‹‹ASC X12N 837 v.5010 Error Codes and Messages››

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‹‹Prior to entry in the daily claims edit cycle, ASC X12N 837 v.5010 submissions must pass numerous system edits.›› Claims failing these edit requirements will be rejected and returned to the provider for correction. ‹‹The error codes and messages listed on the following pages will appear in the *Volser Summary report* on the Medi-Cal Provider Portal.››

‹‹837 Claim Error Codes and Messages Table››

Codes	Messages
001	‹‹CMC Replacement/Void claim cannot be billed with multiple claim lines››
002	Invalid Submission Date in Submitter Control Record
003	Invalid Submitter Name in Submitter Control Record
004	Invalid Claim Count in Submitter Control Record
005	Invalid Billing Amount in Submitter Control Record
006	Invalid Provider Count in Submitter Control Record
007	Invalid create date in Submitter Control Record
008	Submitter not on submission agreement file *
009	Provider control record missing or invalid
010	Data was previously accepted for processing
011	Amount billed on Provider Control Record does not balance
012	Claim count on Provider Control Record does not balance
013	Submitter ID on Provider Control Record is invalid
014	Provider ID on Provider Control Record is invalid
015	Claim type on Provider Control Record is invalid
016	Submission Date on Provider Control Record is not a valid date
017	Provider Name on Provider Control Record is invalid
018	Provider Address line 1 on Provider Control Record is invalid
019	Telecommunication Certification Statement missing or invalid
020	Provider City on Provider Control Record is invalid
021	Provider State on Provider Control Record is invalid
022	Provider ZIP in Provider Control Record is invalid
023	Provider Phone on Provider Control Record is invalid
024	Claim Count on Provider Control Record is invalid
025	Billing Amount on Provider Control Record is invalid
026	Provider/claim type not valid for this submitter †
027	Provider/claim type not on active status †
028	Submission Date on Claim Record not a valid date
029	Not applicable to submitter
030	Claim is not valid for current Provider Control Record
031	Amount Billed on Submitter Control Record does not balance
032	Claim Count on Submitter Control Record does not balance

‹‹837 Claim Error Codes and Messages Table (continued)››

Codes	Messages
033	Job terminated - maximum number of errors exceeded *
034	Amount field of a claim was not numeric
035	Provider Count on Submitter Control Record does not balance
036	Claim contains an embedded blank line
037	Line numbers not in ascending sequence
038	Line numbers outside valid range of claim type
039	Receipt record was not matched to Submitter Control Record *
040	Unable to identify Submitter Control Record - record type not spaces
041	Receipt file check bypassed due to prior error *
042	Submitter agreement check bypassed due to prior error *
043	CMC Replacement for previously processed CIF/Appeal is not Allowed
044	Duplicate control record for same provider/claim type
045	Submission Date on Submitter Control Record exceeds process date
046	Submission Date on Provider Control Record exceeds process date
047	Submission Date on Claim Record exceeds process date
048	Claim Sequence Number not numeric
049	Attachment count on Submitter Control Record not numeric or blanks
050	Attachment count on Provider Control Record does not balance
051	Attachment count on Provider Control Record is invalid
052	Attachment count on Submitter Control Record does not balance
053	Record sequence number not a claim or attachment
054	Claim sequence number not unique for provider/claim type
055	Submitter/claim type not approved for included attachment
056	Attachment Record does not pair up with prior Claim Record
057	Record sequence numbers on attachments not consecutive
058	Media type/claim type not valid for this submitter
059	Submitter Control Record duplicate is invalid
060	Provider Control Record contains invalid record type
061	Claim type on claim record is invalid
062	Provider not valid for claim type billed
063	No claim records present
064	Claim type is inconsistent with record length
065	Invalid record length
066	Line charge field on claim record is not numeric
067	Gross amount field on claim record is not numeric

‹‹837 Claim Error Codes and Messages Table (continued)››

Codes	Messages
068	Service charge field on claim record is not numeric
069	Total charge field on claim record is not numeric
070	Amount field on claim record is not numeric
071	Provider on remarks different from claim provider
073	Field level error-please refer to test letter
076	Claim has both OHC and Medicare Payments and must be hardcopy billed
077	Payer Claim Control Number is not 13 Digits
078	Invalid bill type for CMC crossover claims
079	Medicare type is invalid
080	Submitter not approved to bill crossover claims for this media type
081	Missing Medicare Claim Adjudication Date
082	Charpentier claims must be billed on paper
083	RHC/FQHC/IHS/MOA crossover claims must be billed on paper
084	Medicare Payer ID not present
085	Benefits assignment indicator is not “Y”
086	Claim Line Coinsurance > Medicare Paid
087	Medicare 100% Paid (COINS=0, DEDUCT=0, BLOOD DED=0, PAID>0)
088	Medicare Denial (COINS=0, DEDUCT=0, BLOOD DED=0, PAID=0)
089	Claim Line Coinsurance > 0 and Medicare Paid = 0
090	Service ZIP Code on Provider Control Record is not numeric
091	Billing Provider Address is invalid. PO Box or Lock Box is not acceptable
092	Billing Provider ZIP Code Format = Numeric, Length of 9
093	Service Facility address is invalid. PO Box or Lock Box is not acceptable
094	Service Facility ZIP code Format = Numeric, Length of 9
095	Ambulance Pick Up address is invalid. PO Box or Lock Box is not acceptable
096	A claim cannot contain both ICD-9 and ICD-10 qualifiers
097	ICD-9 codes not valid for dates on/after ICD-10 compliance date
098	ICD-10 codes not valid for dates prior to ICD-10 compliance date
099	Split claim/Page cannot contain informational line

‹‹837 Claim Submission Translation Errors

837 claim submission ITX translation errors are listed in the *Error report* that is available in the EDI Submission application within the Medi-Cal Provider Portal.›› Providers with questions about report details can call the Telephone Service Center (TSC) at 1-800-541-5555, 8 a.m. to 5 p.m., Monday through Friday, except holidays.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Not programmable by submitter
†	Verify with the approval letter from DHCS