Outpatient Code Editor- Medicaid

ID	Rule Name	Source
31	Global Test Only Rule	National Physician Fee Schedule Relative Value File- This edit identifies claim lines that contain codes that have the modifier 26 or TC appended inappropriately. The concept of professional and technical component splits (PC/TC) does not apply since global test only codes identified by the indicator of “4” in the PC/TC column of the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) cannot be split into professional and technical components under CMS rules. Modifier 26 and TC cannot be used with these codes
32	Inappropriate Procedure Age	CPT- Procedure code 99100, Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure), is to be reported on a patient younger than 1 year or 70 years and older.
32	Inappropriate Procedure Age	CPT- Procedure code 99100, Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure), is to be reported on a patient younger than 1 year or 70 years and older.
38	Medicaid Bundled Codes	NPFS/NCCI Manual- Per the NPFS, procedure codes with a status indicator of "B" are either bundled into other services on the same day or are not payable based on CMS and Medicaid Guidelines.
45	Team Surgeons Not Permitted	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code for the team surgery modifier 66. This edit will fire on all Medicaid claim lines containing codes that have an indicator of ''0'' in the team surgery column of the NPFS that are submitted with modifier 66 appended.
51	Medicaid Add-on Procedure without Primary Procedure	CMS Policy/Add-on Code Edits/Transmittal 2636- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS), transmittals and the CPT manual to determine eligibility of an add-on procedure code(s).
52	Co-Surgeons Not Permitted Procedure	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code for the co-surgeon modifier 62. This edit will fire on all Medicaid claim lines containing codes that have an indicator of ''0'' in the co-surgeon column of the NPFS that are submitted with modifier 62 appended.
54	No Payment For Assistant Surgeons Procedure Edits	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code for the assistant surgeon modifiers 80, 81, 82 and AS. This edit will fire on all Medicaid claim lines containing codes that have an indicator of ''1'' in the assistant surgeon column of the NPFS that are submitted with modifier 80, 81, 82 or AS appended.
56	Document Co-Surgeons Procedure	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code for the co-surgeon modifier 62. This edit will fire on all Medicaid claim lines containing codes that have an indicator of ''1'' in the co-surgeon column of the NPFS that are submitted with modifier 62 appended.

58	Injection Service	National Physician Fee Schedule Relative Value File- The edit use the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to identify CPT® codes with the indicator ''T'' in the Status Code column of the NPFS as services payable under the physician fee schedule. Originally, this status code bundled the Indicator ''T'' codes into any service billed on the same date by the same provider. Currently, these services are only bundled into the other service(s) for which payment is made under the NPFS.
59	Document Team Surgery	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code for the team surgeon modifier 66. This edit will fire on all Medicaid claim lines containing codes that have an indicator of ''1'' in the team surgeon column of the NPFS that are submitted with modifier 66 appended.
61	Assistant At Surgery Documentation Required	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code for the assistant surgeon modifiers 80, 81, 82, and AS. This edit will fire on all Medicaid claim lines containing codes that have an indicator of ''0'' in the assistant surgeon column of the NPFS that are submitted with modifier 80, 81, 82, or AS appended.
63	Medicaid Non-Physician Service	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code to be covered under incident to guidelines. The edit will fire on all Medicaid claim lines containing codes that have an indicator of ''5'' in the PC/TC column of the NPFS that are submitted with a location of skilled nursing facility, hospital inpatient or hospital outpatient.
71	Laboratory Physician Interpretation	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code to be split into professional and technical components. This edit will fire on all claim lines containing codes that have an indicator of ''6'' or ''8'' in the PC/TC column of the NPFS that are submitted with modifier TC appended.
77	Technical Component Only Policy	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code to be split into professional and technical components. This edit will fire on all Medicaid claim lines containing codes that have an indicator of ''3'' in the PC/TC column of the NPFS that are submitted with modifier 26 or TC appended.
78	Professional Component Only	National Physician Fee Schedule Relative Value File-The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code to be split into professional and technical components. This edit will fire on all Medicaid claim lines containing codes that have an indicator of ''2'' in the PC/TC column of the NPFS that are submitted with modifier 26 or TC appended.
79	Physician Service Policy	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine the eligibility of a CPT® code to be split into professional and technical components. This edit will fire on all Medicaid claim lines containing codes that have an indicator of ''0'' in the PC/TC column that are submitted with modifier 26 or TC appended.

92	Diagnostic Test in Hospital	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code to be split into professional and technical components. This edit will fire on all Medicaid claim lines containing codes that have an indicator of ''1'' in the PC/TC column of the NPFS that are submitted without modifier 26 appended with a location of inpatient hospital, outpatient hospital or skilled nursing facility.
94	Medicaid Physical, Occupational and Speech Therapists in Private Practice	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine the eligibility of a therapy CPT® code for payment under Medicaid rules. This edit will fire on all Medicaid claim lines containing codes that have an indicator of ''7'' in the PC/TC column of the NPFS that are submitted with a location other than the provider's private office or the patient's private home.
100	Physician Interpretation Only Policy	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code to be split into professional and technical components. This edit will fire on all Medicaid claim lines containing codes that have an indicator of ''8'' in the PC/TC column of the NPFS that are submitted with a place of service other than inpatient.
105	Medicaid Inappropriate Modifier - Professional/Technical Component	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine whether a procedure code billed on a Medicaid claim is submitted with an inappropriate modifier.
109	Medicaid Postoperative Unrelated Service By Provider - Different Diagnosis	Medicare Claims Processing Manual, Chapter 12, Section 30.6.3; Section 30.6.6.A; Section 30.6.9.2.D; Section 40.1.B; Section 40.2.A.7; Section 40.3.B; Section 40.4.A.- Edit identifies Medicaid claim lines that contain E/M code(s) submitted without proper modification when billed with a different diagnosis code during the global period of a previously submitted procedure code by the same provider.
112	Medicaid Return to Operating Room Reduction	National Physician Fee Schedule Relative Value File and the Claims Processing Manual Chapter 12, Sections 40.2.5, 40.4A and 40.4.C; Chapter 23, Addendum- The edit uses the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) and the Medicare Claims Processing Manual to identify when a code with modifier 78 appended is eligible for a reduction. This edit fires on all claim lines that contain a code submitted with modifier 78 appended and have a number, other than zero, in the Intra Op column of the NPFS.
113	Deny Modifier EY	(CMS) Medicare Claims Processing Manual Chapter 20 Durable Medical Equipment, Prosthetics, Orthotics (DMEPOS) section 100.4- The edit identifies claims that contain an EY modifier on all lines indicating "no physician or other licensed health care provider order for this item or service."
113	Deny Modifier EY	(CMS) Medicare Claims Processing Manual Chapter 20 Durable Medical Equipment, Prosthetics, Orthotics (DMEPOS) section 100.4- The edit identifies claims that contain an EY modifier on all lines indicating "no physician or other licensed health care provider order for this item or service."
115	Modifier EY Required	(CMS) Medicare Claims Processing Manual Chapter 20 Durable Medical Equipment, Prosthetics, Orthotics (DMEPOS) section 100.4-The edit identifies claims that contain an EY modifier on any line of a claim.
115	Modifier EY Required	(CMS) Medicare Claims Processing Manual Chapter 20 Durable Medical Equipment, Prosthetics, Orthotics (DMEPOS) section 100.4-The edit identifies claims that contain an EY modifier on any line of a claim.
117	Never Events	CMS Medicare Claims Processing Manual; Medicare Benefit Policy Manual (BPM); National Coverage Determinations (NCD)- This edit will fire on all claim lines containing a modifier PA, PB or PC indicating a particular surgical or other invasive procedure was erroneously performed and is non covered. - PA: Surgery Wrong Body Part- PB: Surgery Wrong Patient- PC: Wrong Surgery on Patient

131	Medicaid Inappropriate Modifier - Follow Up Days	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine whether a procedure code billed on a Medicaid claim is submitted with an inappropriate modifier.
142	Inpatient Principal Procedure Required	Medicare Claim Process Manual, Chapter 23, Section 10 & Chapter 25-The edit will fire when an inpatient claim does not contain a principal procedure in Form Locator (FL) 74 when a secondary (other) procedure is present on the claim in Form Locator (FL) 74A - 74E. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
156	Procedure not typical with Patient Gender	CPT, HCPCS, CMS, FDA, ICD-10-CM, AMA and specialty societies- This rule identifies line items where the listed service is not typically performed for a person of the patient's gender, unless modifier KX is also reported. The Centers for Medicare and Medicaid Services (CMS) states that, "Contractors shall override any gender specific edits (gender/procedure conflict) that occur for a given procedure code if the KX modifier is billed with that code, and allow the claim to continue normal processing."
156	Procedure not typical with Patient Gender	CPT, HCPCS, CMS, FDA, ICD-10-CM, AMA and specialty societies- This rule identifies line items where the listed service is not typically performed for a person of the patient's gender, unless modifier KX is also reported. The Centers for Medicare and Medicaid Services (CMS) states that, "Contractors shall override any gender specific edits (gender/procedure conflict) that occur for a given procedure code if the KX modifier is billed with that code, and allow the claim to continue normal processing."
157	Diagnosis Not Typical for Gender	ICD-9-CM; ICD-10-CM; CMS Policy; AMA and specialty societies- This rule identifies line items where the listed diagnosis is not typically performed for a person of the patient's gender, unless modifier KX is also reported. The Centers for Medicare and Medicaid Services (CMS) states that, "Contractors shall override any gender specific edits (gender/diagnosis conflict) that occur for a given diagnosis code if the KX modifier is billed with that code, and allow the claim to continue normal processing."
157	Diagnosis Not Typical for Gender	ICD-9-CM; ICD-10-CM; CMS Policy; AMA and specialty societies- This rule identifies line items where the listed diagnosis is not typically performed for a person of the patient's gender, unless modifier KX is also reported. The Centers for Medicare and Medicaid Services (CMS) states that, "Contractors shall override any gender specific edits (gender/diagnosis conflict) that occur for a given diagnosis code if the KX modifier is billed with that code, and allow the claim to continue normal processing."
167	Ambulance Required Origin and Destination Modifier Rule	Medicare Claims Processing Manual, Chapter 15 - Ambulance, Section 30.2.1- The edit will fire when a claim line contain an ambulance origin and destination modifier without modifier QM or QN that describe whether the service was provided under arrangement or directly. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
168	Ambulance Service Requires Mileage HCPCS Code Rule	Medicare Claims Processing Manual, Chapter 15 - Ambulance, Section 30.2.1 - A/MAC Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation- The edit will fire when outpatient ambulance claim does not contain both an ambulance service code and an ambulance mileage code on the same claim, for the same patient, on the same date service. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
171	Medicaid Inappropriate Modifier- Co Surgeon	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine whether a procedure code billed on a Medicaid claim is submitted with an inappropriate modifier.
172	Medicaid Inappropriate Modifier- Team Surgery	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine whether a procedure code billed on a Medicaid claim is submitted with an inappropriate modifier.

173	Medicaid Inappropriate Modifier- Assistant Surgeon	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine whether a procedure code billed on a Medicaid claim is submitted with an inappropriate modifier.
176	Medicaid Bundled Code Policy	National Physician Fee Schedule Relative Value File, Calendar Year 2019/Medicaid NCCI- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to identify CPT® codes with the indicator ''P'' in the Status Code column of the NPFS as Bundled or Excluded for which no separate payment should be made under the NPFS.
182	Medicaid Incident To Codes	National Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code to be split into professional and technical components. This edit will fire on all Medicaid claim lines containing codes that have an indicator of ''5'' in the PC/TC column of the NPFS that are submitted with modifier 26 or TC appended.
186	Anesthesia Reduction	CMS Medicare Claims Processing Manual, Chapter 12, Section 50- The edit uses the Centers for Medicare and Medicaid Services' (CMS) Medicare Claims Processing Manual to identify anesthesia services that are submitted with an anesthesia modifier that affects payment for services. This edit fires on all claim lines that contain an anesthesia code, excluding CPT® code 01996, submitted with modifier AD, QK, QX, or QY appended.
187	Medicaid Multiple E/M codes	CMS Medicare Internet Only Manual Chapter 12, Section 30.6.5- The edit uses the Centers for Medicare and Medicaid Services (CMS) guidelines found in the Medicare Claims Processing Manual to identify when more than one Evaluation and Management code is billed on the same day by the same provider. This edit will fire when more than one Evaluation and Management (E/M) code is billed with the same diagnosis by the same provider for the same patient.
195	Medicaid Global Follow Up by Provider	Medicare Claims Processing Manual, Chapter 12, Section 30.6.3; Section 30.6.6.A; Section 30.6.9.2.D; Section 40.1.B; Section 40.2.A.7; Section 40.3.B; Section 40.4.A.- The edit utilizes the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS), the CMS Medicare Claims Processing Manual, and the Medicaid National Correct Coding Initiative (NCCI) to identify evaluation and management (E/M) services billed within the global follow-up days of a prior service. This edit will fire on all claim lines containing an E/M procedure code that has been submitted within the global follow-up days of a prior service by the same provider for the same diagnosis code.
198	Medicaid Global Follow Up by Provider History	Medicare Claims Processing Manual, Chapter 12, Section 30.6.3; Section 30.6.6.A; Section 30.6.9.2.D; Section 40.1.B; Section 40.2.A.7; Section 40.3.B; Section 40.4.A.- The edit utilizes the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS), the CMS Medicare Claims Processing Manual, and National Correct Coding Initiative (NCCI) to identify claim lines that contain a procedure code which has global surgical follow up days and an Evaluation and Management (E/M) service has been submitted in history during the global period by the same provider, with the same diagnosis code.
200	Modifier GZ	CMS Claims Processing Manual Chapter 23 Section 20.9.1.- This edit utilizes the Centers for Medicare and Medicaid Services’ (CMS) Medicare Claims Processing Manual to identify an item or service that is expected to be denied as not reasonable and necessary. This edit will fire on all claim lines submitted with a GZ modifier.

200	Modifier GZ	CMS Claims Processing Manual Chapter 23 Section 20.9.1.- This edit utilizes the Centers for Medicare and Medicaid Services' (CMS) Medicare Claims Processing Manual to identify an item or service that is expected to be denied as not reasonable and necessary. This edit will fire on all claim lines submitted with a GZ modifier.
201	Ambulance Modifiers	Centers for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual, Chapter 15, 30 - General Billing Guidelines, Page 25.- The edit uses the Centers for Medicare and Medicaid Services' (CMS) Medicare Claims Processing Manual to identify when appending a modifier to an Ambulance HCPCS code is appropriate. This edit will fire on all Medicaid claim lines containing an ambulance code identified in the CMS Ambulance HCPCS Codes system list and there is not an ambulance modifier appended that has a first character of D, E, G, H, I, J, N, P, R or S and a second character of D, E, G, H, I, J, N, P, R, S or X.
203	Medicaid Postoperative Unrelated Service By Provider With Different Diagnosis	Medicare Claims Processing Manual, Chapter 12, Section 30.6.3; Section 30.6.6.A; Section 30.6.9.2.D; Section 40.1.B; Section 40.2.A.7; Section 40.3.B; Section 40.4.A.- The edit utilizes the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS), the CMS Medicare Claims Processing Manual, and National Correct Coding Initiative (NCCI) Policy Manual for Medicaid Services to identify claim lines that contain a procedure code which has global surgical follow up days and an Evaluation and Management (E/M) service has been submitted in history during the global period by the same provider, with a different diagnosis code
206	Medicaid Intra-Operative Care Only Reduction--Modifier 54	National Physician Fee Schedule Relative Value File/ IOM 100-04, Chapter 12, Section 40.4.B, Adjudication of Claims for Global Surgeries (Rev. 1, 10-01-03)- This edit will fire on all claim lines when the modifier 54 is present and a number, other than zero, is listed in the Intra Op column in the NPFS.
207	Medicaid Post-Operative Care Only Reduction	National Physician Fee Schedule Relative Value File/ IOM 100-04, Chapter 12, Section 40.4.B, Adjudication of Claims for Global Surgeries (Rev. 1, 10-01-03)- This edit will fire on all claim lines when the modifier 55 is present and a number, other than zero, is listed in the Post Op column in the NPFS.
208	Medicaid Pre-Operative Care Only Reduction	- National Physician Fee Schedule Relative Value File/ IOM 100-04, Chapter 12, Section 40.4.B, Adjudication of Claims for Global Surgeries (Rev. 1, 10-01-03)- This edit will fire on all claim lines when the modifier 56 is present and a number, other than zero, is listed in the Pre Op column in the NPFS.
215	Medicaid Postoperative Unrelated Service By Provider History	Medicare Claims Processing Manual, Chapter 12, Section 30.6.3; Section 30.6.6- The edit identifies Medicaid claim lines that contain a procedure code which has a global follow-up period and an Evaluation and Management (E/M) service has been submitted without an appropriate modifier in history during the global follow-up period by the same provider, with the same diagnosis code.
270	Medicaid Postoperative Unrelated Service By Provider	Medicare Claims Processing Manual, Chapter 12, Section 30.6.3; Section 30.6.6.A; Section 30.6.9.2.D; Section 40.1.B; Section 40.2.A.7; Section 40.3.B; Section 40.4.A - The edit identifies claim lines that contain E/M code(s) submitted without modifier 24 when billed with the same primary diagnosis code during the global period of a previously submitted procedure code by the same provider.
301	Ambulance Revenue Code Rule	Medicare Claims Processing Manual, Chapter 15 - Ambulance, Section 30.2.1 - A/MAC Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation- The edit will fire when an outpatient ambulance claim does not contain both an ambulance service code and an ambulance mileage code on the same claim, for the same patient, on the same date service. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).

312	Anesthesia Secondary Procedure with Modifier Override	CPT Assistant; CMS Policy; American Association of Anesthesiologists (ASA)- The edit identifies multiple anesthesia codes billed by the same provider for the same date of service, and indicates any/all secondary anesthesia procedures. Therefore, only the anesthesia code with the highest base unit value is allowed.
364	Ambulance Mileage Requires HCPCS Code Rule	Medicare Claims Processing Manual, Chapter 15 - Ambulance, Section 30.2.1 - A/MAC Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation- The edit will fire when outpatient ambulance claim does not contain both an ambulance service code and an ambulance mileage code on the same claim, for the same patient, on the same date service. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
368	Medicaid E/M Without Appropriate Modifiers - Major	Chapter 12, Section 30.6.6; Section 40, National Physician Fee Schedule Relative Value File- This edit identifies claim lines where an E/M code is billed without the appropriate modifiers for a major procedure.
374	Medicaid E/M Without Appropriate Modifiers - Major (History)	Chapter 12, Section 30.6.6; Section 40, National Physician Fee Schedule Relative Value File- The edit identifies claim lines that contain an E/M code in history that should be billed with an appropriate modifier when billed on the same day or day before a major procedure.
393	Medicaid E/M Without Appropriate Modifier - Minor	Chapter 12, Section 30.6.6; Section 40, National Physician Fee Schedule Relative Value File- The edit identifies claim lines where an E/M code is billed without the appropriate modifier for a minor procedure. The edit looks for history lines on both a current claim and history claims to identify minor procedure codes billed for the same date of service as the E/M code.
396	Medicaid E/M Without Appropriate Modifier - Minor (History)	Chapter 12, Section 30.6.6; Section 40, National Physician Fee Schedule Relative Value File- The edit identifies claim lines that contain an E/M code in history that should be billed with an appropriate modifier when billed on the same day or day before a minor procedure.
639	ASC POS Code 24 Not Typical for Procedure	CMS Chapter 14 - Ambulatory Surgical Centers, Section 50- The Place of Service (POS) code is 24 for procedures performed in an ASC. The contractors shall assign TOS code “F” to codes billed by specialty 49 for Place of Service 24.
643	ASC Never Events Rule	CMS Claim Processing Manual, Chapter 32, Section 230- Ambulatory Surgical Centers. Providers are required to append one of the following applicable HCPCS modifiers to all lines related to the erroneous surgery(s):• PA: Surgery Wrong Body Part • PB: Surgery Wrong Patient • PC: Wrong Surgery on Patient
672	ASC Inappropriate Gender for Procedure Rule	CMS Claim Processing Manual, Chapter 32, Section 240 - Special Instructions for Certain Claims with a Gender/Procedure Conflict, CMS Transmittal R1877CP- The edit identifies claim lines where the listed procedure code is not typically performed for a person of the patient's gender. This gender specific edit is overridden when a procedure code billed with the KX modifier and allows the service to continue normal processing of the claim. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
677	ASC Inappropriate Gender for Diagnosis Rule	CMS Claim Processing Manual, Chapter 32, Section 240 - Special Instructions for Certain Claims with a Gender/Procedure Conflict, CMS Transmittal R1877CP- The edit will fire on a claim where the listed diagnosis code is not typical for the patient's gender. This gender specific edit is overridden when the KX modifier is billed and allows the claim to continue its normal processing of the claim. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
1006	ASC Missing Patient Gender Rule	CMS Claim Processing Manual, Chapter 4, Section 40.3- The Medicare Claims Processing Manual - Chapter 4 - Part B Hospital Including Inpatient Hospital Part B and OPPS, Section 40.3 – Invalid Sex states the sex code reported must be either M (male) or F (female).

1098	ASC Deleted Procedure Code Rule	CMS Claim Processing Manual, Chapter 14, Section 60.3, January 2013 ASC FS Addendum AA_BB - Payment Indicator D5- The edit will fire on a claim line when a CPT/HCPCS code is submitted that has a payment indicator of D5 on the Ambulatory Surgical Center Fee Schedule (ASCFS). This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
1108	ASC Bilateral Modifier 50 Rule	CMS MedLearn Matters MLN Article SE0742, ASC FAQs- Bilateral procedures should be reported as a single unit on two separate lines or with "2" in the units field on one line, in order for both procedures to be paid. While use of the -50 modifier is not prohibited according to Medicare billing instructions, the modifier is not recognized for payment purposes and if used, may result in incorrect payment to ASCs.
1169	Ambulance Required Modifiers for Ambulance Service HCPCS Code Rule	Medicare Claims Processing Manual, Chapter 15 - Ambulance, Section 30.2.1 - A/MAC Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation- The edit will fire when a claim line contain an ambulance origin and destination modifier without modifier QM or QN that describe whether the service was provided under arrangement or directly. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
1231	Point of Origin for Admission is Required on all Institutional Claims with the Exception of 014X	Transmittal R2250 CP- The edit will fire when a claim is submitted with a Point Of Origin code that is invalid. This is based on requirements from the National Uniform Billing Committee (NUBC) and the Centers for Medicare and Medicaid Services (CMS).
1231	Point of Origin for Admission is Required on all Institutional Claims with the Exception of 014X	Transmittal R2250 CP- The edit will fire when a claim is submitted with a Point Of Origin code that is invalid. This is based on requirements from the National Uniform Billing Committee (NUBC) and the Centers for Medicare and Medicaid Services (CMS).
1452	ASC Terminated Procedure Reduction	CMS Claim Processing Manual Chapter 14, Section 40.4- The edit will fire on a claim line when modifier 52 or 73 is submitted on the Ambulatory Surgical Center (ASC) claim. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
1484	ASC Incorrect Billing of Modifier FB or FC	CMS Claim Processing Manual Chapter 14, Section 40.8, CMS Transmittal R2626CP, dated December 28, 2012- The edit will fire on a claim line when modifier FB or FC is submitted on a CPT/HCPCS code other than a device intensive procedure or if both modifiers are submitted on a single claim line. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
1522	Medicaid Post-Op Surgery By Provider	CMS National Physician Fee Schedule- Surgical procedures with a global period which should not be billed within the global period of another procedure without an appropriate modifier.
1586	New Patient Code for Established Patient Rule Ophthalmology	CMS Outpatient Prospective Payment System Visit Codes FAQs, Evaluation and Management Services Guide- This rule identifies when the patient history indicates the patient has been seen by the same provider within 3 years of the current claim line's beginning date of service. An established patient evaluation and management (E/M) code should be reported instead of the new patient E/M code.
2139	ASC Incorrect Billing of Modifier FB and FC	CMS Claim Processing Manual Chapter 14, Section 40.8, CMS Transmittal R2626CP, dated December 28, 2012- The edit will fire on a claim line when modifier FB or FC is submitted on a CPT/HCPCS code other than a device intensive procedure or if both modifiers are submitted on a single claim line. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
2142	Ambulance Required Service Provided Under Arrangement or Directly Modifier Rule	Medicare Claims Processing Manual, Chapter 15 - Ambulance, Section 30.2.1 - A/MAC Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation- The edit will fire when a claim line contain an ambulance origin and destination modifier without modifier QM or QN that describe whether the service was provided under arrangement or directly. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).

2143	Ambulance Required Modifiers for Ambulance Mileage HCPCS Code Rule	Medicare Claims Processing Manual, Chapter 15 - Ambulance, Section 30.2.1 - A/MAC Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation- The edit will fire when a claim line contain an ambulance origin and destination modifier without modifier QM or QN that describe whether the service was provided under arrangement or directly. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
2169	Modifier GK	National DMEPOS Fee Schedule Relative Value File, Calendar Year 2017; Chapter 1, Section 60.4.2; Chapter 20, Section 120.- When a claim is submitted with the modifier GK, CMS requires that another claim line have either the modifier GA or GZ. The modifier GK cannot be submitted alone.
2169	Modifier GK	National DMEPOS Fee Schedule Relative Value File, Calendar Year 2017; Chapter 1, Section 60.4.2; Chapter 20, Section 120.- When a claim is submitted with the modifier GK, CMS requires that another claim line have either the modifier GA or GZ. The modifier GK cannot be submitted alone.
2511	Ambulance Payment Reduction Non-Emergency BLS Renal Dialysis Facilities for Ambulance Service HCPCS Code	CMS Claims Processing Manual Chapter 15 - Ambulance Section 20.6, CMS Transmittal R4017CP- The edit will fire when claim lines containing HCPCS codes A0428 and A0425 with modifier code "G" or "J" in either the first position (origin code) or second position (destination code) within the two-digit ambulance modifier code. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
2678	Ambulance Payment Reduction for Non-Emergency Basic Life Support (BLS) Transports to and from Renal Dialysis Facilities	Centers for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual, Chapter 15, 30 - General Billing Guidelines, Page 25.- The edit uses the Centers for Medicare and Medicaid Services (CMS) guidelines found in the Medicare Claims Processing Manual to identify when procedure codes A0425 and A0428 are billed with an origin/destination modifier of ''G'' or ''J''.
2730	26/TC Split When Global Procedure is Found in History	CMS Policy- The 26TC edit will fire on the claim line when a global service is already submitted and there is another line with modifier 26/TC on the same date of service. The history as well as the current line will be reviewed for the appropriate use of modifier 26/TC. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS).
2756	Ambulance Payment Reduction Non-Emergency BLS Renal Dialysis Facilities for Ambulance Mileage HCPCS Code	CMS Claims Processing Manual Chapter 15 - Ambulance Section 20.6, CMS Transmittal R4017CP- Effective for claims with dates of service on and after October 1, 2013 through September 30, 2018, the 10% reduction will be calculated and applied to HCPCS code A0428 when billed with modifier code “G” or “J”. The reduction will also be applied to any mileage billed in association with a non-emergency transport of a beneficiary with ESRD to and from renal dialysis treatment. BLS mileage is identified by HCPCS code A0425.
2776	ICD-10-CM Primary Diagnosis Only	ICD-10-CM- Per ICD-10-CM Official Guidelines for Coding and Reporting certain Z codes/categories may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined.
2776	ICD-10-CM Primary Diagnosis Only	ICD-10-CM- Per ICD-10-CM Official Guidelines for Coding and Reporting certain Z codes/categories may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined.
2803	Inappropriate Reporting of Terminated Bilateral Procedure	Integrated OCE Specifications; Medicare Claims Processing Manual - Chapter 4, "Part B Hospital Including Inpatient Hospital Part B and OPPS" Section 231.2-This rule will identify terminated HCPCS procedure codes with a modifier of 50 (bilateral). When a procedure is terminated, the first procedure that was planned should be reported with an appropriate modifier. Any other procedure should

2804	Inappropriate Reporting of Terminated Procedure	Integrated OCE Specifications; Medicare Claims Processing Manual - Chapter 4, "Part B Hospital Including Inpatient Hospital Part B and OPPS" Section 231.2- This rule will identify when a procedure is terminated, the first procedure that was planned should be reported with an appropriate modifier. Any other procedure should not be reported. Terminated procedures are identified with modifier 52 and 73.
2805	Injection Service - History	National Physician Fee Schedule Relative Value File- The edit utilizes the Centers for Medicare and Medicaid Services' (CMS) Physician Fee Schedule (MPFS) to identify CPT® codes with the indicator "T" in the Status
2811	Patient Discharge Status Missing	National Uniform Billing Committee (NUBC), Official UB-04 Data Specifications Manual 2021- The edit will fire when an outpatient claim is submitted with a missing or invalid Patient Status Code. When an invalid discharge status is reported, the patient is presumed to have been discharged alive for the purpose of performing the non-specific principal diagnosis check. This is based on requirements from the National Uniform Billing Committee (NUBC).
2812	Patient Discharge Status Invalid	National Uniform Billing Committee (NUBC), Official UB-04 Data Specifications Manual 2012- The edit will fire when an outpatient claim is submitted with a missing or invalid Patient Status Code. When an invalid discharge status is reported, the patient is presumed to have been discharged alive for the purpose of performing the non-specific principal diagnosis check. This is based on requirements from the National Uniform Billing Committee (NUBC).
2816	Medicaid Team Surgeon Rule - Modifier 66	Medicare Claims Processing Manual Chapter 12, Section 40.8 B- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code for the team surgery modifier 66. The edit will fire when a modifier 66 is appended to a procedure code with an indicator of 1 or 2 in the team surgery column of the NPFS and there is another claim in history for the same procedure and same date of service for a different provider, without modifier 66 appended.
2817	Medicaid Team Surgeon Rule - Modifier 66 - History	Medicare Claims Processing Manual Chapter 12, Section 40.8 B- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code for the team surgery modifier 66. The edit will fire when a modifier 66 is appended to a procedure code with an indicator of 1 or 2 in the team surgery column of the NPFS and there is another claim in history for the same procedure and same date of service for a different provider, without modifier 66 appended.
2818	Medicaid Co-Surgeon Rule - Modifier 62 - History	Medicare Claims Processing Manual Chapter 12, Section 40.8- The edit will fire when a modifier 62 is appended to a procedure code(s) and there is another claim for the same procedure and same date of service for a different provider, without modifier 62 appended.
2819	Medicaid Co-Surgeon Rule - Modifier 62	Medicare Claims Processing Manual Chapter 12, Section 40.8- The edit will fire when a modifier 62 is appended to a procedure code(s) and there is another claim for the same procedure and same date of service for a different provider, without modifier 62 appended.
2826	Manifestation Code Not Allowed as Principal Diagnosis	CMS Integrated OCE (IOCE) Specifications V21.2, CMS Transmittal R2763CP- The edit is triggered when an outpatient claim contains a diagnosis code that is classified as a manifestation code in the principal diagnosis field on a claim. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
2831	Medicaid Post-Op Surgery By Provider - History	CMS National Physician Fee Schedule or State Specified Global Value- The Medicaid global follow-up edit for surgical procedures identifies claim lines containing surgical procedure codes submitted within the follow-up days of another surgical procedure without appropriate modification.

2840	Inpatient Facility Discharge Date Missing	CMS Transmittal R2627CP- The edit will fire on an inpatient claim when the discharge date is missing. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
2843	Unlisted Procedure Code Rule	CMS Transmittal R1657CP, CMS MLN Matters SE1138, CMS Transmittal R3866CP- The edit will fire when an outpatient claim contains a non-specific procedure code. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).CMS Transmittal R1657CP, January 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS), dated December 31, 2008 states an unlisted HCPCS code represents an item, service, or procedure for which there is no specific CPT or Level II alphanumeric HCPCS code.
2934	Facility Medicare ICD-9 Code Rule	CMS Transmittal SE1408, SE1410- DDR Pattern 2934 is triggered when an inpatient claim contains an ICD-9 code type and the "through" date of service is greater than September 30, 2015.
2935	Facility Medicare ICD-10 Code Outpatient Split Claim Rule	CMS Transmittal SE1408, SE1410- DDR Pattern 2935 is triggered when an outpatient claim contains an ICD-10 code type and the "from" date is less than or equal to September 30, 2015 and the "through" date is greater than or equal to October 1, 2015.
2936	Facility Medicare ICD-10 Code Rule	CMS Transmittal SE1408, SE1410- DDR Pattern 2936 is triggered when an inpatient claim contains an ICD-10 code type and the "through" date of service is prior to October 1, 2015.
2962	Injection Procedure not Reported with Reported Supply	CPT; Interpretation of CMS Policy- The edit identifies line items where a drug or substance is reported in the physician's office or the patient's home and an injection or infusion procedure code was not reported.
3429	Possible Duplicate Line by Provider with Procedure Exclusions SystemList	Validation Edit- This is a possible duplicate reporting of a procedure code, with the same modifier(s), if present, performed by the same provider on the same date of service.
3662	Repeat Radiology Requires Repeat Modifier	CPT- The edit fires on a claim line when a repeat radiology procedure does not have the appropriate repeat modifier appended. Modifier 76 is used if the same provider is performing the repeat procedure or service and modifier 77 is used if a different provider is performing the repeat procedure or service.
3774	Inappropriate Use of Repeat Modifier 91 with Lab Codes-Professional Component	CPT- The edit fires when a lab procedure is submitted with modifier 91 signifying the procedure to be a repeat of the same procedure done previously during the day, yet review of claim history shows that there was no original same procedure submitted for that date of service.
3859	Medicaid Venipuncture Policy	Medicare Claim Processing Manual; Chapter 16, Section 60.1- The edit identifies when a laboratory test is performed within the appropriate places of service (office, home, independent laboratory or skilled nursing facility) and a blood collection procedure code is not reported on the same date of service. This edit will prompt review for possible inclusion of a blood collection code.
3876	Never Events	CMS Medicare Claims Processing Manual; Medicare Benefit Policy Manual (BPM); National Coverage Determinations (NCD)- The edit uses the Centers for Medicare and Medicaid Services' (CMS) Claims Processing Manual, Benefit Policy Manual (BPM), and National Coverage Determinations (NCD) to identify services performed erroneously; wrong procedure, wrong body part, or wrong patient.
3984	ASC Skin Substitute Application Procedure Without Appropriate Skin Substitute Product Code	CMS Transmittal R2849CP- The Skin Substitute edit fires when a skin substitute application procedure code is submitted without one of the specified skin substitute product code(s) for the same patient, on the same date of service and the same provider. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).

3997	New Patient Code for Established Patient Rule	CMS Outpatient Prospective Payment System Visit Codes FAQs, Evaluation and Management Services Guide- This rule identifies when the patient history indicates the patient has been seen by the same provider within 3 years of the current claim line's beginning date of service. An established patient evaluation and management (E/M) code should be reported instead of the new patient E/M code.
4006	Inappropriate Modifier Combination	Interpretation of CMS Policy, Interpretation of CPT, Interpretation of HCPCS- The edit identifies CPT® and/or HCPCS modifier combinations that are inappropriate when submitted together on the same claim line.
4006	Inappropriate Modifier Combination	Interpretation of CMS Policy, Interpretation of CPT, Interpretation of HCPCS- The edit identifies CPT® and/or HCPCS modifier combinations that are inappropriate when submitted together on the same claim line.
4006	Inappropriate Modifier Combination	Interpretation of CMS Policy, Interpretation of CPT, Interpretation of HCPCS- The edit identifies CPT® and/or HCPCS modifier combinations that are inappropriate when submitted together on the same claim line.
4239	Missing Patient ID	Validation Edit- This rule identifies claim lines that have a missing Patient ID.
4239	Missing Patient ID	Validation Edit- This rule identifies claim lines that have a missing Patient ID.
4239	Missing Patient ID	Validation Edit- This rule identifies claim lines that have a missing Patient ID.
4246	Missing Patient Gender	Validation- The rule identifies a missing or invalid patient gender.
4246	Missing Patient Gender	Validation- The rule identifies a missing or invalid patient gender.
4265	Third Party Liability	ICD-9-CM; ICD-10-CM; CMS Policy; Centers for Disease Control and Prevention (CDC); American Academy of Family Physicians (AAFP)- The Third Party Liability (TPL) designation is assigned to International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis codes that may involve third-party liability issues and/or possible coordination and/or subrogation of benefits.
4265	Third Party Liability	ICD-9-CM; ICD-10-CM; CMS Policy; Centers for Disease Control and Prevention (CDC); American Academy of Family Physicians (AAFP)- The Third Party Liability (TPL) designation is assigned to International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis codes that may involve third-party liability issues and/or possible coordination and/or subrogation of benefits.
4265	Third Party Liability	ICD-9-CM; ICD-10-CM; CMS Policy; Centers for Disease Control and Prevention (CDC); American Academy of Family Physicians (AAFP)- The Third Party Liability (TPL) designation is assigned to International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis codes that may involve third-party liability issues and/or possible coordination and/or subrogation of benefits.
4272	Modifier Not Appropriate	CMS Policy; CPT; American Medical Association (AMA)- The edit fires on a claim line that does not have the appropriate modifier appended for use with a particular CPT® or HCPCS procedure code.
4272	Modifier Not Appropriate	CMS Policy; CPT; American Medical Association (AMA)- The edit fires on a claim line that does not have the appropriate modifier appended for use with a particular CPT® or HCPCS procedure code.
4282	Medicare ICD9 Code Rule	CMS transmittal R9500TN- The edit utilizes the Centers for Medicare and Medicaid Services (CMS) ICD-10-CM and ICD-9-CM manuals to identify ICD-9-CM codes that are submitted after September 30, 2015.
4282	Medicare ICD9 Code Rule	CMS transmittal R9500TN- The edit utilizes the Centers for Medicare and Medicaid Services (CMS) ICD-10-CM and ICD-9-CM manuals to identify ICD-9-CM codes that are submitted after September 30, 2015.

4291	Facility Medicare ICD-9 Code Rule	CMS Transmittal SE1408, SE1410- The edit is triggered when an outpatient claim contains an ICD-9 code type and the ''through'' date of service is greater than September 30, 2015. This edit is also triggered when an inpatient claim contains an ICD-9 code type and the ''through'' date of service is greater than September 30, 2015.
4295	Facility Medicare ICD-10 Code Rule	CMS Transmittal SE1408, SE1410- The edit is triggered when an outpatient claim contains an ICD-10 code type and the "through" date of service is prior to October 1, 2015.
4310	New Patient Code for Established Patient	CPT; CMS Policy; CPT Assistant; American College of Chest Physicians (ACCP); American Medical Association (AMA)- This rule identifies when the patient history indicates the patient has been seen by the same provider within 3 years of the current claim line's beginning date of service. An established patient evaluation and management (E/M) code should be reported instead of the new patient E/M code.
4311	New Patient Code in History for Established Patient	CPT; CMS Policy; CPT Assistant; American College of Chest Physicians (ACCP); American Medical Association (AMA)- This rule identifies when the patient history indicates the patient has been seen by the same provider within 3 years of the current claim line's beginning date of service. An established patient evaluation and management (E/M) code should be reported instead of the new patient E/M code.
4324	ASC Place of Service Code 24 Missing	CMS Chapter 14 - Ambulatory Surgical Centers, Section 50- The Place of Service (POS) code is 24 for procedures performed in an ASC. The contractors shall assign TOS code “F” to codes billed by specialty 49 for Place of Service 24.
4372	Inappropriate Modifier To Diagnosis Combination	ICD-10-CM- The edit identifies modifier to diagnosis (ICD-10-CM) relationships which indicate a discrepancy with the laterality and/or anatomical site between the diagnosis code and modifier when submitted together on the same claim line.
4372	Inappropriate Modifier To Diagnosis Combination	ICD-10-CM- The edit identifies modifier to diagnosis (ICD-10-CM) relationships which indicate a discrepancy with the laterality and/or anatomical site between the diagnosis code and modifier when submitted together on the same claim line.
4428	Bilateral Payment Adjustment 50	Medicare Claims Processing Manual, Chapter 4, 20.6.2 - Use of Modifiers -50, -LT, and -RT, Medicare Claim Processing Manual Chapter 23, Section 50.6 Physician Fee Schedule Payment Policy Indicator File Record Layout- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to identify procedures where typical payment adjustments for bilateral procedures do not apply.
4438	Bilateral Payment Adjustment LT/RT	Medicare Claims Processing Manual, Chapter 4, 20.6.2 - Use of Modifiers -50, -LT, and -RT, Medicare Claim Processing Manual Chapter 23, Section 50.6 Physician Fee Schedule Payment Policy Indicator File Record Layout- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to identify procedures where typical payment adjustments for bilateral procedures do not apply.
4476	Supply Code not Reported with Reported Injection Procedure	CPT Assistant; Interpretation of CMS Policy- The edit identifies line items where an injection or infusion procedure is reported in the physician’s office or the patient’s home and the drug or substance administered was not reported. The edit is inclusive of any procedure code identified as an injection or infusion, as well as procedure codes that may include an injection or aspiration and “with or without” injection in the code description.

4477	Inappropriate Specification of Bilateral Procedure Same Claim	Integrated OCE (IOCE) CMS Specifications- When an inherently bilateral procedure code with more than one unit for the same date of service it will receive edit 017. This edit applies unless modifier 76 or 77 is submitted.
4478	Inappropriate Specification of Bilateral Procedure Same Claim	Integrated OCE (IOCE) CMS Specifications- When an inherently bilateral procedure code occurs on more than one line for the same date of service it will receive edit 017. This edit applies unless modifier 76 or 77 is submitted on the second or subsequent line.
4499	Inappropriate Use of Repeat Modifier 91 with Lab Codes-Technical Component	CPT- The edit fires when a lab procedure is submitted with modifier 91 signifying the procedure to be a repeat of the same procedure done previously during the day, yet review of claim history shows that there was no original same procedure submitted for that date of service.
4500	Inappropriate Use of Repeat Modifier 91 with Lab Codes-Global	CPT- The edit fires when a lab procedure is submitted with modifier 91 signifying the procedure to be a repeat of the same procedure done previously during the day, yet review of claim history shows that there was no original same procedure submitted for that date of service.
4516	Missing Diagnosis Code	Validation Edit- This rule identifies line items with no diagnosis code listed in the primary diagnosis field.
4516	Missing Diagnosis Code	Validation Edit- This rule identifies line items with no diagnosis code listed in the primary diagnosis field.
4516	Missing Diagnosis Code	Validation Edit- This rule identifies line items with no diagnosis code listed in the primary diagnosis field.
4519	Deleted diagnosis code	Validation Edit- The rule identifies claim lines where the diagnosis code is valid and deleted.
4519	Deleted diagnosis code	Validation Edit- The rule identifies claim lines where the diagnosis code is valid and deleted.
4519	Deleted diagnosis code	Validation Edit- The rule identifies claim lines where the diagnosis code is valid and deleted.
4525	Invalid Procedure Code	CMS Integrated OCE (IOCE) Specifications Version 15.2- The system will analyze each HCPCS code on a claim and determine if the code is valid for the From date of service on the claim.
4527	Repeat Laboratory Procedure Requires Modifier-Professional Component	CPT Assistant- The edit fires on a claim line when a repeat test or procedure is performed on the same date of service, which requires a repeat lab modifier 59 or 91, but is inappropriately submitted without a 59 or 91 modifier.
4528	Repeat Laboratory Procedure Requires Modifier-Technical Component	CPT Assistant- The edit fires on a claim line when a repeat test or procedure is performed on the same date of service, which requires a repeat lab modifier 59 or 91, but is inappropriately submitted without a 59 or 91 modifier.
4529	Repeat Laboratory Procedure Requires Modifier-Global	CPT Assistant- The edit fires on a claim line when a repeat test or procedure is performed on the same date of service, which requires a repeat lab modifier 59 or 91, but is inappropriately submitted without a 59 or 91 modifier.
4530	Invalid Procedure Code	Validation- All procedure codes are validated to determine whether the procedure code is present in the system and valid. If the procedure code is missing or invalid the CPT edit is fired.
4530	Invalid Procedure Code	Validation- All procedure codes are validated to determine whether the procedure code is present in the system and valid. If the procedure code is missing or invalid the CPT edit is fired.
4531	Place of Service	CPT; HCPCS; CMS Policy- This rule identifies claim lines where the place of service reported is not typical with the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) procedure code reported.
4531	Place of Service	CPT; HCPCS; CMS Policy- This rule identifies claim lines where the place of service reported is not typical with the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) procedure code reported.
4535	Invalid Modifier	CMS Integrated OCE (IOCE) Specifications Version 19.2- The modifier is not in the list of valid modifier entries and the revenue code is not 540. Lines submitted on a 32x bill type (HHA) with revenue code 0023 do not have edit 22 applied.

4538	Multiple Assistant Surgery	American College of Surgeons Assistants at Surgery Study- The rule identifies a claim line containing a procedure code appended with an assistant surgeon modifier (80, 81, 82, AS), when another current or historical claim line includes the same procedure with an assistant surgeon modifier, for the same date of service (DOS), submitted with a different provider identification number. In most cases, only one surgical assistant is reported per procedure.
4542	Missing Patient's Date of Birth	Validation Edit- This rule identifies if the patient's date of birth is missing or invalid.
4542	Missing Patient's Date of Birth	Validation Edit- This rule identifies if the patient's date of birth is missing or invalid.
4542	Missing Patient's Date of Birth	Validation Edit- This rule identifies if the patient's date of birth is missing or invalid.
4543	Missing or Invalid Date of Service	Validation Edit- The rule identifies claim lines that have a missing or invalid Beginning or Ending Date Of Service (DOS). If either the Beginning DOS or the Ending DOS is missing or invalid, the line is dropped and the BDS flag is fired.
4543	Missing or Invalid Date of Service	Validation Edit- The rule identifies claim lines that have a missing or invalid Beginning or Ending Date Of Service (DOS). If either the Beginning DOS or the Ending DOS is missing or invalid, the line is dropped and the BDS flag is fired.
4543	Missing or Invalid Date of Service	Validation Edit- The rule identifies claim lines that have a missing or invalid Beginning or Ending Date Of Service (DOS). If either the Beginning DOS or the Ending DOS is missing or invalid, the line is dropped and the BDS flag is fired.
4563	Procedure Age	CPT, HCPCS, FDA, AAP, CMS Policy, ICD-10-CM, AMA- The edit identifies line items where the listed procedure code is not typically performed for a person of the patient's age.
4563	Procedure Age	CPT, HCPCS, FDA, AAP, CMS Policy, ICD-10-CM, AMA- The edit identifies line items where the listed procedure code is not typically performed for a person of the patient's age.
4563	Procedure Age	CPT, HCPCS, FDA, AAP, CMS Policy, ICD-10-CM, AMA- The edit identifies line items where the listed procedure code is not typically performed for a person of the patient's age.
4564	Diagnosis Age	ICD-10-CM, ICD-9-CM, CPT, HCPCS, AMA, Specialty Societies- The edit identifies line items where the listed diagnosis code(s) is not typically performed for a person of the patient's age.
4564	Diagnosis Age	ICD-10-CM, ICD-9-CM, CPT, HCPCS, AMA, Specialty Societies- The edit identifies line items where the listed diagnosis code(s) is not typically performed for a person of the patient's age.
4595	Nonspecific Diagnosis Code	Validation Edit, ICD-9-CM, ICD-10-CM- The rule indicates that the diagnosis code is specified in the system as a non-specific/incomplete diagnosis code.
4595	Nonspecific Diagnosis Code	Validation Edit, ICD-9-CM, ICD-10-CM- The rule indicates that the diagnosis code is specified in the system as a non-specific/incomplete diagnosis code.
4595	Nonspecific Diagnosis Code	Validation Edit, ICD-9-CM, ICD-10-CM- The rule indicates that the diagnosis code is specified in the system as a non-specific/incomplete diagnosis code.
4625	Wrong Procedure Performed Principal Diagnosis	CMS Claim Processing Manual Chapter 32, Section 230, CMS Definitions of Medicare Code Edits Version 31.0, Version 31R- The edit is triggered when an inpatient claim contains a designated ICD-10-CM principal diagnosis code which indicates that a wrong procedure was performed on the patient. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
4626	Wrong Procedure Performed Other Diagnosis	CMS Claim Processing Manual Chapter 32, Section 230, CMS Definitions of Medicare Code Edits Version 31.0, Version 31R- The edit is triggered when an inpatient claim contains a designated ICD-10-CM other diagnosis code which indicates that a wrong procedure was performed on the patient. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).

4640	Documentation Needed with Modifier 59	AMA- Guidelines in Coding with Modifiers, published by the American Medical Association (AMA) states, "Documentation needs to be specific to the distinct procedure or service and clearly identified in the medical record." If modifier 59 is appended to a procedure code on a claim, the D59 flag fires.
4640	Documentation Needed with Modifier 59	AMA- Guidelines in Coding with Modifiers, published by the American Medical Association (AMA) states, "Documentation needs to be specific to the distinct procedure or service and clearly identified in the medical record." If modifier 59 is appended to a procedure code on a claim, the D59 flag fires.
4640	Documentation Needed with Modifier 59	AMA- Guidelines in Coding with Modifiers, published by the American Medical Association (AMA) states, "Documentation needs to be specific to the distinct procedure or service and clearly identified in the medical record." If modifier 59 is appended to a procedure code on a claim, the D59 flag fires.
4653	Units Greater Than One for Bilateral Procedure Billed With Modifier 50	CMS Transmittal R2763CP- Any code on the Conditional or Independent bilateral list is submitted with modifier 50 and units of service are greater than one on the same line.
4688	Manifestation Code as Principal Diagnosis	CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 31.0, Version 31R- The edit is triggered when an inpatient claim contains a diagnosis code that is classified as a Manifestation Code in the principal diagnosis field on a claim. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
4690	Duplicate of Principal Diagnosis Code	CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 31.0, Version 31R- The edit is triggered when an inpatient claim contains a duplicate of the principal diagnosis. This edit looks at any secondary diagnosis code that is the same code as the principal diagnosis. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS)
4691	Duplicate of Other Diagnosis Code	CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 31.0, Version 31R- The edit is triggered when an inpatient claim contains a duplicate of other secondary diagnosis. This edit looks at any secondary diagnosis code that is the same code as other secondary diagnosis. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
4712	Invalid Date	CMS Integrated Outpatient Code Editor - Version 15.2- The edit will fire when the service date falls outside the range of the From and Through dates.
4713	Deleted Procedure Code	Validation- The rule identifies Claim Lines where the procedure code is enabled, valid and deleted.
4713	Deleted Procedure Code	Validation- The rule identifies Claim Lines where the procedure code is enabled, valid and deleted.
4731	Invalid Revenue Code	CMS Integrated Outpatient Code Editor - Version 15.2- This rule will identify missing or invalid revenue codes for the date of service.
4733	Revenue Center Requires HCPCS	Integrated Outpatient Code Editor V18.0, CMS Claim Processing Manual Chapter 4 Section 20.1- The edit evaluates claim lines for missing HCPCS codes. This edit will fire on claim lines with charges, a revenue code that requires a HCPCS code (not packaged), with no HCPCS codes. This edit is based on a requirement from the Centers for Medicare and Medicaid Services (CMS).
4817	Missing Service Date	CMS Integrated Outpatient Code Editor - Version 15.2- The edit will fire when the service date is missing on a claim line.
4837	Telehealth Place of Service	CPT, CMS Policy- This rule identifies procedure codes reported with Place of Service 02, Telehealth, that are not contained in the CPT® codebook Appendix P nor in the Centers for Medicare and Medicaid Services (CMS) List of Telehealth Services found on the CMS.gov website.
4918	Possible Duplicate Line by Different Provider	Validation Edit- This is a possible duplicate reporting of a procedure code, with the same modifier(s), if present, performed by a different provider of the same specialty and group on the same date of service.

4918	Possible Duplicate Line by Different Provider	Validation Edit- This is a possible duplicate reporting of a procedure code, with the same modifier(s), if present, performed by a different provider of the same specialty and group on the same date of service.
5075	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code New Patient	CMS Integrated OCE (IOCE) Specifications V15.3, CMS Transmittal R1395OTN- The edit will fire when a claim with bill type 077x is submitted with one on the required FQHC payment codes and without a required FQHC qualifying visit code. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
5080	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code Established Patient	CMS Integrated OCE (IOCE) Specifications V15.3, CMS Transmittal R1395OTN- The edit will fire when a claim with bill type 077x is submitted with one on the required FQHC payment codes and without a required FQHC qualifying visit code. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
5081	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code IPPE/AWV	CMS Integrated OCE (IOCE) Specifications V15.3, CMS Transmittal R1395OTN- The edit will fire when a claim with bill type 077x is submitted with one on the required FQHC payment codes and without a required FQHC qualifying visit code. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS)
5082	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code Mental Health New Patient	CMS Integrated OCE (IOCE) Specifications V15.3, CMS Transmittal R1395OTN- The edit will fire when a claim with bill type 077x is submitted with one on the required FQHC payment codes and without a required FQHC qualifying visit code. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
5083	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code Mental Health Established Patient	CMS Integrated OCE (IOCE) Specifications V15.3, CMS Transmittal R1395OTN- The edit will fire when a claim with bill type 077x is submitted with one on the required FQHC payment codes and without a required FQHC qualifying visit code. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
5098	Missing or Invalid Type of Bill - Outpatient	Official UB-04 Data Specifications Manual 2015, CMS Claims Processing Manual Ch.25 Section 75- A code indicating the specific type of bill (e.g., hospital inpatient, outpatient, replacements, voids, etc.). The first digit is a leading zero. The fourth digit defines the frequency of the bill for the institutional claim.
5267	Facility Inpatient Limited Covered ICD Procedure	CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 32.0, Version 31R- The edit is triggered when an inpatient claim contains an ICD Procedure Code that is designated as having limited coverage. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
5362	Invalid Type of Bill - Outpatient	Official UB-04 Data Specifications Manual 2015, CMS Claims Processing Manual Ch.25 Section 75- A code indicating the specific type of bill (e.g., hospital inpatient, outpatient, replacements, voids, etc.). The first digit is a leading zero. The fourth digit defines the frequency of the bill for the institutional claim.
5364	Invalid Type of Bill - Inpatient	Official UB-04 Data Specifications Manual 2015, CMS Claims Processing Manual Ch.25 Section 75- The edit will identify a claim that is submitted with a Type of Bill that is invalid or missing. The first and second positions identify the Type of Facility and Classification; the third position contains an indicator identifying the Frequency of Bill. Not all frequency codes are applicable to all types of facilities. This is based on requirements from the National Uniform Billing Committee (NUBC) and The Centers for Medicare and Medicaid Services (CMS).
5428	26/TC Split When Procedure With Modifier 26 or TC is Found in History	CMS Policy- The 26TC edit will fire on the claim line when a global service is already submitted and there is another line with modifier 26/TC on the same date of service. The history as well as the current line will be reviewed for the appropriate use of modifier 26/TC. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS).

5441	Admission Diagnosis External Cause Code ICD-10	CMS Claim Processing Manual Chapter 3 Section 20.2.1, CMS Definitions of Medicare Code Edits Version 33.0- The edit is triggered when an inpatient claim contains a diagnosis code that is classified as an ICD-9 ''E'' Code
5442	Principal Diagnosis External Cause Codes ICD-10	CMS Claim Processing Manual Chapter 3 Section 20.2.1, CMS Definitions of Medicare Code Edits Version 33.0- The edit is triggered when an inpatient claim contains a diagnosis code that is classified as an ICD-9 ''E'' Code in the principal diagnosis field on a claim prior to 10/01/2015 or an External Cause ICD-10 code on or after 10/01/2015. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
5443	Unacceptable Principal Diagnosis Without Secondary Diagnosis ICD-10	CMS Claim Processing Manual Chapter 3 Section 20.2.1, CMS Definitions of Medicare Code Edits Version 31.0, Version 31R- The edit is triggered when the submitted other diagnosis code on the claim is identified as a diagnosis that Medicare has designated as an unacceptable principal diagnosis without the presence of a secondary diagnosis. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
5446	Unacceptable Principal Diagnosis ICD-10	CMS Claim Processing Manual Chapter 3 Section 20.2.1, CMS Definitions of Medicare Code Edits Version 31.0, Version 31R- The edit is triggered when the submitted principal diagnosis code on the claim is identified as a diagnosis that Medicare has designated as an unacceptable principal diagnosis. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
5606	Ambulance Payment Reduction Non-Emergency BLS Transportation	Centers for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual, Chapter 15, 30 - General Billing Guidelines, Page 25.- Contractors shall apply the 10% reduction to claim lines containing HCPCS code A0428 with an origin/destination modifier that contains "G" or "J" in any position
6120	Procedure and Gender Conflict Female	CMS Integrated OCE (IOCE) Specifications Version 15.2- The sex of the patient does not match the sex designated for the procedure coded on the record. This edit is bypassed if condition code 45 is present on the claim.
6122	Procedure and Gender Conflict Male	CMS Integrated OCE (IOCE) Specifications Version 15.2- The sex of the patient does not match the sex designated for the procedure coded on the record. This edit is bypassed if condition code 45 is present on the claim.
6238	Principal Diagnosis and Gender Conflict Female	CMS Integrated OCE (IOCE) Specifications Version 15.2- The diagnosis code includes sex designation, and the sex does not match. This edit is bypassed if condition code 45 is present on the claim.
6243	Principal Diagnosis and Gender Conflict Male	CMS Integrated OCE (IOCE) Specifications Version 15.2- The diagnosis code includes sex designation, and the sex does not match. This edit is bypassed if condition code 45 is present on the claim.
6248	Sequential Intravenous Push Reported by a Physician	CPT, American Medical Association (AMA), CMS Policy- The edit identifies the sequential intravenous push of the same substance/drug, Current Procedural Terminology (CPT®) code 96376, reported on a professional claim. This code is to be reported by a facility only. The CPT codebook states, "96376 may be reported by facilities only."
6385	Missing or Invalid Admission Date	National Uniform Billing Committee (NUBC), Official UB-04 Data Specifications Manual 2021- The edit will fire when a claim is submitted with a missing or invalid Admission date or Statement Covers Period ''From'' and ''Through'' dates. This is based on a requirement from the National Uniform Billing Committee (NUBC) and the Centers for Medicare and Medicaid Services (CMS).
6736	Missing or Invalid Statement Covers Period From/Through Date - Outpatient	UB04 Data Specifications Manual 2015 , Medicare Claims Processing Manual Chapter 25, Section 75.1 p. 17, CMS MLN Special Edition SE1117- The edit will fire when a claim is submitted with a missing or invalid Admission date or Statement Covers Period ''From'' and ''Through'' dates. This is based on a requirement from the National Uniform Billing Committee (NUBC) and the Centers for Medicare and Medicaid Services (CMS).

6830	Medicare ICD-10 Rule	CMS transmittal R9500TN- The edit utilizes the Centers for Medicare and Medicaid Services (CMS) ICD-10-CM and ICD-9-CM manuals to identify ICD-9-CM codes that are submitted on the same claim as ICD-10-CM codes.
6830	Medicare ICD-10 Rule	CMS transmittal R9500TN- The edit utilizes the Centers for Medicare and Medicaid Services (CMS) ICD-10-CM and ICD-9-CM manuals to identify ICD-9-CM codes that are submitted on the same claim as ICD-10-CM codes.
6830	Medicare ICD-10 Rule	CMS transmittal R9500TN- The edit utilizes the Centers for Medicare and Medicaid Services (CMS) ICD-10-CM and ICD-9-CM manuals to identify ICD-9-CM codes that are submitted on the same claim as ICD-10-CM codes.
6962	Missing Provider ID	Validation Edit- This rule verifies if the current line has a provider ID. If Provider ID is missing PRV edit is fired.
6962	Missing Provider ID	Validation Edit- This rule verifies if the current line has a provider ID. If Provider ID is missing PRV edit is fired.
6962	Missing Provider ID	Validation Edit- This rule verifies if the current line has a provider ID. If Provider ID is missing PRV edit is fired.
7089	Missing Principal Diagnosis Code - I-10	Official UB-04 Data Specifications Manual 2015, CMS Claims Processing Manual Ch.25 Section 75- The edit indicates there is no principal diagnosis code on the current claim (outpatient) since it is a required field.
7103	Inappropriate Age for Diagnosis	Professional Specialty Societies, International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), CPT Professional Edition; the American Medical Association (AMA), HCPCS Level II Expert- The edit indicates that the patient’s age is outside the valid age range specified for that diagnosis code (i.e) The patient’s age is less than the beginning age or greater than the ending age for the diagnosis.
7185	Inappropriate Specification of Bilateral Procedure Different Claim	Integrated OCE (IOCE) CMS Specifications- When an inherently bilateral procedure code occurs on more than one line for the same date of service it will receive edit 017. This edit applies unless modifier 76 or 77 is submitted on the second or subsequent line.
7356	Medicaid National Correct Coding Initiative (NCCI) Unbundle	Medicaid National Correct Coding Initiative (NCCI) Policy Manual, Medicaid NCCI Edit Design Manual- The Medicaid unbundle edit verifies if the procedure code on the current line is billed with any other procedure for the same patient on the same day by the same provider. If the codes cannot be billed together and the current claim line is the deny code the edit will trigger.
7418	Device-Intensive Procedure Reported Without Device Code	Integrated OCE (IOCE) CMS Specifications, V22.1- The edit will fire when a device-intensive procedure is submitted without the device HCPCS code on the same date of service. This is based on guidelines from the Centers for Medicare and Medicaid Services (CMS).
7535	Inappropriate Diagnosis Combination - Definitive	ICD-10-CM Excludes1 Note guidelines- The Inappropriate Diagnosis Combination - Definitive (IDCD) edit identifies ICD-10-CM diagnosis codes that are mutually exclusive and cannot be reported together.
7535	Inappropriate Diagnosis Combination - Definitive	ICD-10-CM Excludes1 Note guidelines- The Inappropriate Diagnosis Combination - Definitive (IDCD) edit identifies ICD-10-CM diagnosis codes that are mutually exclusive and cannot be reported together.
7535	Inappropriate Diagnosis Combination - Definitive	ICD-10-CM Excludes1 Note guidelines- The Inappropriate Diagnosis Combination - Definitive (IDCD) edit identifies ICD-10-CM diagnosis codes that are mutually exclusive and cannot be reported together.
7537	Inappropriate Diagnosis Combination - Definitive	ICD-10-CM Excludes1 Note guidelines- The Inappropriate Diagnosis Combination - Definitive (IDCD) edit identifies ICD-10-CM diagnosis codes that are mutually exclusive and cannot be reported together.

7537	Inappropriate Diagnosis Combination - Definitive	ICD-10-CM Excludes1 Note guidelines- The Inappropriate Diagnosis Combination - Definitive (IDCD) edit identifies ICD-10-CM diagnosis codes that are mutually exclusive and cannot be reported together.
7537	Inappropriate Diagnosis Combination - Definitive	ICD-10-CM Excludes1 Note guidelines- The Inappropriate Diagnosis Combination - Definitive (IDCD) edit identifies ICD-10-CM diagnosis codes that are mutually exclusive and cannot be reported together.
7602	Invalid Value Code	UB04 Data Specifications Manual 2015, Medicare Claims Processing Manual, Chapter 15, Section 75.3- DDR 7602 VALf flag fires on an outpatient claim when the value code is present and not valid.
7678	Principal Diagnosis - Age Conflict	Medicare Code Editor V37- The edit is triggered when an inpatient claim contains a principal diagnosis code that is inconsistent with the patient's age. This edit looks at the principal diagnosis code that is submitted on an inpatient claim and determine if the diagnosis have an age designation for the code and calculates the age of the patient using the patient's date of birth and the "through" date on the claim. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
7785	HCPCS G0378-G0384 and G0463 Reported on a Professional Claim	CMS Policy- Healthcare Common Procedure Coding System (HCPCS) codes G0378-G0379, G0380-G0384 and G0463 may not be reported on professional claims. These codes are to be reported for payment under the Outpatient Prospective Payment System (OPPS) on institutional claims. A physician reporting a professional service would submit a CPT® evaluation and management (E/M) code for hospital observation services, emergency department visits or hospital outpatient visits on a professional claim.
7896	POA Exempt Diagnosis Code	MLN Fact Sheet - Present on Admission Indicator Reporting, ICD-9-CM Official Guidelines for Coding and Reporting Effective October 1, 2011, CMS Transmittal R756OTN- The edit is triggered when an inpatient claim contains a diagnosis that is designated as exempt from Present on Admission (POA) reporting submitted with a non-exempt POA indictor for a non-exempt facility. This edit is based on a requirement from ICD-9-CM and ICD-10-CM Official Guidelines for Coding and Reporting, The Centers for Medicare and Medicaid Services (CMS).
8152	Missing or Invalid Admission Date	UB04 Data Specifications Manual 2015 , Medicare Claims Processing Manual Chapter 25, Section 75.1 p. 17, CMS MLN Special Edition SE1117- The edit will fire when a claim is submitted with a missing or invalid Admission date or Statement Covers Period ''From'' and ''Through'' dates. This is based on a requirement from the National Uniform Billing Committee (NUBC) and the Centers for Medicare and Medicaid Services (CMS).
8195	Missing or Invalid POS	Validation Edit- The rule identifies claim lines that have a missing or invalid Place Of Service (POS). If POS is missing or invalid, the line is dropped and the BPS flag is fired.
8195	Missing or Invalid POS	Validation Edit- The rule identifies claim lines that have a missing or invalid Place Of Service (POS). If POS is missing or invalid, the line is dropped and the BPS flag is fired.
8203	Invalid Provider specialty	Validation Edit- The rule identifies claim lines that have an invalid Provider specialty. If Provider specialty is invalid, the line is dropped and the PRS flag is fired.
8203	Invalid Provider specialty	Validation Edit- The rule identifies claim lines that have an invalid Provider specialty. If Provider specialty is invalid, the line is dropped and the PRS flag is fired.
8203	Invalid Provider specialty	Validation Edit- The rule identifies claim lines that have an invalid Provider specialty. If Provider specialty is invalid, the line is dropped and the PRS flag is fired.
8327	Interim Claims with Frequency Code 2 and 3 Requires Patient Discharge Status Code 30 - Outpatient	National Uniform Billing Committee (NUBC), Official UB-04 Data Specifications Manual 2015, CMS MLN Matters Article SE0801, CMS Claim Processing Manual Chapter 1 Section 50.2, CMS Transmittal R2578CP- The edit will fire when a claim with a Type of Bill (TOB) frequency digit 2 or 3 is submitted without patient discharge status code 30. This is based on requirements from the National Uniform Billing Committee (NUBC) and The Centers for Medicare and Medicaid Services (CMS).

8376	Inappropriate Diagnosis Combination - Definitive - Facility	ICD-10-CM Excludes1 Note guidelines- The Inappropriate Diagnosis Combination - Definitive edit identifies ICD-10-CM diagnosis codes that are mutually exclusive and cannot be reported together. The ICD-10-CM guidelines identify specific codes in the Excludes1 notes. These relationships are considered ICD-10-CM definitive in the KnowledgeBase.
8400	Invalid Diagnosis Code	Validation Edit- This rule identifies the claim line which has one or more invalid diagnosis code(s).
8400	Invalid Diagnosis Code	Validation Edit- This rule identifies the claim line which has one or more invalid diagnosis code(s).
8446	Third Party Liability	CMS Policy, Publication 100-05, Medicare Secondary Payer Manual, Chapters 1, 2, 3, 5; Centers for Disease Control and Prevention (CDC), National Institute for Occupational Safety and Health (NIOSH)- This rule identifies diagnosis codes that may involve third-party liability issues and/or possible coordination and/or subrogation of benefits.
8448	Duplicative Laboratory Facility and Professional Procedures	This rule is designed to determine reporting of a duplicate facility laboratory procedure code with modifiers 26, TC or globally submitted on a professional claim for the same date of service. The flag will fire if modifier 90 is not reported on the professional claim.
8638	CCM Included in Other Services During Same Month	CPT; CMS Policy- Chronic care management services, 99487-99491, are included in end stage renal disease (ESRD) service codes 90951-90970 and in physician supervision service codes G0181-G0182 in the same calendar month. This is based on guidelines from the CPT Professional Edition codebook and the Centers for Medicare and Medicaid Services (CMS).
8639	CCM Found in History Included in Other Services During Same Month	CPT- Chronic care management services, 99487-99491, are included in end stage renal disease (ESRD) service codes 90951-90970 and in physician supervision service codes G0181-G0182 in the same calendar month. This is based on guidelines from the CPT Professional Edition codebook and the Centers for Medicare and Medicaid Services (CMS).
8730	Missing Procedure Code	Validation Edit- This rule verifies if the current line has a Procedure Code. If Procedure Code is missing CPT edit is fired.
8730	Missing Procedure Code	Validation Edit- This rule verifies if the current line has a Procedure Code. If Procedure Code is missing CPT edit is fired.
8730	Missing Procedure Code	Validation Edit- This rule verifies if the current line has a Procedure Code. If Procedure Code is missing CPT edit is fired.
8732	Disabled Procedure Code	Validation- All procedure codes are validated to determine whether the procedure code is disabled by end user. If the procedure code is disabled by end user CPT edit is fired.
8732	Disabled Procedure Code	Validation- All procedure codes are validated to determine whether the procedure code is disabled by end user. If the procedure code is disabled by end user CPT edit is fired.
9226	Maximum Frequency	CMS Medically Unlikely Edits; Interpretation of CPT/HCPCS- The Maximum Frequency edit will appear on the line when the total frequency units of the procedure code exceed the maximum number of frequency units specified by the client for that code, within the defined time period.
9226	Maximum Frequency	CMS Medically Unlikely Edits; Interpretation of CPT/HCPCS- The Maximum Frequency edit will appear on the line when the total frequency units of the procedure code exceed the maximum number of frequency units specified by the client for that code, within the defined time period. The MFX Suppression Modifiers list and the MFX Diagnosis Exceptions apply.
9732	Missing Provider specialty	Validation Edit- The rule identifies claim lines that have a missing Provider specialty. If Provider specialty is missing, the line is dropped and the PRS flag is fired.
9732	Missing Provider specialty	Validation Edit- The rule identifies claim lines that have a missing Provider specialty. If Provider specialty is missing, the line is dropped and the PRS flag is fired.

9796	External Cause of Morbidity Code Cannot Be Used as Principal Diagnosis	CMS Integrated OCE (IOCE) Specifications V16.1, CMS Transmittal R3218CP- The edit fires when an external cause of morbidity code is reported as a principle diagnosis. This is based on guidelines from the Center for Medicare and Medicaid Services.
10302	Anesthesia Secondary Procedure in History with Modifier Override	CPT Assistant; CMS Policy; American Association of Anesthesiologists (ASA)- When multiple anesthesia codes are reported by the same provider for the same date of service, only the anesthesia code with the highest base unit value is allowed. All lower base unit value anesthesia codes are considered included in the single anesthesia code having the highest base unit value. Modifier 59 or 78 will override the editing, when appropriate.
10372	Unspecified and Not Otherwise Specified (NOS) ICD-10-CM Codes	ICD-10-CM- The flag will fire when the ICD-10-CM code(s) reported on the claim line define an unspecified or Not Otherwise Specified (NOS) ICD-10-CM diagnosis code.
10372	Unspecified and Not Otherwise Specified (NOS) ICD-10-CM Codes	ICD-10-CM- The flag will fire when the ICD-10-CM code(s) reported on the claim line define an unspecified or Not Otherwise Specified (NOS) ICD-10-CM diagnosis code.
10372	Unspecified and Not Otherwise Specified (NOS) ICD-10-CM Codes	ICD-10-CM- The flag will fire when the ICD-10-CM code(s) reported on the claim line define an unspecified or Not Otherwise Specified (NOS) ICD-10-CM diagnosis code.
11256	Unspecified ICD-10-CM Codes - Laterality Only	ICD-10-CM- The flag will fire when the ICD-10-CM code(s) reported on the claim line define an unspecified ICD-10-CM code which has an equivalent code for right or left, an equivalent code for unilateral or bilateral, or in the instance when the other specified code has a note for unspecified laterality.
11256	Unspecified ICD-10-CM Codes - Laterality Only	ICD-10-CM- The flag will fire when the ICD-10-CM code(s) reported on the claim line define an unspecified ICD-10-CM code which has an equivalent code for right or left, an equivalent code for unilateral or bilateral, or in the instance when the other specified code has a note for unspecified laterality.
11256	Unspecified ICD-10-CM Codes - Laterality Only	ICD-10-CM- The flag will fire when the ICD-10-CM code(s) reported on the claim line define an unspecified ICD-10-CM code which has an equivalent code for right or left, an equivalent code for unilateral or bilateral, or in the instance when the other specified code has a note for unspecified laterality.
11258	Medicaid Post-Op Surgery By Provider	CMS National Physician Fee Schedule or State Specified Global Value- Surgical procedures with a global period which should not be billed within the global period of another procedure without an appropriate modifier.
11269	ICD-10 to ICD-9 Diagnosis Comparison	The ICD-10 to ICD-9 Diagnosis Comparison rule will fire a flag when ICP uses comparison data to map ICD- 10 diagnosis codes to ICD-9 diagnosis codes for historical editing. System rules use this functionality to identify what claims in history should be used for editing.
11994	Corneal Tissue Processing Reported Without Cornea Transplant Procedure	CMS Integrated Outpatient Code Editor, Version 17.0, CMS Transmittal R3425CP- Corneal tissue processing HCPCS (V2785) is reported and there is no corneal transplant procedure present for the same service date.
12004	Service Provided Prior to FDA Approval	CMS Integrated Outpatient Code Editor, Version 17.0- The line item date of service of a code is prior to the date of FDA approval.
12275	Invalid Condition Code	UB04 Data Specifications Manual 2016, Medicare Claims Processing Manual, Chapter 25, Section 75.2- The edit fires on an inpatient or outpatient claim when the condition code is not valid.
12280	Facility Inpatient Missing Patient Discharge Status	Official UB-04 Data Specifications Manual 2016, v10.00- The edit is triggered when an inpatient claim is submitted with a missing Patient Discharge Status Code. This is based on requirements from the National Uniform Billing Committee (NUBC).

12302	Facility Inpatient Invalid Patient Discharge Status	Medicare Claim Processing Manual, Chapter 25, Section 75.2, Medicare Code Editor v36.0- The edit is triggered when a claim is submitted with an invalid Patient Discharge Status Code. When an invalid discharge status is reported, the patient is presumed to have been discharged alive for the purpose of performing the non-specific principal diagnosis check. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS)and the National Uniform Billing Committee (NUBC).
12691	Facility Outpatient Invalid Age	Medicare Claims Processing Manual Chapter 4, Section Section 40.3, Integrated Outpatient Code Editor Specifications Manual, v17.0, Integrated Outpatient Code Editor Software, v17.0- The edit will fire when a claim is submitted with a patient's age that is not between 0 and 124 years. The patient's age is calculated using the submitted date of birth and the ''From'' date on the claim. The patient's age will be considered invalid if the age is non-numeric or outside the range of 0 - 124 years
12692	Facility Outpatient Invalid Gender	Medicare Claims Processing Manual Chapter 4, Section Section 40.3, Integrated Outpatient Code Editor Specifications Manual, v17.0, Integrated Outpatient Code Editor Software, v17.0- The edit will fire when a claim is submitted and the sex code reported is not either 1 (male) or 2 (female, or), 0 (Unknown) or M, F or U. This is based on requirements from The Centers for Medicare and Medicaid Services (CMS).
12771	ICD-10-CM Outpatient Code Editor (OCE) Age	Outpatient Code Editor IOCE Quarterly Data Files- This rule identifies the CMS Outpatient Code Editor (OCE) age ranges for diagnosis codes. The IAG professional rule age designations are sourced to guidelines from the ICD-10-CM, specialty societies and code descriptors.
12771	ICD-10-CM Outpatient Code Editor (OCE) Age	Outpatient Code Editor IOCE Quarterly Data Files- This rule identifies the CMS Outpatient Code Editor (OCE) age ranges for diagnosis codes. The IAG professional rule age designations are sourced to guidelines from the ICD-10-CM, specialty societies and code descriptors.
12795	Facility Outpatient Trauma Code Without Revenue Code and E/M	Claims Processing Manual Chapter 4 Section 160.1, CMS Integrated Outpatient Code Editor, Version 17.0- The edit fires when trauma response critical care code, G0390 is billed without revenue code 068X and critical care code 99291 on the same date of service.
12872	Facility Outpatient Trauma Code Without Revenue Code and E/M	Claims Processing Manual Chapter 4 Section 160.1, CMS Integrated Outpatient Code Editor, Version 17.0- The edit fires when trauma response critical care code, G0390 is billed without revenue code 068X and critical care code 99291 on the same date of service.
12878	Facility Outpatient Trauma Code Without Revenue Code and E/M	Claims Processing Manual Chapter 4 Section 160.1, CMS Integrated Outpatient Code Editor, Version 17.0- The edit fires when trauma response critical care code, G0390 is billed without revenue code 068X and critical care code 99291 on the same date of service.
13248	Invalid Modifier Code	Validation Edit- This rule identifies the claim line which has one or more invalid modifier code(s). All modifiers are validated to verify if they are present in the Modifier Edits table and valid for the date of service. If there is a modifier on the claim line which is not present in the system, has been disabled, or is not effective or valid for the date of service the IMO flag is fired.
13248	Invalid Modifier Code	Validation Edit- This rule identifies the claim line which has one or more invalid modifier code(s). All modifiers are validated to verify if they are present in the Modifier Edits table and valid for the date of service. If there is a modifier on the claim line which is not present in the system, has been disabled, or is not effective or valid for the date of service the IMO flag is fired.
13248	Invalid Modifier Code	Validation Edit- This rule identifies the claim line which has one or more invalid modifier code(s). All modifiers are validated to verify if they are present in the Modifier Edits table and valid for the date of service. If there is a modifier on the claim line which is not present in the system, has been disabled, or is not effective or valid for the date of service the IMO flag is fired.

13280	Anesthesia Crosswalk by Report	CPT, HCPCS, Interpretation of American Society of Anesthesiologists (ASA)- This rule identifies when a CPT surgery, radiology, medicine, or applicable HCPCS (G and S) code is reported on a claim line with an anesthesia specialty, or the Type of Service is 7, and the procedure code has an anesthesia by report status. The by report status is identified as BR. The claim line must be reviewed and the appropriate anesthesia code should be reported in place of the procedure code.
13316	Facility Outpatient Invalid Principal Diagnosis	Integrated Outpatient Code Editor Version 20.0- The edit identifies invalid ICD-9-CM (for dates of service prior to 10/01/2015) or ICD-10-CM (for dates of service on or after 10/01/15) diagnosis codes. This edit will look at each ICD-9-CM/ICD-10-CM diagnosis code for completeness and validity. This is based on guidelines from the Center for Medicare and Medicaid Services, Integrated Outpatient Code Editor.
14321	Multiple Medical Visits on Same Day with Same Revenue Code Without Condition Code G0 - Same Claim	CMS Claim Processing Manual, Chapter 4, Section 180.4, CMS Integrated Outpatient Code Editor - Version 15.2- Multiple medical visits (based on units and/or lines) are present on the same day with the same revenue code, without condition code G0 to indicate that the visits were distinct and independent of each other
14325	Multiple Medical Visits on Same Day with Same Revenue Code Without Condition Code G0	CMS Claim Processing Manual, Chapter 4, Section 180.4, CMS Integrated Outpatient Code Editor - Version 15.2- Multiple medical visits (based on units and/or lines) are present on the same day with the same revenue code, without condition code G0 to indicate that the visits were distinct and independent of each other.
14530	Multiple Medical Visits on Same Day with Same Revenue Code Without Condition Code G0 - Different Claim	CMS Claim Processing Manual, Chapter 4, Section 180.4, CMS Integrated Outpatient Code Editor - Version 15.2- Multiple medical visits (based on units and/or lines) are present on the same day with the same revenue code, without condition code G0 to indicate that the visits were distinct and independent of each other.
15072	Terminated Procedure Reduction	CMS Claim Processing Manual Chapter 4, Section 20.6.4, CMS Integrated OCE (IOCE) Specifications V19.0,- The edit will fire when a claim contains a procedure submitted with either modifier 52 or 73 to indicate a terminated procedure. These claim lines are eligible for terminated procedure reduction (TPRf). This edit is based on a requirement from the Centers for Medicare and Medicaid Services (CMS).
15774	Facility Outpatient Services Provided Outside Of Approval Period	Integrated Outpatient Code Editor Specifications v17.2- The edit is assigned to a claim line that contains specific services which are submitted outside of a limited approval period.
15792	Principal Diagnosis - Gender Conflict	CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 33.0, Version 33.0A- Medicare Code Editor detects inconsistencies between a patient's sex and any diagnosis on the patient's record. For example, a male patient with cervical cancer (diagnosis) or a female patient with a prostatectomy (procedure).
15793	Principal Diagnosis - Gender Conflict	CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 33.0, Version 33.0A- Medicare Code Editor detects inconsistencies between a patient's sex and any diagnosis on the patient's record. For example, a male patient with cervical cancer (diagnosis) or a female patient with a prostatectomy (procedure).
15922	Admit Diagnosis - Gender Conflict	CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 33.0, Version 33.0A- Medicare Code Editor detects inconsistencies between a patient's sex and any diagnosis on the patient's record. For example, a male patient with cervical cancer (diagnosis) or a female patient with a prostatectomy (procedure).

15923	Admit Diagnosis - Gender Conflict	CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 33.0, Version 33.0A- Medicare Code Editor detects inconsistencies between a patient's sex and any diagnosis on the patient's record. For example, a male patient with cervical cancer (diagnosis) or a female patient with a prostatectomy (procedure).
15924	Other Diagnosis - Gender Conflict	CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 33.0, Version 33.0A- Medicare Code Editor detects inconsistencies between a patient's sex and any diagnosis on the patient's record. For example, a male patient with cervical cancer (diagnosis) or a female patient with a prostatectomy (procedure).
15925	Other Diagnosis - Gender Conflict	CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 33.0, Version 33.0A- The edit is triggered when an inpatient claim contains another diagnosis code that is inconsistent with the patient's gender. This edit will identify other diagnosis codes on a claim that has a gender assignment and will validate that the gender of the patient submitted on the claim matches the gender assignment for the other diagnosis code that is effective based on the "through" date on the claim. This edit will bypass if condition code 45 (Ambiguous Gender Category) is present on the claim. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
16624	Principal Diagnosis - Age and Gender Conflict	CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 33.0, Version 33.0A- The edit is triggered when a conflict exists between the patient's calculated age and the designated age parameter set for the principal diagnosis code that is effective based on the "through" date on the claim and/or a conflict exists between the patient's submitted gender and the gender designation of the principal diagnosis code that is effective based on the "through" date on the claim This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
16628	Principal Diagnosis - Age and Gender Conflict	CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 33.0, Version 33.0A- The edit is triggered when a conflict exists between the patient's calculated age and the designated age parameter set for the principal diagnosis code that is effective based on the "through" date on the claim and/or a conflict exists between the patient's submitted gender and the gender designation of the principal diagnosis code that is effective based on the "through" date on the claim This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
16778	Facility Inpatient Procedure Inconsistent with Length of Stay	CMS Transmittal R3504CP, CMS Policy, Pub 100-4, Chapter 3, Section 20.2.1- The edit fires when ICD-10 procedure code 5A1955Z (Respiratory Ventilation, Greater than 96 Consecutive Hours) is reported on a claim with a length of stay of less than four days, after subtracting the amount of days reported with Occurrence Span Code 74 from the total number of days.
16780	Admission Diagnosis - Age and Gender Conflict	CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 33.0, Version 33.0A- The edit is triggered when a conflict exists between the patient's calculated age and the designated age parameter set for the admit diagnosis code that is effective based on the "through" date on the claim and/or a conflict exists between the patient's submitted gender and the gender designation of the admit diagnosis code that is effective based on the "through" date on the claim. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).

16783	Admission Diagnosis - Age and Gender Conflict	CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 33.0, Version 33.0A- The edit is triggered when a conflict exists between the patient's calculated age and the designated age parameter set for the admit diagnosis code that is effective based on the "through" date on the claim and/or a conflict exists between the patient's submitted gender and the gender designation of the admit diagnosis code that is effective based on the "through" date on the claim. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
16784	Other Diagnosis - Age and Gender Conflict	CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 33.0, Version 33.0A- The edit is triggered when a conflict exists between the patient's calculated age and the designated age parameter set for other diagnosis codes that are effective based on the "through" date on the claim and/or a conflict exists between the patient's submitted gender and the gender designation of the other diagnosis codes that is effective based on the "through" date on the claim. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
16785	Other Diagnosis - Age and Gender Conflict	CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 33.0, Version 33.0A- The edit is triggered when a conflict exists between the patient's calculated age and the designated age parameter set for other diagnosis codes that are effective based on the "through" date on the claim and/or a conflict exists between the patient's submitted gender and the gender designation of the other diagnosis codes that is effective based on the "through" date on the claim. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
16801	Claim With Pass-Through Device Lacks Required Procedure	Integrated Outpatient Code Editor Specifications- The edit will fire when a pass-through device is billed without an associated procedure. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS).
16850	Admission Diagnosis - Age Conflict	Medicare Code Editor v37- The edit is triggered when an inpatient claim contains an admitting diagnosis code that is inconsistent with the patient's age. This edit looks at the admitting diagnosis code that is submitted on an inpatient claim and determines if the admitting diagnosis have an age designation and calculates the age of the patient using the patient's date of birth and the "through" date on the claim. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
16853	Other Diagnosis - Age Conflict	Medicare Code Editor V37- The edit is triggered when an inpatient claim contains a secondary diagnosis code that is inconsistent with the patient's age. This edit looks at secondary diagnosis codes that are submitted on an inpatient claim and determine if any of the diagnoses have an age designation for the code and calculates the age of the patient using the patient's date of birth and the "through" date on the claim. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
17398	Facility Outpatient Invalid Reason For Visit Diagnosis	Integrated Outpatient Code Editor Version 20.0- The edit identifies invalid ICD-10-CM diagnosis codes (ICD-9-CM diagnosis codes for claims with from dates prior to 10/1/2015). This edit will look at each ICD-10-CM diagnosis code (ICD-9-CM diagnosis codes for claims with from dates prior to 10/1/2015) for completeness and validity. This is based on guidelines from the Center for Medicare and Medicaid Services, Integrated Outpatient Code Editor.
17399	Facility Outpatient Invalid Other Diagnosis	Integrated Outpatient Code Editor Version 20.0- The edit identifies invalid ICD-10-CM diagnosis codes (ICD-9-CM diagnosis codes for claims with from dates prior to 10/1/2015). This edit will look at each ICD-10-CM diagnosis code (ICD-9-CM diagnosis codes for claims with from dates prior to 10/1/2015) for completeness and validity. This is based on guidelines from the Center for Medicare and Medicaid Services, Integrated Outpatient Code Editor.

17410	Facility Outpatient Incomplete Principal ICD-10 Diagnosis	Integrated Outpatient Code Editor Version 20.0- The edit identifies invalid ICD-10-CM diagnosis codes (ICD-9-CM diagnosis codes for claims with from dates prior to 10/1/2015). This edit will look at each ICD-10-CM diagnosis code (ICD-9-CM diagnosis codes for claims with from dates prior to 10/1/2015) for completeness and validity. This is based on guidelines from the Center for Medicare and Medicaid Services, Integrated Outpatient Code Editor.
17423	Facility Outpatient Incomplete Reason For Visit ICD-10 Diagnosis	Integrated Outpatient Code Editor Version 20.0- The edit identifies invalid ICD-10-CM diagnosis codes (ICD-9-CM diagnosis codes for claims with from dates prior to 10/1/2015). This edit will look at each ICD-10-CM diagnosis code (ICD-9-CM diagnosis codes for claims with from dates prior to 10/1/2015) for completeness and validity. This is based on guidelines from the Center for Medicare and Medicaid Services, Integrated Outpatient Code Editor.
17424	Facility Outpatient Incomplete Other ICD-10 Diagnosis	Integrated Outpatient Code Editor Version 20.0- The edit identifies invalid ICD-10-CM diagnosis codes (ICD-9-CM diagnosis codes for claims with from dates prior to 10/1/2015). This edit will look at each ICD-10-CM diagnosis code (ICD-9-CM diagnosis codes for claims with from dates prior to 10/1/2015) for completeness and validity. This is based on guidelines from the Center for Medicare and Medicaid Services, Integrated Outpatient Code Editor.
17455	Invalid Condition Code	UB04 Data Specifications Manual 2016, Medicare Claims Processing Manual, Chapter 25, Section 75.2- The edit will fire when a claim is submitted with an invalid Condition Code. This is based on requirements from the National Uniform Billing Committee (NUBC) and the Centers for Medicare and Medicaid Services (CMS).
17456	Invalid Value Code	UB04 Data Specifications Manual 2015, Medicare Claims Processing Manual, Chapter 15, Section 75.3,- The edit will fire when a claim is submitted with an invalid Value Code. This is based on requirements from the National Uniform Billing Committee (NUBC) and the Centers for Medicare and Medicaid Services (CMS).
17683	DME Medically Unlikely Edits Units	National Correct Coding Initiative in Medicaid/Medicaid NCCI Edit Files/MUE for Provider Claims for Durable Medical Equipment- The Medicaid medically unlikely edit (sMUE) verifies the number of units appended to the procedure code on the current line billed is within the allowable number of units of service allowed for the same patient on the same day by the same provider. If the number of units is over the allowable amount, the edit will trigger.
17684	Practitioner Medically Unlikely Edits Per Claim Line	National Correct Coding Initiative in Medicaid/Medicaid NCCI Edit Files/MUEs for Practitioner and ASC Services- The Centers for Medicare and Medicaid (CMS) created the Medically Unlikely Edits (MUE) to lower the claims error rate. The National Correct Coding Initiative (CCI) Policy Manual for Medicaid Services states, ''An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances allowable by the same provider for the same beneficiary on the same date of service.''
17973	Not a Commonly Associated Diagnosis for Procedure	CMS Policy-The IAP (Inappropriate Diagnosis to Procedure) edit identifies relationships where the CPT or HCPCS procedure code (excluding unlisted codes) and the International Classification of Diseases (ICD) diagnosis code fall outside the list of commonly associated diagnosis to procedure relationships. It is not intended for denial of services, as it is impossible to capture a comprehensive list due to the volume of potential relationships. The purpose of this flag is to assist the customer in tracking or profiling ICD billings. Although it is possible to set this flag to ''review'' so that the medical record can be examined to verify appropriate coding, the volume of edits may prohibit this type of activity.

17973	Not a Commonly Associated Diagnosis for Procedure	CMS Policy- This rule identifies relationships where the procedure code and diagnosis code fall outside the list of commonly associated diagnosis to procedure relationships. Multiple diagnoses are edited per line item. The rule will not fire if at least one of the diagnoses matches a relationship in the procedure to diagnosis table for the Commercial and Medicaid line of business.
18055	Claim With Pass-Through or Non-Pass-Through Drug Or Biological Lacks Payable Procedure	Integrate OCE (IOCE) CMS Specifications V17.3, CMS Transmittal R3591CP, Integrated Outpatient Code Editor Software Manual V17.3- The edit will fire when a pass-through or non-pass-through drug or biological is billed without an associated payable procedure on the same claim. Pass-through drugs and biologicals include radiopharmaceuticals, contrast agents, skin substitute products and stress agents. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS).
18408	Facility Outpatient Claim Lacks Required Primary Code - Mental Health	Medicare Claim Processing Manual 100-04, Chapter 4 â€“ Part B Hospital, Section 10.2.2 p. 18- The edit will fire when a claim contains an add-on code without a code for its required primary code on the same date of service.
18576	Unlisted Procedure Code	CPT; CPT Assistant; HCPCS; CMS Policy- The rule identifies the procedure code on the claim line as an unlisted code.
18576	Unlisted Procedure Code	CPT; CPT Assistant; HCPCS; CMS Policy- The UNL flag identifies the procedure code on the claim line as an unlisted code. No further relationships or edits are created with unlisted codes within the KnowledgeBase.
18576	Unlisted Procedure Code	CPT; CPT Assistant; HCPCS; CMS Policy- The rule identifies the procedure code on the claim line as an unlisted code.
18849	Other Diagnosis and Gender Conflict Female	CMS Integrated OCE (IOCE) Specifications Version 15.2- The diagnosis code includes sex designation, and the sex does not match. This edit is bypassed if condition code 45 is present on the claim.
18850	Other Diagnosis and Gender Conflict Male	CMS Integrated OCE (IOCE) Specifications Version 15.2- The diagnosis code includes sex designation, and the sex does not match. This edit is bypassed if condition code 45 is present on the claim.
18851	Reason for Visit Diagnosis and Gender Conflict Male	CMS Integrated OCE (IOCE) Specifications Version 15.2- The diagnosis code includes sex designation, and the sex does not match. This edit is bypassed if condition code 45 is present on the claim.
18852	Reason for Visit Diagnosis and Gender Conflict Female	CMS Integrated OCE (IOCE) Specifications Version 15.2- The diagnosis code includes sex designation, and the sex does not match. This edit is bypassed if condition code 45 is present on the claim.
19619	Inpatient Admitting Diagnosis Code Is Required	Official UB-04 Data Specifications Manual 2017- The edit will fire when an inpatient claim, excluding type of bills (TOB) 028X, 065X, 066X or 086X, is submitted without an admitting diagnosis
19663	ASC Corneal Tissue Processing Reported Without Cornea Transplant Procedure	CMS Transmittal R3430CP- The CTPa edit utilizes the Centers for Medicare and Medicaid Services' (CMS) Transmittal R3430CP, January 2016 Update of the Ambulatory Surgery Center Payment System (ASC) to identify corneal transplant procedures performed in an ASC setting. The CTPa edit will fire when procedure code V2785 is submitted on a claim without the corneal transplant procedure on the same day.
20098	ASC Retinal Prosthesis Implantation Procedure	CMS Transmittal R3683CP- HCPCS code 0100T and C1841 must be reported together when a retinal prosthesis is implanted in the ASC.
20099	ASC Retinal Prosthesis Implantation Procedure	CMS Transmittal R3683CP-HCPCS code 0100T and C1841 must be reported together when a retinal prosthesis is implanted in the ASC.
20112	ASC Argus Retinal Prosthesis Add-on Code	CMS Transmittal R3683CP- HCPCS code C1842 (Retinal prosthesis, includes all internal and external components; add on to C1841) must be reported with C1841 when a retinal prosthesis is implanted in the ASC.

20389	Not a Primary Diagnosis Code	ICD-10, American Hospital Association- The rule identifies codes that are not recommended for reporting alone or as a primary diagnosis (i.e., sequenced first).
20389	Not a Primary Diagnosis Code	ICD-10, American Hospital Association- The rule identifies codes that are not recommended for reporting alone or as a primary diagnosis (i.e., sequenced first).
20527	Inpatient Questionable Admission	Medicare Code Editor V. 34 October 2016, Medicare Claims Processing Manual Chapter 100-04, Chapter 3 Section 20.2.1- The edit is triggered when the submitted principal diagnosis code on the claim is identified as a diagnosis that Medicare has designated as insufficient justification for hospital admission (i.e. “Elevated Blood Pressure Reading ”).
20573	Dates of Service to Units Discrepancy	The edit checks for consistency between the number of units on a claim line and the number of dates of service when there is a date span between the beginning and ending dates of service. If units are not equal to the number of dates of service, the edit is issued.
20573	Dates of Service to Units Discrepancy	The edit checks for consistency between the number of units on a claim line and the number of dates of service when there is a date span between the beginning and ending dates of service. If units are not equal to the number of dates of service, the edit is issued.
20576	Principal Procedure - Gender Conflict	CMS Claim Processing Manual Chapter 3, Section 20.2.1, Chapter 32, Section 240.1, CMS Definitions of Medicare Code Edits Version 34.0- The edit is triggered when an inpatient claim contains a principal procedure code that is inconsistent with the patient's gender. This edit will identify a principal procedure code on a claim that has a gender assignment and will validate that the gender of the patient submitted on the claim matches the gender assignment for the principal procedure code that is effective based on the "through" date on the claim. This edit will bypass if condition code 45 (Ambiguous Gender Category) is present on the claim. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
20577	Principal Procedure - Gender Conflict	CMS Claim Processing Manual Chapter 3, Section 20.2.1, Chapter 32, Section 240.1, CMS Definitions of Medicare Code Edits Version 34.0- The edit is triggered when an inpatient claim contains a principal procedure code that is inconsistent with the patient's gender. This edit will identify a principal procedure code on a claim that has a gender assignment and will validate that the gender of the patient submitted on the claim matches the gender assignment for the principal procedure code that is effective based on the "through" date on the claim. This edit will bypass if condition code 45 (Ambiguous Gender Category) is present on the claim. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
20578	Other Procedure - Gender Conflict	CMS Claim Processing Manual Chapter 3, Section 20.2.1, Chapter 32, Section 240.1, CMS Definitions of Medicare Code Edits Version 34.0- The edit is triggered when an inpatient claim contains other procedure codes that are inconsistent with the patient's gender. This edit will identify other procedure codes on a claim that have a gender assignment and will validate that the gender of the patient submitted on the claim matches the gender assignment for the other procedure codes that are effective based on the "through" date on the claim. This edit will bypass if condition code 45 (Ambiguous Gender Category) is present on the claim. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).

20579	Other Procedure - Gender Conflict	CMS Claim Processing Manual Chapter 3, Section 20.2.1, Chapter 32, Section 240.1, CMS Definitions of Medicare Code Edits Version 34.0- The edit is triggered when an inpatient claim contains other procedure codes that are inconsistent with the patient's gender. This edit will identify other procedure codes on a claim that have a gender assignment and will validate that the gender of the patient submitted on the claim matches the gender assignment for the other procedure codes that are effective based on the "through" date on the claim. This edit will bypass if condition code 45 (Ambiguous Gender Category) is present on the claim. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS)
20607	Inpatient Missing Gender	Medicare Claims Processing Manual - Chapter 3, Section 20.2.1, MCE Manual V34- The edit is triggered when a claim is submitted and the sex code is missing on the claim. This is based on requirements from the Centers for Medicare and Medicaid Services (CMS).
20608	Inpatient Invalid Gender	Medicare Claims Processing Manual - Chapter 3, Section 20.2.1, MCE Manual V34- The edit is triggered when a claim is submitted and the sex code reported is not either 1 (male) or 2 (female). This is based on requirements from the Centers for Medicare and Medicaid Services (CMS).
20610	Inpatient Invalid Age	Medicare Claims Processing Manual - Chapter 3, Section 20.2.1, MCE Manual V34- The edit is triggered when an inpatient claim contains an age that is not between 0 and 124 years. This rule will calculate the patients' age in years using the submitted date of birth and the ''through'' date on the claim. If the calculated patient age is not equal to or between 0 and 124 years.
20615	Inpatient Limited Coverage Procedure	Medicare Claims Processing Manual - Chapter 3, Section 20.2.1, MCE Manual V34- The edit is triggered when an inpatient claim contains an ICD-10-CM Procedure Code of 02RK0JZ and 02RL0JZ which are designated as having limited coverage when combined with diagnosis code Z006. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
20618	Patient Reason for Visit Required	National Uniform Billing Committee (NUBC), Official UB-04 Data Specifications Manual 2017- The edit will fire when an outpatient claim is missing a required patient reason for visit diagnosis code. The edit will fire for Medicare claims when Type of Bill (TOB) 013x or 085x is submitted with type of admission code 1, 2 or 5 and revenue code 045x, 0516 or 0762 without a patient reason for visit diagnosis code. The edit will fire for Commercial and Medicaid National claims when Type of Bill (TOB) 013x, 078x or 085x is submitted with type of admission code 1, 2 or 5 and revenue code 045x, 0516, 0526 or 0762 without a patient reason for visit diagnosis code. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS) and the National Uniform Billing Committee (NUBC).
20662	Inpatient Invalid Admitting Diagnosis	Official UB-04 Data Specifications Manual 2017- The edit will fire when an inpatient claim, excluding type of bills (TOB) 028X, 065X, 066X or 086X, is submitted with an admit diagnosis code that is invalid. This edit checks each admit diagnosis code against a table of valid codes that are valid and effective based on the ''through'' date on the claim.
20664	Inpatient Incomplete Admitting Diagnosis	Official UB-04 Data Specifications Manual 2017- The edit will fire when an inpatient claim, excluding type of bills (TOB) 028X, 065X, 066X or 086X, is submitted with an admitting diagnosis code that has a missing digit. This edit will fire when a diagnosis code is found on the claim that requires a digit that is valid and effective for the "through" date on the claim .
20673	Inpatient Missing Principal Diagnosis	CMS Claim Processing Manual Chapter 3, Section 20.2.1, Chapter 32, Section 240.1, CMS Definitions of Medicare Code Edits Version 34.0- The edit will fire on an inpatient claim submitted without the principal diagnosis code.

20674	Inpatient Invalid Principal Diagnosis	CMS Claim Processing Manual Chapter 3, Section 20.2.1, Chapter 32, Section 240.1, CMS Definitions of Medicare Code Edits Version 34.0- The edit will fire on an inpatient claim when the principal diagnosis code is not found in the knowledgebase or the principal diagnosis code is invalid based on the "through" date on the claim.
20675	Inpatient Incomplete Principal Diagnosis	CMS Claim Processing Manual Chapter 3, Section 20.2.1, Chapter 32, Section 240.1, CMS Definitions of Medicare Code Edits Version 34.0- The edit will fire on an inpatient claim when the principal diagnosis code does not have the required additional digits
20686	Inpatient Invalid Other Diagnosis	CMS Claim Processing Manual Chapter 3, Section 20.2.1, Chapter 32, Section 240.1, CMS Definitions of Medicare Code Edits Version 34.0- The edit will fire on an inpatient claim when a secondary diagnosis code is not found in the knowledgebase or the secondary diagnosis code is invalid based on the "through" date on the claim.
20687	Inpatient Incomplete Other Diagnosis	CMS Claim Processing Manual Chapter 3, Section 20.2.1, Chapter 32, Section 240.1, CMS Definitions of Medicare Code Edits Version 34.0- The edit will fire on an inpatient claim when the secondary diagnosis code does not have the required additional digits.
20689	Inpatient Invalid Principal Procedure	CMS Claim Processing Manual Chapter 3, Section 20.2.1, Chapter 32, Section 240.1, CMS Definitions of Medicare Code Edits Version 34.0- The edit will fire on an inpatient claim when the principal procedure code is not found in the knowledgebase or the principal procedure code is invalid based on the "through" date on the claim.
20698	Inpatient Incomplete Principal Procedure	CMS Claim Processing Manual Chapter 3, Section 20.2.1, Chapter 32, Section 240.1, CMS Definitions of Medicare Code Edits Version 34.0- The edit will fire on an inpatient claim when the principal procedure code does not have the required additional digits.
20700	Inpatient Invalid Other Procedure	CMS Claim Processing Manual Chapter 3, Section 20.2.1, Chapter 32, Section 240.1, CMS Definitions of Medicare Code Edits Version 34.0- The edit is triggered when an inpatient claim contains other secondary procedure codes that are invalid based on the "though" date on the claim. This edit checks each secondary procedure code against a table of valid procedure codes effective based on the "through" date of the claim.
20701	Inpatient Incomplete Other Procedure	CMS Claim Processing Manual Chapter 3, Section 20.2.1, Chapter 32, Section 240.1, CMS Definitions of Medicare Code Edits Version 34.0- The edit will fire on an inpatient claim when an other procedure code does not have the required additional digits.
20732	Missing Provider ID - Outpatient	National Uniform Billing Committee, Medicare Claims Processing Manual, Chapter 25, Section 75.5- The edit will fire when a claim is submitted with a missing provider ID.
20743	Missing Type of Admission	Official UB-04 Data Specifications Manual 2017, CMS Claims Processing Manual Ch.25 Section 75, Transmittal R2250CP- The edit will fire when a claim is submitted with a missing or invalid Type of Admission code. This is based on requirements from the National Uniform Billing Committee (NUBC) and the Centers for Medicare and Medicaid Services (CMS)
20743	Missing Type of Admission	Official UB-04 Data Specifications Manual 2017, CMS Claims Processing Manual Ch.25 Section 75, Transmittal R2250CP- The edit will fire when a claim is submitted with a missing or invalid Type of Admission code. This is based on requirements from the National Uniform Billing Committee (NUBC) and the Centers for Medicare and Medicaid Services (CMS).
20753	Missing Patient ID - Outpatient	National Uniform Billing Committee, Medicare Claims Processing Manual, Chapter 25, Section 75.1- The edit will fire when a claim is submitted without a patient identification number (Medical/Health Record Number FL 3b).

20789	Invalid Type of Admission	Official UB-04 Data Specifications Manual 2017, CMS Claims Processing Manual Ch.25 Section 75, Transmittal R2250CP- The edit will fire when a claim is submitted with a missing or invalid Type of Admission code. This is based on requirements from the National Uniform Billing Committee (NUBC) and the Centers for Medicare and Medicaid Services (CMS).
20835	ASC MUE Medicaid By Line	National Correct Coding Initiative in Medicaid/Medicaid NCCI Edit Files/MUEs for Practitioner and ASC Services, CMS Transmittal R1421OTN- The edit will fire when the units of service (UOS) are clinically impossible or unreasonable for the service billed. The presence of certain modifiers will override this edit for claim line edits. This edit is based on a requirement from the Centers for Medicare and Medicaid Services (CMS)
20836	ASC MUE Medicaid By Line	National Correct Coding Initiative in Medicaid/Medicaid NCCI Edit Files/MUEs for Practitioner and ASC Services, CMS Transmittal R1421OTN- The edit will fire when the units of service (UOS) are clinically impossible or unreasonable for the service billed. The presence of certain modifiers will override this edit for claim line edits. This edit is based on a requirement from the Centers for Medicare and Medicaid Services (CMS).
20876	Referring Physician Missing	Validation- This rule identifies procedure code that requires referring physician and if referring provider ID is missing REF edit is fired.
20876	Referring Physician Missing	Validation- This rule identifies procedure code that requires referring physician and if referring provider ID is missing REF edit is fired.
20886	Invalid Occurrence Span Code	UB04 Data Specifications Manual 2017, CMS Claims Processing Manual, Chapter 25, section 75.3- The edit will fire when a claim is submitted with an invalid occurrence span code or the occurrence span code's From or Through dates are invalid. This is based on requirements from the National Uniform Billing Committee (NUBC) and the Centers for Medicare and Medicaid Services (CMS).
20904	Missing Account ID - Outpatient	National Uniform Billing Committee (NUBC), Medicare Claim Processing Manual Chapter 25, Section 75.1- The edit will fire when a claim is submitted with a missing Account ID.
20908	Typically Cosmetic Procedure	This rule identifies claim lines containing procedures that may be considered cosmetic. If the procedure code is considered Cosmetic then COS edit is issued.
20908	Typically Cosmetic Procedure	Validation edit- This rule identifies claim lines containing procedures that may be considered cosmetic. If the procedure code is considered Cosmetic then COS edit is issued.
20909	Typically Investigational	This rule identifies claim lines containing procedures that may be considered cosmetic. If the procedure code is considered Cosmetic then COS edit is issued. **[SH] Adding correct description from commercial spreadsheet - This rule identifies line items containing procedures that may be considered investigational/experimental. If the procedure code is Investigational/Experimental then INV edit fires.**
20909	Typically Investigational	This rule identifies claim lines containing procedures that may be considered cosmetic. If the procedure code is considered Cosmetic then COS edit is issued. **[SH] Adding correct description from commercial spreadsheet - This rule identifies line items containing procedures that may be considered investigational/experimental. If the procedure code is Investigational/Experimental then INV edit fires.**
20948	Duplicate Claim in History Outpatient	Medicare Claim Processing Manual Chapter 1, Section 120- This claim is a possible duplicate of outpatient claim in history. This edit identifies an entire claim that is a potential duplicate of a previously submitted outpatient claim.

20949	Invalid Occurrence Code	UB04 Data Specifications Manual 2017, CMS Claims Processing Manual, Chapter 25, section 75.3- The flag fires on an inpatient or outpatient claim when the occurrence code is not valid. Rule determines whether the occurrence code on the current claim is invalid. Or, the occurrence code date "From" date is missing or invalid.
20951	Duplicate Claim Line Same Claim	CMS Claims Processing Manual, Chapter 1, Section 120- This edit identifies line items that are potentially duplicates when two lines entered on one or more claims have identical providers, dates of service, procedure codes, modifiers, number of units, revenue codes and submitted charges.
20953	Duplicate Claim in History Inpatient	Medicare Claim Processing Manual Chapter 1, Section 120- This claim is a possible duplicate of inpatient claim in history. This edit identifies an entire claim that is a potential duplicate of a previously submitted inpatient claim.
20974	Patient DOB is Invalid - Outpatient	National Uniform Billing Committee (NUBC), Medicare Claim Processing Manual Chapter 25, Section 75.1- The edit will fire when a claim is submitted with a Statement Covers Period From or Through date, Admission Date or Entry Date that precedes the patient's date of birth.
20978	Invalid Occurrence Span Code	UB04 Data Specifications Manual 2017, CMS Claims Processing Manual, Chapter 25, section 75.3- The edit will fire when a claim is submitted with an invalid occurrence span code or the occurrence span code's From or Through dates are invalid. This is based on requirements from the National Uniform Billing Committee (NUBC) and the Centers for Medicare and Medicaid Services (CMS).
20999	Invalid Occurrence Code	UB04 Data Specifications Manual 2017, CMS Claims Processing Manual, Chapter 25, section 75.3- The edit fires on an inpatient or outpatient claim when the occurrence code is not valid. Rule determines whether the occurrence code on the current claim is invalid. Or, the occurrence code date "From" date is missing or invalid.
21005	Occurrence Code Missing Begin Date	UB04 Data Specifications Manual 2017, CMS Claims Processing Manual, Chapter 25, section 75.3- The edit will fire on an inpatient or outpatient claim when the occurrence code is missing the begin date.
21006	Occurrence Code Missing Begin Date	UB04 Data Specifications Manual 2017, CMS Claims Processing Manual, Chapter 25, section 75.3- The edit will fire on an inpatient or outpatient claim when the occurrence code is missing the begin date.
21032	Patient DOB is Missing - Outpatient	National Uniform Billing Committee (NUBC), Medicare Claim Processing Manual Chapter 25, Section 75.1- The edit will fire when a claim is submitted with a missing date of birth.
21342	Medicaid Add-On Procedure - Critical Care	CMS Policy/Add-on Code Edits/Transmittal 2636- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS), transmittals and the CPT manual to determine eligibility of an add-on procedure code(s).
21546	Medicaid Add-On Procedure - Primary Procedure Flagged	CMS Policy/Add-on Code Edits/Transmittal 2636- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of an add-on procedure code(s).
21549	Medicaid Add-On Procedure - Critical Care Primary Procedure Flagged	CMS Policy/Add-on Code Edits/Transmittal 2636- The edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of an add-on procedure code(s).
21830	Inappropriate Specification of Bilateral Procedure Different Claim	Integrated OCE (IOCE) CMS Specifications- The edit fires when an inherently bilateral procedure code occurs on more than one line or with more than one unit for the same date of service. This edit applies unless modifier 76 or 77 is submitted on the second or subsequent line or units Condition code G0 will override edit 17 for inherently bilateral codes with a status indicator of ''V.'' This edit is based on a requirement from the Centers for Medicare and Medicaid Services (CMS).

21906	Invalid Present on Admission (POA) Indicator	MLN Fact Sheet - Present on Admission Indicator Reporting, ICD-9-CM Official Guidelines for Coding and Reporting Effective October 2016- The edit is triggered when an inpatient claim contains an invalid Present on Admission (POA) indicator. This edit is based on a requirement from ICD-10-CM Official Guidelines for Coding and Reporting and the Centers for Medicare and Medicaid Services (CMS).
21919	Duplicate Claim Line Different Claim	CMS Claims Processing Manual, Chapter 1, Section 120- This edit identifies line items that are potentially duplicates when two lines entered on one or more claims have identical providers, dates of service, procedure codes, modifiers, number of units, revenue codes and submitted charges.
22274	Procedure Age Excluding Vaccine Codes Sourced to FDA	CPT, HCPCS, FDA, AAP, CMS Policy, ICD-10-CM, AMA- The edit identifies line items where the listed procedure code is not typically performed for a person of the patient's age excluding the vaccine codes (90476-90756) which are sourced to the Food and Drug Administration (FDA). Although the FDA provides age information for approved use, some physicians may find a vaccine is warranted even if the patients age is not within the recommended FDA approved use age range.
22274	Procedure Age Excluding Vaccine Codes Sourced to FDA	CPT, HCPCS, FDA, AAP, CMS Policy, ICD-10-CM, AMA- The edit identifies line items where the listed procedure code is not typically performed for a person of the patient's age excluding the vaccine codes (90476-90756) which are sourced to the Food and Drug Administration (FDA). Although the FDA provides age information for approved use, some physicians may find a vaccine is warranted even if the patients age is not within the recommended FDA approved use age range.
22274	Procedure Age Excluding Vaccine Codes Sourced to FDA	CPT, HCPCS, FDA, AAP, CMS Policy, ICD-10-CM, AMA- The edit identifies line items where the listed procedure code is not typically performed for a person of the patient's age excluding the vaccine codes (90476-90756) which are sourced to the Food and Drug Administration (FDA). Although the FDA provides age information for approved use, some physicians may find a vaccine is warranted even if the patients age is not within the recommended FDA approved use age range.
22423	Medicaid Prior Authorization	State Fee Schedules- The edit utilizes Medicaid state-specific fee schedules to identify claim lines that include a procedure code that requires prior authorization.
22452	Medicaid Health Care-Acquired Condition Non-exempt Diagnosis Code	Medicaid Provider Preventable Conditions Frequently Asked Questions, Federal Register, Volume 76, Number 108, dated June 6, 2011- The edit will trigger when an inpatient Medicaid claim contains a principal or other (secondary) diagnosis code designated as a Health Care-Acquired Condition(HCAC) with an exempt Present on Admission (POA) indicator (1 or Empty).
22453	Medicaid Health Care-Acquired Condition Non-exempt Diagnosis Code	Medicaid Provider Preventable Conditions Frequently Asked Questions, Federal Register, Volume 76, Number 108, dated June 6, 2011- The edit will trigger when an inpatient Medicaid claim contains other (secondary) diagnosis code (HAC category 11 - Surgical Site Infection - Bariatric Surgery) designated as a Health Care-Acquired Condition(HCAC) with an exempt Present on Admission (POA) indicator (1 or Empty).
22621	Medicaid Documentation-By Report	State Fee Schedules- The flag identifies Medicaid claim lines that need additional information submitted by providers in order to determine if billing requirements have been met.
22676	Medicaid Non Covered	State Fee Schedules- The edit identifies Medicaid claim lines that are considered "non-covered services" per individual state Medicaid guidelines.
22814	Missing or Invalid Type of Bill - Inpatient	Official UB-04 Data Specifications Manual 2015, CMS Claims Processing Manual Ch.25 Section 75- A code indicating the specific type of bill (e.g., hospital inpatient, outpatient, replacements, voids, etc.). The first digit is a leading zero. The fourth digit defines the frequency of the bill for the institutional claim.

22831	Missing or Invalid Statement Covers Period From/Through Date - Inpatient	UB04 Data Specifications Manual 2015 , Medicare Claims Processing Manual Chapter 25, Section 75.1 p. 17, CMS MLN Special Edition SE1117- The edit will fire when a claim is submitted with a missing or invalid Admission date or Statement Covers Period ''From'' and '''Through'' dates. This is based on a requirement from the National Uniform Billing Committee (NUBC) and the Centers for Medicare and Medicaid Services (CMS).
22837	Interim Claims with Frequency Code 2 and 3 Requires Patient Discharge Status Code 30 - Inpatient	National Uniform Billing Committee (NUBC), Official UB-04 Data Specifications Manual 2021, CMS MLN Matters Article SE0801, CMS Claim Processing Manual Chapter 1 Section 50.2, CMS Transmittal R2578CP- The edit fires when a claim contains a TOB with a frequency digit of 2 or 3 and the Patient Discharge Status code does not equal 30.
22894	Inappropriate Diagnosis Code(s) on Newborn Record	ICD-10-CM- This edit identifies when a maternal delivery diagnosis code(s) is reported on a newborn record.
22894	Inappropriate Diagnosis Code(s) on Newborn Record	ICD-10-CM- This edit identifies when a maternal delivery diagnosis code(s) is reported on a newborn record.
22895	Inappropriate Diagnosis Code(s) on Maternal Record	ICD-10-CM- This edit identifies when a maternal delivery diagnosis code(s) is reported on a newborn record.
22895	Inappropriate Diagnosis Code(s) on Maternal Record	ICD-10-CM- This edit identifies when a maternal delivery diagnosis code(s) is reported on a newborn record.
22900	Missing Account ID - Inpatient	National Uniform Billing Committee (NUBC), Medicare Claim Processing Manual Chapter 25, Section 75.1- The edit will fire when a claim is submitted with a missing Account ID.
22901	Patient DOB is Missing - Inpatient	National Uniform Billing Committee (NUBC), Medicare Claim Processing Manual Chapter 25, Section 75.1- The edit will fire when a claim is submitted with a missing date of birth.
23163	Inappropriate Diagnosis Combination - Definitive - Facility	ICD-10-CM Excludes1 Note guidelines- The Inappropriate Diagnosis Combination - Definitive edit identifies ICD-10-CM diagnosis codes that are mutually exclusive and cannot be reported together. The ICD-10-CM guidelines identify specific codes in the Excludes1 notes. These relationships are considered ICD-10-CM definitive in the KnowledgeBase.
23256	Type of Admission Frequency	UB-04 Data Specifications Manual 2018/Point of Origin for Admission or Visit, CMS Claims Processing Manual Ch.25 Section 75- The UB-04 Manual states, "Any human should only have a Priority (Type of Admission) (FL 14) = 4 once in their lifetime."
23256	Type of Admission Frequency	UB-04 Data Specifications Manual 2018/Point of Origin for Admission or Visit, CMS Claims Processing Manual Ch.25 Section 75- The UB-04 Manual states, "Any human should only have a Priority (Type of Admission) (FL 14) = 4 once in their lifetime."
23762	Psychiatric Collaborative Care Management Episode	CPT- Initial psychiatric collaborative care management service code 99492 may not be reported within six calendar months of another psychiatric collaborative care management service code, 99492 or 99493. The CPT® codebook guidelines state "A new episode of care starts after a break in episode of six calendar months or more."
23763	HCPCS Codes for RHCs and FQHCs Reported on a Professional Claim	CMS Policy- Healthcare Common Procedure Coding System (HCPCS) codes G0071, G0466-G0470, G0511, G0512, G2025 may not be reported on professional claims. These codes are to be reported by the Federally Qualified Health Center (FQHC) for the FQHC prospective payment system (PPS) and the Rural Health Clinics (RHCs) billing under the All-Inclusive Rate (AIR).
23769	Psychiatric Collaborative Care Management Services During Same Month	CPT- Based on CPT guidelines, subsequent psychiatric collablorative care code 99493 may not be reported in the same calendar month as initial psychiatric collablorative care code 99492 . 99493 is reported in a subsequent month from 99492.

23790	Behavioral Health Integration Care Management	CPT; CMS Policy- The CPT® Professional Edition and the Centers for Medicare and Medicaid Services (CMS) guidelines state that Behavioral Health Integration (BHI) care management, codes 99484 and G2214, and psychiatric collaborative care management, codes 99492, 99493 and 99494, may not be reported by the same physician or other qualified health care professional in the same month.
24080	Medicaid Unbundle	National Correct Coding Initiative Policy Manual For Medicaid Services- The Medicaid National Correct Coding Initiative Edits history edit, sUH, verifies if the procedure code on a claim line in history is billed with any other procedure for the same patient on the same day by the same provider. If the codes cannot be billed together and the code in history is the deny code and on a separate claim, the edit will trigger.
24080	Medicaid Unbundle	National Correct Coding Initiative Policy Manual For Medicaid Services- The Medicaid National Correct Coding Initiative Edits history edit, sUH, verifies if the procedure code on a claim line in history is billed with any other procedure for the same patient on the same day by the same provider. If the codes cannot be billed together and the code in history is the deny code and on a separate claim, the edit will trigger.
24080	Medicaid Unbundle	National Correct Coding Initiative Policy Manual For Medicaid Services- The Medicaid National Correct Coding Initiative Edits history edit, sUH, verifies if the procedure code on a claim line in history is billed with any other procedure for the same patient on the same day by the same provider. If the codes cannot be billed together and the code in history is the deny code and on a separate claim, the edit will trigger.
25277	Ambulatory Surgical Center Invalid Age	Medicare Claims Processing Manual Chapter 4, Section Section 40.3, Integrated Outpatient Code Editor Specifications Manual, v17.0, Integrated Outpatient Code Editor Software, v17.0- The edit will fire when a claim is submitted with a patient's age that is not between 0 and 124 years. The patient's age is calculated using the submitted date of birth and the service start date on the claim. The patient's age will be considered invalid if the age is non-numeric or outside the range of 0 - 124 years.
25307	Inpatient Questionable Obstetric Admission	Medicare Code Editor V. 36 October 2018, Medicare Claims Processing Manual Chapter 100-04, Chapter 3 Section 20.2.1- The edit identifies submitted ICD-10-PCS procedure codes describing a cesarean section or vaginal delivery without a corresponding secondary diagnosis code describing the outcome of delivery.
25539	Transfer Rebundle	AMA/CPT- The Transfer/Rebundle edit identifies multiple procedure codes submitted together when a single, comprehensive code description includes all procedure components, based on Current Procedural Terminology CPT® Professional Edition code descriptors/guidelines and the Centers for Medicare and Medicaid Services (CMS) code descriptors, guidelines, and policies that indicate a more accurate code(s) exist(s) to represent the codes submitted.
25988	Supply Code Not Reported with an Always Injection Procedure	National Correct Coding Initiative Policy Manual For Medicaid Services- CPT Assistant; Interpretation of CMS Policy- The edit identifies line items where a procedure for an injection or infusion, or includes an injection or infusion, is reported in the physician’s office or the patient’s home and the drug or substance administered was not reported. This edit includes procedure codes that utilize an injection or infusion only. Procedure codes that could be used for an aspiration or contain "with or without" injection are excluded from this DDR.
26063	Laboratory Test in Hospital	Medicare Physician Fee Schedule Relative Value File, Medicare Claim Processing Manual 100-04, Chapter 16- The edit utilizes the Centers for Medicare and Medicaid Services' (CMS) Medicare Physician Fee Schedule (MPFS) to determine eligibility of a CPT® code to be split into professional and technical components. This edit will fire on all claim lines containing codes that have an indicator of ''9'' in the PC/TC column of the MPFS that are submitted with a location of inpatient or outpatient hospital.

26064	Laboratory Interpretation in Hospital	Medicare Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) Medicare Physician Fee Schedule (MPFS) to determine eligibility of a CPT® code to be split into professional and technical components. This edit will fire on all claim lines containing codes that have an indicator of ''6'', when submitted with a modifier 26, in the PC/TC column of the MPFS that are submitted with a location of inpatient or outpatient hospital.
26065	Technical Component in Hospital	Medicare Physician Fee Schedule Relative Value File- The edit uses the Centers for Medicare and Medicaid Services' (CMS) Medicare Physician Fee Schedule (MPFS) to determine eligibility of a CPT® code to be split into professional and technical components. The edit will fire on all claim lines containing codes that have an indicator of ''3'' in the PC/TC column of the MPFS that are submitted with a location of inpatient or outpatient.
26188	Inappropriate Age for Procedure	CPT, HCPCS, FDA, AAP, CMS Policy, ICD-10-CM, AMA- The edit identifies line items where the listed procedure code is not typically performed for a person of the patient's age.
26246	Duplicate Diagnosis Code	ICD-10-CM Official Guidelines for Coding and Reporting- The ICD-10-CM Official Guidelines for Coding and Reporting state, "Each unique ICD-10-CM diagnosis code may be reported only once for an encounter."
26246	Duplicate Diagnosis Code	ICD-10-CM Official Guidelines for Coding and Reporting- The ICD-10-CM Official Guidelines for Coding and Reporting state, "Each unique ICD-10-CM diagnosis code may be reported only once for an encounter."
26246	Duplicate Diagnosis Code	ICD-10-CM Official Guidelines for Coding and Reporting- The ICD-10-CM Official Guidelines for Coding and Reporting state, "Each unique ICD-10-CM diagnosis code may be reported only once for an encounter."
26266	Service Provided Prior to Initial Marketing Date	Integrated Outpatient Code Editor Specifications Version 20.0- The edit identifies when the reported line item date of service of a code is prior to the initial marketing date for which it can be reported.
26308	ASC Facility - Claim With Pass-Through Device Lacks Required Procedure	CMS Transmittal R4191CP- The edit will fire when a pass-through device is billed without an associated procedure. Pass through devices have a status indicator (SI) ''H.'' This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS).
26488	Professional Services for Home Infusion Therapy Drug	CMS Policy- Effective January 1, 2019, CMS has established G-codes for the professional services rendered on an infusion drug administration calendar day for each payment category. Each payment category will be paid at amounts consistent with the physician fee schedule for codes and units of such codes.
26551	Professional Services for Home Infusion Therapy	CMS Policy- Effective January 1, 2019, CMS has established G-codes for the professional services rendered on an infusion drug administration calendar day for each payment category. Each payment category will be paid at amounts consistent with the physician fee schedule for codes and units of such codes
26574	Professional Services for Home Infusion Therapy in History	CMS Policy- Effective January 1, 2019, CMS has established G-codes for the professional services rendered on an infusion drug administration calendar day for each payment category. Each payment category will be paid at amounts consistent with the physician fee schedule for codes and units of such codes.
26617	Behavioral Health Integration Care Management in History	The CPT® Professional Edition and the Centers for Medicare and Medicaid Services (CMS) guidelines state that Behavioral Health Integration (BHI) care management, codes 99484 and G2214, and psychiatric collaborative care management, codes 99492, 99493 and 99494, may not be reported by the same physician or other qualified health care professional in the same month.
26640	Psychiatric Collaborative Care Management Services in History During Same Month	CPT- Based on CPT guidelines, subsequent psychiatric collablorative care code 99493 may not be reported in the same calendar month as initial psychiatric collablorative care code 99492 . 99493 is reported in a subsequent month from 99492.

26689	Missing Patient ID - Inpatient	National Uniform Billing Committee, Medicare Claims Processing Manual, Chapter 25, Section 75.1- The edit will fire when a claim is submitted without a patient identification number (Medical/Health Record Number FL 3b).
26696	Missing Provider ID - Inpatient	National Uniform Billing Committee, Medicare Claims Processing Manual, Chapter 25, Section 75.5- The edit will fire when a claim is submitted with a missing provider ID.
26699	Patient DOB is Invalid - Inpatient	National Uniform Billing Committee (NUBC), Medicare Claim Processing Manual Chapter 25, Section 75.1- The edit will fire when a claim is submitted with a Statement Covers Period From or Through date, Admission Date or Entry Date that precedes the patient's date of birth.
26735	Medicaid Modifier Not Appropriate	CMS Policy; CPT; American Medical Association (AMA)- The edit fires on a claim line that does not have the appropriate modifier appended for use with a particular CPT® or HCPCS procedure code.
26735	Medicaid Modifier Not Appropriate	CMS Policy; CPT; American Medical Association (AMA)- The edit fires on a claim line that does not have the appropriate modifier appended for use with a particular CPT® or HCPCS procedure code.
26765	Bilateral Modifier 50 Billed With More Than 1 Unit	Medicare Claims Processing Manual chapter 23 section 20.9.3.2 Medicare Claims Processing Manual chapter 12 section 40.7- The edit identifies claim lines that contain a procedure code with modifier 50 appended and billed with more than 1 unit of service. These codes are identified by indicators "1" or "3" in the bilateral column of the MPFS.
26837	Medicaid Surgical Separate Procedure	National Correct Coding Initiative Policy Manual for Medicaid Services Effective January 1, 2019, Chapter I- The separate procedure edit identifies when the procedure code on the current line is a separate procedure that is not included in the NCCI edits and is billed with any other related procedure for the same patient, on the same day by the same provider without an appropriate modifier override.
27049	Modifier 33 with Moderate Sedation Services	CMS Transmittal 3763 CR 10075- The edit identifies when a moderate sedation services (G0500 or 99153) are performed in conjunction with screening colonoscopy services (G0105 or G0121), coinsurance and deductible are waived when modifier 33 is not entered on the moderate sedation claim.
27083	Invalid Procedure Code	CMS Integrated OCE (IOCE) Specifications Version 15.2- The edit fires when an invalid HCPCS code or a HCPCS code that is invalid for the patient's date of service is submitted on a claim. This edit will look at all the HCPCS codes on the outpatient facility claim and determine if the submitted codes are valid and effective in the Facility Knowledgebase for the ''From'' date of service on the claim. This is based on guidelines from the Centers for Medicare and Medicaid Services (CMS).
27186	Facility Only Modifiers	Medicare Claims Processing Manual Chapter 4 Section - 20.6.4- The edit identifies claim lines containing modifier 73 or 74, when billed with a provider specialty other than 49, to advise that it is inappropriate to report Modifier 73 or 74 for discontinued provider services on a professional claim.
27288	Medicaid Modifier Not Appropriate	CMS Policy; CPT; American Medical Association (AMA)- The editfires on a claim line that does not have the appropriate modifier appended for use with a particular CPT® or HCPCS procedure code.
27288	Medicaid Modifier Not Appropriate	CMS Policy; CPT; American Medical Association (AMA)- The editfires on a claim line that does not have the appropriate modifier appended for use with a particular CPT® or HCPCS procedure code.
27609	Medicaid Multiple Assistant Surgery	American College of Surgeons Assistants at Surgery Study- The edit utilizes the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule NPFS) and/or state Medicaid policies and guidelines to identify CPT® codes eligible for the assistant surgeon modifiers 80, 81, 82, and AS. The edit will fire on all claim lines containing a procedure code, appended with an assistant surgeon modifier (80, 81, 82, AS) when another claim line in history includes the same procedure with an assistant surgeon modifier, for the same date of service (DOS) submitted by a different provider.

27736	New Patient Code in History for Established Patient	CMS Outpatient Prospective Payment System Visit Codes FAQs, Evaluation and Management Services Guide- This rule identifies when a new patient evaluation and management (E/M) code was reported in history by the same provider within 3 years of the current claim line's beginning date of service. An established patient evaluation and management (E/M) code should be reported instead of the new patient E/M code.
27829	Medicaid Surgical Separate Procedure History	National Correct Coding Initiative Policy Manual for Medicaid Services Effective January 1, 2019, Chapter I- The separate procedure edit identifies when the procedure code on the current line is a separate procedure that is not included in the NCCI edits and is billed with any other related procedure for the same patient, on the same day by the same provider without an appropriate modifier override.
28158	ICD-10-CM Outpatient Code Editor (OCE) Age	Outpatient Code Editor IOCE Quarterly Data Files- The rule identifies the CMS Integrated Outpatient Code Editor (IOCE) age ranges for ICD-10-CM codes.
28158	ICD-10-CM Outpatient Code Editor (OCE) Age	Outpatient Code Editor IOCE Quarterly Data Files- The rule identifies the CMS Integrated Outpatient Code Editor (IOCE) age ranges for ICD-10-CM codes.
28286	New Patient Ophthalmology Code in History for Established Patient	CMS Outpatient Prospective Payment System Visit Codes FAQs, Evaluation and Management Services Guide- This rule identifies when a new patient evaluation and management (E/M) code was reported in history by the same provider within 3 years of the current claim line's beginning date of service. An established patient evaluation and management (E/M) code should be reported instead of the new patient E/M code.
28321	Interprofessional Telehealth Consultations and Face-To-Face Service Reported in 14 Days	CPT- Based on guidelines from the CPT codebook, an Interprofessional Telehealth Consultation, codes 99446-99451, may not be reported within 14 days of a face-to-face service by the same physician.
28322	Interprofessional Telehealth Consultation Found in History with a Face-To-Face Service Reported in 14 Days	CPT- Based on guidelines from the CPT codebook, an Interprofessional Telehealth Consultation, codes 99446-99451, may not be reported within 14 days of a face-to-face service by the same physician.
28811	Duplicative Radiology Facility and Professional Procedures	This rule is designed to determine reporting of a duplicate facility radiology procedure code with modifiers 26, TC or globally submitted on a professional claim for the same date of service.
29855	Inappropriate Use of Repeat Radiology Modifier-1	CPT- This rule identifies a radiology claim line when a radiology procedure or service is submitted with a 76 or 77 modifier, signifying the procedure or service is a repeat of the same procedure done previously, yet review of claim history identifies no original same procedure or service submitted for that date of service or procedure. In addition, the rule identifies radiology claim lines submitted with modifier 76 and the same procedure done previously by different provider on the same date of service or radiology claim lines submitted with modifier 77 and the same procedure done previously by same provider on the same date of service.
29973	Post-Operative Care Modifier Rule	Medicare Claim Processing Manual Chapter 12, Section 40 Surgeons and Global Surgery, 40.2 - Billing Requirements for Global Surgeries- The edit utilizes the Centers for Medicare and Medicaid Services (CMS) Global Surgery Booklet and the Medicare Claims Processing Manual to identify claim lines that include a procedure code with modifier 55 appended and there is a claim line in history with the same procedure code for the same date of service from a different provider which does not include modifier 54.

30171	History Post-Operative Care Modifier Rule	Medicare Claim Processing Manual Chapter 12, Section 40 Surgeons and Global Surgery, 40.2 - Billing Requirements for Global Surgeries- The edit uses the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS),Global Surgery Booklet, and the Medicare Claims Processing Manual to identify claim lines that include a procedure code without modifier 54 appended and there is a claim line in history with the same procedure code for the same date of service from a different provider with modifier 55.
30242	Duplicative Laboratory Procedure Reported By Provider and Independent/Reference Laboratory	CPT; CPT Assistant; Principles of CPTÂ® Coding; Coding with Modifiers- This rule identifies a duplicate laboratory procedure code submitted with modifier 90 by a provider on a professional claim and an independent or reference laboratory is also reporting the same laboratory procedure code for the same patient on the same date of service. This is based on guidelines from the American Medical Association (AMA).
30352	Multiple Gestation Delivery	CPT Assistant- This rule identifies the reporting of vaginal or cesarean delivery of twins (or other multiple gestations). The diagnosis code for multiple gestation and outcome of delivery code from category Z37 should be indicated on the claim.
30443	Duplicative Laboratory Procedure Reported By Provider in History and Independent/Reference Laboratory	CPT; CPT Assistant; Principles of CPTÂ® Coding; Coding with Modifiers- This rule identifies a duplicate laboratory procedure code submitted with modifier 90 by a provider on a professional claim found in history and an independent or reference laboratory is also reporting the same laboratory procedure for the same patient on the same date of service. This is based on guidelines from the American Medical Association (AMA).
30530	Inappropriate Use of Repeat Radiology Modifier in History	CPT- The edit fires on a radiology claim line when a radiology procedure or service is submitted with a 76 or 77 modifier, signifying the procedure or service is a repeat of the same procedure done previously, yet review of claim history identifies no original same procedure or service submitted for that date of service.
30616	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code New Patient	CMS Integrated OCE (IOCE) Specifications V21.3- The edit will fire when a claim with bill type 077x is submitted with one on the required FQHC payment codes and without a required FQHC qualifying visit code. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
30617	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code Established Patient	CMS Integrated OCE (IOCE) Specifications V21.3- The edit will fire when a claim with bill type 077x is submitted with one on the required FQHC payment codes and without a required FQHC qualifying visit code. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
30619	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code IPPE/AWV	CMS Integrated OCE (IOCE) Specifications V21.3- The edit will fire when a claim with bill type 077x is submitted with one on the required FQHC payment codes and without a required FQHC qualifying visit code. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
30620	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code Mental Health New Patient	CMS Integrated OCE (IOCE) Specifications V21.3- The edit will fire when a claim with bill type 077x is submitted with one on the required FQHC payment codes and without a required FQHC qualifying visit code. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
30621	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code Mental Health Established Patient	CMS Integrated OCE (IOCE) Specifications V21.3- The edit will fire when a claim with bill type 077x is submitted with one on the required FQHC payment codes and without a required FQHC qualifying visit code. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).
30677	Professional Services for Home Infusion Therapy Drug	CMS Claim Processing Manual, Chapter 32, Section 411- The Centers for Medicare and Medicaid Services (CMS) has established G-codes for the professional services rendered on an infusion drug administration calendar day for each payment category. Each payment category will be paid at amounts consistent with the physician fee schedule for codes and units of such codes.

30678	Professional Services for Home Infusion Therapy	CMS Claim Processing Manual, Chapter 32, Section 411- The Centers for Medicare and Medicaid Services (CMS) has established G-codes for the professional services rendered on an infusion drug administration calendar day for each payment category. Each payment category will be paid at amounts consistent with the physician fee schedule for codes and units of such codes.
30679	Professional Services for Home Infusion Therapy in History	CMS Claim Processing Manual, Chapter 32, Section 411- The Centers for Medicare and Medicaid Services (CMS) has established G-codes for the professional services rendered on an infusion drug administration calendar day for each payment category. Each payment category will be paid at amounts consistent with the physician fee schedule for codes and units of such codes.
30684	Professional Services for Home Infusion Therapy Specialty	CMS Claim Processing Manual, Chapter 32, Section 411- The guidelines from the Centers for Medicare and Medicaid Services (CMS) Claims Processing Manual, Chapter 32, section 411, for Home Infusion Therapy Services states “Contractors shall accept and pay for home infusion therapy services to eligible home infusion suppliers (new specialty D6) effective for claim lines with dates of service on or after January 1, 2021…”
30695	Professional Services for Home Infusion Therapy - 60 days	CMS Claim Processing Manual, Chapter 32, Section 411- The guidelines from the Centers for Medicare and Medicaid Services (CMS) Claims Processing Manual, Chapter 32, section 411, for Home Infusion Therapy Services states “To differentiate the first visit from all subsequent visits, home infusion therapy [HIT] suppliers may only bill on of the ‘initial visit’ G-codes to indicate a visit for a new patient who had previously received their last home infusion therapy service visit more than 60 days prior to the new initial home infusion therapy service visit.”
30699	Supplementary or Additional Code Not Allowed as Principal Diagnosis	Integrated Outpatient Code Editor (IOCE) Specifications V21.3- The edit will fire on an outpatient claim when the principal diagnosis code reported is considered supplementary or an additional code and cannot be used as the principal diagnosis.
31204	Duplicative Laboratory Professional and Facility Procedures	CMS Claims Processing Manual Chapter 4, Section 20.2- The edit identifies facility laboratory codes that have a potential duplicate technical service on a professional claim or a Critical Access Hospital (CAH) facility laboratory service with a professional revenue code with a potential duplicate on a professional claim submitted on the same date of service. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS).
31471	Covid-19 Lab Add-On Code Reported Without Required Primary Procedure	Integrated Outpatient Code Editor (IOCE) Specifications V22.0- The flag will fire on an outpatient claim when a COVID-19 lab add-on HCPCS code is submitted and an applicable primary procedure is not reported on the same date of service.
31486	Inappropriate Use of Repeat Radiology Modifier-2	CPT- The edit fires on a radiology claim line when a radiology procedure or service is submitted with a 76 or 77 modifier, signifying the procedure or service is a repeat of the same procedure done previously, yet review of claim history identifies no original same procedure or service submitted for that date of service.
31605	Duplicative Radiology Professional and Facility Procedures	CMS Claims Processing Manual Chapter 4, Section 20.2- The edit identifies potential duplicate radiology procedures submitted on a professional claim in history for the same date of service.
31619	Medicaid Modifier - 51 Required	Medicare Claims Processing Manual, Chapter 12, 40.6 â€“ Claim for Multiple Surgeries (Rev.1, 10-01-03)- The edit identifies Medicaid claim lines that contain a procedure code that has an indicator of ''2, 3, 4, 5, 6 or 7'' in the multiple procedure column of the NPFS signifying that they are eligible for modifier 51. The edit then ranks each procedure submitted that has an indicator of ''2, 3, 4, 5, 6 or 7'' in the multiple procedure column of the NPFS in descending order according to the appropriate corresponding CMS NPFS RVUs. The edit fires on all claim lines that do not have modifier 51 appended, except the claim line with the highest CMS NPFS RVU value

31621	Medicaid Modifier - 51 Inappropriate	Medicare Claims Processing Manual, Chapter 12, 40.6 â€“ Claim for Multiple Surgeries (Rev.1, 10-01-03)- The edit identifies Medicaid claim lines that contain a procedure code with the modifier 51 appended inappropriately. The edit ranks all codes with an indicator of ''2, 3, 4, 5, 6 or 7'' from the multiple procedure column of the NPFS, when submitted by the same physician, for the same patient, and on the same date of service, in descending order according to the appropriate CMS NPFS RVU. The edit fires when modifier 51 is inappropriately appended to the code with the highest CMS NPFS RVU. The edit also fires when the modifier 51 is appended inappropriately to codes with an indicator of ''0, 1, or 9'' from the multiple procedure column of the NPFS.
31738	Supplementary or Additional Code Not Allowed as Principal Diagnosis	Integrated Outpatient Code Editor (IOCE) Specifications V21.3- The edit will fire on an outpatient claim when the principal diagnosis code reported is considered supplementary or an additional code and cannot be used as the principal diagnosis.
31974	Only Incidental Services Reported	CMS Integrated Outpatient Code Editor, Version 19.0, CMS Transmittal R3425CP- The edit will fire when a claim is submitted with only incidental (payment status indictor of ''N'') services. These services are packaged under the outpatient prospective payment system and are paid as part of another primary service or procedure that is performed. When these procedures are submitted on a claim with no other services reported the claim will be rejected with the exception of laboratory procedure codes submitted on bill type 013x or 014x or 012x without condition code W2. This is based on guidelines from the Centers for Medicare and Medicaid Services (CMS).
32356	FDA Non Covered Codes - COVID-19 Vaccines and Monoclonal Antibodies	Medicare Part B Drug Average Sales Price/COVID-19 Vaccines and Monoclonal Antibodies- The edit identifies when an FDA non covered COVID-19 Vaccine or Monoclonal Antibody code is submitted.
32873	Observation Code G0378 Not Allowed to be Reported More Than Once Per Claim	CMS Integrated Outpatient Code Editor (IOCE) Specifications V22.2- HCPCS code G0378 can only be submitted once per claim for TOB 013X or 085X.
32881	Token Charge Less Than $1.01 Billed By Provider	Integrated Outpatient Code Editor V22.2- The edit will fire when a token charge for a drug HCPCS with a status indicator of G or K is less than $1.01.
32895	Modifier 63 Age	CPT The edit identifies claim lines where modifier 63 is reported on patients whose age is greater than 1 year. Modifier 63 may only be reported for infants less than 1 year of age.
33765	Medicaid Practitioner MUE Per Claim Line	National Correct Coding Initiative in Medicaid/Medicaid NCCI Edit Files/MUEs for Practitioner and ASC Services- The Medicaid medically unlikely edit verifies the number of units appended to the procedure code on the current line billed is within the allowable number of units of service allowed for the same patient on the same day by the same provider. If the number of units is over the allowable amount, the edit will trigger.
33766	Medicaid DME MUE Units	National Correct Coding Initiative in Medicaid/Medicaid NCCI Edit Files/MUE for Provider Claims for Durable Medical Equipment- The Medicaid medically unlikely edit verifies the number of units appended to the procedure code on the current line billed is within the allowable number of units of service allowed for the same patient on the same day by the same provider. If the number of units is over the allowable amount, the edit will trigger.
33889	ASC MUE Medicaid By Line	National Correct Coding Initiative in Medicaid/Medicaid NCCI Edit Files/MUEs for Practitioner and ASC Services, CMS Transmittal R1421OTN- The Centers for Medicare and Medicaid (CMS) created the Medically Unlikely Edits (MUE) to lower the claims error rate. The National Correct Coding Initiative (CCI) Policy Manual for Medicaid Services states, ''An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances allowable by the same provider for the same beneficiary on the same date of service.''

33892	ASC MUE Medicaid By Line	National Correct Coding Initiative in Medicaid/Medicaid NCCI Edit Files/MUEs for Practitioner and ASC Services, CMS Transmittal R1421OTN- The Centers for Medicare and Medicaid (CMS) created the Medically Unlikely Edits (MUE) to lower the claims error rate. The National Correct Coding Initiative (CCI) Policy Manual for Medicaid Services states, ''An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances allowable by the same provider for the same beneficiary on the same date of service.''
33910	Medicaid Medically Unlikely Edits By Line	National Correct Coding Initiative in Medicaid/Medicaid NCCI Edit Files/MUEs for Outpatient Services in Hospitals- The edit reviews if the current claim line procedure code has the allowable number of units of service per the CMS MUEs. If the unit of service on the current claim line is over the maximum allowable number of units per the CMS MUEs, the edit is triggered.
33930	ASC Bilateral Procedures Rule	CMS Claims Processing Manual, Chapter 14 - Section 40.5, MedLearn Matters MLN Article SE0742, ASC FAQs- The edit will fire on an Ambulatory Surgery Center (ASC) claim, bill type 083x when a claim line with a procedure with a bilateral surgery indicator of 1 is billed with modifier LT or RT with multiple units or a claim contains the same procedure with a bilateral surgery indicator of 1 on two claim lines with the same date of service and both lines have the same modifier RT or LT. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS).
33934	ASC Bilateral Procedures Rule	CMS Claims Processing Manual, Chapter 14 - Section 40.5, MedLearn Matters MLN Article SE0742, ASC FAQs- The edit will fire on an Ambulatory Surgery Center (ASC) claim, bill type 083x when a claim line with a procedure with a bilateral surgery indicator of 1 is billed with modifier LT or RT with multiple units or a claim contains the same procedure with a bilateral surgery indicator of 1 on two claim lines with the same date of service and both lines have the same modifier RT or LT. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS).
34241	Transfer Rebundle No Virtual Lines	AMA/CPT- The Transfer/Rebundle edit identifies multiple procedure codes submitted together when a single, comprehensive code description includes all procedure components, based on Current Procedural Terminology CPT® Professional Edition code descriptors/guidelines and the Centers for Medicare and Medicaid Services (CMS) code descriptors, guidelines, and policies that indicate a more accurate code(s) exist(s) to represent the codes submitted.