Details for Billing Staff, Clearinghouses and Vendors: New Edit Checks

New Edit Checks, Effective April 13, 2007

If you submit your claims using the HIPAA 837I electronic transaction, you may encounter the following error codes and descriptions on your X12 277 Claim Acknowledgment (277CA) Transaction or 277CA printable report.

Claim Status Code	Claim Status Category Code	Claim Status Description	How to resolve the edit
679	A3	Submit newborn services on mother's claim [GROUP-SPECIFIC ONLY]	Ensure that revenue codes 170-172, & 179 are submitted on the mother's claim
578 & 228	A8	578 = Insurance Type Code 228 = Type of bill for UB claim	Ensure that the bill type is 11*, 21*, 41*, 51*; or [81*, or 82* and revenue code is 655 or 656] when Medicare Part A is reported as other insurance.
672	A3	Other payer's payment information is out of balance	Ensure that the sum of all LINE level CAS amounts + the LINE level paid amount is = the LINE charge reported for each payer identified on all non-host claims.
678	A3	Revenue code and patient gender mismatch	Ensure that the patient's gender is valid for the revenue code reported (edit not applied when 'U'/unknown gender is reported).
286	A6	Other payer's Explanation of Benefits/payment information	Ensure that CAS codes and amounts are reported at the claim or line level when the reported other payer claim level paid amount does NOT= the total claim charge on all non-host claims.
188 & 486 for	A8	188 = Statement from-through dates 486 = Principle Procedure Date	Ensure that the principle procedure code date is no more than three days prior

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principle			to the statement covered from date and not greater than the statement covered thru dates on all inpatient institutional claims.
188 & 492 for other	A8	188 = Statement from-through dates 492 = Other Procedure Date	Ensure that the other procedure code date is no more than three days prior to the statement covered from date and not greater than the statement covered thru dates on all inpatient institutional claims.
465 & 486 for principle	A7	465 = Principal Procedure Code for Service(s) Rendered 486 = Principle Procedure Date	Ensure Principal Procedure Code is in a valid format for Procedure Code Method reported. Fifth position must be a space when the procedure coding qualifier is 'BR' . Fifth position must be populated when procedure coding qualifier is 'BP.
490 & 492 for other	A7	490 = Other Procedure Code for Service(s) Rendered 492 = Other Procedure Date	Ensure the Other Procedure Codes is in valid format for the procedure code method reported. Fifth position must be a space when the procedure coding qualifier is 'BQ' . Fifth position must be populated when procedure coding qualifier is 'BO'. Must be in the same format as the principal procedure code.
164, with entity ID IL	A6	Entity's contract/member number IL = Insured or Subscriber	Ensure that a contract id is reported on professional and institutional HOST claims.
158, with entity ID QC & 187	A8	Entity's date of birth QC = Patient 187 = Date(s) of service	Ensure that the patient's reported date of birth is prior to the date of service on professional and institutional claims.

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156	A6 or A3	Patient relationship required	Ensure that the relationship code is reported in the subscriber loop when the subscriber is the patient. If the patient is NOT the subscriber, ensure that that relationship code is reported in the patient loop.
126, with entity ID IL	A6	Entity's address IL = Insured or Subscriber	Ensure that the subscriber's address is reported when the subscriber is the patient.
33	A3	Subscriber and subscriber ID not found	Ensure that the submitted subscriber id is a valid Highmark id number for all non-host claims.
463	A7	NUBC Value Code(s) and/or Amount(s)	Ensure value codes 80-83, A1, B1, C1, A2, B2, C2, A3, B3, C3, A7, B7 or C7 are NOT reported.