percentage
E	Supplier information from original 837	L	Total dollar amount received for non-assigned claims
F	Total Assigned claims received	M	Dollar amount for accepted non-assigned claims and percentage of total non-assigned claims received.
G	Accepted Assigned claims and percentage of total assigned claims received		

Report 7I6006 – CMN Reject Listing

The CMN Reject Listing report is included in the electronic report package if there was one or more CMNs rejected on a claim. The CMN Reject Listing report appears at the end of the DME MAC electronic report package and lists claims with rejected CMNs. The claim will be accepted into the DME MAC processing system but the CMN may be rejected.

Rejected CMNs have a four-digit reject code and are listed at the end of this chapter. All CMN rejections occur when another CMN is on file in our system for the same procedure code and beneficiary. Duplicate CMNs will be rejected. If another provider has provided same or similar equipment previously, a current CMN may already be on file. Review CMNs before transmitting with any claims. CMNs should only be transmitted when needed and not with every claim.

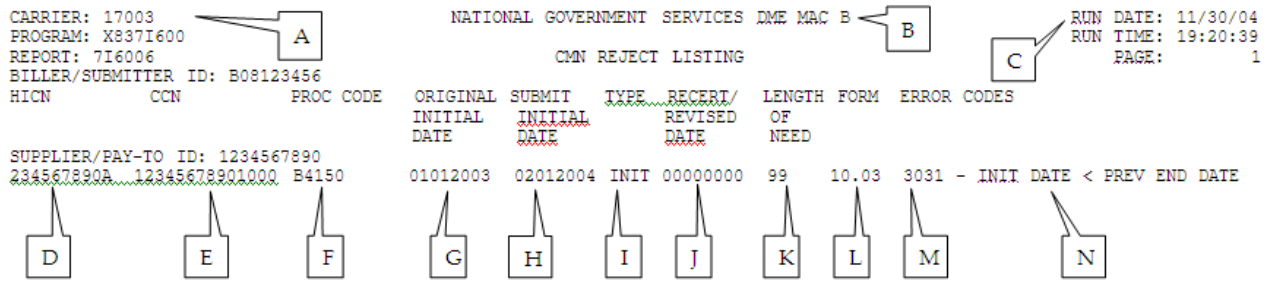
Information present on this report includes:

- 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 with the rejected CMN.
  - **Note:** Since a CCN was assigned to the claim, the claim will be processed. Depending on the CMN rejection code listed on this report, the claim may be denied in processing.
- Procedure code – the procedure code submitted on the claim for the rejected CMN.
- Original initial date – this is the initial date the DME MAC has on file.
- 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 is four-digits and explains why the CMN was rejected. A brief description is provided next to the error code. (A list of the error codes is provided after the CMN Reject Listing example.)
- Total CMNs Rejected – this number indicates the total number of CMNs rejected per submitter. This report will print once per submitter, per run date.

Many CMNs are rejected because they are not completed properly. Here are some tips to help ensure CMNs are completed correctly. Consider the following before transmitting claims:

- Is this the correct type of CMN transmitted based on the documentation requirements in the various policies: initial, revision, or recertification?
- Are all the sections of the CMN completed?
- Is the correct CMN sent with the first claim that will be affected?

- Does the date on the CMN transmitted overlap that of a CMN already transmitted to the DME MAC?



A	Contractor Code for the Jurisdiction generating this report	**H**	Initial date submitted in 837
B	Name of the Jurisdiction generating this report	**I**	Type of CMN submitted in 837
C	Date and time this report was created by the EDI systems	**J**	Recert/Revised date submitted in 837, if applicable
D	HICN/Medicare ID of the patient	**K**	Length of need submitted in 837
E	Claim Control Number of claim	**L**	CMN form number submitted in 837
F	HCPCS with attached CMN	**M**	Reject code
G	Initial date on file with Medicare	**N**	Reject text

The following are definitions of the CMN reject error codes, the reason for the rejection, and possible resolutions to these situations.

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 01/14/01along 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 a DME MAC 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/Providers 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.
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 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 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 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 must furnish the revised CMN upon request from the DME MAC. 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 must 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 a 08/01/00 date for procedure code B4150 (enteral formula). The CMN is transmitted electronically and posted to a DME MAC's CMN files 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 a DME MAC has already posted the CMN with the revised date of 08/01/00. **Resolution:** Make sure CMNs are transmitted in sequence. If this error is received 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.
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, a DME MAC 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 a DME MAC has on file an initial date of 06/01/01. **Resolution:** The initial date on file with a DME MAC 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.
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 their medical need changed and now they qualified for a K0011 wheelchair. A DME MAC would set the K0001 CMN to be discontinued. **Resolution:** If this happens, contact the beneficiary, physician, and/or other supplier. Check the medical files and if it still cannot be resolved, call the Public Relations Department.
3052	CMN CLSD-NO REV	The revised 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, a DME MAC 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 the medical 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.