Important Claim/Encounter Submission Information

On January 1, 2020, MeridianCare will integrate with its parent company, WellCare Health Plans in Tampa, Florida. This bulletin highlights the most frequent claim/encounter edits known in the industry as SNIP Edits (Strategic National Implementation Process edits).

We appreciate your attention in reviewing these edits to ensure all billing meets these top edits and all other industry SNIP edits. This will help avoid delay and rejection of your claims/encounters.

For inquiries related to the SNIP rejections or information provided in the grid, please contact our EDI team at **EDI-Master@wellcare.com**.

Thank you,

WellCare Health Plans, Inc.

ERROR_ID	ERROR_SHORT_DESC	RESOLUTION
W3938af8	Admission Date/Hour is required on inpatient claims.	Per the 2019 NUBC Billing Guide (FL 12-PG 34) Admission/Start of Care Date is the start date for this episode of care. For inpatient services, this is the date of admission. For other (home health) services, it is the date the episode of care began. • UB-04: Required on all inpatient claims (IP), 012x, 022x, 032x, 034x, 081x and 082x. • 005010: Required on inpatient claims, home health claims and hospice claims.
W3938b7f	Admission Date/Hour may be used on inpatient claims only. Do not send on Outpatient Bill Types.	Per the 2019, NUBC Billing Guide (Page 20) Field 12 (Admit Date) is required on all inpatient claims (IP) and on claims with Type of Bill (Field 4) Types (012X, 022X, 032X, 034x, 081X and 082X). Per the 2019 NUBC Billing Guide (Page 20) Exceptions to Inpatient/Outpatient List, Field 13 (Admit HR) is required on all inpatient claims (IP) except Type of Bill (Field 4) 021X.
W39392e2 or W39392bd	Admission Source Code is required for inpatient claims. Admission Source Code is required for outpatient claims.	Per the 2019, NUBC Billing Guideline (Page 20) Admission Source code is required on claims with Bill Type 012x, 022x and inpatient claims except 028x, 065x, 066x, 086. Action needed. Remove the Admitting Diagnosis and resubmit a new claim

W3938af6	Admitting Diagnosis is required on inpatient admission claims.	Per the 2019 NUBC Billing Guide (FL 69, PG 20) – Admitting Diagnosis • UB-04: Situational. Required when claim involves an inpatient admission. Required on 012x, 022x and inpatient claims (IP) except 028x, 065x, 066x and 086x. • 005010: Situational. Required when claim involves an inpatient admission.
W3938b80	Admitting Diagnosis may be used only when claim involves inpatient admission.	Per the 2019 NUBC Billing Guide (FL 69, PG 20) – Admitting Diagnosis • UB-04: Situational. Required when claim involves an inpatient admission. Required on 012x, 022x and inpatient claims (IP) except 028x, 065x, 066x and 086x. • 005010: Situational. Required when claim involves an inpatient admission. Provider will need to make the necessary changes and remove the admit Diagnosis code for claims that do not have the following TOB (FL04) 012X, 022X and Inpatient claims except for 028X, 065X, 066X and 086X. Once the changes are made, the provider can resend the claim as NEW.
W3938af8	Date – Admission is required on inpatient claims.	Per the 2019 NUBC Billing Guide (FL 12, PG 20), Admission/Start of Care Date is the start date for this episode of care. For inpatient services, this is the date of admission. For other (home health) services, the episode of care began the date. • UB-04: Required on all inpatient claims (IP), 012x, 022x, 032x, 034x, 081x and 082x. • 005010: Required on inpatient claims, home health claims and hospice claims.
W3938b8e	Discharge Hour may be used on final inpatient claims only.	Per the 2019 NUBC Billing Guide (FL16, PG 20) Discharge hour – Code indicating the discharge hour of the patient from inpatient care. • UB-04: Situational. Required on all final inpatient claims (IP) except 021x. This includes claims with a Frequency Code of 1 (Admit through Discharge), 4 (Interim – Last Claim) and 7 (Replacement of Prior Claim) when the replacement is for a prior final claim.

		• 005010: Situational. Required on all final inpatient claims.
W3938bf0	Patient Reason For Visit is required on unscheduled outpatient visits.	Per the 2019 NUBC Billing Guide (FL 70a-c) Patient Reason for Visit UB-04: Situational. 1. Required for all unscheduled outpatient visits. An unscheduled outpatient visit is defined as an outpatient Type of Bill 013x, 085x, or 078x when: a) Form Locator 14 (Priority (Type) of Admission or Visit) codes or visit 1, 2 or 5 are reported and b) Revenue Codes 045x, 0516, 0526 or 0762 are reported. 2. Reporting Patient's Reason for visit is restricted to the three bill types above. If not required, it may be reported on other 013x, 078x and 085x claims that fail to meet the criteria in a) or b) above at the sender's discretion when this information substantiates the medical necessity, but cannot be required by the receiver.
W393966a or W3939676	ICD-10 is a required identifier when it is mandated for use.	For dates of service on and after Oct. 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard healthcare claim transactions are among those for which ICD-10 codes must be used for dates of service on and after Oct. 1, 2015. **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1408.pdf**

W39394b7	Value of element DTP03 (Date – Service Date) is incorrect. Claims that span ICD-10 implementation date should be split, so all ICD-9 codes remain on one claim with Service Date before implementation date and all ICD-10 codes are placed on the other claim with Service Date beginning on implementation date and later. Please consult payer specific requirements.	When a claim spans the ICD-10 implementation date for institutional, professional, and supplier claims. For example, the beneficiary is admitted as an inpatient in late September 2015 and is discharged after Oct. 1, 2015. Another example is a DME claim for monthly billing that spans between September and October 2015 (that is, the monthly billing dates are Sept. 15, 2015 to Oct. 14, 2015). The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable. **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1408.pdf**
W534	837P/CMS1500 Claims with Clinical Trial DX codes must contain Clinical Trial 8 digit # and a Q1 modifier.	Medicare specific requirement-clinical trial requirements in CMS billing guidelines. Investigational clinical service provided in a clinical research study that is in an approved clinical research study. When a service is performed as part of an approved clinical research study and the claim must have an 8-digit Clinical Trial Number.
W61a	Patient Discharge status code reported is 20, 40, 41 or 42; Occurrence code 55 must also be billed as of 10/1/12	Per the NUBC 2019 Billing Guideline, the patient's discharge status is required on all institutional claims. Identifying the appropriate code may be confusing; judgment must be used in all cases. A basic rule of thumb is to code to the highest level of care that is known. For example, an individual discharged to home with a home health plan of care is coded as 06, rather than 01. Discharge Status Code: 01 – Discharged to home or self-care. This code should not be used for patients who die while under hospice care. 30 – Still a hospice patient – Hospice services continue to be provided.
W3938b3f	Claim Check or Remittance Date is required when claim has been adjudicated.	See COB Balancing guidance – This rejection indicates the adjudication date is missing on the payment from the primary payer. Provider must add an adjudication date to the primary payment and resend

		the claim as NEW. **https://www.wellcare.com/California/Providers/Medicare/Claims/COB**
W3938bda	Payer Claim Control Number is required.	Per the 2019 NUBC Billing Guide Document Control Number (DCN), the control number (Payer Control Number) assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. • UB-04: Situational. Required when Type of Bill Frequency Code (FL 04) indicates this claim is a replacement or void to a previously adjudicated claim. • 005010: Situational. (Payer Claim Control Number) required when CLM05-3 (Claim Frequency Code 7 or 8) indicates this claim is a replacement or void to a previously adjudicated claim.
W3938bf4	The date of death is required.	Per the 2019 NUBC Billing Guideline. Populate the Date of Death (FL 31) when Status Code 20 – Expired is reported in the patient discharge status codes 20 (expired), 40 (expired at home), 41 (expired in a medical facility), or 42 (expired – place unknown) are used. Populate FL 31 Occurrence Code 50 and with the Date of the Death.
W273	The RR modifier billed for services with a QTY greater than “1” for DME is incorrect or the RR modifier billed is invalid for HCPCS code	Medicare specific requirement – DME requirements in CMS billing guidelines – Monthly rental of DME, orthotics or prosthetics identified by the applicable code with a rental modifier RR and/or modifiers KH, KI, KJ, KR appended will be reimbursed once per calendar month to the same Specialty Physician, Hospital, Ambulatory Surgical Center or Other Healthcare Professional. A calendar month is the period of duration from a day of one month to the corresponding day of the next month (please see Definitions) and is determined based on the From date reported on the claim. If a code is submitted with modifier RR and/or modifiers KH, KI, KJ, KR with units greater than 1, or multiple times during the same calendar month, WellCare will only reimburse one monthly rate per calendar month to the Same Specialty

		Physician Hospital, Ambulatory Surgical Center or Other Healthcare Professional.
W520	HIPPS codes are required on all Skilled Nursing Home Health claims with Bill Type 021x or 032x.	Health Insurance Prospective Payment System (HIPPS) Code Requirements: Effective July 1, 2014, all claims from Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs) must appropriately bill with a valid HIPPS code for Type of Bill 018x, 021x, or 032x (x represents the Type of Bill Frequency). SNFs Bill Types and HHAs Bill Types must bill the HIPPS code derived from the Initial Assessment The first line must be the PPS Revenue Code (0022 or 0023), and corresponding HIPPS code Submit subsequent lines in the appropriate order as detailed in the Uniform Billing guide at **https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/hippscodememo.pdf**
W2e6	NPI on the claim is not present in the roster or NPI is present but name doesn't match	Medicare specific requirement – Ordering Prescribing and Referring registry requirements in CMS billing guidelines
W2e7	NPI on the claim is not present in the roster or NPI is present but name doesn't match	In April 2007, the Centers for Medicare and Medicaid Services (CMS) issued guidance related to the implementation of the National Provider Identifier (NPI). CMS allowed entities to invoke a contingency plan aimed at completing any outstanding preparations to fully comply with the NPI mandate no later than May 23, 2008. All providers are required to report the NPI, unless the provider is considered NPI Exempt AKA an A-Typical Provider and these providers Tax ID, must be registered on WellCare's A-Typical Provider to avoid future rejections.

W2e9	Referring/Ordering provider mismatch	The ordering/referring provider's name does not match the NPI. Step 1: Verify the ordering/referring provider name and NPI are correct using the CMS Ordering Referring Report **https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html** Step 2: Validate how you are registered on the PECO system. Step 3: Once you have obtained the correct name and NPI, resubmit a new initial claim. Be sure to enter the name and NPI exactly as it appears in the PECOS records.
W2e8	Referring/Ordering provider not allowed to refer	A Referring/Ordering provider must be registered on the DME PECO Registry in order to be allowed to refer. Effective May 1, 2013, Medicare will deny claims for all covered Medicare Part B, durable medical equipment, orthotics, and supplies (DMEPOS), and Part A home health agency (HHA) services when the ordering/referring provider is not enrolled in Medicare and the claim does not list the national provider identification (NPI) number for the ordering or referring provider. You must submit a new claim with a provider that is allowed to refer for DMEPOS.
W2ea	Referring/Ordering provider NPI is required	The ordering/referring provider NPI was either missing from the claim, is not found on the ordering/referring physician file, or has been terminated. Step 1: Verify that the ordering/referring provider name and NPI are correct using the CMS Ordering Referring Report **https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html** Step 2: Validate how you are registered on the PECO system. Step 3: Once you have obtained the correct name and NPI, resubmit a new initial claim. Be sure to enter the name

		and NPI exactly as it appears in the PECOS records.
W522	Anesthesia modifier or modifier position is invalid. QS, G8, G9 or GC cannot be billed in primary position	Medicare specific requirement – See Anesthesia requirements in CMS billing guidelines. The only anesthesia modifiers that Medicaid will recognize are QS and YA. HCPCS modifiers AA, AD, AE, QJ, QO, QQ, QX, and QZ will not be recognized and if billed, will result in the claim being denied.
W521	Incorrect Unit of Measure billed	Medicare specific requirement – See Anesthesia requirements in CMS billing guidelines. If the claim has an MJ qualifier then the amount reported is Minutes. If the Anesthesia claims is reported as UN for Units than the claim will reject unless others indicated by CMS for Epidural procedures. Enter the default time increment in minutes. This establishes the Base Unit. Note: Refer to CPT Coding Book for proper Anesthesia minutes.
W517	Invalid anesthesia modifier billed with non-anesthesia service.	Modifiers must be billed with anesthesia procedure codes to indicate whether the procedure was personally performed, medically directed or medically supervised. Service will deny - When billed without appropriate modifier for provider's specialty - When modifier is not billed in the appropriate modifier position. - When billed with invalid modifier combinations. (See incorrect modifier billing combination grid below) - If not billed in accordance with standard coding/billing guidelines and Neighborhood's policies Incorrect Billing Modifiers Modifier Do Not file on the same claim line with: AA – Anesthesiologists AD, QY, QK, QX,

		or QZ QY – Anesthesiologists AA, AD, QK, QX, or QZ QK – Anesthesiologists AA, AD, QY, QX, or QZ AD – Anesthesiologists AA, QY, QK, QX, or QZ QX – CRNAs AA, AD, QY, QK, or QZ QZ – CRNAs AA, AD, QY, QK, or QX
W518	Final bill types with patient discharge status 30, indicating the patient is still in the hospital is not allowed.	Final bill types with patient discharge status 30, indicating the patient is still in the hospital is not allowed. Claims that have a Frequency Code of 1 or 4 is considered a FINAL BILL. Claims with this type of Frequency Code cannot have a Status Code 30 (Still a Patient). Please re-enter or resubmit the claim as New and with the appropriate Status code. Per the 2019 NUBC (Page 57) Q: Can discharge status 30, Still Patient, be used on both inpatient and outpatient claims? A: Yes, it can be used on both types of claims. Note, however, that Code 30 is primarily designed to be used on inpatient claims when billing for leave of absence days or interim bills; on outpatient claims, the primary method to identify that the patient is still receiving care is the bill type frequency code (e.g., Frequency Code 3: Interim – Continuing Claim).
W393967b or W393960e	Claim Frequency Type Code is invalid.	This rejection indicates that an incorrect submission reason was included on the claim per the payer's requirements. The Invalid Claim Frequency Code refers to the Submit Reason selected on the encounter. The appropriate submission code depends on the payer's requirements. For example, most Medicare payers will not accept any claim submission reason other than 1 –Original.

W3938c8f	External cause code cannot be used as Principal Diagnosis code.	Use of a Valid Code set
W3939613	HCPCS Modifier Code is invalid in a Professional or in an Institutional Service Line.	This rejection indicates that (per the payer) one of the procedure (CPT/HCPCS) modifiers submitted on the claim was invalid for the date of service being billed. Please review, make the necessary changes, and resend the claim as NEW.
W3939612	HCPCS Procedure Code is invalid in Institutional Service Line or Line adjudication information or in a Professional Service Line.	This rejection indicates one of the Procedure (CPT/HCPCS) codes billed on the claim is not valid for the date of service listed. If your claim is EDI and it is rejected for an invalid HCPC Code, please check your Current 2019 HCPC Coding Book and ensure you are using the correct HCPC Qualifier of HC and not the HIPPS Qualifier of HP. Please make the necessary changes and resend a NEW EDI Claim.
W393964c or W393966c	ICD-10-CM Diagnosis code is invalid in one of the following: Other Diagnosis Information or Principle Diagnosis, or Admitting Diagnosis or Health Care Diagnosis Code.	Claim rejected for an invalid ICD-10 Code please check your Current 2019 ICD-10 Code or use the following link – **http://www.icd10data.com/**. In preparation of ICD-10, some ICD codes went from 4 digits to multiple digits starting with an Alpha Character. Please make the necessary changes and send a NEW Claim.
W3939631	ICD-9-CM Diagnosis code is invalid in Principle Diagnosis or in Other Diagnosis Information.	Only ICD-10-ICD is accepted.
W393934d	Local Patient Status Codes are not allowed.	This rejection indicates the claim is rejecting for an invalid Patient Discharge Status Code. The provider needs to validate the Patient Status Code per the NUBC guideline. Make the necessary changes and resend the claim as NEW.
W3938b7f	Other Procedure Information may be used on inpatient claims only.	Per the 2019 NUBC Billing Guideline Field 74a-e Other Procedure Code and Dates. This is a situational field. It only is required on inpatient claims when additional procedures must be reported. If not required (i.e., on outpatient claims) do not send. The provider will need to make the necessary to changes and resend the claims as NEW via EDI.

W393933d	Patient Status Code is invalid.	Use of a Valid Code set – UB-04 Institutional Rejection indicates the claim is missing the Patient Discharge Status Code. Per the payer's requirements, all institutional claims now require the Patient Discharge Status Code. The provider will need to populate the Discharge Status and send the claim as NEW.
W3939626	Place of Service Code is invalid.	Place of service code, on line (number will be indicated) is invalid. The place of service code in box 24b on the indicated line item is invalid. Verify the place of service code in box 24 on the indicated line item, update the claim as necessary, and resend the claim as NEW.
W393931d or W393931e	Point of Origin for Admission or Visit Code is invalid.	Per the 2019 NUBC Billing Guideline (FL15-PG 38) – Page Point of Origin – A code indicating the point of patient origin for this admission or visit. • UB-04: Required on all bill types except 014x. • 005010: Situational. Required for all inpatient and outpatient services. (Note: Required on all bill types marked IP and OP per FL 04 Pages 3 – except bill type 014x, which is equivalent to the UB-04 requirement.)
W3938b7f	Principal Procedure Information may be used on inpatient claims only.	Per the 2019 NUBC Billing Guideline Field 74 Principle Procedure Code and Dates. This is a situational field. It only is required when a procedure was performed. If not required (i.e., on outpatient claims), do not send. The provider will need to make the necessary changes and resend the claims as NEW via EDI.
W393931f	Priority (Type) of Admission or Visit Code is invalid.	Use of a Valid Code set – This rejection indicates the claim is missing Point of Origin Code for Admission or Visit. Per the payer's requirements, all institutional claims now require the Point of Origin for Admission or Visit except Type of Bill 014x. Provider must enter the admitting type on the claim and resend as NEW.
W3939339	Revenue Code is invalid.	Per the 2019 NUBC Guidelines Revenue Codes (Page 114), codes that identify specific accommodation, ancillary service

		or unique billing calculations or arrangements. Revenue Code (FL 4) is a required field consisting of 4 numbers.
W393961d	Type of Bill is invalid.	Per the NUBC Billing Guidance, the Type of Bill is a required field. The Type of Bill Matrix, which follows CMS general guidelines on what constitutes an Inpatient or Outpatient claim depends on the first three digits of the Type of Bill (TOB) field 4. When submitting a claim, do not include the leading zero on an EDI claim. Provider will need to make the necessary changes and resend the claim as NEW.
W3939629	Value Code is invalid in Value Information.	Per the NUBC, Value Code is situational. However, if populated in field 39-41, it must be a valid Value Code and Amount. The provider must validate the Value Code, make the necessary changes and resend the claim as NEW.
W3939342	ZIP code is invalid in Billing Provider or Other Subscriber or Service Facility Location or Subscriber when validating the City, State and ZIP code against USPS.	The reason for this rejection is because the ZIP code is not valid for the city or state that was entered on the claim. If the correct ZIP code is not known, users can reference the U.S. Postal Service website (**https://tools.usps.com/go/ ZipLookupAction!input.action**) to find the correct ZIP code for the address.
W39395e7	First available Diagnosis Code Pointer should be used.	Use of proper Syntax-populate first placeholder first. This rejection indicates one of the following issues with the claim. There is an empty diagnosis pointer for the ICD-10 DX codes that are listed on the HCFA 1500 form field 21 A-L and on the UB04 claim field 67 A-Q. Action Needed: Add a Diagnosis Pointer to the claim and resubmit as a NEW Original claim.
W3939642	First available Other Procedure Information code should be used.	Use of proper Syntax – populate first placeholder first
W39392fc	First/Middle/Prefix/Suffix name should only be used when Billing Provider is a person.	Use of proper Syntax – Don't give type 2 organizations a first or middle name like a type 1 individual. – This rejection is caused by a GROUP Name in a person format. Provider needs to use an Entity of 2 to populate the group name as ABC FACILITY even if the Group is the Providers Individual Billing name and not

		use Entity of 1, which is in a LNAME, FNAME format. Provider will need to resend the claim as NEW.
W3939305	Insured Group Name should not be used when Group Number is used.	For both Institutional and Professional claims: Insured Group Name (SBR04) should not be used when Group Number (SBR03) is used. Action needed: Remove the Group Name (SBR04) and resubmit.
W810021	Leading zeros are not allowed.	Per the NUBC and Implementation Guide Leading Zeros are not allowed. Enter the total number of covered accommodation days, ancillary units of service, or visits, where appropriate. - Leading zeros must not be reported. - If the amount is an integer, no decimal point is reported. - The maximum length for this field is 7 digits excluding the decimal. - When a decimal is used, the maximum number of digits allowed to the right of the decimal is three.
W39395ec or W3939656 or W39395ee	Duplicate Diagnosis Code in Diagnosis Code or Occurrence/Occurrence Span Codes or Procedure modifiers.	ICD-10 Diagnostic codes cannot be repeated or duplicated on the HCFA 1500 form field 21 A-L and on the UB04 claim field 67 A-Q. Action Needed: Remove the Duplicate Diagnosis Code and submit the claim as a NEW Original claim.
W261 or W26b or W26a or W260	The Billing Provider Address or the Service Location Address contains a PO Box Address. Please verify the information and resubmit a corrected claim with the appropriate Billing Provider or Service Location Address.	In EDI claims, a PO Box address in the billing provider address is not permitted. In Paper claims, a PO Box address is acceptable in the billing provider address ONLY if a physical address is present in the Service Facility box 32-CMS1500 or box 1-UB-04
W3938ed5	Claim failed to balance against total charge amount.	This rejection indicates the adjudication date is missing on the payment from the primary payer. Provider must add an adjudication date to the primary payment and resend the claim as NEW. See COB Balancing guidance at **https://www.wellcare.com/ /https://www.wellcare.com/ <enter correct state name>/ Providers/Medicare/Claims/COB**

W3938edc	COB claim failed to balance: paid amount did not equal adjusted charge amount.	See COB Balancing guidance at **https://www.wellcare.com/<enter correct state name>/Providers/Medicare/Claims/COB**
W3938edd	COB service line failed to balance: paid amount did not equal adjusted charge amount.	See COB Balancing guidance at **https://www.wellcare.com/<enter correct state name>/Providers/Medicare/Claims/COB**
W39393cd	Payer ID should match to Other Payer Primary Identifier.	See COB Balancing guidance at **https://www.wellcare.com/<enter correct state name>/Providers/Medicare/Claims/COB**