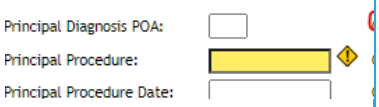
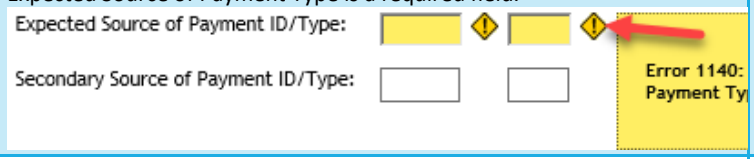
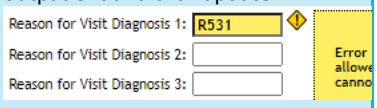
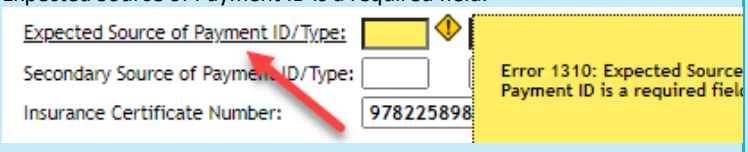
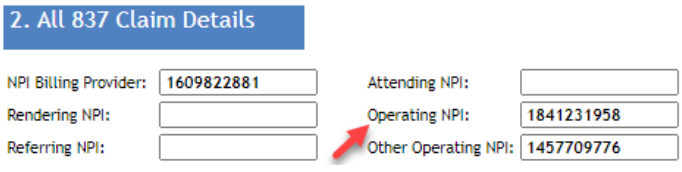
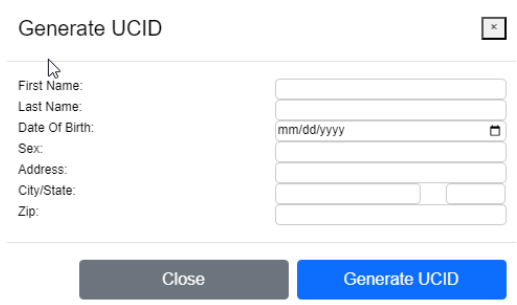
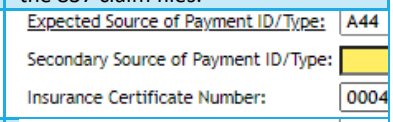
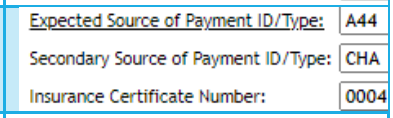
7.10 Edit Codes and Descriptions

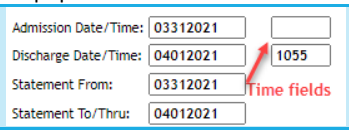
Notes are provided to help users work and/or clear edits.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ▲	Notes and fixing edits Click "Update" in WIpop to clear edit
1000	PTTYPE	The Patient Type supplied is invalid. Assigned by WHAIC unless DDE.	1=INP OR 2=OP
1005	SERVCODE	The Place of Service Code supplied does not match the revenue codes associated with this patient. See Appendix 7.5 - Place of Service Direct Data Entry users must consult manual and enter accordingly.	WHAIC assigns place of service using the revenue line-item detail, based on the hierarchy of codes outlined in Appendix 7.5 with some exceptions.
1006	SERVCODE	This facility type "FASC" must use place of service 1 (OPS)	Applies to DDE users
1010	BDAT	Date of Birth is a required field. MMDDYYYY	Verify DOB in MR
1030	ZIP	Zip Code is a required field. Unless patient is homeless – then record must contain condition code 17.	Condition Code 17 must be used for homeless or unknown on WIpop screen.
1040	SEX	Gender is a required 1 alpha character field. M and F also allow O (other) or U (unknown). Q424 Added X – NonBinary Option. Examples of O or U might include transgender, baby born with both parts, Agender, Androgynous, Bigender, nonbinary, etc. Condition code 45 is a billing code used in Medicare to identify claims related to transgender, intersex, and gender-expansive issues: • Purpose Condition code 45, also known as "Ambiguous Gender Category", allows claims to bypass sex-related edits and be processed normally. • When to use This code should be used for inpatient and outpatient claims related to transgender, intersex, and gender-expansive issues.	If O or U, Enter Condition Code 45 in the first unused condition code in Section 2. All 837 Claim Detail in the Edit Record Screen of WIpop. 
1050	RACE	Race is a required field for the state mandated discharge data collection. Race may be documented as declined (7) or unknown (9). The patient determines this field. Facility should not choose for the patient or map data to specific races.	See Appendix 7.2 Race and Ethnicity Codes. Batches will be denied if >25% of records are supplied with denied or unavailable.
1060	ADMS	Point of Origin is a required field for this type of patient record.	See Appendix 7.7 or 7.7.1 in the case of newborns.
1065	RACE	Race 1 and Race 2 fields cannot contain the same value.	Delete race 2 and click update.
1070	ADMT	Type of Admission is a required field for this type of patient record. Required on INP records.	See NUBC / UB-04 Guidelines
1080	ADAT	Admission Date is a required field for this type of patient record. Applies to INP and ED records.	Applies to Inpatient and ED records.
1081	ADAT	Admission Date is a required since Discharge date is provided.	One without the other will create an edit.
1090	DXP_REQ	Principal Diagnosis is a required field.	Check claim or EMR for diagnosis ode.
1091	DXP_POA	Principal Diagnosis Present on Admission is a required field. Applies to INP records. Acceptable values are Y, N, U, W and Blank for exempt.	See Coding Guidelines Appendix 7.6.
1092	DXP_POA	Principal Diagnosis Present on Admission does not correspond to accepted values. Acceptable values are Y, N, U, W and **blank** for exempt.	If you have a 1, E or a value other than what is acceptable, delete the value and click update.
1093	DXP_POA	Principal Diagnosis Present on Admission is exempt from the reported Principal Diagnosis and cannot be submitted. Refer to the current ICD-10 Coding Guidelines.	If exempt from reporting, field must be blank. Remove the value (Y, N, U, W) and hit update. *Most Status Codes "Z" range are exempt*
1094	DXP_POA	Principal Diagnosis Present on Admission is not allowed on this patient type.	PoA is only allowed on inpatient records. Delete the value and update record.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ⚠	Notes and fixing edits Click "Update" in WIpop to clear edit
1100	DXA	Admitting Diagnosis is a required field. Applies to INP records.	Edit will occur if provided on OP records. Delete if the code exist on an outpatient record.
1110	PINA	Attending NPI is a required field. Applies to INP and ED records.	Edit will occur if missing, review record and add NPI.
1120	DDAT	Discharge Date is a required field for this type of patient record.	Applies to INP and ED records/encounters.
1121	DDAT	Discharge Date is a required since Admission date is provided.	Cannot have one without the other.
1130	PTSTATUS	Discharge Status is a required field for this type of patient record.	See Appendix 7.8 – according to the NUBC it is a required field on all institutional claims.
1140	SOPTYPE	Expected Source of Payment Type is a required field. 	Appendix 7.3 Expected Source of Payment for correct mapping. Commercial payer codes start with 'A' - example: Aetna is A10 – 09. The A10 is the Payment ID and the 09 is the Payment Type code.
1150	TC	Total Charges is a required field. *Must match total charges in revenue detail.	Exclude professional services if on the record.
1160	BILLTYPE	Type of Bill is a required field. See Appendix 7.4 Type of Bill.	See UB-04 Data Specification Manual (NUBC). User may reference Appendix 7.4 to review acceptable TOB.
1170	SERVCODE (Aka POS)	The SERVCODE is the same as Place of Service (POS) supplied is invalid. See Appendix 7.5 Place of Service for correct Mapping requirements.	WHAIC will assign based on revenue code detail or type of facility.
1180	MRN	Medical Records Number is a required field.	Special characters are not acceptable, example: <1231>
1190	STPERIODF	Statement Covers Period From is a required field for this patient record. From means the date the service started.	Required on OBS, Therapies, Lab/Rad and other hospital outpatient data.
1200	STPERIODT	Statement Covers Period 'Through 'To' is a required field for this patient record. 'To' means the date the service ended.	Required on OBS, Therapies, Lab/Rad and other hospital outpatient data
1220	REVCODE	Revenue Code is a required field for this type of patient record.	All outpatient records require revenue codes except for FASC.
1240	UNITSERV	Units of Service is a required field.	Positive whole numbers only.
1245	UNITSERV	Units of Service must be greater than zero when Revenue Charge is greater than or equal to zero.	Units are required – must be 1 or greater. Units in the revenue line-item detail cannot be '0'
1250	REVCHG	Revenue Charge is a required field. Cannot be left blank.	$0 is acceptable
1260	DX	Additional Diagnosis is a required field when an injury code exists in the S and some T ranges.	Add an external cause code from the V00 – Y99 ICD-10 coding book range to explain – how, what, and/or where accident occurred.
1261	DXRV1	Reason for Visit 1 is required for this type of patient record. One code required for RHC 013x and 085x, and 078x with Revenue Codes 045x, 0516, 0526, or 0762. Up to 3 codes allowed for any outpatient record.	This definition is provided according to the NUBC coding guidelines.
1262	DXRV2	Reason for Visit 2 cannot be submitted without Reason for Visit 1.	Adjust record according to edit.
1263	DXRV3	Reason for Visit 3 cannot be submitted without Reason for Visit 1 & Reason for Visit 2.	Adjust record accordingly.
1265	DXRV1	Reason for visit 1 does not correspond to accepted values.	Reference code in ICD-10 CM, remove decimals, contact WHAIC if correct and you want an override.
1266	DXRV2	Reason for visit 2 does not correspond to accepted values.	Reference code in ICD-10 CM, remove decimals, contact WHAIC if correct.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ⚠	Notes and fixing edits Click "Update" in WIpop to clear edit
1267	DXRV3	Reason for visit 3 does not correspond to accepted values.	Reference code in ICD-10 CM, remove decimals, contact WHAIC if correct
1269	DX	Additional Diagnosis not allowed if Principal Diagnosis not submitted.	Reference code in ICD-10 CM, remove decimals, contact WHAIC if correct.
1270	PR	Additional Procedure is a required field. Valid when facility creates an additional procedure.	WHAIC adds from the 837-claim file, applies to DDE users only.
1271	DXRV1	Reason for visit 1 is not allowed for this patient type and cannot be submitted. The Patient's Reason (FL 70a-c) is a "Situational" reported field. It is required for Medicare institutional claims processing on Type of Bill 013x and 085x when: a) Form Locator 14 (Priority (Type) of Admission or Visit) codes 1, 2, or 5 are reported; and b) Revenue Codes 045x, 0516, or 0762 are reported. The requirement for reporting Patient's Reason for Visit is restricted to the outpatient bill types above.	Delete the code if the record is not outpatient and click update. 
1272	DXRV2	Reason for visit 2 is not allowed for this patient type and cannot be submitted. The Patient's Reason (FL 70a-c) is a "Situational" reported field. It is required for Medicare institutional claims processing on Type of Bill 013x and 085x when: a) Form Locator 14 (Priority (Type) of Admission or Visit) codes 1, 2, or 5 are reported; and b) Revenue Codes 045x, 0516, or 0762 are reported. The requirement for reporting Patient's Reason for Visit is restricted to the outpatient bill types above.	Delete the code if the record is not outpatient and click update.
1273	DXRV3	Reason for visit 3 is not allowed for this patient type and cannot be submitted. The Patient's Reason (FL 70a-c) is a "Situational" reported field. It is required for Medicare institutional claims processing on Type of Bill 013x and 085x when: a) Form Locator 14 (Priority (Type) of Admission or Visit) codes 1, 2, or 5 are reported; and b) Revenue Codes 045x, 0516, or 0762 are reported. The requirement for reporting Patient's Reason for Visit is restricted to the outpatient bill types above.	Delete the code if the record is not outpatient and click update.
1274	DXRV1	Reason for Visit 1 is a duplicate of another Reason for Visit diagnosis	Delete duplicate.
1275	DXRV2	Reason for Visit 2 is a duplicate of another Reason for Visit diagnosis	Delete duplicate and update accordingly.
1280	PRDATE	Additional Procedure Date is a required field when additional procedure is supplied. Effective 01/18	WHAIC assigns based on revenue code details. But DDE users should verify EMR for details.
1310	SOPID	Expected Source of Payment ID is a required field. 	Appendix 7.3 Expected Source of Payment for correct mapping. Commercial payer codes start with 'A' - example: Aetna is A10 – 09. The A10 is the Payment ID and the 09 is the Payment Type code. Click on the underline to see who the payer listed on the claim is to map correctly.
1340	PINB	Operating Provider NPI 1 is required on outpatient surgery records. 	Must identify the physician/other qualified health care provider who performed surgery. It is unnecessary to populate the Attending on any record besides INP and ED. Other Operating NPI should be identified if there is a secondary surgeon on the record.
1350	ETHN	Ethnicity is a required field. See Appendix 7.2	See Appendix 7.2 for list of acceptable codes.
1360	UCID	Unique (encrypted) Case ID is a required field.	Complete the questions in the "Generate UCID box to create the

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
			UCID and populate the WIpop screens.
1365	PRP	Principal Procedure must be specified for outpatient surgery encounters / patient record. WHAIC pulls the principal procedure in from the claim file unless it is not included.	Mostly applies to anyone doing direct data entry facility. Required for outpatient surgery records.
1370	PRP	Evaluation & Management codes are not an acceptable Principal Procedure.	Use appropriate procedural CPT/HCPCS code. Applies to DDE. WHAIC populates all 837 files.
1375	PRP	Principal Procedure required if Operating Provider NPI 1 is reported.	Required on OPS records.
1380	PRP	Principal Procedure required when Procedure Date is reported.	WHAIC populates the principal and procedure date.
1385	PRP	Principal Procedure must be specified if Other Provider NPI 2 is reported.	WHAIC assigns procedure codes – contact WHAIC for review.
1390	PRP	Principal Procedure must be specified when Additional Procedures are reported.	Applies to DDE – WHAIC populated procedure codes based on revenue line-item detail.
1395	ADPRPD	Principal Procedure code does not appear in the revenue lines. All CPT/HCPCS codes must be identified in the revenue lines below. *This section is intended to identify services that meet the definition of "procedure."	Typically applies to direct data entry of records. This means you cannot populate the principal without repeating it along with the cost of the procedure in the rev line detail.
1396	ADPRPD	Additional Procedure code does not appear in the revenue lines. All CPT/HCPCS codes must be identified in the revenue lines below. *This section is intended to identify services that meet the definition of "procedure."	Typically applies to direct data entry of records. This means you cannot populate the additional procedure code(s) without repeating it along with the cost of the procedure in the rev line detail.
1400	PRPD	Principal Procedure Date required if Principal Procedure is reported.	Generally, applies to DDE because WHAIC assigns the date to the WIpop table based on the detail in the 837 claim files.
1410	SOPTYPE2	Secondary Source of Payment Type is required when Secondary Source of Payment ID is specified.	
1420	SOPID2	Secondary Source of Payment ID is required when Secondary Source of Payment Type is specified.	
1555	CERTNUM	Insurance Certificate Number is a required field unless self-pay.	For self-pay (OTH-61) use NULL or Blank
1590	LVDAYS	Leave Days cannot be a value greater than zero for this type of patient record.	Delete value and click update.
1600	PINB	Operating Provider NPI 1 cannot be specified if Principal Procedure is not reported.	Delete Operating NPI or add Principal Procedure
1605	PINC	Other Provider NPI 2 cannot be specified if Principal Procedure is not reported.	Delete NPI 2.
1610	PINC	Other Provider NPI 2 cannot be specified if Operating Provider NPI 1 is not reported.	Delete NPI 2 or add operating NPI.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ⚠	Notes and fixing edits Click "Update" in WIpop to clear edit
2010	BDAT	Date of Birth (DOB) does not correspond to a valid date (mmddyyyy).	Review record and update accordingly.
2015	BDAT	Date of Birth cannot be **after** Admit, Principal Procedure or Statement Covers From date.	Verify DOB in EMR and correct WIpop record.
2020	ADAT	Admission Date does not correspond to a valid date (mmddyyyy).	
2021	ATIME	Admission Time does not correspond to a valid time (hhmm)	
2022	ATIME	Admission Time must be blank when Admission Date is blank	
2030	PRPD	Principal Procedure Date does not correspond to a valid date (mmddyyyy).	
2040	DDAT	Discharge Date does not correspond to a valid date (mmddyyyy).	Correct date field and click update.
2041	DTIME	Discharge Time does not correspond to a valid time (hhmm)	Correct time field and click update
2042	DTIME	Discharge Time must be blank when Discharge Date is blank	
2050	STPERIODF	Statement Covers Period From does not correspond to a valid date.	Format date: mmddyyyy
2060	STPERIODT	Statement Covers Period To does not correspond to a valid date.	Format date: mmddyyyy
2065	STPERIODT	The date specified does not fall within the boundary of the working quarter. **Discharge date** is used to determine which quarter to use when reporting to WHAIC. For example, if service started on 06/30 and ended on 07/01, the record should be included in the 3rd quarter data submission. *This does not apply to outpatient surgery records.*	This record should be pulled into the following quarter if it crosses a quarter (*This does not apply to outpatient surgery records*.) This applies to both inpatients and most outpatient. Inpatient is based on discharge date and outpatient data like OBS, Therapies and lab/radiology are based on statement through date.
2066	STPERIODF	Statement Covers Period From must match the minimum service date in submitted revenue records.	Verify the statement from and through match the revenue record dates of service.
2067	STPERIODT	Statement Covers Period To must be no more than one day greater than the maximum service date in submitted revenue records.	
2070	SERVDATE	Service Date does not correspond to a valid date (mmddyyyy).	Review file: DTP*434 Loop
2075	SERVDATE	Service Date is a required field for this type of patient record.	Review file: DTP*434 Loop
2080	PRDATE	Additional Procedure Date does not correspond to a valid date.	The date must be formatted: mmddyyyy. Applies to direct data entry, WHAIC adds the additional procedure dates from revenue line-item details.
2090	TC	Total Charges cannot be less than zero.	Value must equal the value in revenue sect.
2100	UNITSERV	Units of Service do not correspond to a valid non-zero data format (nnnnnnn).	A value of 1 must be used – whole numbers only.
2310	LVDAYS	Leave Days must be a non-negative integer value (nnn).	Calculated by WHAIC
2311	LVDAYS	Leave Days should be less than Length of Stay.	Calculated by WHAIC
2340	UCID	Unique Case ID is not properly formatted. The value must contain 64 characters.	AKA – UCID.
2345	UCID	Unique Case ID is a required field.	
2350	DDAT	LOS cannot be greater than 7 days for ER (Discharge Date minus Admit Date).	Review the claim, EMR and correct accordingly. If correct, contact WHAIC to do an override if necessary.
3020	ZIP	ZIP Code does not correspond to accepted values.	Verify in the patient record and update. For out of country patients, use 00000

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ⚠	Notes and fixing edits Click "Update" in WIpop to clear edit
3030	SEX	Gender does not correspond to accepted values. Value of U or O requires Condition Code 45 if transgender or ambiguous gender.	If U or O, add Condition Code 45 to first available space in WIpop.
3040	RACE	Race does not correspond to accepted values.	See Appendix 7.2
3045	RACE2	Race 2 must be valid if specified.	See Appendix 7.2
3046	RACE	Declined or Unavailable race cannot be combined with another valid race. Two or more valid races may be included.	Delete unavailable or declined race when valid race is provided and hit update.
3050	ADMS	Point of Origin does not correspond to accepted values.	Review Claim or NUBC for correct Point of Origin or (AKA Source of Admission)
3060	ADMT	Type of Admission does not correspond to accepted values. See Official NUBC UB-04 Manual for values.	Refer to Appendix 7.7.1 for Admit Type listing.
3070	DXP	Principal Diagnosis does not correspond to accepted values, or code was deleted.	Verify accuracy of code choice. Refer to the current ICD-10 Manual.
3080	DXA	Admitting Diagnosis does not correspond to accepted values, or code was deleted.	Verify accuracy of code choice. Refer to the current ICD-10 Manual.
3110	PINA	Attending Provider NPI does not correspond to accepted values.	Verify NPI before contacting WHAIC. Verify NPI Number in the NPPES NPI Registry https://npiregistry.cms.hhs.gov/
3120	PINB	Operating Provider NPI 1 does not correspond to accepted values.	Verify NPI before contacting WHAIC. Verify NPI Number in the NPPES NPI Registry https://npiregistry.cms.hhs.gov/
3130	PINC	Other Provider NPI 2 does not correspond to accepted values.	Verify NPI before contacting WHAIC. Verify NPI Number in the NPPES NPI Registry https://npiregistry.cms.hhs.gov/
3136	PIND	Rendering Provider does not correspond to accepted values.	Verify NPI before contacting WHAIC. Often in the ASC file, the rendering provider is the same as the operating NPI.
3137	PINF	Referring Provider does not correspond to accepted values.	Verify NPI before contacting WHAIC. Referring NPI is not the same as the billing NPI. Verify the NPI number for the Referring Provider is a human and not a facility.
3140	PRP	Principal Procedure does not correspond to accepted values, or code was deleted. Verify code in CPT or HCPCS if OP.	If outpatient record, verify code is a valid CPT or HCPCS. INP record – verify code with ICD-10 PCS
3145	PRP	Principal Procedure contains a valid procedure code, but not a valid principal procedure code. May be an add-on code or non-procedure code like a DME or Supply code.	If outpatient record, verify code in CPT or HCPCS. INP record – verify code with ICD-10 PCS
3150	PTSTATUS	Discharge Status does not correspond to accepted values. See Appendix 7.8 - Discharge status or Official NUBC UB-04 Specifications.	See Appendix 7.8 - Discharge status or Official NUBC UB-04 Specification
3180	BILLTYPE	Type of Bill does not correspond to accepted values.	See Appendix 7.4 – some TOBs are not acceptable
3181	BILLTYPE	Type of Bill 0999 is not allowed for hospitals.	Hospitals must use the TOB that is on the claim form.
3185	BILLTYPE	Zero charge records require Nonpayment/Zero charge Bill Type. See Appendix 7.4 - Type of Bill	As per NUBC guidance, type of bill must end in zero for total charges to be equal to zero.
3186	BILLTYPE	Type of bill (TOB)must match the record type. Edit 3186 will apply when either of these states is true:	This is a new 2020 edit to avoid hospitals and ASCs pre-mapping or

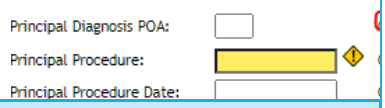
Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ▲	Notes and fixing edits Click "Update" in WIpop to clear edit
		• The record is inpatient and TOB is NOT in the 110 – 121 range • The record is outpatient and TOB is in the 110-121 range	assigning records to a specific TOB without regard to what is on the claim.
3210	REVCODE	Revenue Code does not correspond to accepted values. The whole file will reject if revenue code is longer than 4 digits. Transaction | Claim | Error 1 | 2 | Error on field REVCODE (loop 2400 SV201), maximum length 4, value = 0360A	Revenue codes are 4 digits and the leading zero, if applicable, must be present. Verify in UB-04.
3211	LVDAYS	At least one revenue record WITH a valid 018x revenue code must exist WHEN Leave Days is NOT 0 OR empty.	WHAIC assigns based on rev record detail.
3214	REVCODE	This revenue code cannot be submitted as a standalone record. 01/2018 **edit updated to avoid over-reporting of stand-alone ambulance claims.	Records that contain revenue codes 054X, 037X and 062X that are not accompanied by other revenue codes indicating a face-to-face encounter on the record will receive an edit.
3215	REVCODE	Revenue code cannot include professional charges. Professional Rev codes 096X - 098X excluded.	Delete line item, adjust the total charges if necessary.
3216	REVCODE	FASCs are not required to use revenue codes, if one is provided the acceptable range is: 0250, 0278, 0279, 0329, 036+, 0400, 0481, 049+, 0636, or 0750	Most FASC should be submitting data using the 837P which does not have a space for the revenue codes.
3220	HCPCSRATE	HCPCS/Rate Code must be accepted value or valid rate.	If code is valid, contact WHAIC and we will update table.
3225	HCPCSMOD1	HCPCS Modifier 1 does not correspond to accepted values.	WHAIC only accepts valid NUBC Modifiers. Exclude Vendor, Internal or Payer Modifiers.
3226	HCPCSMOD2	HCPCS Modifier 2 does not correspond to accepted values.	WHAIC only accepts valid NUBC Modifiers. Exclude Vendor, Internal or Payer Modifiers.
3227	HCPCSMOD3	HCPCS Modifier 3 does not correspond to accepted values.	WHAIC only accepts valid NUBC Modifiers. Exclude Vendor, Internal or Payer Modifiers.
3228	HCPCSMOD4	HCPCS Modifier 4 does not correspond to accepted values.	WHAIC only accepts valid NUBC Modifiers. Exclude Vendor, Internal or Payer Modifiers.
3230	DX	Additional Diagnosis does not correspond to accepted values, or code was deleted. Verify code in the ICD-10 CM	Verify code in the ICD-10 CM and adjust accordingly.
3235	HCPCSMOD1	Records for professional services are not acceptable.	Delete line items, adjust the total charges if necessary.
3236	HCPCSMOD2	Records for professional services are not acceptable.	Delete line item, adjust the total charges if necessary.
3237	HCPCSMOD3	Records for professional services are not acceptable.	Delete line item, adjust the total charges if necessary.
3238	HCPCSMOD4	Records for professional services are not acceptable.	Delete line item, adjust the total charges if necessary.
3240	PR	Additional Procedure does not correspond to accepted values, or code was deleted.	If the code is valid, contact whaicinfocenter@wha.org to request a code review.
3245	PRMOD1	Additional Procedure Modifier 1 does not correspond to accepted values.	Review current CPT or HCPCS and UB Manual.
3246	PRMOD2	Additional Procedure Modifier 2 does not correspond to accepted values.	Consult with current CPT or HCPCS Manual
3247	PRMOD3	Additional Procedure Modifier 3 does not correspond to accepted values.	Review current CPT or HCPCS and UB Manual.
3248	PRMOD4	Additional Procedure Modifier 4 does not correspond to accepted values.	Review current CPT or HCPCS and UB Manual.

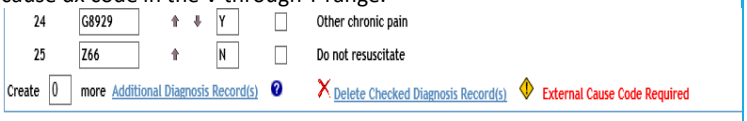
Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ⚠	Notes and fixing edits Click "Update" in WIpop to clear edit
3250	ETHN	Ethnicity does not correspond to accepted values.	See Appendix 7.1.2 Race and Ethnicity.
3340	CCODE1	Condition Code 1 does not correspond to accepted values	Review claim and NUBC Specifications.
3341	CCODE2	Condition Code 2 does not correspond to accepted values	Review claim and NUBC Specifications.
3342	CCODE3	Condition Code 3 does not correspond to accepted values	Review claim and NUBC Specifications.
3343	CCODE4	Condition Code 4 does not correspond to accepted values	Review claim and NUBC Specifications.
3350	CCODE1	Condition Code 1 is a duplicate of another Condition Code	Delete one of the other duplicate CC
3351	CCODE2	Condition Code 2 is a duplicate of another Condition Code	Delete one of the other duplicate CC
3352	CCODE3	Condition Code 3 is a duplicate of another Condition Code	Delete one of the other duplicate CC
3360	CCODE1	Condition Code 1 must be populated first if other Condition Code exist	If Condition Code 1 is blank, move Condition Code 2 value up.
3361	CCODE2	Condition Code 2 cannot be blank if other Condition Code is not blank	
3362	CCODE3	Condition Code 3 cannot be blank if other Condition Code is not blank	
3770	SOPID	OTH-54 is obsolete as of Q1 2022. Use CHA-03 instead.	NEW Edit 2022: OTH-54 was redundant and eliminated.
3771	SOPID2	OTH-54 is obsolete as of Q2 2022. Use CHA-03 instead.	NEW Edit 2022: OTH-54 was redundant and eliminated. Combine all military with CHA-03
3772	SOPID	OTH-31 is obsolete as of Q22022. Use OTH-21 instead.	OTH-31 was redundant and was combined with OTH-21.
3773	SOPID2	OTH-31 is obsolete as of Q22022. Use OTH-21 instead.	OTH-31 was redundant and was combined with OTH-21.
3775	SOPID	Must be accepted Source of Payment ID and Type combination. See Appendix 7.3 Expected Source of Payment Mapping.	See Appendix 7.3 Expected Source of Payment Mapping.
3785	SOPID2	Must be accepted Secondary Source of Payment ID and Type combination. See Appendix 7.3 Expected Source of Payment Mapping.	See Appendix 7.3 Expected Source of Payment Mapping.
3805	PRPMOD1	Principal Procedure Modifier 1 does not meet accepted values.	Review modifier in proper Manual.
3806	PRPMOD2	Principal Procedure Modifier 2 does not meet accepted values.	Review modifier in proper Manual.
3807	PRPMOD3	Principal Procedure Modifier 3 does not meet accepted values.	Review modifier in proper Manual.
3808	PRPMOD4	Principal Procedure Modifier 4 does not correspond to accepted values.	Review modifier in proper Manual.
3810	PRPMOD1	Principal Procedure Modifier 1 is a duplicate of another Principal Procedure Modifier	Review and remove duplicate.
3811	PRPMOD2	Principal Procedure Modifier 2 is a duplicate of another Principal Procedure Modifier	Review and remove duplicate.
3812	PRPMOD3	Principal Procedure Modifier 3 is a duplicate of another Principal Procedure Modifier	Review and remove duplicate.
3815	PRPMOD1	Principal Procedure Modifier 1 cannot be blank when a later Principal Procedure Modifier is not blank	Review and remove duplicate.
3816	PRPMOD2	Principal Procedure Modifier 2 cannot be blank if other Modifier exist	Review and remove duplicate.
3817	PRPMOD3	Principal Procedure Modifier 3 cannot be blank if other Modifier exist	Review and remove duplicate.
3820	PRMOD1	Additional Procedure Modifier 1 is a duplicate of another Additional Procedure Modifier	Review and remove duplicate.
3821	PRMOD2	Additional Procedure Modifier 2 is a duplicate of another Additional Procedure Modifier	Review and remove duplicate.
3822	PRMOD3	Additional Procedure Modifier 3 is a duplicate of another Additional Procedure Modifier	Review and remove duplicate.
3825	PRMOD1	Additional Procedure Modifier 1 cannot be blank when a later Additional Procedure Modifier is not blank	Review and remove duplicate.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ▲	Notes and fixing edits Click "Update" in WIpop to clear edit
3826	PRMOD2	Additional Procedure Modifier 2 cannot be blank when a later Additional Procedure Modifier is not blank	Review and remove duplicate.
3827	PRMOD1	Additional Procedure Modifier 3 cannot be blank when a later Additional Procedure Modifier is not blank	Review and remove duplicate.
3830	HCPCSMOD1	HCPCS/CPT Modifier 1 is a duplicate of another Modifier	Review and remove duplicate.
3831	HCPCSMOD2	HCPCS/CPT Modifier 2 is a duplicate of another Modifier	Review and remove duplicate.
3832	HCPCSMOD3	HCPCS/CPT Modifier 3 is a duplicate of another Modifier	Review and remove duplicate.
3835	HCPCSMOD1	HCPCS/CPT Modifier 1 cannot be blank when other Modifier exist.	Move modifier to correct position.
3836	HCPCSMOD2	HCPCS/CPT Modifier 2 cannot be blank when other Modifier exist.	Move modifier to correct position.
3837	HCPCSMOD3	HCPCS/CPT Modifier 3 cannot be blank when other Modifier exist	Move modifier to correct position.
3900	MARITALS	Marital Status does not correspond to accepted values. See Appendix 7.11 for acceptable codes or contact WHAIC to update our table.	This is not a required field, but if collected must match table in Appendix 7.11
3930	AUTOACD	Auto Accident State does not correspond to accepted values	This is a 2-digit value based on National State Abbreviations. http://www.50states.com/abbreviations.htm
3950	BLKGRP	Census Block Group - a 12-digit number. Field is created based on address and specification in 837 Companion Guide.	Value created by WHAIC within 24 hours after the file is submitted with the patient address.
4010	DDAT	Discharge Date outside boundaries for selected quarter. Change the DOS or delete the record and resubmit in correct quarter.	Applies to IP and ED only. It verifies the discharge date is within the correct quarter.
4020	SERVDATE	Service Date outside boundaries of the admission and discharge dates (72 hours prior to admission date is allowed). **For Emergency Department (ED) records:** Place of service (POS) assignment is based on the established hierarchy and use of revenue codes as defined in Appendix 7.5. In order to accommodate services that occur in the emergency department (ED) and the uniform billing rules, two new bypass edits for services rendered in the ED have been created. See explanation below. a. For hospitals that provide recurring specialty type services such as infusions or dialysis in the ED and the patient is also treated for a minor procedure or service during the course of the recurring visits in the ED: • WHAIC will bypass edits for recurring outpatient hospital records with multiple revenue line items for outpatient lab/radiology or other outpatient services and also has an ED visit that occurred during the course of treatment. In order for the bypass edit to work the record must contain multiple service dates, a 0450 rev code, a statement 'From and Through' date of at minimum 7, 14 or 30 days that match the service dates in the revenue line item detail. To clarify: 1. If the encounter/record has less than seven (7) days of service line items, the record is ED. 2. If the encounter/record has more than seven (7) days, the place of service will be determined by the OHO revenue codes. b. For hospitals that perform a minor outpatient surgery procedure such as a suture in the ED, the record will be counted and included in the ED record volume: • WHAIC will overlook revenue code 0361 (minor surgery) on an ED record as long as there is at least one revenue code of 0450, 0451, 0452, or 0459. This bypass edit allows the ED record take precedence over the outpatient surgery revenue code. **c. OHO DATA:** For all other hospital outpatient (OHO) data, the 0361 revenue line will not be used to set the place of service, unless it's the only revenue line on the record.	4020 applies to IP and ED only. It applies if any of these are true: • Revenue service date is after the discharge date • IP, and Revcode 030+, and servdate is more than 10 days prior to admit date • IP, and Revcode NOT 030+, and servdate is more than 3 days prior to admit date • ED, and servdate is more than 3 days prior to admit date. Edit Reviewed 07/2021 for accuracy.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ⚠	Notes and fixing edits Click "Update" in WIpop to clear edit
4025	SERVDATE	Service Date outside boundaries of Statement Period. Dates in revenue line item must match the statement from/through dates.	Applies to OHO only. It applies if the revenue service date is before the statement period from date, or after the statement period through date.
4030	PRPD	Principal Procedure Date occurs outside boundaries of the admission and discharge dates (72 hours prior to admission date is allowed).	Applies to inpatient, outpatient surgery or any other data type that has a principal procedure.
4035	SERVDATE	Service Date outside accepted date range. For outpatient surgery (OPS) records: 01/2018 WHAIC cannot accommodate every scenario that might occur on any given claim or circumstance, however; in an effort to reduce the number of edits for services or encounters on records for claims that occur within the 90-day global surgical period (such as cataract surgeries that are often performed on both eyes within the 90-day global surgery period), we have made an exception. If there is an LT or RT modifier on any revenue line, then all revenue lines are allowed to have a service date up to 90 days after the principal procedure date. We will look for the highest charge first to account for the initial service data. If two or more revenue line items have the same (highest) charge, the earliest service date will be marked as the principal procedure. *Defined in 12/2017 Newsletter* New 2/18: PRE-OP visits that occur ***within 7 days*** of the outpatient surgery will not receive an edit.	4035 applies to OPS only. It applies if any of these are true: • Revenue service date is more than seven (7) days before the principal procedure date • Revenue service date is more than ten days after the principal procedure date To correct the edit, adjust the date to meet the criteria. WHAIC does not include DOS in the data sets we release, so it is acceptable for the facility to adjust the dates on the record to accommodate the record and clear the edit.
4040	BDAT	Date of Birth exceeds human lifespan of 124 years.	Review MR, EMR or claim for accurate DOB.
4060	DXP	Principal Diagnosis contains a valid diagnosis code, but not a valid Principal diagnosis code.	Verify the ICD-10 CM dx code and make a swap of another code on the record according to the appropriate coding guidelines.
4070	DXA	Admitting Diagnosis contains a valid diagnosis code, but not a valid admitting diagnosis code.	Review the medical record/documentation for a new code.
4071	DXA	Admitting Diagnosis is not allowed for this patient type and cannot be submitted. Do not include admitting diagnosis on outpatient records.	Admitting diagnosis code is not allowed on outpatient records. Delete the code.
4400	PRPD	Principal Procedure Date outside boundaries for selected quarter.	Verify the date. If the DOS is for previous quarter, delete the record. If deleting more than 5 records, email WHAIC to caveat.
4405	PRPD	Principal Procedure date does not fall in Statement Period.	OPS records are defined by surgery date.
4410	PRPD	Principal Procedure Date cannot be before Birth Date.	Review claim and/or EMR.
4480	DDAT	Discharge Date cannot be before Birth Date.	Review claim and/or EMR.
4500	VALCODE1	Value Code 1 does not correspond to accepted values.	Review claim, EMR or consult NUBC.
4501	VALCODE2	Value Code 2 does not correspond to accepted values	Review claim, EMR or consult NUBC.
4502	VALCODE3	Value Code 3 does not correspond to accepted values	Review claim, EMR or consult NUBC.
4503	VALCODE4	Value Code 4 does not correspond to accepted values	Review code.
4504	VALCODE1	Value Code 1 is a duplicate of another Value Code	Review claim and/or EMR.
4505	VALCODE2	Value Code 2 is a duplicate of another Value Code	Remove duplicate.
4506	VALCODE3	Value Code 3 is a duplicate of another Value Code	Remove duplicate.
4507	VALCODE1	Value Code 1 cannot be blank when a later Value Code is not blank	
4508	VALCODE2	Value Code 2 cannot be blank when a later Value Code is not blank	

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ▲	Notes and fixing edits Click "Update" in WIpop to clear edit
4509	VALCODE3	Value Code 3 cannot be blank when a later Value Code is not blank	
4510	VALAMT1	Value Code 1 Amount cannot be blank when Value Code 1 is not blank	
4511	VALAMT2	Value Code 2 Amount cannot be blank when Value Code 2 is not blank	
4512	VALAMT3	Value Code 3 Amount cannot be blank when Value Code 3 is not blank	
4513	VALAMT4	Value Code 4 Amount cannot be blank when Value Code 4 is not blank	
4514	VALAMT1	Value Code 1 Amount must be blank when Value Code 1 is blank	
4515	VALAMT2	Value Code 2 Amount must be blank when Value Code 2 is blank	
4516	VALAMT3	Value Code 3 Amount must be blank when Value Code 3 is blank	
4517	VALAMT4	Value Code 4 Amount must be blank when Value Code 4 is blank	
4600	OCC1	Occurrence Code 1 does not correspond to accepted values	Review codes.
4601	OCC2	Occurrence Code 2 does not correspond to accepted values	Review codes
4602	OCC3	Occurrence Code 3 does not correspond to accepted values	Review claim, EMR or consult NUBC.
4603	OCC4	Occurrence Code 4 does not correspond to accepted values	
4604	OCC1	Occurrence Code 1 is a duplicate of another Occurrence Code	
4605	OCC2	Occurrence Code 2 is a duplicate of another Occurrence Code	
4606	OCC3	Occurrence Code 3 is a duplicate of another Occurrence Code	
4607	OCC1	Occurrence Code 1 cannot be blank when a later Occurrence Code is not blank.	
4608	OCC2	Occurrence Code 2 cannot be blank when a later Occurrence Code is not blank.	
4609	OCC3	Occurrence Code 3 cannot be blank when a later Occurrence Code is not blank.	
4610	OCCSTART1	Occurrence Code 1 Start cannot be blank when Occurrence Code 1 is not blank.	
4611	OCCSTART2	Occurrence Code 2 Start cannot be blank when Occurrence Code 2 is not blank.	
4612	OCCSTART3	Occurrence Code 3 Start cannot be blank when Occurrence Code 3 is not blank.	
4613	OCCSTART4	Occurrence Code 4 Start cannot be blank when Occurrence Code 4 is not blank.	
4614	OCCSTART1	Occurrence Code 1 Start must be blank when Occurrence Code 1 is blank.	
4615	OCCSTART2	Occurrence Code 2 Start must be blank when Occurrence Code 2 is blank.	
4616	OCCSTART3	Occurrence Code 3 Start must be blank when Occurrence Code 3 is blank.	
4617	OCCSTART4	Occurrence Code 4 Start must be blank when Occurrence Code 4 is blank.	
4618	OCCEND1	Occurrence Code 1 End must be blank when Occurrence Code 1 Start is blank.	
4619	OCCEND2	Occurrence Code 2 End must be blank when Occurrence Code 2 Start is blank.	
4620	OCCEND3	Occurrence Code 3 End must be blank when Occurrence Code 3 Start is blank.	
4621	OCCEND4	Occurrence Code 4 End must be blank when Occurrence Code 4 Start is blank.	
4650	OCCSTART1	Occurrence Code 1 Start does not correspond to a valid date (mmddyyyy).	
4651	OCCSTART2	Occurrence Code 2 Start does not correspond to a valid date (mmddyyyy).	
4652	OCCSTART3	Occurrence Code 3 Start does not correspond to a valid date (mmddyyyy).	
4653	OCCSTART4	Occurrence Code 4 Start does not correspond to a valid date (mmddyyyy).	
4654	OCCEND1	Occurrence Code 1 End does not correspond to a valid date (mmddyyyy).	
4655	OCCEND2	Occurrence Code 2 End does not correspond to a valid date (mmddyyyy).	
4656	OCCEND3	Occurrence Code 3 End does not correspond to a valid date (mmddyyyy).	
4657	OCCEND4	Occurrence Code 4 End does not correspond to a valid date (mmddyyyy).	
4658	OCCEND1	Occurrence Code 1 End cannot be before Occurrence Code 1 Start.	
4659	OCCEND2	Occurrence Code 2 End cannot be before Occurrence Code 2 Start.	

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit ⚠	Notes and fixing edits Click "Update" in WIpop to clear edit
4660	OCCEND3	Occurrence Code 3 End cannot be before Occurrence Code 3 Start.	
4661	OCCEND4	Occurrence Code 4 End cannot be before Occurrence Code 4 Start.	
5010	ADAT	Admission Date must be equal to Birth Date when Principal Diagnosis is 'Z38' with a fourth digit of 0, 3 or 6.	Newborn baby born inside a hospital
5020	ADAT	Admission Date can be no more than two days after Birth Date when Principal Diagnosis is 'Z38' with the fourth digit NOT 0, 3 or 6.	Means baby was born outside of hospital and was later admitted.
5030	PRP	Principal Procedure is gender specific and does not match Gender specified. This requires a 45 in first available Condition Code field.	Add condition code 45 to one of the condition code fields to bypass edit. 
5050	DDAT	Discharge Date cannot occur before Admission Date.	Verify Dates of Service on claim.
5070	BDAT	Date of Birth must be less than or equal to the Admission Date.	Review claim or EMR details.
5120	DX	Additional Diagnosis is a duplicate of Principal Diagnosis. Verify if the procedure was performed twice.	Verify procedure performed twice. Review the claim and revenue code details and the additional procedures. Delete extra code.
5151	DXP	Code first rule specifies that diagnosis xxx must be sequenced before diagnosis yyy.	Review coding guidelines and/or EMR. WHAIC is not an insurance company. Our goal is to record services rendered. Users may flip codes or provide documentation to WHAIC to do an override.
5166	DX	Additional Diagnosis requires a corresponding Primary or Additional Diagnosis which was not found.	Review medical record to determine all codes submitted.
5167	DXP	Principal Diagnosis requires a corresponding Additional Diagnosis which was not found.	Review EMR and claim. Update record accordingly.
5180	TC	The sum of all Revenue Charges must equal the Total Charge.	Click on the "Calculate Total Charge" in the Revenue line item.
5191	ADMS	Source of Admission must be '5', or '6' if the Type of Admission equals '4' (newborn).	Review claim and/or NUBC guidelines.
5210	ADMT	Admit Type cannot equal '4' (newborn) if Age in Days is calculated as greater than '1' and Point of Origin equals 6.	Review claim and/or NUBC guidelines.
5240	DXP	Principal Diagnosis is gender specific and does not match the Gender specified.	Review EMR/Claim. If accurate, add condition code 45 to bypass edit.
5250	DXA	Admitting Diagnosis is gender specific and does not match the Gender specified.	Review EMR/Claim. If accurate, add condition code 45 to bypass edit..
5255	ADMT	Admit Type must equal '4' when Age Days is calculated as less than one day.	
5256	ADMT	Admit Type cannot equal '4' (newborn) for this type of patient record.	Review EMR and Claim
5257	ADMT	Admit Type cannot equal '4' (newborn) if Age in Days is calculated as greater than '0' and Point of Origin equals 5.	
5258	ADMT	Admit Type must be 5 when 068x revenue code in on the record.	
5260	DX	Additional Diagnosis is gender specific and does not match the Gender specified.	Review EMR/Claim. If accurate, add condition code 45 to bypass edit.
5270	DXRV1	Reason for Visit 1 is gender specific and does not match the Gender specified.	Review EMR/Claim. If accurate, add condition code 45 to bypass edit.
5271	DXRV2	Reason for Visit 2 is gender specific and does not match the Gender specified.	Review EMR/Claim. If accurate, add condition code 45 to bypass edit.
5272	DXRV3	Reason for Visit 3 is gender specific and does not match the Gender specified.	Review EMR/Claim. If accurate, add condition code 45 to bypass edit.
5305	REVCODE	At least one revenue record is required.	Review claim and add details to record.
5310	DX	Duplicate Additional Diagnosis codes are not allowed.	Delete duplicate code.
5312	DX_POA	Diagnosis Present on Admission is exempt from the reported Diagnosis and cannot be submitted. Field must be blank if exempt from reporting.	Delete the value in the POA field and click update.

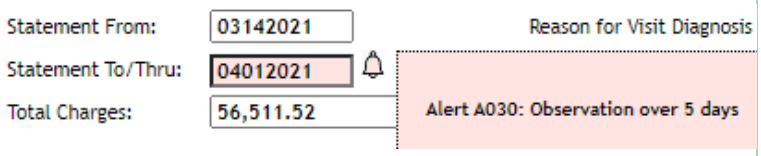
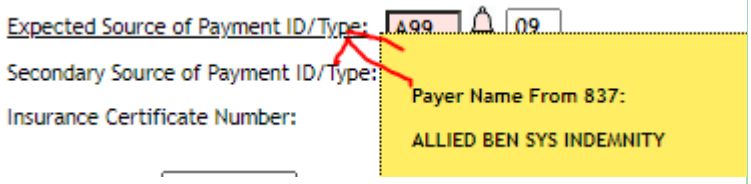
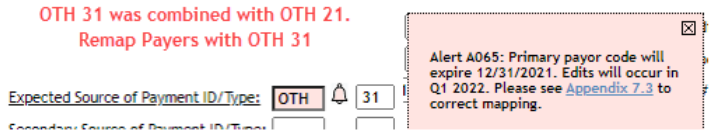
Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Triangle to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
5313	DX_POA	Diagnosis Present on Admission is not allowed on this patient type.	Only allowed on inpatient records. Delete the value and click update.
5314	DX_POA	Diagnosis Present on Admission does not correspond to accepted values.	Only values are Y, N, W, U and blank if exempt from reporting.
5315	DX_POA	Diagnosis Present on Admission is a required field. Correct values are Y, N, W, U and blank if not required.	Review EMR and claim, update accordingly.
5330	PRP	Principal Procedure is age specific and does not match Date of Birth specified.	Review EMR/claim to verify DOB. Update record.
5340	PR	Additional Procedure is age specific and does not match Date of Birth.	Review EMR/claim to verify DOB. Update record..
5355	PR	This code does not meet the definition of a procedure. This edit applies to codes that start with A, B, E, J or 8, if the code is in the 992 range, or if the code is in the 00 – 01 range and does not end with a letter.	This applies to direct data entry. Do not use E&M Codes, pathology, simple blood draws 36415, supply codes, DME codes, etc. in the procedure fields.
5360	PR	Additional Procedure is gender specific and does not match the Gender specified.	Review EMR / Claim. If accurate, add condition code 45 to one of the four condition code fields to bypass the edit.
5370	DX	Diagnosis codes in the S-T range, w/some exceptions require an external cause dx code in the V through Y range. 	At least one external cause code must be specified when a diagnosis exists in the S – Injury Code range. Add a 1 to "Create" box and click on the more "Additional Diagnosis Records" to add a line item.
5390	HCPCSRATE	This revenue code requires an HCPCS or CPT code. Reference Coding Guidelines.	Most outpatient revenue codes require a corresponding CPT/HCPCS code defining what was performed or provided.
5400	PBLID	Provider-based Location ID does not correspond to accepted values.	Contact WHAIC to update the PBL Table.
6040	SERVCODE	Place of Service cannot be specified for this type of patient record.	INP records do not require a place of service.
8500	PROVID	NPI Billing Provider NPI is a required field and must be valid.	Populate NPI number of the billing facility. WHAIC uses the NPPES to validate NPI numbers.

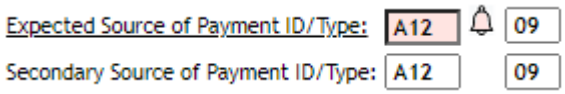
7.10.1 ALERT CODES

WHAIC follows CMS lead on most edits and definitions as it relates to inpatient, observation, and other patient status / stays. Our Alerts are set up with that in mind in order to stay consistent with our validation reports and quality of the data.

Alerts are not Edits or Errors. Alerts are intended to be an opportunity to review the data more closely and timely. Our intent is to allow ample time to make necessary changes before the end of the year. * The alert bell may draw your attention to specific areas of race, ethnicity, payer, and inpatient/observation stays. Examples might include patients over 65 reported as non-Medicare, other/unknown payer, race declined/unavailable, OBS over 5 days, IP under 2 days, unknown payer, etc. WIpop Batch files will contain an Alert Records section for each Patient Type on the far right of the screen. You are not required to work all alerts!

Alert Code	Alert Defined and what it might look like	Alert reconciliation how to handle and examples
A010	Race is Declined.	Review EMR and update patient account if race is in the EMR.
A011	Race is Unavailable.	Review EMR and update patient account. *Continue to encourage and remind patient registration of the importance of asking / including

Alert Code	Alert Defined and what it might look like	Alert reconciliation how to handle and examples
		this detail in the EMR even with all the COVID testing and vaccination encounters.
A020	Ethnicity is Declined	Review EMR and update patient account if ethnicity is in the EMR.
A021	Ethnicity is Unavailable	Review EMR and update patient account. Continue to encourage and remind patient registration of the importance of asking / including this detail in the EMR even with all the COVID testing and vaccination encounters
A030	Observation over 5 days. 	Review EMR and Claim – verify correct use of rev code 0762 with multiple days in hospital. Adjust record if needed. **According to CMS**: Observation services are not expected to exceed 48 hours in duration. Observation services greater than 48 hours in duration are seen as rare and exceptional cases. If medically necessary, Medicare will cover up to 72 hours of observation services.
A060	Unknown or Other Primary Payor. 	Verify the correct payer is assigned. In this record the Alert is produced for the A99 code. Clicking on the Expected Source of Payment will provide the name of the payer. A google search will lead the reviewer to noticing this is a Benefit Plan Admin. Or TPA. **The correct mapping should be OTH 21, NOT A99.**
A065	Primary Payor Code will expire 12/31/2021. See Appendix 7.3 for more information. 	Multiple payer codes have been combined or removed to reduce the amount of facility payer mapping required. Payer Alerts are set up to instruct submitters and editors to review Appendix 7.3 and adjust codes accordingly. • MED and T18 – combined to MED-09 = Medicare, Medicare Sup / MediGap, Medicare Part A, B, C - all Medicare patients. • OTH 21 and OTH 31 – combined to OTH-21 = self-insured/TPA and benefit plan administration (BPA) or private employer funded insurance. • CHA 03 and OTH 55 – combined to CHA 03 = current and former military (insurance) benefits regardless of who is managing contract. • OTH 54, 59 & 71 – combined to OTH 54 = free/subsidized government programs, nonprofit organizations, health departments, and grant/research funds. • OTH 99 and 98 – combined to OTH 99 = TPL, MVA, state funded crime victim or safe funds, and some other unknown payers that are not related to commercial, private, or other forms identified in the mapping table. From auto insurance to crime victim claims. • *Facilities are no longer required to identify the Plan PayTypes: 01 – FFS and 02 - HMO/PPO for Medicare, Medicaid or BadgerCare. Please **report all payers using one option PayType = 09*** **A067** Primary and Secondary Payors are the same. Verify patient has the same payer as primary and secondary. It is not uncommon to list two (2) Medicare

Alert Code	Alert Defined and what it might look like	Alert reconciliation how to handle and examples
		payers if the patient has a dual Medicare plan. Typically, it is not common for patients to have the same duplicate plans such as BC Anthem.
A070	Unknown or Other Secondary Payor	This code has been suspended.
A075	Secondary Payor Code will be Invalid after Q12021. See Appendix 7.3 for more information.	Multiple payer codes have been combined or removed to reduce the amount of facility payer mapping required. Payer Alerts are set up to instruct submitters and editors to review Appendix 7.3 and adjust codes accordingly. • MED and T18 – combined to MED-09 = Medicare, Medicare Sup / MediGap, Medicare Part A, B, C - all Medicare patients. • OTH 21 and OTH 31 – combined to OTH-21 = self-insured/TPA and benefit plan administration (BPA) or private employer funded insurance. • CHA 03 and OTH 55 – combined to CHA 03 = current and former military (insurance) benefits regardless of who is managing contract. • OTH 54, 59 & 71 – combined to OTH 54 = free/subsidized government programs, nonprofit organizations, health departments, and grant/research funds. • OTH 99 and 98 – combined to OTH 99 = TPL, MVA, state funded crime victim or safe funds, and some other unknown payers that are not related to commercial, private, or other forms identified in the mapping table. From auto insurance to crime victim claims. • *Facilities are no longer required to identify the Plan PayTypes: 01 – FFS and 02 - HMO/PPO for Medicare, Medicaid or BadgerCare. Please* ***report all payers using one option PayType = 09***
A080	Over 65 non-Medicare Payer should be mapped to MED. See Appendix 7.9	This is not an edit, if the patient is still working and does not have Medicare, leave as is. However, most 65 and older patients have Medicare as a primary payer. Commercial plans offering Medicare Advantage is MPC-09, Med Sup should be mapped to MED – 09.
A090	Inpatient stay under 2 days.	**According to CMS**: **Inpatient services defined** "An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will require hospital care that is expected to span at least two midnights and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight."