# Pre-Adjudication Crosswalk

## (Rejected Claims)

# Pre-Adjudication Crosswalk

➤ **Electronic claims are validated against a set of preliminary, front end edits that are checked prior to adjudication**

➤ **If <u>no errors are found</u> - the claim is forwarded for adjudication**

➤ **If <u>errors are found</u> - the codes listed in the Pre-Adjudication Crosswalk table will report the specific error condition that was identified**

➤ **When submitted claims fail any of the Pre-Adjudication edits they will not be adjudicated**

# Pre-Adjudication Crosswalk

➤ **The Pre-Adjudication crosswalk lists the specific values returned by the eMedNY system in the 277CA Health Care Claim Acknowledgment and in the ePACES Claim Status Response**

➤ **It is extremely important that providers react to the front end responses sent by eMedNY**

➤ **Claims rejected by the front end process are <u>NOT</u> reported on the Remittance Advice**

➤ **Pharmacy (NCPDP/D.0) rejection codes are <u>NOT</u> listed in the Pre-Adjudication Crosswalk**

➤ **Providers MUST <u>correct</u> and <u>resubmit</u> rejected claims**

# Pre-Adjudication Crosswalk

# Pre-Adjudication Crosswalk

**NYS Medicaid Pre-Adjudication Crosswalk for Health Care Claims**

# Pre-Adjudication Crosswalk

## NYS MEDICAID PRE-ADJUDICATION CROSSWALK FOR HEALTH CARE CLAIMS
### VERSION 5010 (BATCH AND REAL-TIME)

The specifications for the transactions referenced here are the property of the Accredited Standards Committee X12 and are available at:

http://www.wpc-edi.com/
http://store.x12.org/

Implementation Guide (TR3):
005010X212
005010X214

It is extremely important that providers, as well as the vendors that service the eMedNY provider community, react to the front end responses sent by eMedNY. Claims rejected by the front end process are not reported in the Remittance Advice or any other transactions.

The following table lists the specific values returned by the eMedNY system in the ASC X12N 277 Health Care Claim Acknowledgment in the loop 2200D and 2220D STC segment for Claim Status Category Code (STC01-1), Claim Status Code (STC01-2), and Entity Identifier Code (STC01-3) in response to electronic healthcare claims submitted on the ASC X12N 837 Health Care Claim. Note also that by default, an STC segment with STC01 valued with A1|20 is returned in loop 2200B.

Inbound claims are validated against a set of preliminary edits that are checked prior to adjudication but after EDI translation. If no errors are found on a specific claim, the claim is forwarded for adjudication. Otherwise the codes listed in the table below will report the specific error condition that was identified. When submitted claims fail any of these edits they will not be adjudicated.

| 277CA (OUTBOUND RESPONSE TO CLAIMS) | | | | | | | | | NYS Medicaid Conditions | INBOUND CLAIM (VERSION 5010) | | | |
| CLAIM LEVEL (LOOP 2200D) | | | | | | LINE LEVEL (LOOP 2220D) | | | | BATCH | | | REAL-TIME |
| STC01- | | | STC10- | | | STC01- | | | | 837- | | | 837- |
| -1 | -2 | -3 | -1 | -2 | -3 | -1 | -2 | -3 | | INST | PROF | DENT | PROF |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A1 | 18 | PR | | | | | | | No errors detected at Claim Level; Claim rejected due to line-level errors: STC segment in Loop 2220D provides detail (see bottom of worksheet). Returned in response to v. 5010 batch transactions ONLY. | ✓ | ✓ | ✓ | |
| A1 | 18 | 40 | | | | | | | No errors detected at Claim Level; Claim rejected due to line-level errors: STC segment in Loop 2220D provides detail (see bottom of worksheet). | | | | ✓ |
| A2 | 20 | | | | | | | | No error being reported (((Claim has been forwarded to adjudication))) | ✓ | ✓ | ✓ | ✓ |
| A3 | 117 | 1P | | | | | | | Provider Signature-on-File indicator not set to "Y" | | ✓ | ✓ | ✓ |
| A3 | 121 | | | | | | | | Maximum lines (999) exceeded in claim | ✓ | | | |
| A3 | 121 | | | | | | | | Maximum lines (50) exceeded for conversion of Institutional to Professional claim (applies only to claims submitted on 837I with no Rate Code.) | ✓ | | | |
| A3 | 121 | | | | | | | | Maximum lines (50) exceeded in claim | | ✓ | ✓ | |

# Pre-Adjudication Crosswalk

## NYS Medicaid Conditions

### NYS MEDICAID PRE-ADJUDICATION CROSSWALK FOR HEALTH CARE CLAIMS
**VERSION 5010 (BATCH AND REAL-TIME)**

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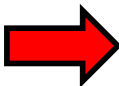http://store.x12.org/

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| 277CA (OUTBOUND RESPONSE TO CLAIMS) | | | | | | | | | NYS Medicaid Conditions | INBOUND CLAIM (VERSION 5010) | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CLAIM LEVEL (LOOP 2200D) | | | | | | LINE LEVEL (LOOP 2220D) | | | | BATCH | | | REAL-TIME |
| STC01- | | | STC10- | | | STC01- | | | | 837- | | | 837- |
| -1 | -2 | -3 | -1 | -2 | -3 | -1 | -2 | -3 | | INST | PROF | DENT | PROF |
| A1 | 18 | PR | | | | | | | No errors detected at Claim Level; Claim rejected due to line-level errors: STC segment in Loop 2220D provides detail (see bottom of worksheet). Returned in response to v. 5010 batch transactions ONLY. | ✓ | ✓ | ✓ | |
| A1 | 18 | 40 | | | | | | | No errors detected at Claim Level; Claim rejected due to line-level errors: STC segment in Loop 2220D provides detail (see bottom of worksheet). | | | | ✓ |
| A2 | 20 | | | | | | | | No error being reported (((Claim has been forwarded to adjudication))) | ✓ | ✓ | ✓ | ✓ |
| A3 | 117 | 1P | | | | | | | Provider Signature-on-File indicator not set to "Y" | | ✓ | ✓ | ✓ |
| A3 | 121 | | | | | | | | Maximum lines (999) exceeded in claim | ✓ | | | |
| A3 | 121 | | | | | | | | Maximum lines (50) exceeded for conversion of Institutional to Professional claim (applies only to claims submitted on 837I with no Rate Code.) | ✓ | | | |
| A3 | 121 | | | | | | | | Maximum lines (50) exceeded in claim | | ✓ | ✓ | |

# Pre-Adjudication Crosswalk

### NYS MEDICAID PRE-ADJUDICATION CROSSWALK FOR HEALTH CARE CLAIMS
#### VERSION 5010 (BATCH AND REAL-TIME)

The specifications for the transactions referenced here are the property of the Accredited Standards Committee X12 and are available at:

http://www.wpc-edi.com/
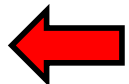http://store.x12.org/

Implementation Guide (TR3):
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| 277CA (OUTBOUND RESPONSE TO CLAIMS) | | | | | | | | | NYS Medicaid Conditions | INBOUND CLAIM (VERSION 5010) | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CLAIM LEVEL (LOOP 2200D) | | | | | | LINE LEVEL (LOOP 2220D) | | | | BATCH | | | REAL-TIME |
| STC01- | | | STC10- | | | STC01- | | | | 837- | | | 837- |
| -1 | -2 | -3 | -1 | -2 | -3 | -1 | -2 | -3 | | INST | PROF | DENT | PROF |
| A1 | 18 | PR | | | | | | | No errors detected at Claim Level; Claim rejected due to line-level errors: STC segment in Loop 2220D provides detail (see bottom of worksheet). Returned in response to v. 5010 batch transactions ONLY. | ✓ | ✓ | ✓ | |
| A1 | 18 | 40 | | | | | | | No errors detected at Claim Level; Claim rejected due to line-level errors: STC segment in Loop 2220D provides detail (see bottom of worksheet). | | | | ✓ |
| A2 | 20 | | | | | | | | No error being reported (((Claim has been forwarded to adjudication))) | ✓ | ✓ | ✓ | ✓ |
| A3 | 117 | 1P | | | | | | | Provider Signature-on-File indicator not set to "Y" | | ✓ | ✓ | ✓ |
| A3 | 121 | | | | | | | | Maximum lines (999) exceeded in claim | ✓ | | | |
| A3 | 121 | | | | | | | | Maximum lines (50) exceeded for conversion of Institutional to Professional claim (applies only to claims submitted on 837I with no Rate Code.) | ✓ | | | |
| A3 | 121 | | | | | | | | Maximum lines (50) exceeded in claim | | ✓ | ✓ | |

# Pre-Adjudication Crosswalk

**Client Information**

Client ID:                    Name:

**Claim Level Status**

(A7) - Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected (New as of 10/02) - (255) Diagnosis code.

Bill Type:

| Payer Claim Control # | Total Claim Charge Amount | Paid Amount | Dates of Service | Status Effective Date |
|---|---|---|---|---|
|  | $ 40.00 | $0.00 | 12/1/2020 | 12/30/2020 |

**Line Level Status**

| Line | Status | Service Line Dates | Proc/NDC Code & Mod | Line Charge Amount | Paid Amount | Units. | Status Date |
|---|---|---|---|---|---|---|---|
|  |  |  |  |  |  |  |  |

# Pre-Adjudication Crosswalk

| 277CA (OUTBOUND RESPONSE TO CLAIMS) | | | | | | | | | NYS Medicaid Conditions | INBOUND CLAIM (VERSION 5010) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CLAIM LEVEL (LOOP 2200D) | | | | | | LINE LEVEL (LOOP 2220D) | | | | BATCH | | | REAL-TIME |
| STC01- | | | STC10- | | | STC01- | | | | 837- | | | 837- |
| -1 | -2 | -3 | -1 | -2 | -3 | -1 | -2 | -3 | | INST | PROF | DENT | PROF |
| A7 | 232 | | | | | | | | ICD-10 diagnosis code for Admitting Diagnosis is invalid or not payable per NYSDOH policy (also applies to ICD-9 for services or discharges before October 1, 2015) | ✓ | | | |
| A7 | 234 | | | | | | | | Invalid Patient Discharge Status | ✓ | | | |
| A7 | 249 | | | | | | | | Invalid Place-of-Service Code | | ✓ | ✓ | ✓ |
| A7 | 254 | | | | | | | | ICD-10 diagnosis code for Principal Diagnosis is invalid or not payable per NYSDOH policy (also applies to ICD-9 for services or discharge before October 1, 2015) | ✓ | | | |
| A7 | 255 | | | | | | | | ICD-10 diagnosis code for Other Diagnosis (837I) or Health Care Diagnosis Code (837P, 837D) is invalid or not payable per NYSDOH policy (also applies to ICD-9 for services or discharges before October 1, 2015) | ✓ | ✓ | ✓ | ✓ |
| A7 | 726 | | | | | | | | Rate Code validation error | ✓ | | | |
| A7 | 465 | | | | | | | | ICD-10 procedure code for Principal Procedure is invalid or not payable per NYSDOH policy (also applies to ICD-9 for services or discharges before October 1, 2015) | ✓ | | | |
| A7 | 490 | | | | | | | | ICD-10 procedure code for Other Procedure is invalid or not payable per NYSDOH policy (also applies to ICD-9 for services or discharges before October 1, 2015) | ✓ | | | |
| A7 | 500 | 77 | | | | | | | Invalid zip-code for Service Facility address | ✓ | ✓ | ✓ | ✓ |
| A7 | 500 | 85 | | | | | | | Invalid zip-code for Billing Provider address | ✓ | ✓ | ✓ | ✓ |
| A7 | 501 | 85 | | | | | | | Invalid state for Billing Provider address | ✓ | ✓ | ✓ | ✓ |
| A7 | 501 | 87 | | | | | | | Invalid state for Pay-to address | ✓ | ✓ | ✓ | ✓ |
| A7 | 501 | FA | | | | | | | Invalid state for facility or laboratory address | ✓ | ✓ | ✓ | ✓ |
| A7 | 501 | GB | | | | | | | Invalid state for other insured address | ✓ | ✓ | ✓ | ✓ |
| A7 | 501 | IL | | | | | | | Invalid state for subscriber address | ✓ | ✓ | ✓ | ✓ |
| A7 | 501 | P4 | | | | | | | Invalid state for payer address | | | | ✓ |
| A7 | 501 | PR | | | | | | | Invalid state for payer address | ✓ | ✓ | ✓ | |
| A7 | 501 | P4 | | | | | | | Invalid state for other payer address | | | | ✓ |
| A7 | 501 | PR | | | | | | | Invalid state for other payer address | ✓ | ✓ | ✓ | |
| A7 | 521 | | | | | | | | Invalid Claim Adjustment Reason Code (CARC) at claim-level, or missing Claim Check or Remittance Date | ✓ | ✓ | ✓ | ✓ |
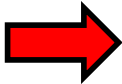
# Pre-Adjudication Crosswalk

**Client Information**

Client ID:                       Name:

**Claim Level Status**

(A3) - Acknowledgement/Returned as unprocessable claim-The claim/encounter has been rejected and has not been entered into the adjudication system. - (400) - Claim is out of balance - (P4) Prior Insurance Carrier

**Bill Type:**

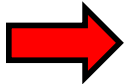Patient Control #:     123456

Pharmacy Control #:

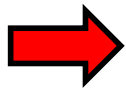| Payer Claim Control # | Total Claim Charge Amount | Paid Amount | Dates of Service | Status Effective Date |
|---|---|---|---|---|
| | 250.00 | 0.00 | 12/1/2020 | 12/30/2020 |

**Line Level Status**

| Line | Status | Service Line Dates | Proc/NDC Code & Mod | Line Charge Amount | Paid Amount | Units. | Status Date |
|---|---|---|---|---|---|---|---|

# Pre-Adjudication Crosswalk

| 277CA (OUTBOUND RESPONSE TO CLAIMS) | | | | | | | | | | INBOUND CLAIM (VERSION 5010) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CLAIM LEVEL (LOOP 2200D) | | | | | | LINE LEVEL (LOOP 2220D) | | | | BATCH | | | REAL-TIME |
| STC01- | | | STC10- | | | STC01- | | | | 837- | | | 837- |
| -1 | -2 | -3 | -1 | -2 | -3 | -1 | -2 | -3 | **NYS Medicaid Conditions** | INST | PROF | DENT | PROF |
| A3 | 156 | QC | | | | | | | Patient Hierarchical Level (dependent loop) present | ✔ | ✔ | ✔ | ✔ |
| A3 | 400 | 85 | | | | | | | Claim is out-of-balance (charges) | ✔ | ✔ | ✔ | ✔ |
| A3 | 400 | P4 | | | | | | | Claim is out-of-balance (Coordination of Benefits) | | | | ✔ |
| A3 | 400 | PR | | | | | | | Claim is out-of-balance (Coordination of Benefits) | ✔ | ✔ | ✔ | |
| A3 | 479 | P4 | | | | | | | Coordination of Benefits payer at line level (loop 2430 SVD01) not matched to claim level (loop 2330B NM109) | | | | ✔ |
| A3 | 479 | PR | | | | | | | Coordination of Benefits payer at line level (loop 2430 SVD01) not matched to claim level (loop 2330B NM109) | ✔ | ✔ | ✔ | |
| A3 | 742 | | | | | | | | Invalid or repeated Payer Responsibility Sequence Number Code (same code occurred more than once in a claim or code "U" in non-crossover claim) | ✔ | ✔ | ✔ | ✔ |
| A7 | 33 | IL | | | | | | | Invalid client ID (CIN#) | ✔ | ✔ | ✔ | ✔ |
| A7 | 33 | IL | | | | | | | Client is not on file | ✔ | ✔ | ✔ | ✔ |
| A7 | 96 | 41 | | | | | | | ETIN Not Certified for Use | ✔ | ✔ | ✔ | |
| A7 | 96 | 44 | | | | | | | ETIN Not Certified for Use | | | | ✔ |
| A7 | 132 | 85 | | | | | | | Invalid NYS Medicaid Provider ID for Billing Provider, or Billing Provider (identified by NPI or Medicaid ID) not on file or not active on date of service (for Inpatient claims with Rate Codes 2946 or 2953 the "Through" Statement Date is used) | ✔ | ✔ | ✔ | ✔ |
| A7 | 132 | 71 | | | | | | | Invalid NYS Medicaid Provider ID for Attending Provider | ✔ | | | |
| A7 | 132 | 82 | | | | | | | Invalid NYS Medicaid Provider ID for Rendering Provider | | ✔ | | ✔ |
| A7 | 132 | DN | | | | | | | Invalid NYS Medicaid Provider ID for Referring Provider | | ✔ | | |
| A7 | 162 | GB | | | | | | | Invalid Identifier for Other Insured (After 12/31/2019, when Medicare is involved the MBI must be used.) | ✔ | ✔ | | ✔ |
| A7 | 187 | | | | | | | | Statement Dates failed "reasonability" validation (within 6 years of processing date) | ✔ | | ✔ | |
| A7 | 228 | | | | | | | | Invalid Uniform Billing Claim Form Bill Type | ✔ | | | |
| A7 | 229 | | | | | | | | Invalid NUBC Admission Source Code (Point of Origin) | ✔ | | | |
| A7 | 231 | | | | | | | | Invalid NUBC Admission Type Code | ✔ | | | |

# Pre-Adjudication Crosswalk

## Common 277CA Rejection Codes

| 277CA Response | Brief Description |
|---|---|
| A7 \| 132 \| 85 | Invalid NYS Medicaid Provider ID for Billing Provider |
| A7 \| 96 \| 41 | ETIN Not Certified for Use |
| A7 \| 454 | HCPCS (Procedure) Code is Invalid |
| A7 \| 33 \| IL | Client is Not on File |
| A7 \| 132 \| 71 | Invalid NYS Medicaid Provider ID for Attending Provider |
| A7 \| 162 \| GB | Invalid Identifier for Other Insured (Medicare MBI Must be Used) |

# Pre-Adjudication Crosswalk

➢ **Electronic claims are validated against a set of preliminary edits that are checked prior to adjudication**

➢ **If Pre-Adjudication errors are found - codes are reported in the 277CA / ePACES Claim Status Response**

➢ **Pre-Adjudication Crosswalk will assist providers in identifying the specific error codes**

➢ **Claims rejected by the front end process are <u>not</u> reported in the Remittance Advice**

➢ **Providers MUST <u>correct</u> and <u>resubmit</u> rejected claims**

# Pre-Adjudication Crosswalk

<mark>**Reference and Contact Information**</mark>

➢ **eMedNY Website**
- **www.emedny.org**

➢ **ePACES - Claim Status Inquiry and Response**
  - ➢ https://www.emedny.org/HIPAA/QuickRefDocs/ePACES-Claim_Status_Inquiry_Response.pdf

➢ **eMedNY Pre-Adjudication Crosswalk**
- **www.emedny.org/HIPAA/5010/transactions/crosswalks/eMedNY%20Pre-Adjudication%20Crosswalk%20(837%20Health%20Care%20Claims).pdf**

➢ **X12 Website**
- **www.x12.org/index.php/reference**

➢ **eMedNY Call Center**
- **800-343-9000**

# THANK YOU