Code Definitions

Use the information in this document in conjunction with the applicable Claims Resolution Matrix (i.e., institutional or professional). These code definitions are derived from other sources, including the Washington Publishing Company (*www.wpc-edi.com/reference*), and are published by Independence Blue Cross solely for your convenience. The information was current at the time of publication.

If you have further questions after reviewing this document, please call Highmark EDI Operations at 1-800-992-0246, Monday through Friday from 8 a.m. to 5 p.m., ET.

Claims Status Category Codes (STC01-1, STC10-1, STC11-1)

A3	The claim/encounter has been rejected and has not been entered into the adjudication system.
A6	The claim/encounter is missing the information specified in the status details and has been rejected.
A7	The claim/encounter has invalid information as specified in the status details and has been rejected.
A8	Rejected for relational field in error.

Claim Status Codes (STC01-2, STC10-2, STC11-2)

24	Entity not approved as an electronic submitter
26	Entity not found
33	Subscriber and subscriber ID not found
116	Claim submitted to incorrect payer
121	Service line number greater than maximum allowable for payer
124	Entity's name, address, phone, and ID number
126	Entity's address
128	Entity's tax ID
129	Entity's Blue Cross provider ID
130	Entity's Blue Shield provider ID
131	Entity's Medicare provider ID
133	Entity's UPIN
138	Entity's site ID
145	Entity's specialty code
153	Entity's ID number
156	Patient relationship to subscriber
158	Entity's date of birth
162	Entity's health insurance claim number (HICN)
164	Entity's contract/member number
171	Other insurance coverage information (Claim Filing Indicator)

178	Submitted charges
181	Hospital s room rate
187	Date(s) of service
188	Statement from/through dates
189	Facility admission date
190	Facility discharge date
192	Date of first service for current series/symptom/illness
195	Unable to work dates
196	Return to work dates
214	Original date of prescription/orders/referral
218	NDC number
222	Drug dispensing units and average wholesale price (AWP)
228	Type of bill for UB claim
229	Hospital admission source
230	Hospital admission hour
231	Hospital admission type
232	Admitting diagnosis
233	Hospital discharge hour
234	Patient discharge status
247	Line information
248	Accident date, state, description, and cause
249	Place of service
251	Total anesthesia minutes
255	Diagnosis code
258	Days/units for procedure/revenue code
259	Frequency of service
262	Type of surgery/service for which anesthesia was administered
286	Other payer's Explanation of Benefits/payment information
306	Detailed description of service
397	Date of onset/exacerbation of illness/condition
400	Claim is out of balance
402	Amount must be greater than zero
404	Specific findings, complaints, or symptoms necessitating service
448	Invalid Billing combination. See STC12 for details. This code should only be used to indicate an inconsistency between two or more data elements on the claim. A detailed explanation is required in STC12 when this code is used.
452	Total visits in total number of hours/day and total number of hours/week

453	Procedure code modifier(s) for service(s) rendered
454	Procedure code for services rendered
455	Revenue code for services rendered
460	NUBC condition code(s)
461	NUBC occurrence code(s) and date(s)
462	NUBC occurrence span code(s) and date(s)
463	NUBC value code(s) and/or amount(s)
465	Principal procedure code for service(s) rendered
475	Procedure code not valid for patient's age
476	Missing or invalid units of service
477	Diagnosis code pointer is missing or invalid
479	Other carrier payer ID is missing or invalid
480	Other carrier payer Claim Filing Indicator is missing or invalid
482	Date error, century missing
486	Principle procedure date
488	Diagnosis code(s) for the services rendered
490	Other procedure code for service(s) rendered
492	Other procedure date
493	Version/release/industry ID code not currently supported by information holder
496	Submitter not approved for electronic claim submissions on behalf of this entity
501	Entity's state/province
506	Entity is changing processor/clearinghouse. This claim must be submitted to the new processor/clearinghouse
507	HCPCS
513	HIPPS rate code for services rendered
521	Adjustment Reason Code
535	Claim frequency code
554	Date claim paid
562	Entity's NPI
578	Insurance type code
596	Non-covered charge amount
631	Reimbursement rate
633	Related causes code
672	Other payer's payment information is out of balance
673	Patient reason for visit
675	Facility admission through discharge dates
676	Entity possibly compensated by facility

678	Revenue code and patient gender mismatch
679	Submit newborn services on mother's claim
685	Claim could not complete adjudication in real-time. Claim will continue processing in batch mode. Do not resubmit.
688	Present on admission (POA) indicator for reported diagnosis code(s)
693	Amount must be greater than 0
700	ICD-10
718	Claim/service not submitted within the required timeframe (timely filing)
719	NUBC occurrence code(s)
720	NUBC occurrence code date(s)
721	NUBC occurrence span code(s)
722	NUBC occurrence span code date(s)
724	Drug Quantity
725	NUBC value code(s)
727	Accident date
728	Accident state
732	Information inconsistent with billing guidelines
740	Drop-off location
751	Ambulance pick-up state or province
771	Claim submitted prematurely. Please resubmit after crossover/payer to payer COB allotted waiting period.

Entity Codes (STC01-3, STC10-3, STC11-3)

40	Receiver
41	Submitter
71	Attending Physician
72	Operating Physician
77	Service Location
82	Rendering Provider
85	Billing Provider
DN	Referring Provider
IL	Insured or Subscriber
PR	Payer
QC	Patient