Outpatient Code Editor-Tricare

Pattern ID	Pattern Name	Flag Message
9	Medicare Modifier 53	Per Medicare guidelines, procedure code <1> when billed with modifier 53, is subject to carrier medical review and priced by individual consideration.
10	Medicare Statutory Exclusion Service	Per Medicare guidelines the procedure code is an item or service that is not in the statutory definition of physician services for fee schedule payment purposes. No RVUS or payment amounts are shown for this code(s), and no payment may be made under the physician fee schedule.
27	Inappropriate Use of Repeat Lab Modifier	Inappropriate use of a repeat modifier with laboratory procedure code <1>. The laboratory code is not found in history without a repeat modifier on the same date of service.
31	Global Test Only Rule	Per Medicare guidelines, modifier <1> is inappropriately appended to procedure code <2>.
32	Inappropriate Procedure Age	Procedure code 99100 is not typical for age of patient.
33	Modifier EY - Order Not supplied	Per Medicare guidelines, payment can not be made for a service or items that does not have a physician order or prescription.
45	Team Surgeons Not Permitted	Per Medicare guidelines, team surgery is not permitted for procedure code <1>.
52	Co-Surgeons Not Permitted Procedure	Per Medicare guidelines,billing for co-surgeons is not permitted for procedure code <1>.
54	No Payment For Assistant Surgeons Procedure Edits	Per Medicare guidelines, a statutory payment restriction for assistants at surgery applies to procedure code <1>.
56	Document Co-Surgeons Procedure	Per Medicare guidelines, procedure code <1> requires a review of documentation to establish the medical necessity of two surgeons.
58	Injection Service	Per Medicare guidelines, the current procedure code <1> is considered a bundled service when procedure code <2> in history on claim ID <3> and line ID <4> is billed on the same day by the same provider.
59	Document Team Surgery	Per Medicare guidelines, procedure code <1> requires documentation to establish the medical necessity of a surgical team.
61	Assistant At Surgery Documentation Required	Per Medicare guidelines, procedure code <1> submitted with modifier <2> requires a review of documentation to establish the medical necessity of a surgical assistant.
64	Modifier GA - Facility	The presence of modifier GA indicates that a waiver of liability statement is issued and service may deny as beneficiary liable.
65	Modifier GX - Facility	The presence of modifier GX indicates this is not eligible for payment.
71	Laboratory Physician Interpretation	Per the Medicare Physician Fee Schedule, Procedure <1> is inappropriate with Modifier -TC. Performance of the test is paid under the lab fee schedule.
73	Modifier GZ - Facility	The presence of modifier GZ indicates this is not eligible for payment.
77	Technical Component Only Policy	Per Medicare guidelines, procedure code <1> describes only the technical portion of a service or diagnostic test. Modifier 26 or TC is not appropriate.
78	Professional Component Only	Per Medicare guidelines, procedure code <1> describes the physician work portion of a diagnostic test. Modifier 26 or TC on current line ID <2> is not appropriate.
79	Physician Service Policy	Per Medicare guidelines, procedure code <1> describes the physician service. Use of modifier 26 or TC is not appropriate.
81	Modifier 27 - Multiple EM Visits on Same Date of Service (DOS)	This patient received multiple EM visits on the same date of service (DOS) and modifier 27 is not appended.

92	Diagnostic Test in Hospital	Per Medicare guidelines, procedure code <1> describes a diagnostic procedure that requires a professional component modifier in POS <2>.
93	Medicare Always Therapy	Per Medicare guidelines procedure code <1> requires modifier GP, GO, or GN.
100	Physician Interpretation Only Policy	Per Medicare guidelines, procedure code <1> describes a physician interpretation for this service and is inappropriate in place of service <2>.
113	Deny Modifier EY	Per Medicare guidelines, a service or item that does not have a physician order or prescription is not payable.
115	Modifier EY Required	Per CMS guidelines, all claim lines on the same claim must contain the modifier EY.
117	Never Events	Per CMS guidelines, this procedure is considered to be a non-covered service because it is not deemed a 'medical necessity' by the payer.
118	Care Plan Oversight	Only one individual may report a single care plan oversight CPT code per patient in the same month.
119	Telephone Services with E/M in Previous 7 Days	Telephone code <1> cannot be reported for services related to an E/M code on Claim ID <2> provided in the previous 7 days.
120	Medicare Screening Pelvic	Per Medicare guidelines the diagnosis code(s) billed does not support the medical necessity of G0101.
123	Telephone Services with Decision to See Patient in 24 Hours	Telephone Procedure Code <1> was found in history on Claim ID <2>, Line ID <3>. Telephone codes cannot be reported when there is a decision to see patient within 24 hours.
124	Online Services and E/M Reported in Previous 7 Days	Online Procedure Code <1> cannot be reported for services related to an E/M code on Claim ID <2> provided in the previous 7 days.
142	Inpatient Principal Procedure Required	A principal procedure code is required when a procedure code is found in the other procedure code field.
153	Medicare Nonpayable Function-related G-Codes	Medicare Physician Fee Schedule Status Indicator Q code is a Nonpayable Function-related G-Code and is used for required reporting purposes only.
156	Procedure not typical with Patient Gender	Procedure code <1> is not typically performed for a patient whose gender is <2>.
157	Diagnosis Not Typical for Gender	Diagnosis code(s) <1> typically would not be reported for a patient whose gender is <2>.
158	Assistant at Surgery Rule	Assistant at surgery modifiers are only payable by Medicare in Method II Critical Access Hospitals (CAHs).
159	Only One Therapy Service Modifier Per Line Rule	Only one therapy modifier can be reported on a line of service.
160	Therapy Service Revenue Code Requires Therapy Service Modifier	A therapy service revenue code requires a therapy service modifier.
161	Therapy Service Modifier Requires Therapy Service Revenue Code	Therapy service modifier requires therapy service revenue code.
162	Always Therapy Services	Hospitals MUST ALWAYS report a therapy modifier for "Always Therapy" procedure codes.
165	Capped Rental Frequency Exceeded Facility	The capped rental frequency of once per month for 13 months has been exceeded for this code.
167	Ambulance Required Origin and Destination Modifier Rule	Invalid or missing required ambulance modifier(s).
168	Ambulance Service Requires Mileage HCPCS Code Rule	Ambulance service HCPCS code requires an ambulance mileage HCPCS code.
170	Condition Codes H3, H4, H5 Can Only Be Submit on TOB 072x	Condition codes H3, H4 and H5 must be submitted on end stage renal disease claims.

186	Anesthesia Reduction	Per Medicare guidelines, based on anesthesia code <1> and modifier <2>, a reduction in the base units or allowed amount should be applied to this line.
192	Revenue Codes 0860 and 0861 Must Be Submitted on TOBs 013x or 085x	Revenue code 0860 or 0861 is submitted with inappropriate type of bill.
193	Medicare Postoperative Unrelated Service By Provider	Per Medicare guidelines, E/M code <1> was submitted without an appropriate modifier and is within the global period of procedure code <2> found in history on claim ID <3>, line ID <4>, with the same diagnosis code, billed by the same provider as the current line provider.
197	Modifier AS - Assistant at Surgery Rule	Modifier 80, 81 or 82 must also be billed in conjunction with modifier AS.
200	Modifier GZ	Per Medicare guidelines, the presence of modifier GZ indicates this service/item is not eligible for payment.
209	Revenue Code 0880 Not Specified	Must use revenue code that is to the highest specificity; 0880 is not specified.
267	Possible Duplicate Same Provider Includes Modifier GA	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2> reported by the same provider using G modifiers.
275	Sequential Billing for Partial Hospitalization (PHP) Claims Frequency Code 1 - Admit through Discharge Claim within 7 Days of the From Date	Bills for a continuous course of treatment must be submitted in the same sequence in which the services are furnished.
286	Sequential Billing for Partial Hospitalization (PHP) Claims Frequency Code 1 - Admit through Discharge Claim within 7 Days after the Through Date	Bills for a continuous course of treatment must be submitted in the same sequence in which the services are furnished.
301	Ambulance Revenue Code Rule	Ambulance HCPCS codes require an appropriate revenue code.
309	Sequential Billing for Partial Hospitalization (PHP) Claims Frequency Code 2 - Interim - First Claim within 7 Days of the From Date	Bills for a continuous course of treatment must be submitted in the same sequence in which the services are furnished.
310	Sequential Billing for Partial Hospitalization (PHP) Claims Frequency Code 2 - Interim - First Claim within 7 Days after the Through Date	Bills for a continuous course of treatment must be submitted in the same sequence in which the services are furnished.
311	Sequential Billing for Partial Hospitalization (PHP) Claims Frequency Code 3 - Interim - Continuing Claim within 7 Days of the From Date	Bills for a continuous course of treatment must be submitted in the same sequence in which the services are furnished.
312	Anesthesia Secondary Procedure with Modifier Override	An anesthesia service with an equal or higher base unit value than Procedure Code <1> was reported on <2> on Claim ID <3>, Line ID <4>. Only the anesthesia code with the highest base unit value should be billed per operative session.

315	Sequential Billing for Partial Hospitalization (PHP) Claims Frequency Code 4 - Interim - Last Claim within 7 Days of the From Date	Bills for a continuous course of treatment must be submitted in the same sequence in which the services are furnished.
318	HCPCS Code G0257 Has Been Submitted on TOB Other Than 013x or 085x	Code G0257 must be submitted with TOB 013X or 085X.
364	Ambulance Mileage Requires HCPCS Code Rule	Ambulance mileage HCPCS code requires an ambulance service HCPCS code.
412	Speech Therapy Codes Appropriate for Therapy Revenue Codes	A therapy code has been submitted with inappropriate therapy revenue code.
413	Physical Therapy Codes Appropriate for Therapy Revenue Code 042x	A therapy code has been submitted with inappropriate therapy revenue code.
414	Occupational Therapy Codes Appropriate for Therapy Revenue Codes 043x	A therapy code has been submitted with inappropriate therapy revenue code.
427	Hysterectomy by Specialty	A hysterectomy must be reported by specialty General Surgeon (2), Obstetrics/Gynecology (16), Urology (34), Surgical Oncology (91) or Gynecological Oncology (98).
444	EPO and Aransep Should Not Be Submitted Without HCPCS Code G0257	Codes Q4081 and J0882 must be submitted with code G0257.
454	Procedure Code 90935 Must Be Submitted On TOB 12x, 13x or 85x	Code 90935 must be submitted on TOBs 012x, 013x or 085x.
458	Possible Duplicate Same Provider Includes Modifier GY	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2> reported by the same provider using G modifiers.
460	Online Services Found in History with E/M Reported in Previous 7 Days	Online Procedure Code <1> found in history on Claim ID <2>, Line ID <3> cannot be reported for services related to an E/M code on Claim ID <4> provided in the previous 7 days.
493	Medicare Eval Code without Functional G-codes	Evaluative procedure code <1> requires the reporting of one or more functional G-codes, G8978-G8999, G9186, G9158-G9176.
497	HCPCS Codes Q4081 or J0882 Requires Value Code 48 or 49	An appropriate value code is required for HCPCS codes Q4081 or J0882.
498	Modifier EE or ED	Modifier EE or ED must be submitted on codes J0882 or Q4081 when value code 48 is greater than 13.0 or value code 49 is greater than 39.0.
513	Definitive/AMA Designated Add-on Code Reported Without Primary Procedure Code	Add-on procedure code <1> has been submitted without an appropriate primary procedure code by the same provider.
517	Modifiers JA or JB Required On HCPCS Code Q4081 or J0882	Modifier JA or JB must be submitted with code Q4081 or J0882.
518	EPO(Q4081) Revenue Codes 0634 and 0635	Code Q4081 must be submitted with revenue code 0634 or 0635.
519	Anrasep, HCPCS Code J0882, Must Be Submitted With Revenue Code 0636	Code J0882 must be submitted with revenue code 0636.

522	Medicare Pneumococcal Vaccine Requires Diagnosis	A diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid.
523	Medicare Pneumococcal Vaccine Administration Requires Diagnosis	A diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid.
524	Vaccine Administration Required Revenue Code	Vaccine HCPCS codes require an appropriate revenue code.
527	Medicare Influenza Vaccine Requires Diagnosis	A diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid.
530	Medicare Influenza Vaccine Administration Requires Diagnosis	A diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid.
552	Medicare Hepatitis Vaccine Requires Diagnosis	A diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid.
554	Medicare Hepatitis Vaccine Administration Requires Diagnosis	A diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid.
639	ASC POS Code 24 Not Typical for Procedure	Procedure code <1> is not typically performed in an ASC setting.
643	ASC Never Events Rule	Per Medicare guidelines, these are considered to be non-covered services because this is not deemed a 'medical necessity' by the payer.
648	Modifier EE or ED Required on HCPCS Code Q4081 and J0882	Modifier EE or ED must be submitted on codes J0882 or Q4081 when value code 48 is greater than 13.0 or value code 49 is greater than 39.0.
649	Only One Modifier EE or ED Appropriate for Claim Line	Only one modifier EE or ED is appropiate for a claim line.
664	Modifier EE or ED Only Needed When Value Code 48 is Greater Than 13 or if Value Code 49 is Greater Than 39	Modifier EE or ED should only be used when value code 48 is greater than 13 or value code 49 is greater than 39.
670	Modifiers EA, EB or EC Must Be Reported With Non ESRD HCPCS Codes J0881 and J0885 and Only One Modifier May be Reported	HCPCS codes J0881 and J0885 must be submitted with modifier EA, EB or EC.
671	HCPCS Codes J0881 and J0885 Must be Reported With Revenue Code 0636	HCPCS codes J0881 and J0885 must be reported with revenue code 0636.
672	ASC Inappropriate Gender for Procedure Rule	Procedure not typical for gender.
677	ASC Inappropriate Gender for Diagnosis Rule	Diagnosis not typical for patient gender.
689	Possible Duplicate Same Provider Includes Modifier GC	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2> reported by the same provider using G modifiers.
693	Possible Duplicate Same Provider Includes Modifier GZ	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2> reported by the same provider using G modifiers.
769	Home Health Revenue Code Required With Location Code	Home Health Prospective Payment System (HH PPS) claims require specific revenue codes with location code Q5001, Q5002 and Q5009.

773	At Least One Home Health Location Code Must Be Reported	Home Health Prospective Payment System (HH PPS) claims require location code Q5001, Q5002 or Q5009.
774	Home Health Location Code Requires HCPCS Visit G-Code	Home Health Prospective Payment System (HH PPS) location code requires corresponding G HCPCS visit code.
777	ASC Inappropriate age for Diagnosis Rule	Diagnosis not typical for age.
957	Hospice Frequency of Billing Span Multiple Months	Per Medicare guidelines, only one hospice claim can be submitted per month and the statement date range cannot be greater than 1 month.
960	The Same Location Codes Q5001, Q5002 or Q5009 Can Not Be Reported on Consecutive Days	The same location code Q5001, Q5002 or Q5009 must not be reported on consecutive days on the same Home Health Prospective Payment System (HH PPS) claim.
961	Physical Therapy Home Health Revenue Codes	Home health services must be reported with an appropriate home health physical therapy revenue code.
972	Occupational Therapy Home Health Revenue Codes	Home health services must be reported with an appropriate home health occupational therapy revenue code.
974	Speech Language Pathology Home Health Revenue Codes	Home health services must be reported with an appropriate home health speech language pathology revenue code.
975	Skilled Nursing Home Health Revenue Codes	Home health services must be reported with an appropriate home health skilled nursing revenue codes.
976	Social Service Home Health Revenue Codes	Home health services must be reported with an appropriate home health social service revenue code.
977	Hysterectomy Following Ectopic Pregnancy or C/S Delivery	A hysterectomy following surgical treatment of an ectopic pregnancy or a c/section delivery may not be reported by any specialty other than Obstetrics/Gynecology (16).
978	Home Health Aide Revenue Codes	Home health services must be reported with an appropriate home health aide revenue code.
980	Cardiac Device Frequency 90 Day	Procedure code <1> may not be reported more than once in a 90 day period.
981	Hospice Frequency of Billing	Per Medicare guidelines, only one hospice claim can be submitted per month and the statement date range cannot be greater than 1 month.
1006	ASC Missing Patient Gender Rule	The gender for this patient is either missing or invalid.
1029	Annual Wellness Visit (AWV) Frequency Rule	Per Medicare, this service is only covered once a lifetime.
1070	Annual Wellness Visit (AWV) with an Initial Preventive Physical Examination (IPPE) in History Rule	Service occurred within a year of an initial preventive physical exam.
1073	Annual Wellness Visit (AWV) Subsequent Visit Rule	Service occurred within a year of last covered annual wellness visit.
1098	ASC Deleted Procedure Code Rule	Procedure code billed is not correct/valid for the services billed or the date of service billed.
1108	ASC Bilateral Modifier 50 Rule	Modifier 50 is not recognized in an Ambulatory Surgical Center (ASC).
1152	Unbundle Interrogation Device Evaluation In Person and Remote by the Same Provider in a 90 Day Period (93288)	A remote interrogation device evaluation code <1> on History Claim ID <2>, Line ID <3> was reported with an in person interrogation device evaluation code <4> on the Current Claim ID <5>, Line ID <6> of the same device during the same period. Only the remote service may be reported.

1155	In Person Interrogation Device Evaluation (93288) Reported in 90 Day History of a Remote Evaluation (93294, 93296) by the Same Provider	An in person interrogation device evaluation code <1> on History Claim ID <2>, Line ID <3> was reported with a remote interrogation device evaluation code <4> on the Current Claim ID <5>, Line ID <6> of the same device during the same period. Only the remote service may be reported.
1157	In Person Interrogation Device Evaluation (93289) Reported in 90 Day History of a Remote Evaluation (93295, 93296) by the Same Provider	An in person interrogation device evaluation code <1> on History Claim ID <2>, Line ID <3> was reported with a remote interrogation device evaluation code <4> on the Current Claim ID <5>, Line ID <6> of the same device during the same period. Only the remote service may be reported.
1160	Unbundle Interrogation Device Evaluation In Person and Remote by the Same Provider in a 90 Day Period (93289)	A remote interrogation device evaluation code <1> on History Claim ID <2>, Line ID <3> was reported with an in person interrogation device evaluation code <4> on the Current Claim ID <5>, Line ID <6> of the same device during the same period. Only the remote service may be reported.
1161	Unbundle Interrogation Device Evaluation In Person and Remote by the Same Provider in a 30 Day Period (93290)	A remote interrogation device evaluation code <1> on History Claim ID <2>, Line ID <3> was reported with an in person interrogation device evaluation code <4> on the Current Claim ID <5>, Line ID <6> of the same device during the same period. Only the remote service may be reported.
1162	In Person Interrogation Device Evaluation (93290) Reported in 30 Day History of a Remote Evaluation (93297, 93299) by the Same Provider	An in person interrogation device evaluation code <1> on History Claim ID <2>, Line ID <3> was reported with a remote interrogation device evaluation code <4> on the Current Claim ID <5>, Line ID <6> of the same device during the same period. Only the remote service may be reported.
1163	ASC Editing Device Intensive Procedures	Medicare does not pay separately for this service <1>.
1164	Unbundle Interrogation Device Evaluation In Person and Remote by the Same Provider in a 30 Day Period (93291)	A remote interrogation device evaluation code <1> on History Claim ID <2>, Line ID <3> was reported with an in person interrogation device evaluation code <4> on the Current Claim ID <5>, Line ID <6> of the same device during the same period. Only the remote service may be reported.
1165	In Person Interrogation Device Evaluation (93291) Reported in 30 Day History of a Remote Evaluation (93298, 93299) by the Same Provider	An in person interrogation device evaluation code <1> on History Claim ID <2>, Line ID <3> was reported with a remote interrogation device evaluation code <4> on the Current Claim ID <5>, Line ID <6> of the same device during the same period. Only the remote service may be reported.
1166	Cardiac Device Frequency 30 Day	Procedure code <1> may not be reported more than once in a 30 day period.
1169	Ambulance Required Modifiers for Ambulance Service HCPCS Code Rule	Invalid or missing required ambulance modifier(s).
1230	Modifier 62 Required in History - Current Line Includes Modifier 62	Modifier 62 is present on procedure code <1>. The same procedure code without modifier 62 appended was previously reported by a different provider on claim ID <2> line ID <3>.
1231	Point of Origin for Admission is Required on all Institutional Claims with the Exception of 014X	Point of origin for admission is missing or invalid.
1232	Code J0890 Must be Submitted With Modifier JA or JB to Report Administration	Code J0890 must be reported with modifier JA or JB.

1235	ESA Codes J0882 or Q4081 Must Not Report Default Value 99.99 for Value Code 48 or 49	Value code default of 99.99 cannot be reported on code J0882 or Q4081.
1252	Possible Duplicate Same Provider - Bilateral LT/RT Modifiers	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2> reported by the same provider using LT or RT modifier.
1323	Possible Duplicate Same Provider Includes Anatomic Modifier-Finger	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2> reported by the same provider using anatomic modifiers.
1334	Hospice Value Code 61	Revenue Code must be submitted with appropriate value code.
1335	Hospice Value Code G8	Revenue Code must be submitted with appropriate value code.
1336	Hospice Pre-Election Evaluation and Counseling Services HCPCS Code G0337	Code G0337 must be submitted with revenue code 0657 only on the claim with a hospice type of bill and no other revenue code may be present.
1337	Hospice Pre-election Evaluation and Counseling Services Require Revenue Code 0657	Code G0337 must be submitted with revenue code 0657 only on the claim with a hospice type of bill and no other revenue code may be present.
1338	Hospice Pre-election Evaluation and Counseling Services Revenue Code 0657 Submitted With Another Revenue Code on Claim	Hospice revenue code 0657 must not be submitted with any other revenue code on the same claim.
1377	Hospice Location Codes With Revenue Code 065X	Hospice location codes must be submitted with revenue codes 0651, 0652, 0655 or 0656.
1379	Hospice Location Code Not Reported With Appropriate Revenue Code	Hospice location codes must be submitted with revenue codes 0651, 0652, 0655 or 0656.
1381	Hospice Revenue Code 0652 Cannot Report More Than 96 Units	Hospice services revenue code 0652 must not exceed 96 units.
1383	Hospice Physical Therapy Revenue Code and HCPCS Code	Hospice claim with revenue code 042x must be submitted with hospice HCPCS code G0151.
1384	Hospice Occupational Therapy Revenue Codes and HCPCS Code	Hospice claim with revenue code 043x must be submitted with hospice HCPCS code G0152.
1385	Hospice Speech Language Revenue Codes and HCPCS Code	Hospice claim with revenue code 044x must be submitted with hospice HCPCS code G0153.
1388	Hospice Social Service Revenue Codes and HCPCS Code	Hospice claim with revenue code 056x must be submitted with hospice HCPCS code G0155.
1389	Hospice Aide Revenue Codes and HCPCS Code	Hospice claim with revenue code 057x must be submitted with hospice HCPCS code G0156.
1390	Hospice Revenue Codes and HCPCS Code G0156	Hospice HCPCS code G0156 must be submitted with revenue code 057x.
1391	Hospice Revenue Codes and HCPCS Code G0155	Hospice HCPCS code G0155 must be submitted with revenue code 056x.
1393	Hospice Revenue Codes and HCPCS Code G0153	Hospice HCPCS code G0153 must be submitted with revenue code 044x.

1394	Hospice Revenue Codes and HCPCS Code G0152	Hospice HCPCS code G0152 must be submitted with revenue code 043x.
1395	Hospice Revenue Codes and HCPCS Code G0151	Hospice HCPCS code G0151 must be submitted with revenue code 042x.
1403	Home Health RAP Claim HIPPS and Revenue Codes	Revenue code 0023 must be billed with a Home Health HIPPS code.
1416	Skilled Nursing Facility Revenue Code 0022	Revenue code 0022 is required on type of bill <1>.
1417	Skilled Nursing Facility Revenue and HIPPS Codes	Revenue code 0022 requires a SNF HIPPS code.
1418	SNF HIPPS Code Submitted without Revenue Code 0022	A SNF HIPPS code must be submitted with revenue code 0022.
1452	ASC Terminated Procedure Reduction	The surgical procedure code contains a terminated modifier and should be reviewed for a 50% reduction.
1467	ASC Packaged Item/Service Rule	Medicare does not pay separately for this service.
1484	ASC Incorrect Billing of Modifier FB or FC	Incorrect billing of modifier FB and/or FC.
1586	New Patient Code for Established Patient Rule Ophthalmology	This patient received care by the same provider on Claim ID <1>, Line ID <2> on Date of Service <3> and is within the last three years. An established patient E/M code should be used.
1714	Revenue Codes Cannot Be Submitted on Type of Bill 022X	The revenue code cannot be submitted with TOB 022X
1732	Medicare Excluded from Physician Fee Schedule	Per Medicare guidelines the procedure code billed is an item or service that is excluded from the National Physician Fee Schedule by regulation.
1757	Possible Duplicate Same Provider Excludes Modifier GA	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2> reported by the same provider using G modifiers.
1813	Revenue Codes Cannot Be Reported On Part B Hospital TOB 012X	Only revenue codes for Part B inpatient services can be submitted on TOB 012X.
1908	Outpatient Therapy Functional Reporting Severity/Complexity Modifiers	This outpatient therapy functional reporting HCPCS code requires a severity/complexity modifier.
1909	Outpatient Therapy Functional Reporting Physical Therapy	This procedure code requires functional reporting HCPCS code(s).
1910	Outpatient Therapy Functional Reporting Occupational Therapy	This procedure code requires functional reporting HCPCS code(s).
2040	Medicare Restricted Coverage	Per Medicare guidelines the procedure code billed is an item or service that has restricted coverage.
2045	Possible Duplicate Same Provider Excludes Modifier GZ	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2> reported by the same provider using G modifiers.
2047	Possible Duplicate Same Provider Excludes Modifier GY	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2> reported by the same provider using G modifiers.
2048	Possible Duplicate Same Provider Excludes Modifier GC	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2> reported by the same provider using G modifiers.
2049	Medicare Measurement Code	Per Medicare guidelines the procedure code billed is an item or service that Medicare considers a measurement code and is used for reporting purposes only.

2138	Vaccine Drug Required Revenue Code	Vaccine HCPCS codes require an appropriate revenue code.
2139	ASC Incorrect Billing of Modifier FB and FC	Incorrect billing of modifier FB and/or FC.
2142	Ambulance Required Service Provided Under Arrangement or Directly Modifier Rule	Invalid or missing required ambulance modifier(s).
2143	Ambulance Required Modifiers for Ambulance Mileage HCPCS Code Rule	Invalid or missing required ambulance modifier(s).
2169	Modifier GK	Per Medicare guidelines, modifier GK cannot be submitted alone, another line with GA or GZ must be present on the same claim.
2172	Medicare Reduced Services	A procedure code has been submitted with modifier 52, reduced services. Per Medicare guidelines, documentation is required. Claim payment may be reduced.
2254	Modifier 62 Required - Current Line Excludes Modifier 62	Modifier 62 is not present on procedure code <1> and the same procedure with modifier 62 is reported by a different provider on same DOS on claim ID <2>.
2410	Medicare Nonpayable Function-related G-Codes Required with Severity/Complexity Required Modifiers	A severity/complexity modifier, CH, CI, CJ, CK, CL, CM, CN is required to be appended to Medicare nonpayable function-related G-Codes.
2511	Ambulance Payment Reduction Non-Emergency BLS Renal Dialysis Facilities for Ambulance Service HCPCS Code	A reduction should be applied to HCPCS code <1> when it is for a non-emergency BLS transport to and from a renal dialysis facility for an ESRD patient.
2513	Comprehensive Outpatient Rehabilitation Facility (CORF) 075X TOB and Revenue Code	Revenue code <1> is inappropriate for TOB 075X.
2514	Outpatient Rehabilitation Services 90901 and 90911 Must be Reported on TOB 12X, 13X, 22X, 23X, 34X, 74X, 75X, or 85X	Inappropriate type of bill or revenue code for outpatient rehabilitation service.
2515	HCPCS Code G0409 Must be Submitted With Revenue Code 0569 or 0911	Inappropriate type of bill or revenue code for outpatient rehabilitation service.
2516	Biofeedback HCPCS Reported Without Appropriate Revenue Code	Inappropriate type of bill or revenue code for outpatient rehabilitation service.
2517	Postpartum Care Within 49 Days of Delivery	It is not appropriate to submit postpartum code 59430 within 49 days of an obstetrical package code <1> found on claim ID <2>, line ID <3>.
2615	Possible Duplicate Same Provider Excludes Anatomic Modifier-Finger	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2> reported by the same provider using anatomic modifiers.
2645	Possible Duplicate Same Provider Includes Anatomic Modifier-Toe	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2> reported by the same provider using anatomic modifiers.
2646	Possible Duplicate Same Provider Excludes Anatomic Modifier-Toe	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2> reported by the same provider using anatomic modifiers.

2648	Possible Duplicate Same Provider Includes Anatomic Modifier-Eyelid	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2> reported by the same provider using anatomic modifiers.
2649	Possible Duplicate Same Provider Excludes Anatomic Modifier-Eyelid	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2> reported by the same provider using anatomic modifiers.
2679	Medicare Ambulance Reduction	Per Medicare guidelines apply a <1> reduction to claim lines containing HCPCS code A0425 and A0428 when billed with an origin/destination modifier that contains G or J in any position.
2685	Antepartum Care Codes Submitted in History Prior to OB Package Code	Antepartum care code 59425 or 59426 was found in history on Claim ID <1>. Antepartum care codes may not be submitted 280 days prior to global delivery code <2>.
2708	Maximum Frequency ESRD Related Services 4 or More Face-To-Face Visits Based on Age of Patient	It is inappropriate to submit an ESRD related service code (4 or more face-to-face visits based on patient's age) more than once per month.
2730	26/TC Split When Global Procedure is Found in History	The global diagnostic test procedure code <1> has been submitted in history on Claim ID <2>, Line ID <3>. An override modifier is not found on the current or history line.
2733	Medicare Postoperative Unrelated Service By Provider-10 day	Per Medicare guidelines, E/M code <1> exists in history, without an appropriate modifier, on claim ID <2>, line ID <3>, with the same diagnosis code, billed by the same provider as procedure code <4>, on the current claim line.
2734	Medicare Postoperative Unrelated Service By Provider - 90 days	Per Medicare guidelines, E/M code <1> exists in history, without an appropriate modifier, on claim ID <2>, line ID <3>, with the same diagnosis code, billed by the same provider as procedure code <4>, on the current claim line.
2756	Ambulance Payment Reduction Non-Emergency BLS Renal Dialysis Facilities for Ambulance Mileage HCPCS Code	A reduction should be applied to HCPCS code <1> when it is for a non-emergency BLS transport to and from a renal dialysis facility for an ESRD patient.
2760	Maximum Frequency ESRD Related Services 2-3 Face-To-Face Visits Based on Age of Patient	It is inappropriate to submit an ESRD related service code (2-3 face-to-face visits based on patient's age) more than once per month.
2761	Maximum Frequency - One Per Day	Maximum frequency per day for procedure code <1> has exceeded the allowed number of units of <2>.
2762	Maximum Frequency - Two Per Day	Maximum frequency per day for procedure code <1> has exceeded the allowed number of units of <2>.
2763	Maximum Frequency - Three Per Day	Maximum frequency per day for procedure code <1> has exceeded the allowed number of units of <2>.
2764	Maximum Frequency - 96 Per Day	Maximum frequency per day for procedure code <1> has exceeded the allowed number of units of <2>.
2765	Maximum Frequency - Four Per Day	Maximum frequency per day for procedure code <1> has exceeded the allowed number of units of <2>.
2766	Incorrect Billing of Blood and Blood Products	Incorrect billing of blood and blood products.
2767	Incorrect Billing of Blood and Blood Products	Incorrect billing of blood and blood products.
2768	Incorrect Billing of Blood and Blood Products	Incorrect billing of blood and blood products.
2769	Incorrect Billing of Blood and Blood Products	Incorrect billing of blood and blood products.
2770	Incorrect Billing of Blood and Blood Products	Incorrect billing of blood and blood products.

2772	Maximum Frequency ESRD Related Services 1 Face-To-Face Visit Based on Age of Patient	It is inappropriate to submit an ESRD related service code (1 face-to-face visit based on patient's age) more than once per month.
2775	Medicare Co-Surgeon Rule - Modifier 62	Modifier 62 is not present on procedure code <1> on the current claim line. The same procedure code with modifier 62 appended was reported in history by a different provider, with a different specialty on claim ID <2>, line ID <3>.
2776	ICD-10-CM Primary Diagnosis Only	The ICD-10-CM code <1> may only be used as first-listed or primary diagnosis position.
2777	Medicare Team Surgeon Rule - Modifier 66	Modifier 66 is not present on procedure code <1>. The same procedure code with modifier 66 appended was reported by a different provider on claim ID <2> and line id <3>.
2803	Inappropriate Reporting of Terminated Bilateral Procedure	Terminated procedures should not be billed as bilateral.
2804	Inappropriate Reporting of Terminated Procedure	Terminated procedures should not be billed with multiple units of service.
2805	Injection Service - History	Per Medicare guidelines, the procedure code in history on claim ID <1> and line ID <2> is considered a bundled service with procedure code <3> when other payable services are billed on the same day by the same provider.
2806	Inappropriate Use of Modifier 27	Modifier 27 is not appropriate as another line with an evaluation and management code is not found in history.
2807	Medicare Team Surgeon Rule - Modifier 66 - History	Modifier 66 is present on procedure code <1>. The same procedure code in history without modifier 66 appended was reported by a different provider on claim ID <2> and line id <3>.
2808	Medicare Co-Surgeon Rule - Modifier 62 - History	Modifier 62 is present on procedure code <1> on the current claim line. The same procedure code without modifier 62 appended was reported in history by a different provider on claim ID <2> and line ID <3>.
2811	Patient Discharge Status Missing	The patient discharge status code is missing.
2812	Patient Discharge Status Invalid	The patient status code <1> is invalid.
2820	Telephone and Online Services Reported for a New Patient	Telephone or online code <1> is intended to be reported on an established patient. This patient has not received services by this provider within the past three years.
2822	Anterior Cervical Interbody Fusion with Anterior Cervical Discectomy	Procedure code 63075 is reported by a different provider on claim ID <1>. Documentation indicating that the service was provided on a separate level may be necessary.
2826	Manifestation Code Not Allowed as Principal Diagnosis	Manifestation codes cannot be used as the principal diagnosis.
2833	Medicare Annual Wellness Visit (AWV) Frequency Rule	Per Medicare, this service is covered once in a lifetime.
2834	Medicare Annual Wellness Visit (AWV) with an Initial Preventive Physical Examination (IPPE) in History Rule	Service occurred within a year of an initial preventive physical exam.
2835	Medicare Annual Wellness Visit (AWV) Subsequent Visit Rule	Service occurred within a year of last covered annual wellness visit.
2840	Inpatient Facility Discharge Date Missing	The discharge date is missing.
2841	RNHCI Required principal and secondary diagnosis	Principal ICD-9 diagnosis 799.9 and the first other diagnosis ICD-9 V62.3 are required on all 041x RNHCI claims.

2842	RNHCI Required Principal and Secondary Diagnosis ICD-10	Principal ICD-10 diagnosis R69 and the first other diagnosis ICD-10 Z53.1 are required on all 041x RNHCI claims.
2843	Unlisted Procedure Code Rule	An unlisted procedure code is billed; a corresponding description of that procedure is required.
2844	Anterior Cervical Discectomy with Anterior Cervical Interbody Fusion	Procedure code 22554 is reported by a different provider on claim ID <1>. Documentation indicating that the service was provided on a separate level may be necessary.
2845	Multiple Imaging Composite Ultrasound (US) Rule	Per CMS, composite APCs provide a single payment for the family of imaging procedures for ultrasound. CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.
2846	Multiple Imaging Composite Computed Tomography and Computed Tomographic Angiography (CT/CTA) Rule	Per CMS, composite APCs provide a single payment for the family of imaging procedures for computed tomography and computed tomographic angiography (CT/CTA). CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.
2847	Multiple Imaging Composite Magnetic Resonance Imaging and Magnetic Resonance Angiography (MRI/MRA) Rule	Per CMS, composite APCs provide a single payment for the family of imaging procedures for magnetic resonance imaging and magnetic resonance angiography (MRI/MRA). CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.
2934	Facility Medicare ICD-9 Code Rule	ICD-9 code types cannot be billed for dates of service greater than September 30, 2015.
2935	Facility Medicare ICD-10 Code Outpatient Split Claim Rule	Medicare requires providers to split the claim so all ICD-10 codes remain on one claim with Dates of Service (DOS) beginning 10/1/2015 and later. For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 codes.
2936	Facility Medicare ICD-10 Code Rule	Per CMS guidelines, ICD-10 codes cannot be billed for dates of service prior to October 1, 2015.
2962	Injection Procedure not Reported with Reported Supply	The administered drug or substance code <2> performed in POS <1> has been reported without an appropriate injection or infusion procedure code.
3069	HH PPS (TOB 0327,0328,0329) and RAP (TOB 0322) Claims Must Report Value Code 61 to Report Location	Value Code 61 must be reported on all Home Health PPS and RAP claims to report location.
3086	Cancelled Claims (TOB 0328) Must Submit Condition Code D5 or D6	Type of Bill 0328 or 0338 must be submitted with condition code D5 or D6.
3097	Home Health Claims Must Submit Revenue Code 0023	All Home Health claims must be submitted with revenue code 0023.
3363	Codes G0378 and G0379 Only Allowed With Bill Type 13X and 85X	Observation HCPCS codes can only be billed with a bill type of 013X or 085X.
3429	Possible Duplicate Line by Provider with Procedure Exclusions SystemList	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2>, Line ID <3> performed by the same provider on the same day.
3474	Medicare Inappropriate Modifier - Co Surgeon	Per Medicare guidelines, modifier <1> is not appropriate for procedure code <2>.
3589	Modifier PD billed with ModifierTC	The PD modifier may not be billed with the TC modifier.
3590	Medicare Modifier PD billed without 26 Modifier	The PD modifier must be billed with the 26 modifier.
3655	Medicare Non Covered HCPCS Codes and Modifiers Rule	Per Medicare guidelines, the HCPCS code or modifier billed is a non covered HCPCS code or modifier.
3662	Repeat Radiology Requires Repeat Modifier	Repeat radiology procedure <1> may require a repeat procedure modifier. The same radiology procedure code found on Claim ID <2><4><6><8>, Line ID <3><5><7><9> was performed on the same day.

3719	Medicare Multiple Therapy Reduction	Per Medicare guidelines, a multiple procedure reduction should be applied to this claim line.
3720	Qualifying Stay Edit For Skilled Nursing Facility (SNF) and Swing Bed (SB)	Per Medicare, qualified stay requirements have not been met.
3722	Medicare Multiple Therapy Reduction	Per Medicare guidelines, a multiple procedure reduction should be applied to this claim line.
3774	Inappropriate Use of Repeat Modifier 91 with Lab Codes-Professional Component	Inappropriate use of a repeat modifier 91 with laboratory procedure code <1>. The procedure code with the same date of service is not found in history without a repeat modifier.
3776	Physiologic Data Collection in History within 30 Days of CPO	Procedure code 99091 found in history on Claim ID <1>, Line ID <2> is included in care plan oversight service Code <3>, when reported in the same 30 day period.
3778	Laparoscopic Appendectomy at Time of Other Major Procedure	Procedure code 44970 should not be reported for a laparoscopic appendectomy performed in conjunction with Procedure Code <1> that has been reported on Claim ID <2>, Line ID <3>. There may be a more appropriate code to report for a non-incidental appendectomy.
3814	Ambulance SNF to SNF Transfer-CCT	Per Medicare guidelines, Medicare does not pay separately for ambulance services for residents in a SNF Part A stay. This service cannot be billed separately.
3860	Annual Wellness Visit Rule - CCT Facility/Professional	The frequency for HCPCS code <1> has been exceeded, per CMS the limit is once in a lifetime.
3861	Annual Wellness Visit Rule - CCT Facility/Professional	Service occurred within a year of last covered annual wellness visit on a previous professional claim in history, Claim ID <1>.
3862	Annual Wellness Visit Rule - CCT Facility/Professional	Service occurred within a year of an initial preventive physical exam (IPPE) on a previous professional claim in history.
3928	Transtelephonic Pacemaker Frequency 90 Day	Procedure code <1> may not be reported more than once in a 90 day period.
3929	Medicare Influenza Vaccine Requires Administration	Per Medicare guidelines, the associated administration code for vaccine procedure code <1>, is missing or invalid.
3930	Medicare Influenza Vaccine Administration Requires Drug	Per Medicare guidelines, the associated vaccine code for administration procedure code <1>, is missing or invalid.
3981	Skin Substitute Application Procedure Without Appropriate Skin Substitute Product Code	Skin substitute application procedure code <1> must be submitted with the appropriate skin substitute product procedure code on the same date of service.
3982	Skin Substitute Application Procedure Without Appropriate Skin Substitute Product Code	Skin substitute application procedure code <1> must be submitted with the appropriate skin substitute product procedure code on the same date of service.
3984	ASC Skin Substitute Application Procedure Without Appropriate Skin Substitute Product Code	Skin substitute product procedure code <1> must be submitted with the appropriate skin substitute application procedure code on the same date of service.
3991	Speech Therapy Code Appropriate for Speech Therapy Revenue Codes 044X	A therapy code has been submitted with inappropriate therapy revenue code.
3997	New Patient Code for Established Patient Rule	This patient received care by the same provider on Claim ID <1>, Line ID <2> on Date of Service <3> and is within the last three years. An established patient E/M code should be used.
4006	Inappropriate Modifier Combination	Modifier <1> and cannot be submitted on the same claim line.
4013	Venipuncture Policy	Procedure code <1> has been reported on <2> without a corresponding venipuncture code. Add a venipuncture code, if appropriate.

4054	Timely Filing	The statement covers period through date of service, <1>, is past the Medicare institutional timely filing limit.
4055	Home Health RAP Timely Filing	The statement covers period from date of service, <1>, is past the Medicare institutional timely filing limit.
4056	Intra-Operative Care Only Reduction	Per CMS Guidelines, the presence of modifier 54 indicates that only the intraoperative portion of the global fee should be reimbursed.
4087	Medicare Bundled Code	Per CMS guidelines, payment for procedure code <1> is always bundled into payment for other services not specified and no separate payment is made.
4090	Medicare Not Valid For Payment	Procedure code <1> is not valid for Medicare purposes.
4231	Post-Operative Care Only Reduction	Per CMS Guidelines, the presence of modifier 55 indicates that only the postoperative portion of the global fee should be reimbursed.
4232	Pre-Operative Care Only Reduction	Per CMS Guidelines, the presence of modifier 56 indicates that only the preoperative portion of the global fee should be reimbursed.
4239	Missing Patient ID	The Patient ID is missing.
4240	Inappropriate Use Of Modifier 25	E/M Code <1> reported with modifier 25 was provided on the same date as Procedure Code <2> on Claim ID <3>, Line ID <4>. Only a major surgical procedure is found in history.
4246	Missing Patient Gender	The Gender for this patient is either missing or invalid.
4262	Hospice Five Day Payment Limit for Respite Care	Per CMS, hospice respite care should not be reported for more than 5 days at a time.
4263	Hospice Five Day Payment Limit for Respite Care	Per CMS guidelines, Medicare contractors shall return to the provider hospice claims reporting occurrence span code M2 with more than 5 days in the span period.
4264	Hospice Five Day Payment Limit for Respite Care	Hospice respite care must be submitted with occurrence span code M2.
4265	Third Party Liability	Diagnosis code(s) <1> could involve third-party liability and/or subrogation of benefits.
4272	Modifier Not Appropriate	Use of modifier(s) <1> is not typical for procedure code <2>.
4278	Antepartum Care Codes Submitted Prior to OB Package Code	Antepartum care code <1> cannot be submitted 280 days prior to global delivery codes 59400, 59510, 59610, 59618 found on Claim ID <2>, Line ID <3> reported by the same provider.
4282	Medicare ICD9 Code Rule	Per CMS guidelines ICD-9 codes cannot be billed with dates of service greater than September, 30, 2015.
4291	Facility Medicare ICD-9 Code Rule	ICD-9 code types cannot be billed for dates of service greater than September 30, 2015.
4295	Facility Medicare ICD-10 Code Rule	Per CMS guidelines, ICD-10 codes cannot be billed for dates of service prior to October 1, 2015.
4310	New Patient Code for Established Patient	This patient received care by provider <1> on Claim ID <2>, Line ID <3> on Date of Service <4> and is within three years of Procedure Code <5> on current line. An established patient E/M code should be used.
4311	New Patient Code in History for Established Patient	New patient E/M Code <1> found in history on Claim ID <2>, Line ID <3> on Date of Service <4> is within three years of Procedure Code <5> on current line. An established patient E/M code should have been used.
4312	Unlisted Procedure Code	Procedure code <1> is an unlisted procedure or service. Supporting documentation must be attached.
4324	ASC Place of Service Code 24 Missing	Place service code 24 is required with provider specialty code 49.
4372	Inappropriate Modifier To Diagnosis Combination	There is a discrepancy between diagnosis code and modifier combination(s) <1>. Review the medical record to verify if the correct diagnosis and/or modifier is assigned.

4389	Occurrence Code 50 Required for Inpatient Rehabilitation Facilities	Inpatient rehabilitation facilities (TOB 011X) must always submit occurrence code 50 to report assessment dates.
4428	Bilateral Payment Adjustment 50	Per Medicare Guidelines, the usual payment adjustment for bilateral procedures does not apply. Base payment for each side on the lower of the actual charge for each side or 100% of the fee schedule amount for each side.
4438	Bilateral Payment Adjustment LT/RT	Per Medicare Guidelines, procedure code <1> with modifier <2> with history procedure code <3> with modifier <4> found on History Claim ID <5>, Line ID <6> does not qualify for the usual bilateral payment adjustment. Base payment for each side on the lower of the actual charge for each side or 100% of the fee schedule amount for each side.
4442	Inappropriate Use Of Modifier 57	E/M code <1> reported with modifier 57 was provided on the same date as Procedure Code <2> on Claim ID <3>, Line ID <4>. Only a minor procedure or other service is found in history.
4448	Missing Account ID	The Account ID is missing.
4450	Telehealth Modifier Not Appropriate	Use of modifier(s) <1> is not typical for procedure code <2>.
4476	Supply Code not Reported with Reported Injection Procedure	The injection or infusion procedure code <2> performed in POS <1> has been reported without an appropriate drug or substance code.
4477	Inappropriate Specification of Bilateral Procedure Same Claim	HCPCS code <1> is inherently bilateral and should not be billed more than once for the same date of service.
4478	Inappropriate Specification of Bilateral Procedure Same Claim	The HCPCS code on this line was also billed on history claim <1> on history line <2> for the same date of service. This code is inherently bilateral and should not be billed more than once for the same date of service.
4489	Service Billable Only to Durable Medical Equipment Regional Carrier	Code can only be billed to the DME Regional Carrier.
4499	Inappropriate Use of Repeat Modifier 91 with Lab Codes-Technical Component	Inappropriate use of a repeat modifier 91 with laboratory procedure code <1>. The procedure code with the same date of service is not found in history without a repeat modifier.
4500	Inappropriate Use of Repeat Modifier 91 with Lab Codes-Global	Inappropriate use of a repeat modifier 91 with laboratory procedure code <1>. The procedure code with the same date of service is not found in history without a repeat modifier.
4511	Multiple Medical Visits on Same Day with Same Revenue Code Without Condition Code G0 - Same Claim	Multiple medical visits on same day (based on units and/or lines), same revenue code without condition code G0.
4514	Multiple Medical Visits on Same Day with Same Revenue Code Without Condition Code G0	Multiple medical visits on same day (based on units and/or lines), same revenue code without condition code G0.
4515	Transfusion or Blood Product Exchange Without Specification of Blood Product	The Blood Administration code <1> requires that a HCPCS Blood Product code be present on the claim.
4516	Missing Diagnosis Code	There is no Primary Diagnosis listed for this procedure.
4517	Observation Revenue Code on Line Item with Non-Observation HCPCS Code	Observation room revenue code without specification of appropriate observation room service.
4518	Non-Reportable for Site of Service	Not reportable for this site of service.
4519	Deleted diagnosis code	Diagnosis code <1> has been deleted.

4525	Invalid Procedure Code	Invalid HCPCS code, <1> for the From date of service on the claim.
4527	Repeat Laboratory Procedure Requires Modifier-Professional Component	Repeat lab procedure <1> may require a repeat modifier. The same lab procedure code found on Claim ID <2>, Line ID <3> was performed by the same provider on the same day.
4528	Repeat Laboratory Procedure Requires Modifier-Technical Component	Repeat lab procedure <1> may require a repeat modifier. The same lab procedure code found on Claim ID <2>, Line ID <3> was performed by the same provider on the same day.
4529	Repeat Laboratory Procedure Requires Modifier-Global	Repeat lab procedure <1> may require a repeat modifier. The same lab procedure code found on Claim ID <2>, Line ID <3> was performed by the same provider on the same day.
4530	Invalid Procedure Code	Procedure Code <1> is invalid.
4531	Place of Service	Procedure code <1> is not typically performed by a provider in place of service <2> (<3>).
4535	Invalid Modifier	The modifier code(s) <1> is either not a valid code or not valid for the from date of service on the claim.
4538	Multiple Assistant Surgery	There is more than one occurrence of procedure code <1> on the same date of service, on Claim ID <2>, Line ID <3> with a surgical assistant modifier.Typically only one surgical assistant is allowed per procedure.
4539	Procedure Reduction Modifiers 80 81 82 AS	Procedure code <1> on Claim ID <2>, Line ID <3> is subject to a reduction for assistant surgeon modifier and will pay at <4>%.
4541	Physiologic Data Collection within 30 Days of CPO	Procedure code 99091 cannot be reported within 30 days of the care plan oversight Code <1> reported on Claim ID <2>, Line ID <3>.
4542	Missing Patient's Date of Birth	Patient's Date of Birth is missing or invalid.
4543	Missing or Invalid Date of Service	The beginning or ending Date of Service is invalid or missing.
4544	Anesthesia Crosswalk	The surgical procedure code <1> has been crosswalked to anesthesia procedure code <2> for editing of the claim.
4563	Procedure Age	Procedure Code <1> is not typical for a patient whose age is <2> <3>.
4564	Diagnosis Age	Diagnosis code(s) <1> is not typical for a patient whose age is <2> <3>.
4583	Follow-up Outpatient Consultation Services	Consultation code <1> is reported 1 day after consultation code <2> on Claim ID <3>, Line ID <4>.
4584	Follow-up Inpatient Consultation Services	Consultation code <1> is reported 1 day after consultation code <2> on Claim ID <3>, Line ID <4>.
4595	Nonspecific Diagnosis Code	Additional digits are required for nonspecific diagnosis code(s) <1>.
4613	Laparoscopic Appendectomy in History at Time of Other Major Procedure	Procedure code 44970 found in history on Claim ID <1>, Line ID <2>, should not be reported for a laparoscopic appendectomy performed in conjunction with Procedure Code <3>. There may be a more appropriate code to report for a non-incidental appendectomy.
4616	Medicare Incident To Codes	Per Medicare guidelines, procedure code <1> is a service covered incident to a physician's service and modifier 26 or TC is not appropriate.
4618	Medicare Non-Physician Service	Procedure Code <1> does not typically require performance by a physician in Place of Service <2> per Medicare Guidelines.
4625	Wrong Procedure Performed Principal Diagnosis	The Principal diagnosis code <1> indicates that a wrong procedure was performed.
4626	Wrong Procedure Performed Other Diagnosis	The Other diagnosis code <1> indicates that a wrong procedure was performed.
4636	Questionable Covered Procedures	The HCPCS code <1> on this line is designated as a questionable covered service.
4638	Typically No Surgical Assistant	Procedure Code <1> typically requires no surgical assistant.

4640	Documentation Needed with Modifier 59	A procedure code has been submitted with modifier 59. Per AMA guidelines, use of modifier 59 may require supporting documentation.
4653	Units Greater Than One for Bilateral Procedure Billed With Modifier 50	Units greater than one for bilateral procedure billed with modifier 50.
4688	Manifestation Code as Principal Diagnosis	Manifestation codes cannot be used as the Principal diagnosis.
4690	Duplicate of Principal Diagnosis Code	The "other" diagnosis code <1> is a duplicate of the principal diagnosis code.
4691	Duplicate of Other Diagnosis Code	The other diagnosis code <1> is a duplicate of another other diagnosis code on the claim.
4692	Code2 of a Code Pair That Would Be Allowed by NCCI if Appropriate Modifier Were Present - Same Claim	Procedure code <1> is considered to be a component of the comprehensive code <2> on claim ID <3> Line ID <4> and this line should be denied. Review documentation to determine if a modifier is appropriate.
4693	Mental Health Code Not Approved For Partial Hospitalization Program	HCPCS code <1> is not approved for a partial hospitalization claim.
4694	Mental Health Not Payable Outside the Partial Hospitalization Program	Approved partial hospitalization mental health services submitted with bill type 12X or 13X must have condition code 41 on the claim.
4695	Incorrect Billing of Revenue Code with HCPCS Code	Revenue codes 381 and 382 can only be used when billing for packed red blood cells (381) and whole blood (382).
4697	Code2 of a Code Pair That Would Be Allowed by NCCI if Appropriate Modifier Were Present	History procedure code <1> on history claim <2> on history line <3> is considered to be a component of the comprehensive procedure code <4> and the history line may be denied. Review the medical record to determine if an appropriate modifier should be assigned.
4712	Invalid Date	The service date <1> on line <2>, is not within the From and Through dates of service on the claim.
4713	Deleted Procedure Code	Procedure Code <1>.
4731	Invalid Revenue Code	Invalid or Missing Revenue Code.
4733	Revenue Center Requires HCPCS	Claim line revenue code <1> requires submission of a HCPCS code.
4734	Code Requires Manual Pricing	Code requires manual pricing.
4735	Charge Exceeds Token Charge ($1.01)	The charged amount for HCPCS code C9898 cannot exceed $1.01.
4736	Medically Unlikely Edit (MUE) Darbepoetin Alfa Greater Than 1200 Units	Per Medicare's Medically Unlikely Edits, the units submitted <1> for Darbepoetin Alfa exceed the allowed units of 1,200.
4789	Invalid Billing of Device Credit	Value code FD requires a condition code reported on the claim.
4796	Code Not Recognized By OPPS	HCPCS code <1> is not recognized by OPPS.
4809	Add-on Code with Modifier 51	Procedure code <1> is an add-on code. Modifier 51 (Multiple Procedures) is not appropriate with the add-on code on claim ID <2>, line ID <3>.
4817	Missing Service Date	The service date on the line is missing.
4837	Telehealth Place of Service	Procedure code <1> is not typically performed by a provider in place of service <2> (<3>).
4852	Hospital Discharge Services Group Frequency Per Day	Hospital discharge services code 99238 and/or 99239 have been reported more than once per day. Only one individual may report a single hospital discharge service code per patient per day.
4854	Online Digital E/M or Assessment Group Frequency 7 Days	Only 1 Online Digital E/M or Assessment code may be reported by the same provider in a 7-day period. Procedure Code <1> was reported on Claim ID <2>, Line ID <3> by the same Provider.
4883	Medicare Non-Covered Service	Procedure code <1> is not covered by Medicare.

4918	Possible Duplicate Line by Different Provider	Procedure Code <1> is a possible duplicate of the same procedure code found on Claim ID <2>, Line ID <3> performed by a different provider from the same Group <5> on the same date.
4919	Possible Duplicate Different Provider - Bilateral LT/RT Modifiers	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <2> reported by a different provider, same group, same specialty using the LT or RT modifier.
5075	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code New Patient	A FQHC claim requires both the FQHC payment code and a qualifying visit code.
5077	Incorrect Revenue Code Reported for Federally Qualified Health Clinics (FQHC) Payment Code	The FQHC payment code requires specific revenue codes.
5079	Item or Service Not Covered Under FQHC PPS or for RHC	Items or services are not covered under the FQHC PPS and RHC claims.
5080	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code Established Patient	A FQHC claim requires both the FQHC payment code and a qualifying visit code.
5081	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code IPPE/AWV	A FQHC claim requires both the FQHC payment code and a qualifying visit code.
5082	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code Mental Health New Patient	A FQHC claim requires both the FQHC payment code and a qualifying visit code.
5083	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code Mental Health Established Patient	A FQHC claim requires both the FQHC payment code and a qualifying visit code.
5098	Missing or Invalid Type of Bill - Outpatient	The type of bill code is invalid.
5110	Possible Duplicate Line Different Provider Modifier GA/GC/GX/GY/GZ	Procedure code <> is a possible duplicate of the same procedure code found on Claim ID, Line ID reported by a different provider in the same group and speciality using modifier GA, GC, GX, GY OR GZ
5111	Possible Duplicate Line in History Different Provider Modifier GA/GC/GX/GY/GZ	Procedure code <> found on claim id, line id, reported without modifier GA,GC,GX,GY, or GZ in history, is a possible duplicate of the current line reported by a different provider in the same group and specialty on the same using modifier GA, GC, GX, GY or GZ.
5113	Interprofessional Telephone/Internet/EHR Consultation Group Frequency 7 Days	Only 1 Interprofessional Telephone, Internet, or EHR Consultation code may be reported by the same provider in a 7-day period. Procedure Code <1> was reported on Claim ID <2>, Line ID <3> by the same Provider.
5117	Interprofessional Telephone/Internet/EHR Consultation Group Frequency in Previous 7 Days	Only 1 Interprofessional Telephone, Internet, or EHR Consultation code may be reported by the same provider in a 7-day period. Procedure Code <1> was reported on Claim ID <2>, Line ID <3> by the same Provider.

5253	Code2 of a Code Pair That Is Not Allowed by NCCI Even if Appropriate Modifier is Present - Same Claim	Procedure code <1> is considered to be a component of the comprehensive code <2> on claim ID <3> Line ID <4> and this line should be denied. A modifier will not override this edit.
5264	Code2 of a Code Pair That Is Not Allowed by NCCI Even if Appropriate Modifier is Present	History procedure code <1> on history claim <2> on history line <3> is considered to be a component of the comprehensive procedure code <4> on the current line and the history line may be denied. A modifier will not override this edit.
5265	Facility Inpatient Non Covered ICD Procedure	ICD procedure code(s) <1>, is non-covered.
5267	Facility Inpatient Limited Covered ICD Procedure	ICD procedure code(s) <1> is a limited coverage code.
5268	Facility Inpatient Non Covered Procedure Without Qualifying Diagnosis Code ICD-10	ICD procedure code <1> is non-covered unless exempted by a qualifying diagnosis code or procedure code.
5362	Invalid Type of Bill - Outpatient	The type of bill code is invalid or missing.
5364	Invalid Type of Bill - Inpatient	The type of bill code is invalid or missing.
5428	26/TC Split When Procedure With Modifier 26 or TC is Found in History	The diagnostic test procedure code <1> has been submitted in history on claim ID <2>, Line ID <3> with the modifiers 26 or TC. An override modifier is not found on the current or history line.
5441	Admission Diagnosis External Cause Code ICD-10	An External Cause code cannot be used as the Admit diagnosis code.
5442	Principal Diagnosis External Cause Codes ICD-10	An External Cause code cannot be used as the principal diagnosis code.
5443	Unacceptable Principal Diagnosis Without Secondary Diagnosis ICD-10	Diagnosis code <1> is unacceptable as a principal diagnosis unless a required secondary diagnosis is included on the claim.
5446	Unacceptable Principal Diagnosis ICD-10	Diagnosis code <1> is unacceptable as a principal diagnosis.
5519	Incorrect Revenue Code Reported for Federally Qualified Health Clinics (FQHC) Payment Code	The FQHC payment code requires specific revenue codes.
5598	Medicare Bundled Item or Service	Per Medicare guidelines procedure code <1> is an item or service that has no separate payment under the physician fee schedule.
6055	Medicare HAC Non-exempt Diagnosis Code	The diagnosis code <1> requires a non-exempt POA indicator.
6065	Service on Same Day as Inpatient Procedure	Ancillary service billed on the same day as an inpatient only procedure.
6069	Medicare HAC Non-exempt Diagnosis Code	The diagnosis code <1> requires a non-exempt POA indicator.
6120	Procedure and Gender Conflict Female	Per CMS Integrated OCE (IOCE) specifications, the HCPCS code, <1> includes a gender designation and the gender submitted on the claim does not match.
6122	Procedure and Gender Conflict Male	Per CMS Integrated OCE (IOCE) specifications, the HCPCS code, <1> includes a gender designation and the gender submitted on the claim does not match.
6187	Inpatient Psychiatric Facility (IPF) ECT Treatments	Inpatient psychiatric facility requires ICD procedure for electroconvulsive therapy (ECT).

6238	Principal Diagnosis and Gender Conflict Female	The principal diagnosis code <1> is designated for female patients only and this conflicts with the submitted gender of the patient.
6243	Principal Diagnosis and Gender Conflict Male	The principal diagnosis code <1> is designated for male patients only and this conflicts with the submitted gender of the patient.
6248	Sequential Intravenous Push Reported by a Physician	Sequential intravenous push code 96376 reported on Claim ID <1>, Line ID <2> may only be reported by facilities. This service is not to be reported on a professional claim.
6385	Missing or Invalid Admission Date	Missing admission date or invalid Statement Covers Period "From" or "Through" dates.
6692	ASC Editing Device Intensive Procedures	Medicare does not pay separately for this service <1>.
6736	Missing or Invalid Statement Covers Period From/Through Date - Outpatient	Missing admission date or invalid Statement Covers Period "From" or "Through" dates.
6830	Medicare ICD-10 Rule	Per CMS guidelines ICD9 codes and ICD10 codes cannot be billed on the same claim.
6897	Medicare Medical Visit on Same Day as a Type T or S Procedure Without Modifier 25 - Same Claim	Medical visit is on the same day as a procedure <1> with a status indicator of T or S without modifier 25, on claim ID <2> line ID <3>.
6925	Bilateral Procedure Reduction	Per Medicare guidelines, procedure code <1> on claim ID <2><5><8> indicates that bilateral surgeries were performed; reimbursement for the second procedure may be reduced by 50%.
6962	Missing Provider ID	The Provider ID is missing.
7011	Maximum Frequency Exceeded Once per Calendar Month - 99487, 99490, 99491	The maximum frequency for the procedure code has been exceeded. The allowable maximum frequency for the procedure is 1 time per calendar month.
7075	Hospice Invalid Principal Diagnosis Codes - I-10	Invalid principal diagnosis code <1> for hospice bill type 081x and 082x.
7089	Missing Principal Diagnosis Code - I-10	The principal diagnosis code is missing.
7103	Inappropriate Age for Diagnosis	Diagnosis code(s) <1> is not typical for a patient whose age is <2> <3>.
7156	Multiple Medical Visits on Same Day with Same Revenue Code Without Condition Code G0 - Different Claim	Multiple medical visits billed on the same day (based on units and/or line), for the same revenue code without condition code G0. E/M visit found on history claim <1> on history line <2>.
7168	Medicare Medical Visit on Same Day as a Type T or S Procedure Without Modifier 25 - Different Claim	Medical visit is on the same day as a procedure <1> with a status indicator of T or S without modifier 25, on claim ID <2> line ID <3>.
7169	Medicare Medical Visit on Same Day as a Type T or S Procedure Without Modifier 25 - History Claim	Medical visit <1>, on claim ID <2> line ID <3> is on the same day as a procedure with a status indicator of T or S without modifier 25.
7185	Inappropriate Specification of Bilateral Procedure Different Claim	The HCPCS code on this line was also billed on history claim <1> on history line <2> for the same date of service. This code is inherently bilateral and should not be billed more than once for the same date of service.
7267	Service Billable Only to Durable Medical Equipment Regional Carrier	Code can only be billed to the DME Regional Carrier.

7349	Code2 of a Code Pair That Would Be Allowed by NCCI if Appropriate Modifier Were Present - Different Claim	Procedure code <1> is considered to be a component of the comprehensive code <2> on claim ID <3> Line ID <4> and this line should be denied. Review documentation to determine if a modifier is appropriate.
7376	Code2 of a Code Pair That Is Not Allowed by NCCI Even if Appropriate Modifier is Present - Different Claim	Procedure code <1> is considered to be a component of the comprehensive code <2> on claim ID <3> Line ID <4> and this line should be denied. A modifier will not override this edit.
7418	Device-Intensive Procedure Reported Without Device Code	A device-dependent procedure <1> requires that a device HCPCS code be submitted on the same day.
7535	Inappropriate Diagnosis Combination - Definitive	Per the ICD-10-CM Excludes1 note guideline, diagnosis codes <1> identify two conditions that cannot be reported together except when the two conditions are unrelated.
7537	Inappropriate Diagnosis Combination - Definitive	Per the ICD-10-CM Excludes1 note guideline, diagnosis codes <1> identify two conditions that cannot be reported together except when the two conditions are unrelated.
7556	CCM or TCM Submitted in Global Period	Procedure Code <1> is within the global period of <5> days of Procedure Code <2> on Claim ID <3>, Line ID <4> performed by the same provider.
7602	Invalid Value Code	This claim has an invalid value code <1>.
7663	Facility Non Covered Codes	Per Medicare, the item, service, or code is a non-covered service.
7678	Principal Diagnosis - Age Conflict	Age conflict; the Principal diagnosis <1> is not permissible for the patient's age.
7729	Invalid Billing of Device Credit	Value code FD requires a condition code reported on the claim.
7785	HCPCS G0260, G0378-G0384 and G0463 Reported on a Professional Claim	Procedure code <1> found on claim ID <2> is a facility service code. This service is not to be reported on a professional claim.
7870	Screening Digital Breast Tomosynthesis Required Revenue Code	Screening digital breast tomosynthesis HCPCS code <1> requires the appropriate revenue code.
7871	Screening Digital Breast Tomosynthesis Type of Bill Requirements	The type of bill code <1> submitted on the claim is inappropriate for screening digital breast tomosynthesis.
7896	POA Exempt Diagnosis Code	The diagnosis code <1> is exempt from POA reporting.
7900	POA Non-exempt Diagnosis Code	The diagnosis code <1> requires a Present on Admission (POA) indicator.
7961	Procedure Reduction Co-Surgeons	Procedure code <1> on Claim ID <2>, Line ID <3> is subject to a reduction for co-surgeon modifier and will pay at <4>%.
8117	Medicare Post-Op Surgery by Provider	Per Medicare guidelines, procedure code <1> is within the global period of procedure code <2> found on history Claim ID <3> performed by the same provider.
8152	Missing or Invalid Admission Date	Missing admission date or invalid Statement Covers Period "From" or "Through" dates.
8195	Missing or Invalid POS	The place of service (<1>) is missing or invalid.
8196	Medicare Ambulance Origin and Destination Modifiers	Per CMS guidelines, HCPCS Code <1> is identified as an ambulance code and requires an ambulance modifier appended.
8203	Invalid Provider specialty	The Provider specialty <1> is invalid.
8246	Service Billable Only to Durable Medical Equipment Regional Carrier	Code can only be billed to the DME Regional Carrier.

8290	Pre-op Procedure One Day Before Surgery	Pre-Op E/M Service <1> performed one day before the History Surgical Procedure Code <2> on Claim ID <3>, Line ID <4> is not allowed as part of the global surgical package without an appropriate modifier.
8291	Pre-op Procedure in History One Day Before Surgery	History Pre-Op E/M Service <1> on Claim ID <2>, Line ID <3> performed one day before a Surgical Procedure Code <4> is not allowed as part of the global surgical package without an appropriate modifier.
8293	Surgical Global Followup - Same Provider	Procedure Code <1> is within the global period of <6> days of History Procedure Code <2> performed on <3> on Claim ID <4>, Line ID <5> by the same provider.
8296	Medicare E/M Without Appropriate Modifiers - Major	Per Medicare guidelines, E/M code <1> should not be billed without an appropriate modifier, on the same day of a minor procedure, or the same day or day before a major procedure, found on claim ID <2>, line ID <3>.
8300	Medicare E/M Without Appropriate Modifier - Minor	Per Medicare guidelines, E/M code <1> should not be billed without an appropriate modifier, on the same day of a minor procedure, or the same day or day before a major procedure, found on claim ID <2>, line ID <3>.
8327	Interim Claims with Frequency Code 2 and 3 Requires Patient Discharge Status Code 30 - Outpatient	Per Medicare guidelines, the patient discharge status code must be 30 [still patient] when the frequency digit is the type of bill 2 [Interim- First Claim] or the frequency digit is the type of bill 3 [Interim- Continuing Claim].
8332	Surgical Global Followup in History - Same Provider	History Procedure Code <1> performed on <2> on Claim ID <3>, Line ID <4> is within the global period of <6> days of Procedure Code <5> on the Current Line.
8339	Incorrect Billing of Blood and Blood Products	Incorrect billing of blood and blood products.
8344	Incorrect Billing of Blood and Blood Products	Incorrect billing of blood and blood products.
8346	Incorrect Billing of Blood and Blood Products	Incorrect billing of blood and blood products.
8376	Inappropriate Diagnosis Combination - Definitive - Facility	Per the ICD-10-CM Excludes1 note guideline, diagnosis codes <1> identify two conditions that cannot be reported together except when the two conditions are unrelated.
8397	Medicare Physical, Occupational, Speech Therapists in Private Practice	Per Medicare guidelines, procedure code <1> is a therapy service. No payment is made if provided in place of service <2>.
8400	Invalid Diagnosis Code	The diagnosis code(s) <1> are invalid.
8446	Third Party Liability	Diagnosis code(s) <1> could involve third-party liability and/or subrogation of benefits.
8448	Duplicative Laboratory Facility and Professional Procedures	This claim line has a duplicate procedure code on facility Claim ID <1><3>, Line ID <2><4> for the same date of service. This procedure code submitted should be reviewed for potential overpayment.
8468	Anesthesia Crosswalk Individual Review	Procedure Code <1> requires a crosswalk to an anesthesia code prior to editing. Replace the surgical CPT code with the appropriate anesthesia code (<2>).
8499	Medicare E/M Without Appropriate Modifiers - Major (History)	Per Medicare guidelines, claim line <1> in history on Claim ID <2> contains E/M code <3> billed on the same day of a minor procedure or the same day or day before a major procedure. An appropriate modifier is required.
8521	Medicare E/M Without Appropriate Modifier - Minor (History)	Per Medicare guidelines, claim line <1> in history on Claim ID <2> contains E/M code <3> billed on the same day of a minor procedure or the same day or day before a major procedure. An appropriate modifier is required.
8553	Incorrect Billing of Blood and Blood Products	Incorrect billing of blood and blood products.

8564	Procedure Reduction Surgical Team	Procedure code <1> on Claim ID <2>, Line ID <3> is subject to a reduction for surgical team modifier and will pay at <4>%.
8575	Incorrect Billing of Blood and Blood Products	Incorrect billing of blood and blood products.
8578	Incorrect Billing of Blood and Blood Products	Incorrect billing of blood and blood products.
8580	Incorrect Billing of Blood and Blood Products	Incorrect billing of blood and blood products.
8632	Medicare Post-Op Surgery by Provider	Per Medicare guidelines, procedure code <1> is within the global period of procedure code <2> found on history Claim ID <3> performed by the same provider.
8638	CCM Included in Other Services During Same Month	Chronic care management service Procedure Code <1> is included in Procedure Code <2> reported on Claim ID <3>, Line ID <4> when reported in the same calendar month.
8639	CCM Found in History Included in Other Services During Same Month	Chronic care management service Procedure Code <1> on History Claim ID <2>, Line ID <3> is included in Procedure Code <4> when reported in the same calendar month.
8687	Maximum Allowable Administrations of Darbepoetin Alfa	Per Medicare guidelines, the maximum number of administrations of Darbepoetin Alfa, HCPCS code <1> for a billing cycle is 5 times in 30/31 days.
8730	Missing Procedure Code	Procedure Code is missing.
8732	Disabled Procedure Code	Procedure Code <1> is disabled.
9226	Maximum Frequency	The <1> frequency of <2> time(s) per <3> <4> for procedure <5> <6> has been exceeded by <7>. The following claim(s) and associated claim line(s) contributed to frequency: <8>
9409	Inconsistency Between Implanted Device or Administered Substance and Implantation or Associated Procedure	Inconsistency between implanted device and implantation procedure.
9576	Medicare Ambulance Reduction	Per Medicare guidelines apply a <1> reduction to claim lines containing HCPCS code A0425 and A0428 when billed with an origin/destination modifier that contains G or J in any position.
9732	Missing Provider specialty	The Provider specialty is missing.
9767	Definitive/AMA Designated Add-on Code Reported Without a Primary Procedure Code - Includes CMS Designated Primary	Add-on procedure code <1> has been submitted without an appropriate primary procedure code by the same provider.
9769	AMA Designated and Interpreted Add-on Code Reported Without Primary Procedure Code - Includes CMS Designated Primary	Add-on procedure code <1> has been submitted without an appropriate primary procedure code by the same provider.
9796	External Cause of Morbidity Code Cannot Be Used as Principal Diagnosis	External cause of morbidity code <1> cannot be used as a principal diagnosis.
10302	Anesthesia Secondary Procedure in History with Modifier Override	An anesthesia service with a lower base unit value than Procedure Code <1> was reported on <2> on Claim ID <3>, Line ID <4>. Only the anesthesia code with the highest base unit value should be billed per operative session.
10315	Facility Non Covered Codes	Per Medicare, the item, service, or code is a non-covered service.

10372	Unspecified and Not Otherwise Specified (NOS) ICD-10-CM Codes	The ICD-10-CM code(s) <1> defines an unspecified or Not Otherwise Specified (NOS) ICD-10-CM diagnosis code. Review documentation to verify whether or not a more specific ICD-10-CM diagnosis code is appropriate.
10390	Medicare Post-Op Surgery by Provider - History	Per Medicare guidelines, procedure code <2> found in history on claim ID <3> and line ID <4> is within the global period of procedure code <1> by the same provider for the same patient.
10473	Outpatient Therapy Functional Reporting Speech-Language Pathology	This procedure code requires functional reporting HCPCS code(s).
11256	Unspecified ICD-10-CM Codes - Laterality Only	The ICD-10-CM code(s) <1> defines an unspecified ICD-10-CM diagnosis code which has an equivalent code for laterality (right or left). Review documentation to verify whether or not a more specific ICD-10-CM diagnosis code is appropriate.
11269	ICD-10 to ICD-9 Diagnosis Comparison	The following codes were translated <1> with Diagnosis Code Mappings <2>.
11282	Hospice Revenue Codes and HCPCS Codes G0299, G0300	Hospice HCPCS codes G0299 and G0300 must be submitted with revenue code 055x.
11288	Hospice Nursing Revenue Codes and HCPCS Code G0299 and G0300	Hospice claim with revenue code 055x must be submitted with hospice HCPCS code G0299 or G0300.
11333	Medical Visit on Same Day as a Type S Procedure Without Modifier 25 - Same Claim	Medical visit is on the same day as a procedure <1> with a status indicator of S without modifier 25, on claim ID <2> line ID <3>.
11334	Medical Visit on Same Day as a Type S Procedure Without Modifier 25 - Different Claim	Medical visit is on the same day as a procedure <1> with a status indicator of S without modifier 25, on claim ID <2> line ID <3>.
11335	Medical Visit on Same Day as a Type T or S Procedure Without Modifier 25 - History Claim	Medical visit <1>, on claim ID <2> line ID <3> is on the same day as a procedure with a status indicator of T or S without modifier 25.
11389	Skilled Nursing Home Health Revenue Codes	Home health services must be reported with an appropriate home health skilled nursing revenue codes.
11460	Medicare Pneumococcal Vaccine Requires Administration	Per Medicare guidelines, the associated administration code for vaccine procedure code <1>, is missing or invalid.
11461	Medicare Pneumococcal Vaccine Administration Requires Drug	Per Medicare guidelines, the associated vaccine code for administration procedure code <1>, is missing or invalid.
11462	Medicare Hepatitis Vaccine Requires Administration	Per Medicare guidelines, the associated administration code for vaccine procedure code <1>, is missing or invalid.
11463	Medicare Hepatitis Vaccine Administration Requires Drug	Per Medicare guidelines, the associated vaccine code for administration procedure code <1>, is missing or invalid.
11521	Invalid Professional Component Modifier	Modifier -26 is not appropriate with Procedure Code <1> because that procedure is defined as 100% professional or 100% technical.
11622	Medicare Influenza Rule	Per Medicare guidelines, a diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid.
11623	Medicare Pneumococcal Vaccine Rule	Per Medicare guidelines, a diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid.
11625	Medicare Hepatitis B Vaccine Rule	Per Medicare guidelines, a diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid.

11652	Modifier 62 Required for TAVR/TAVI Services	Procedure code requires modifier 62.
11765	Modifier 26 Required	Procedure Code <1> requires a modifier -26 when billing for the professional component in place of service <2>.
11994	Corneal Tissue Processing Reported Without Cornea Transplant Procedure	The corneal tissue processing HCPCS code <1> requires a corneal transplant procedure submitted on the same date of service.
12004	Service Provided Prior to FDA Approval	The HCPCS code <1> on this line is billed on a line item service date that is prior to the FDA approval date.
12025	Service Provided Prior to Date of National Coverage Determination (NCD) Approval	The HCPCS code <1> on this line is billed on a line item service date that is prior to the date of National Coverage Determination (NCD).
12275	Invalid Condition Code	The condition code <1> on the claim is invalid.
12280	Facility Inpatient Missing Patient Discharge Status	The patient status code is missing.
12302	Facility Inpatient Invalid Patient Discharge Status	The patient status is not valid.
12458	Facility Outpatient Modifier CA With Multiple Procedures	Use of modifier CA with more than one procedure or units greater than one is not allowed.
12505	Non-Covered Service Submitted for Verification of Denial	Non-Covered Service submitted for verification of denial (Condition Code 21).
12577	Service Submitted for MAC Review	Non-Covered Service submitted for review (Condition Code 20).
12691	Facility Outpatient Invalid Age	Patient's age must be between 0 and 124 years.
12692	Facility Outpatient Invalid Gender	The patient's gender is invalid or missing.
12697	Code Not Recognized By Medicare	The HCPCS code <1> on this line is not recognized by Medicare.
12771	ICD-10-CM Outpatient Code Editor (OCE) Age	The diagnosis code(s) is not typical for age of the patient.
12792	Facility Outpatient G0379 Only Allowed With G0378	Observation HCPCS code G0378 is missing on the claim.
12795	Facility Outpatient Trauma Code Without Revenue Code and E/M	A trauma response critical care code has been submitted without revenue code 068x and CPT code 99291.
12872	Facility Outpatient Trauma Code Without Revenue Code and E/M	A trauma response critical care code has been submitted without revenue code 068x and CPT code 99291.
12878	Facility Outpatient Trauma Code Without Revenue Code and E/M	A trauma response critical care code has been submitted without revenue code 068x and CPT code 99291.
12959	Facility Outpatient Partial Hospitalization Condition Code 41 Not Approved for Type of Bill	Partial hospitalization Condition Code 41 is not appropriate for this Type of Bill.
13189	Facility Outpatient Only Mental Health Education And Training Services Reported	Mental health training and education services are not payable when it is the only service(s) submitted on a day or on the claim.
13221	Facility Outpatient Non-Covered By Statute	Non-covered based on statutory exclusion.

13231	Facility Outpatient Revenue Code Not Recognized By Medicare	Revenue code <1> is not recognized by Medicare.
13248	Invalid Modifier Code	The modifier code(s) <1> are invalid.
13256	Facility Other Diagnosis Adolescent Age Conflict	The other diagnosis code <1> is for adolescents and is not typical for the patient's age <2> years.
13264	ASC Packaged Item/Service Rule	Procedure code <1> is a packaged item or service and should not be separately billed on an ASC claim.
13265	Medicare Hospital Acquired Condition - Other Diagnosis - HAC Category 1	HAC: Foreign Object Retained After Surgery - The POA indicator and diagnosis code <1> found on the claim indicate that Hospital Acquired Condition (HAC) has been met. Code is by-passed when calculating reimbursement.
13280	Anesthesia Crosswalk by Report	The system was unable to crosswalk this surgical code <1> to an anesthesia code since the Anesthesia Crosswalk status is By Report. Review the claim and enter the appropriate anesthesia code in place of the surgical CPT code.
13281	Anesthesia Performed by Non-Anesthesia Provider	Procedure code <1> was reported by a provider that is not an Anesthesiology provider.
13316	Facility Outpatient Invalid Principal Diagnosis	The principal diagnosis code <1> is either not a valid diagnosis or is invalid for the date of service on the claim.
13350	Medicare Modifier AT For Chiropractic Services	Per Medicare guidelines, modifier AT is required when billing procedure code <1> for active treatment. Medicare does not pay for maintenance therapy.
13356	Medicare Hospital Acquired Condition - Other Diagnosis - HAC Category 6	HAC: Catheter-Associated Urinary Tract Infection (UTI) - The POA indicator and diagnosis code <1> found on the claim indicate that Hospital Acquired Condition (HAC) has been met. Code is by-passed when calculating reimbursement.
13492	Medicare Hospital Acquired Condition - Other Diagnosis - HAC Category 11 - I-10	HAC: Surgical Site Infection Following Bariatric Surgery for Obesity - The POA indicator, principal diagnosis, diagnosis code <1> and procedure code <2> found on the claim indicate that Hospital Acquired Condition (HAC) has been met. Code is by-passed when calculating reimbursement.
13544	Medical Visit on Same Day as a Type T or S Procedure Without Modifier 25 - Same Claim	Medical visit is on the same day as a procedure <1> with a status indicator of T or S without modifier 25, on claim ID <2> line ID <3>.
13547	Medical Visit on Same Day as a Type T or S Procedure Without Modifier 25 - Different Claim	Medical visit is on the same day as a procedure <1> with a status indicator of T or S without modifier 25, on claim ID <2> line ID <3>.
13553	Medical Visit on Same Day as a Type T or S Procedure Without Modifier 25 - History Claim	Medical visit <1>, on claim ID <2> line ID <3> is on the same day as a procedure with a status indicator of T or S without modifier 25.
14321	Multiple Medical Visits on Same Day with Same Revenue Code Without Condition Code G0 - Same Claim	Multiple medical visits on same day (based on units and/or lines), same revenue code without condition code G0.
14325	Multiple Medical Visits on Same Day with Same Revenue Code Without Condition Code G0	Multiple medical visits on same day (based on units and/or lines), same revenue code without condition code G0.
14530	Multiple Medical Visits on Same Day with Same Revenue Code Without Condition Code G0 - Different Claim	Multiple medical visits billed on the same day (based on units and/or line), for the same revenue code without condition code G0. E/M visit found on history claim <1> on history line <2>.

14739	Medicare Hospital Acquired Condition - Other Diagnosis - HAC Category 8 - I-10	HAC: Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG) - The POA indicator and diagnosis code <1> and procedure code <2> found on the claim indicate that Hospital Acquired Condition (HAC) has been met. Code is by-passed when calculating reimbursement.
14761	Screening Digital Breast Tomosynthesis Required Revenue Code	Screening digital breast tomosynthesis HCPCS code <1> requires the appropriate revenue code.
14901	Medicare Hospital Acquired Condition - Other Diagnosis - HAC Category 10 - I-10	HAC: Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures - The POA indicator and diagnosis code <1> and procedure code <2> found on the claim indicate that Hospital Acquired Condition (HAC) has been met. Code is by-passed when calculating reimbursement.
14907	Medicare Hospital Acquired Condition - Other Diagnosis - HAC Category 12 - I-10	HAC: Surgical Site Infection Following Certain Orthopedic Procedures - The POA indicator and diagnosis code <1> and procedure code <2> found on the claim indicate that Hospital Acquired Condition (HAC) has been met. Code is by-passed when calculating reimbursement.
14913	Antepartum care/Delivery/Postpartum by Specialty	Procedure <1> should not be performed by specialty <2>.
14939	Medicare Hospital Acquired Condition - Other Diagnosis - HAC Category 13 - I-10	HAC: Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED) - The POA indicator and diagnosis code <1> and procedure code <2> found on the claim indicate that Hospital Acquired Condition (HAC) has been met. Code is by-passed when calculating reimbursement.
14942	Medicare Hospital Acquired Condition - Other Diagnosis - HAC Category 14 - I-10	HAC: Iatrogenic Pneumothorax with Venous Catheterization - The POA indicator and diagnosis code <1> and procedure code <2> found on the claim indicate that Hospital Acquired Condition (HAC) has been met. Code is by-passed when calculating reimbursement.
14969	Total Global Obstetrical Care	The total global obstetrical care code <1> cannot be reported when an antepartum care code, a delivery only code or a postpartum care code has been submitted in history by a different provider on claim ID <2>, line ID <3>.
15072	Terminated Procedure Reduction	The surgical procedure code <1> contains a terminated modifier and should be reviewed for a 50% reduction.
15147	Modifier 51 required	Procedure code <1> on claim ID <2>, line ID <3> has been billed on the same DOS as another procedure without an appropriate modifier. Typically, procedures or services with the lower relative value should be reported with modifier 51.
15774	Facility Outpatient Services Provided Outside Of Approval Period	The HCPCS code <1> on this line is billed for a date of service that is not within the specified approval date for this service.
15775	Medicare Add-On Procedure without Primary Procedure	Add-on procedure code <1> has been submitted without an appropriate primary procedure code.
15792	Principal Diagnosis - Gender Conflict	Gender conflict; the patient's gender and Principal diagnosis code, <1> on the claim are not permissible.
15793	Principal Diagnosis - Gender Conflict	Gender conflict; the patient's gender and Principal diagnosis code, <1> on the claim are not permissible.
15922	Admit Diagnosis - Gender Conflict	Gender conflict; the patient's gender and Admission diagnosis code, <1> on the claim are not permissible.
15923	Admit Diagnosis - Gender Conflict	Gender conflict; the patient's gender and Admission diagnosis code, <1> on the claim are not permissible.
15924	Other Diagnosis - Gender Conflict	Gender conflict; the patient's gender and other diagnosis code, <1> on the claim are not permissible.
15925	Other Diagnosis - Gender Conflict	Gender conflict; the patient's gender and other diagnosis code, <1> on the claim are not permissible.
16624	Principal Diagnosis - Age and Gender Conflict	Age and gender conflict; the Principal diagnosis code <1> is not permissible for the patient's age and gender.
16628	Principal Diagnosis - Age and Gender Conflict	Age and gender conflict; the Principal diagnosis code <1> is not permissible for the patient's age and gender.

16778	Facility Inpatient Procedure Inconsistent with Length of Stay	Procedure code 5A1955Z should not be reported when the patient's length of stay is less than or equal to four days.
16780	Admission Diagnosis - Age and Gender Conflict	Age and gender conflict; the Admission diagnosis code <1> is not permissible for the patient's age and gender.
16783	Admission Diagnosis - Age and Gender Conflict	Age and gender conflict; the Admission diagnosis code <1> is not permissible for the patient's age and gender.
16784	Other Diagnosis - Age and Gender Conflict	Age and gender conflict; the Other diagnosis code <1> is not permissible for the patient's age and gender.
16785	Other Diagnosis - Age and Gender Conflict	Age and gender conflict; the Other diagnosis code <1> is not permissible for the patient's age and gender.
16801	Claim With Pass-Through Device Lacks Required Procedure	This claim contains a pass-through device code <1>, but lacks the required associated procedure.
16850	Admission Diagnosis - Age Conflict	Age conflict; the Admission diagnosis <1> is not permissible for the patient's age.
16853	Other Diagnosis - Age Conflict	Age conflict; the Other diagnosis <1> is not permissible for the patient's age.
17198	Medicare Modifier Not Appropriate	Per Medicare guidelines use of modifier <1> is not typical for procedure code <2>.
17207	Service Billable Only to Durable Medical Equipment Regional Carrier	Code can only be billed to the DME Regional Carrier.
17334	Medicare Abdominal Aortic Aneurysm Screening Limitation	Per Medicare guidelines, the frequency does not meet policy requirements for the procedure code.
17371	Medicare Add-On Procedure without Primary Procedure - Critical Care	Add-on procedure code <1> has been submitted without an appropriate primary procedure code.
17398	Facility Outpatient Invalid Reason For Visit Diagnosis	The reason for visit diagnosis code <1> is either not a valid diagnosis or is invalid for the date of service on the claim.
17399	Facility Outpatient Invalid Other Diagnosis	The other diagnosis code <1> is either not a valid diagnosis or is invalid for the date of service on the claim.
17410	Facility Outpatient Incomplete Principal ICD-10 Diagnosis	The principal diagnosis code <1> requires a 4th, 5th, 6th, or 7th character for the dates of service on the claim.
17423	Facility Outpatient Incomplete Reason For Visit ICD-10 Diagnosis	The reason for visit diagnosis code <1> requires a 4th, 5th, 6th, or 7th character for the dates of service on the claim.
17424	Facility Outpatient Incomplete Other ICD-10 Diagnosis	The other diagnosis code <1> requires a 4th, 5th, 6th, or 7th character for the dates of service on the claim.
17455	Invalid Condition Code	The condition code <1> on the claim is invalid.
17456	Invalid Value Code	This claim has an invalid value code <1>.
17605	Facility Principal Diagnosis Newborn Age Conflict	The principal diagnosis code <1> is for newborns and is not typical for the patient's age <2> years.
17606	Facility Principal Diagnosis Adolescent Age Conflict	The principal diagnosis code <1> is for adolescents and is not typical for the patient's age <2> years.
17607	Facility Principal Diagnosis Maternity Age Conflict	The principal diagnosis code <1> is for maternity and is not typical for the patient's age <2> years.
17608	Facility Principal Diagnosis Adult Age Conflict	The principal diagnosis code <1> is for adults and is not typical for the patient's age <2> years.

17610	Facility Other Diagnosis Newborn Age Conflict	The other diagnosis code <1> is for newborns and is not typical for the patient's age <2> years.
17615	Facility Other Diagnosis Maternity Age Conflict	The other diagnosis code <1> is for maternity and is not typical for the patient's age <2> years.
17616	Facility Other Diagnosis Adults Age Conflict	The other diagnosis code <1> is for adults and is not typical for the patient's age <2> years.
17663	DME Medically Unlikely Edits Per Date of Service	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2> <3>.
17678	Practitioner Medically Unlikely Edits Per Date of Service	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2> <3>.
17679	DME Medically Unlikely Edits Per Claim Line	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2>.
17680	Practitioner Medically Unlikely Edits Per Claim Line	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2>.
17681	MUE Medicare Per Date Of Service	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2> <3>.
17682	Medicare MUE By Line	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2>.
17920	Medicare MUE By Line Asst Surg	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2>.
17921	Medicare MUE By Line Prof Fees	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2>.
17922	MUE Medicare Per Date Of Service Asst Surg	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2> <3>.
17923	MUE Medicare Per Date Of Service Prof Fees	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2> <3>.
17924	Medicare DME MUE By Line	Per Medicare's DME Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2>.
17926	Medicare DME MUE By Date of Service	Per Medicare's DME Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2> <3>.
17973	Not a Commonly Associated Diagnosis for Procedure	None of the diagnosis code(s) on this claim line are commonly associated diagnosis code(s) for procedure XXXXX.
18055	Claim With Pass-Through or Non-Pass-Through Drug Or Biological Lacks Payable Procedure	This claim contains a pass-through or non-pass-through drug or biological HCPCS code <1>, but lacks the associated payable procedure that must be submitted on the same claim.
18385	Facility Reason For Visit Diagnosis Adolescent Age Conflict	The reason for visit diagnosis code <1> is for adolescents and is not typical for the patient's age <2> years.
18386	Facility Reason For Visit Diagnosis Adult Age Conflict	The reason for visit diagnosis code <1> is for adults and is not typical for the patient's age <2> years.
18387	Facility Reason For Visit Diagnosis Newborn Age Conflict	The reason for visit diagnosis code <1> is for newborns and is not typical for the patient's age <2> years.

18388	Facility Reason For Visit Diagnosis Maternity Age Conflict	The reason for visit diagnosis code <1> is for maternity and is not typical for the patient's age <2> years.
18408	Facility Outpatient Claim Lacks Required Primary Code - Mental Health	The HCPCS add-on code <1> is lacking a required primary code on the claim.
18576	Unlisted Procedure Code	Procedure code <1> is an unlisted procedure or service. Supporting documentation must be attached.
18849	Other Diagnosis and Gender Conflict Female	The other diagnosis code <1> is designated for female patients only and this conflicts with the submitted gender of the patient.
18850	Other Diagnosis and Gender Conflict Male	The other diagnosis code <1> is designated for male patients only and this conflicts with the submitted gender of the patient.
18851	Reason for Visit Diagnosis and Gender Conflict Male	The reason for visit diagnosis code <1> is designated for male patients only and this conflicts with the submitted gender of the patient.
18852	Reason for Visit Diagnosis and Gender Conflict Female	The reason for visit diagnosis code <1> is designated for female patients only and this conflicts with the submitted gender of the patient.
18917	Inpatient Separate Procedures Not Paid	Per CMS, procedure code <1> is designated as an inpatient separate procedure performed in an outpatient hospital setting.
18988	Inpatient Procedure	Per CMS, procedure code <1> is designated as an inpatient only procedure performed in an outpatient hospital setting.
18990	Inpatient Procedure	Per CMS, procedure code <1> is designated as an inpatient only procedure performed in an outpatient hospital setting.
19032	Inpatient Procedure	Per CMS, procedure code <1> is designated as an inpatient only procedure performed in an outpatient hospital setting.
19084	Facility Outpatient CA Modifier Requires Discharge Status Indicating Deceased Or Transferred	CA modifier requires patient discharge status indicating expired or transferred.
19085	Facility Outpatient Modifier CA With Multiple Procedures	Use of modifier CA with more than one procedure or units greater than one is not allowed.
19086	Facility Outpatient Modifier CA With Multiple Procedures	Use of modifier CA with more than one procedure or units greater than one is not allowed.
19087	Facility Outpatient Modifier CA With Multiple Procedures	Use of modifier CA with more than one procedure or units greater than one is not allowed.
19166	No Additional Diagnoses Are Required on RNHCI Claims Other Than Principal and First Other	Admit diagnosis <1> is not required on RNHCI claims.
19172	No Additional Diagnoses Are Required on RNHCI Claims Other Than Principal and First Other - ICD 10	Other diagnosis <1> is not required on RNHCI claims other than the first other diagnosis.
19228	HCPCS Code 90999 Must Be Present On All Lines With Revenue Code 082x	Revenue code 082X requires HCPCS code 90999.
19257	Always ESRD Related Drugs With Modifier AY	Always ESRD related drugs subject to consolidated billing cannot be reported with modifier AY.

19258	Always ESRD Related Drugs With Modifier AY; Exception HCPCS Code J0878	A secondary diagnosis code supporting the use of modifier AY must be submitted for always ESRD-related HCPCS code J0878.
19259	Condition Code Must Be Present On All TOB 072x ESRD Claims	Per CMS guidelines, one condition code 59, 71, 72, 73, 74, 76, 80 or 87 must be present on End Stage Renal Disease (ESRD) type of bill 072x claims.
19260	Always ESRD Related Drugs With Modifier AY; Exception HCPCS Code J3370	A secondary diagnosis code supporting the use of modifier AY must be submitted for always ESRD-related HCPCS code J3370.
19261	Value Code D5 Not Present on ESRD Claim TOB 072x	Value code D5 is required on TOB 072X ESRD claims.
19264	Modifiers V5, V6 and V7 Must Be Reported With Revenue Code 0821	Modifier V5, V6 or V7 must be submitted with revenue code 0821.
19293	ESRD Frequency of Billing Span Multiple Months	Per Medicare guidelines, the statement date range cannot be greater than 1 month.
19305	Acute Kidney Injury Claim Without A Required Diagnosis	The Acute Kidney Injury (AKI) claim is missing one of the required ICD-10-CM diagnosis codes.
19347	Hemodialysis Code 90999 Missing Appropriate G Modifier for Urea Reduction Ratio (URR)	Code 90999 is missing appropriate URR modifier (G1-G6).
19348	Occurrence Code 51 Must Be Submitted on TOB 072x Unless Value Code D5 With Amount 9.99 or 8.88 is Present	Occurrence code 51 must be submitted on all ESRD claims unless value code D5 with amount 9.99 or 8.88 is present.
19351	Principal Diagnosis Required for End Stage Renal Disease - ICD-10	Principal ICD-10 diagnosis N18.6 is required on all 072X ESRD claims.
19352	HCPCS Code G0491 and CPT Code 90999 Can Not be Reported On The Same Claim	Acute Kidney Injury (AKI) code G0491 and End Stage Renal Disease (ESRD) hemodialysis code 90999 are not allowed on the same claim.
19421	Acute Kidney Injury Claim Without Required Procedure	The Acute Kidney Injury (AKI) claim is missing the required procedure code.
19423	Modifier AY Can Not Be Reported on an Acute Kidney Injury (AKI) Claim	Modifier AY is not allowed on an Acute Kidney Injury (AKI) claim.
19425	Acute Kidney Injury (AKI) Code G0491 Submitted On the Same Day as Hemodialysis Code 90935 or 90947	Acute Kidney Injury (AKI) code <1> should not be reported on the same day as hemodialysis code <2> on history claim ID <3> Line ID <4>.
19426	Acute Kidney Injury Claim Without Required Revenue Code	The Acute Kidney Injury (AKI) claim is missing the required revenue code.
19482	Medicare Anesthesia Modifiers	Per Medicare guidelines, anesthesia code <1> on claim line ID <2> requires an appropriate modifier.
19518	Argatroban, HCPCS J0883, Can Not Be Submitted On TOB 072X	Argatroban, HCPCS code J0883 can not be submitted on TOB 072X.
19575	Rural Health Clinic (RHC) Revenue Center Requires HCPCS	Claim line revenue code <1> requires submission of a HCPCS code for RHC claims.

19576	Rural Health Clinic (RHC) Revenue Code Not Allowed	Claim line revenue code <1> not allowed for RHC claims.
19619	Inpatient Admitting Diagnosis Code Is Required	The admitting diagnosis code is missing.
19655	Inpatient Admitting Diagnosis Code Is Required - Medicare	The admitting diagnosis code is missing.
19656	Initial Preventive Physical Examination (IPPE) Frequency Rule	Per Medicare, IPPE is only covered once a lifetime.
19663	ASC Corneal Tissue Processing Reported Without Cornea Transplant Procedure	The corneal tissue processing HCPCS code <1> requires a corneal transplant procedure submitted on the same date of service.
19665	ASC Corneal Tissue Processing Reported Without Cornea Transplant Procedure	The corneal tissue processing HCPCS code <1> requires a corneal transplant procedure submitted on the same date of service.
19668	Medical Services and Preventive Health RHC Must Be Billed With Revenue Code 052X	Procedure code <1> is for either medical services or preventive health services and must be billed with revenue code 052X for Rural Health Clinic (RHC) claims.
19669	Mental Health Services RHC Must Be Billed With Revenue Code 0900	Procedure code <1> is for mental health services and must be billed with revenue code 0900 for Rural Health Center (RHC) claims.
19670	Telehealth Services RHC Must Be Billed With Revenue Code 0780	Procedure code <1> is a telehealth service and must be billed with revenue code 0780 for Rural Health Clinic (RHC) claims.
19713	Home Health Claim Without Skilled Nursing Must Have Condition Code 54	Home health claims without skilled nursing visits must contain condition code 54.
19714	Negative Pressure Wound Therapy (NPWT) CPT Code Missing Appropriate Revenue Code	Negative pressure wound therapy CPT codes must be billed with revenue code 042X, 043X, or 559 on a home health claim.
19715	Negative Pressure Wound Therapy (NPWT) Not Allowed On Home Health Type Of Bill 032x	Negative Pressure Wound Therapy (NPWT) procedure code <1> is not allowed on Home Health bill type 032x.
19718	Revenue Code 0559 Can Only Be Reported With Negative Pressure Wound Therapy (NPWT) Codes On Home Health Type Of Bill 034x	Procedure code <1> can not be reported with revenue code 0559 on Home Health claim, bill type 034x.
19720	Negative Pressure Wound Therapy (NPWT) Billed On Home Health (HH) Claim, Bill Type 034x Without HH Episode Claim, Bill Type 032x In History	Negative Pressure Wound Therapy (NPWT) procedure code <1> billed on Home Health claim, bill type 034x without a Home Health episode claim in history, bill type 032x.
19721	CMS CT Modifier Reduction Rule	Per CMS Guidelines, procedure code <1> when billed with modifier CT, is eligible for a reduction of the technical or TC portion of the service.
19736	Medicare Modifiers AU, AV and AW Required on Select DME	Modifier AU, AV or AW must be appended to HCPCS code <1>.

19798	Facility Outpatient CA Modifier Requires Discharge Status Indicating Deceased Or Transferred	CA modifier requires patient discharge status indicating expired or transferred.
19824	Reduction for FX and FY Modifiers	Per CMS guidelines, modifier FX or FY is eligible for a reduction when billed on an imaging service, procedure code <1> that is an x-ray taken using film or computed radiography technology.
19837	HSCT Allogeneic Transplant Lacks Required Revenue Code Line For Donor Acquisition	HSCT allogeneic transplantation, procedure code <1>, lacks required revenue code line 815 for donor acquisition.
20065	Advance Care Planning	Advance Care Planning (ACP) procedure code <1> is a packaged service when billed with other OPPS payable services, procedure code <2> and should not be separately paid.
20073	Separate Payment For Services Is Not Provided By Medicare	Separate payment for procedure code <1> is not provided by Medicare.
20098	ASC Retinal Prosthesis Implantation Procedure	The HCPCS code <1> is lacking a required additional code when a retinal prosthesis is implanted in the ASC.
20099	ASC Retinal Prosthesis Implantation Procedure	The HCPCS code <1> is lacking a required additional code when a retinal prosthesis is implanted in the ASC.
20112	ASC Argus Retinal Prosthesis Add-on Code	The HCPCS add-on code <1> is lacking a required primary code when a retinal prosthesis is implanted in the ASC.
20113	Computed Tomography (CT) Scan Reduction	Per CMS guidelines, a reduction should be applied to HCPCS code <1> when modifier CT is appended to the claim line.
20115	ASC Argus Retinal Prosthesis Add-on Code	The HCPCS add-on code <1> is lacking a required primary code when a retinal prosthesis is implanted in the ASC.
20176	Item Or Service With Modifier PN Not Allowed Under PFS	Item or service <1> with modifier PN is not allowed.
20177	Item Or Service With Modifier PN Not Allowed Under PFS	Item or service <1> with modifier PN is not allowed.
20206	Service Not Eligible for All-Inclusive Rate	Rural Health Clinic (RHC) claim, bill type 071x contains procedure code <1> reported with modifier CG that is not eligible for the RHC all-inclusive rate.
20207	ASC Retinal Prosthesis Implantation Procedure	The HCPCS code <1> is lacking a required additional code when a retinal prosthesis is implanted in the ASC.
20208	ASC Retinal Prosthesis Implantation Procedure	The HCPCS code <1> is lacking a required additional code when a retinal prosthesis is implanted in the ASC.
20228	Medicare Modifier QG Rule for Stationary Oxygen Delivery	Per Medicare guidelines, when procedure code <1> for stationary oxygen is billed with modifier QG or QR appended, the fee schedule amount for stationary oxygen is increased by 50 percent.
20229	Medicare Modifier QG Rule with Portable Oxygen in History	Per Medicare guidelines, the current claim HCPCS code <1> is not billable with HCPCS code <2><3> in history. It is inappropriate to bill for both stationary oxygen with Modifier QG or QR and portable oxygen equipment on the same date or within 30 days of each other.
20389	Not a Primary Diagnosis Code	Diagnosis code <1> describes an external cause, or requires the diagnosis code for the first underlying disease, and should never be listed as the primary diagnosis for a procedure.
20437	Patient Reason for Visit Required	A patient reason for visit diagnosis code is required.
20527	Inpatient Questionable Admission	Principal diagnosis code <1> indicates a questionable admission.

20573	Dates of Service to Units Discrepancy	Discrepancy detected between the number of units <1> on this claim line and the difference between the Beginning DOS <2> and the Ending DOS <3> which is <4> days.
20576	Principal Procedure - Gender Conflict	Gender conflict; the patient's gender and Principal procedure code, <1> on the claim are not permissible.
20577	Principal Procedure - Gender Conflict	Gender conflict; the patient's gender and Principal procedure code, <1> on the claim are not permissible.
20578	Other Procedure - Gender Conflict	Gender conflict; the patient's gender and Other procedure code <1> on the claim are not permissible.
20579	Other Procedure - Gender Conflict	Gender conflict; the patient's gender and Other procedure code <1> on the claim are not permissible.
20598	Reduction for FX and FY Modifiers	Per CMS Guidelines, procedure code <1> when billed with modifier <2><3>, is eligible for a reduction of the technical or TC portion of the service.
20607	Inpatient Missing Gender	The patient gender is missing.
20608	Inpatient Invalid Gender	The Patient Gender is invalid. Gender must be 1, 2, M, or F.
20610	Inpatient Invalid Age	Age invalid; <1> years, not in range 0-124 years.
20615	Inpatient Limited Coverage Procedure	Procedure codes 02RK0JZ and 02RL0JZ are limited coverage when Z006 diagnosis code is present.
20618	Patient Reason for Visit Required	A patient reason for visit diagnosis code is required.
20653	Claim Reported With Pass-Through Device Prior To FDA Approval For The Procedure	The pass-through device code <1> is billed prior to the FDA approval date.
20654	Type I Add-On Procedure Without Primary Procedure	Add-on procedure code <1> has been submitted without an appropriate primary procedure code.
20656	Facility Inpatient Non Covered Procedure Without Qualifying Diagnosis Code ICD-10	ICD procedure code <1> is non-covered unless exempted by a qualifying diagnosis code or procedure code.
20657	Medicare Timely Filing	The beginning date of service occurred more than 12 months from the entry date <1>, this exceeds Medicare's timely filing guidelines.
20659	Medicare Return to Operating Room Reduction	Per Medicare guidelines, the presence of modifier 78 indicates that only the intra-operative portion of the global fee for procedure code <1> may be reimbursed. The intra-operative percentage for this procedure is <2> on the physician fee schedule.
20662	Inpatient Invalid Admitting Diagnosis	The admission diagnosis code <1> is invalid.
20663	Inpatient Invalid Admitting Diagnosis - Medicare	The admission diagnosis code <1> is invalid.
20664	Inpatient Incomplete Admitting Diagnosis	The admission diagnosis code <1> is invalid because it has an incomplete number of digits.
20665	Inpatient Incomplete Admitting Diagnosis - Medicare	The admission diagnosis code <1> is invalid because it has an incomplete number of digits.
20673	Inpatient Missing Principal Diagnosis	The principal diagnosis code is missing on the claim.
20674	Inpatient Invalid Principal Diagnosis	The principal diagnosis code <1> is invalid.
20675	Inpatient Incomplete Principal Diagnosis	The principal diagnosis code <1> is incomplete.
20686	Inpatient Invalid Other Diagnosis	The other diagnoses codes <1> are invalid.
20687	Inpatient Incomplete Other Diagnosis	The other diagnoses codes <1> are invalid due to having an incomplete number of digits.
20689	Inpatient Invalid Principal Procedure	The principal procedure code <1> is invalid.

20690	ASC MUE Medicare By Line	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2>.
20691	ASC MUE Medicare Per Date Of Service	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2> <3>.
20692	ASC MUE Medicare Per Date Of Service	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2> <3>.
20693	Medicare Venipuncture Edit	Procedure code <1> has been billed on <2> without a corresponding venipuncture code. Add a venipuncture code, if appropriate.
20698	Inpatient Incomplete Principal Procedure	The principal procedure code <1> is incomplete.
20700	Inpatient Invalid Other Procedure	The other procedure code <1> is invalid.
20701	Inpatient Incomplete Other Procedure	The other procedure code <1> has an incomplete number of digits.
20732	Missing Provider ID - Outpatient	The provider ID is missing from the claim.
20733	Medicare Hospital Acquired Condition - Principal Diagnosis - HAC Category 1	HAC: Foreign Object Retained After Surgery - The POA indicator and principal diagnosis code <1> indicate that Hospital Acquired Condition (HAC) has been met.
20735	Medicare Hospital Acquired Condition - Principal Diagnosis - HAC Category 6	HAC: Catheter-Associated Urinary Tract Infection (UTI) - The POA indicator and principal diagnosis code <1> indicate that Hospital Acquired Condition (HAC) has been met.
20739	Medicare Hospital Acquired Condition - Principal Diagnosis - HAC Category 8 - I-10	HAC: Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG) - The POA indicator, principal diagnosis code <1>, and procedure code <2> found on the claim indicate that Hospital Acquired Condition (HAC) has been met.
20741	Medicare Hospital Acquired Condition - Principal Diagnosis - HAC Category 10 - I-10	HAC: Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures - The POA indicator, principal diagnosis code <1>, and procedure code <2> found on the claim indicate that Hospital Acquired Condition (HAC) has been met.
20742	Invalid Type of Admission	This claim has an invalid type of admission code <1>.
20743	Missing Type of Admission	This claim has a missing type of admission code.
20745	Medicare Hospital Acquired Condition - Principal Diagnosis - HAC Category 12 - I-10	HAC: Surgical Site Infection Following Certain Orthopedic Procedures - The POA indicator, principal diagnosis code <1>, and procedure code <2> found on the claim indicate that Hospital Acquired Condition (HAC) has been met.
20747	Medicare Hospital Acquired Condition - Principal Diagnosis - HAC Category 13 - I-10	HAC: Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED) - The POA indicator, principal diagnosis code <1>, and procedure code <2> found on the claim indicate that Hospital Acquired Condition (HAC) has been met.
20749	Medicare Hospital Acquired Condition - Principal Diagnosis - HAC Category 14 - I-10	HAC: Iatrogenic Pneumothorax with Venous Catheterization - The POA indicator, principal diagnosis code <1>, and procedure code <2> found on the claim indicate that Hospital Acquired Condition (HAC) has been met
20753	Missing Patient ID - Outpatient	No patient ID was submitted on the claim.
20772	Medicare Portable Xray Reduction Rule	Per Medicare, procedure code R0075 has been billed with a modifier <1>. A reduction in reimbursement may be appropriate.
20789	Invalid Type of Admission	This claim has an invalid type of admission code <1>.
20809	Medicare Post-Op Unrelated Service by Provider	Per Medicare guidelines, procedure code <1> is within the global period of procedure code <2> performed on <5> on claim ID <3> and line ID <4> submitted by the same provider. The diagnosis indicates it is not for the same condition.

20810	Medicare Post-Op Unrelated Service by Provider History - 90 Day	Per Medicare guidelines, procedure code <1> exists in history on claim ID <2> and line ID <3> with a different diagnosis by the same provider as submitted procedure code <4> during the global period.
20816	Medicare Multiple Evaluation and Management Codes	Procedure Code <1> was performed on the same day of History Procedure Code <2> performed on Claim ID <3>, Ext/Int Line ID <4> by the same provider. The diagnosis indicates it is for the same condition.
20817	Item Or Service With Modifier PN Not Allowed Under PFS	Item or service <1> with modifier PN is not allowed.
20820	Medicare Global Follow-Up by Provider	Per Medicare guidelines, E/M code <1> is within the global period of procedure code <2> found in history on claim ID <3>, line ID <4> submitted with the same diagnosis code billed by the same provider as the current line provider.
20821	Medicare Global Follow-Up by Provider History - 10 day	Per Medicare guidelines, E/M code <1> exists in history on claim ID <2>, line ID <3>, with the same diagnosis code, by the same provider as procedure code <4>, on the current claim line billed by the same provider during the global period.
20827	Medicare Modifier - 51 Required	Per Medicare guidelines, procedure code <1> on claim ID <2>, line ID <3> has been billed on the same DOS as another procedure without an appropriate modifier. Typically, procedures or services with the lower relative value should be reported with modifier 51.
20830	Medicare Modifier GY	Per Medicare guidelines, the presence of modifier GY indicates this is not eligible for payment.
20840	Item Or Service With Modifier PN Not Allowed Under PFS	Item or service <1> with modifier PN is not allowed.
20841	Item Or Service With Modifier PN Not Allowed Under PFS	Item or service <1> with modifier PN is not allowed.
20843	Only One Condition Code (71-76, 87) Allowed on ESRD Claim	Only one of the following condition codes 71, 72, 73, 74, 75, 76 or 87 can be submitted on an ESRD claim.
20872	Medicare Portable X-Ray Modifier Required for Multiple Patients Seen	Per Medicare HCPCS code R0075 was billed without the required UN, UP, UQ, UR, or US modifier.
20876	Referring Physician Missing	The procedure code <1> requires a referring physician.
20885	E/M Condition Not Met for Observation and Line Item Date for Code G0378 is 1/1	Per CMS guidelines there is no specified E/M or critical care visit the day of or the day preceding the observation HCPCS code G0378, therefore the APC composite requirement is not met.
20886	Invalid Occurrence Span Code	The occurrence span code <1> on the claim is invalid.
20887	Medicare Outpatient Never Events	The claim line contains a PA modifier which indicates that this surgical code was performed on the wrong body part and should be denied.
20891	Inpatient Non Covered Procedure With Diagnosis	Procedure code <1> is non-covered when a designated diagnosis code(s) <2> is present.
20897	Service Provided On or After Effective Date of National Coverage Determination (NCD)	HCPCS code <1> was provided after the end date of the approved coverage in the national coverage determination
20904	Missing Account ID - Outpatient	The Account ID is missing from the claim.
20908	Typically Cosmetic Procedure	Procedure <1> is typically considered cosmetic. Review plan benefits and claim documentation.
20909	Typically Investigational	Procedure Code <1> is considered investigational or experimental. Review plan benefits and/or request claim documentation.
20910	Non-Covered Service	Procedure code <1> is a non-covered service per the Non-covered service list.

20920	Global Follow-Up - Same Provider	Procedure Code <1> is within the global period of <6> days of History Procedure Code <2> performed on <3> on Claim ID <4>, Line ID <5> by the same provider.
20936	Medicare Outpatient Never Events	The claim line contains a PB modifier which indicates that this surgical code was performed on the wrong patient and should be denied.
20937	Medicare Outpatient Never Events	The claim line contains a PC modifier which indicates that the wrong surgical code was performed on the patient and should be denied.
20948	Duplicate Claim in History Outpatient	This claim is a possible duplicate claim of History Claim ID <1>.
20949	Invalid Occurrence Code	The occurrence code <1> on the claim is invalid.
20951	Duplicate Claim Line Same Claim	The claim line <1> is a possible duplicate of claim line <2>.
20953	Duplicate Claim in History Inpatient	This claim is a possible duplicate claim of History Claim ID <1>.
20974	Patient DOB is Invalid - Outpatient	Patient's Date of Birth <1> is invalid on the claim.
20978	Invalid Occurrence Span Code	The occurrence span code <1> on the claim is invalid.
20981	Medicare Modifier QF Rule with Portable Oxygen Delivery in History	Per Medicare guidelines, the current claim HCPCS code <1> is not billable with HCPCS code <2><3><4><5> in history. It is inappropriate to bill for both stationary oxygen and portable oxygen equipment on the same date or within 30 days of each other when both services do not have modifier QF appended or both services do not have modifier QB appended.
20999	Invalid Occurrence Code	The occurrence code <1> on the claim is invalid.
21005	Occurrence Code Missing Begin Date	An occurrence code on the claim is missing the begin date.
21006	Occurrence Code Missing Begin Date	An occurrence code on the claim is missing the begin date.
21032	Patient DOB is Missing - Outpatient	Patient's Date of Birth is missing on the claim.
21495	Non Covered ICD Procedure With Age	Procedure code <1> is non-covered since this patient's age is <2> years.
21497	Add-On Procedure Without Primary Procedure	Add-on procedure code <1> has been submitted without an appropriate primary procedure code.
21498	Medicare Modifier - 51 Inappropriate	Per Medicare guidelines, procedure code <1> on claim ID <2>, line ID <3> submitted with modifier 51 is inappropriate. Modifier 51 should not be appended to the procedure code with the highest RVU or the use of modifier 51 is not appropriate with the procedure code.
21541	Timely Filing	The statement covers period through date of service, <1>, is past the Medicare institutional timely filing limit.
21678	Modifier CG for Type of Bill 072X	The presence of modifier CG indicates the dialysis treatment does not meet medical justification requirements and should not be paid separately.
21680	Condition Code 54 Not Allowed on TOB	Condition code 54 is not allowed on this Type of Bill.
21791	Mental Health RHC Frequency Rule	Per Medicare, only one service line per day with revenue code 0900 with a qualifying visit mental health HCPCS code is allowed on a RHC claim. This claim contain more than one qualifying mental health visit HCPCS code <1> and should not be billed with multiple units of service <2>.
21797	Mental Health RHC Frequency Rule - Same Claim	Per Medicare, only one service line per day with revenue code 0900 with a qualifying visit mental health HCPCS code <1> is allowed on a RHC claim. HCPCS code <2> was billed on claim ID <3> on claim line <4>.
21798	Mental Health RHC Frequency Rule - Different Claim	Per Medicare, only one service line per day with revenue code 0900 with a qualifying visit mental health HCPCS code <1> is allowed on a RHC claim. HCPCS code <2> was billed on claim ID <3> on claim line <4>.
21807	ASC Medicare CCI Unbundle - Modifier Allowed - Same Claim	Per Medicare CCI Guidelines, procedure code <1> has an unbundle relationship with history procedure code <2>, line ID <3> on claim ID <4>.

21808	ASC Medicare CCI Unbundle - Modifier Allowed - Different Claim	Per Medicare CCI Guidelines, procedure code <1> has an unbundle relationship with history procedure code <2>, line ID <3> on claim ID <4>.
21811	ASC Medicare CCI Unbundle - Modifier Allowed - History	Per Medicare CCI Guidelines, history procedure code <1> on claim ID <2> on line ID <3> has an unbundle relationship with the procedure code <4>.
21813	ASC Medicare CCI Unbundle - Modifier Not Allowed - Same Claim	Per Medicare CCI Guidelines, procedure code <1> has an unbundle relationship with history procedure code <2>, line ID <3> on claim ID <4>.
21814	ASC Medicare CCI Unbundle - Modifier Not Allowed - Different Claim	Per Medicare CCI Guidelines, procedure code <1> has an unbundle relationship with history procedure code <2>, line ID <3> on claim ID <4>.
21815	ASC Medicare CCI Unbundle - Modifier Not Allowed - History	Per Medicare CCI Guidelines, history procedure code <1> on claim ID <2> on line ID <3> has an unbundle relationship with the procedure code <4>.
21830	Inappropriate Specification of Bilateral Procedure Different Claim	The HCPCS code on this line was also billed on history claim <1> on history line <2> for the same date of service. This code is inherently bilateral and should not be billed more than once for the same date of service.
21835	Timely Filing	The statement covers period through date of service, <1>, is past the Medicare institutional timely filing limit.
21839	Value Code 42 and Condition Code 26 Must Both Be Present	Value code 42 and condition code 26 must both be present on the claim.
21840	Timely Filing	The statement covers period through date of service, <1>, is past the Medicare institutional timely filing limit.
21899	Present On Admission Indicator Not Valid For Type Of Bill	Present on Admission (POA) indicator is not valid for this Type of Bill (TOB).
21906	Invalid Present on Admission (POA) Indicator	The Present on Admission (POA) indicator <1> is invalid.
21915	Hospice Vaccine Claim With Revenue Code Other Than 0771 Or 0636	A revenue code other than 0636 or 0771 is not allowed on a Hospice claim if revenue code 0771 is present.
21919	Duplicate Claim Line Different Claim	The claim line <1> is a possible duplicate of historical claim <2>, history claim line <3>.
21947	Global Follow-Up in History - Same Provider	History Procedure Code <1> performed on <2> on Claim ID <3>, Line ID <4> is within the global period of <6> days of Procedure Code <5> by the same provider.
22172	Discharge Status Requires Occurrence Code 55	Occurrence code 55 is required on the claim when the patient discharge status is <1>.
22206	Rural Health Clinic (RHC) Medical Services Qualifying Visits Frequency - Same Claim	Per Medicare, only one service line per day with revenue code 052X with a qualifying visit medical services HCPCS code <1> is allowed on a RHC claim. HCPCS code <2> was billed on claim ID <3> on claim line <4> (excluding approved preventive services and modifier 59 or 25).
22207	Rural Health Clinic (RHC) Medical Services Qualifying Visits Frequency - Different Claim	Per Medicare, only one service line per day with revenue code 052X with a qualifying visit medical services HCPCS code <1> is allowed on a RHC claim. HCPCS code <2> was billed on claim ID <3> on claim line <4> (excluding approved preventive services and modifier 59 or 25).
22210	Rural Health Clinic (RHC) Medical Services Qualifying Visits Frequency Rule	Per Medicare, only one service line per day with revenue code 052X with a qualifying visit medical services HCPCS code is allowed on a RHC claim. This claim contains more than one qualifying medical services HCPCS code <1> and should not be billed with multiple units of service <2>.
22274	Procedure Age Excluding Vaccine Codes Sourced to FDA	Procedure Code <1> is not typical for a patient whose age is <2> <3>.
22522	Medicare Screening Pelvic	Per Medicare guidelines the diagnosis code(s) billed does not support the medical necessity of G0101.

22549	Revenue Code 0023 Only Allowed Once on Request for Anticipated Payment Claims	Revenue code 0023 can only be billed one time on RAP (Request for Anticipated Payment) claims.
22574	HCPCS Code E1399 Must be Billed with Revenue Code 0292 on Home Health Claims	HCPCS code E1399 must be billed with revenue code 0292 on Home Health claims.
22650	Telehealth Services Must Be Billed With Revenue Code 0780	Procedure code <1> is a telehealth service and must be billed with revenue code 0780 for outpatient hospital claims.
22659	Bill Type With Frequency Code Q Cannot Be Submitted Within Normal Timely Filing Parameters	Bill types with a frequency code of Q, can only be billed after the normal timely filing parameters have expired.
22660	Type of Bills With Frequency Code Q Must Have Appropriate Condition Codes	Type of Bills with frequency code Q must have condition code W2.
22664	Type of Bills With Frequency Code Q Must Have Appropriate Condition Codes	Type of Bills with frequency code Q must have condition code D0, D1, D2, D4, D9 or E0.
22665	Type of Bills With Frequency Code Q Must Have Appropriate Condition Codes	Type of Bills with frequency code Q must have a condition code from the R1-R9 range.
22716	Hospice Notice of Election Claims with Occurrence Code 56 Require Condition Code D0	Hospice Notice of Election claims with occurrence code 56 require condition code D0.
22717	Date of Certification Must Match the From and Admit Date for Hospice Notice of Election Claims	The Date of Certification (occurrence code 27) must match the From and Admit dates for hospice Notice of Election claims.
22756	Modifier AX Must Be Billed With HCPCS Code J0604 or J0606	Modifier AX must be billed with HCPCS code J0604 or J0606.
22758	HCPCS Code J0604 or J0606 With Modifier AX Must Be Billed With Revenue Code 0636	When HCPCS code J0604 or J0606 is billed with modifier AX on an End Stage Renal Disease claim (TOB 072X), the revenue code must be 0636.
22814	Missing or Invalid Type of Bill - Inpatient	The type of bill code is invalid.
22831	Missing or Invalid Statement Covers Period From/Through Date - Inpatient	Missing admission date or invalid Statement Covers Period "From" or "Through" dates.
22837	Interim Claims with Frequency Code 2 and 3 Requires Patient Discharge Status Code 30 - Inpatient	Per Medicare guidelines, the patient discharge status code must be 30 [still patient] when the frequency digit is the type of bill 2 [Interim- First Claim] or the frequency digit is the type of bill 3 [Interim- Continuing Claim].
22894	Inappropriate Diagnosis Code(s) on Newborn Record	Per ICD-10-CM guidelines, diagnosis code(s) <1> is only for use on the maternal record, never on the newborn record.
22895	Inappropriate Diagnosis Code(s) on Maternal Record	Per ICD-10-CM guidelines, diagnosis code(s) <1> is only for use on the newborn record, never on the maternal record.

22898	Timely Filing	The statement covers period through date of service, <1>, is past the timely filing limit.
22900	Missing Account ID - Inpatient	The Account ID is missing from the claim.
22901	Patient DOB is Missing - Inpatient	Patient's Date of Birth is missing on the claim.
22904	Medicare Frequency for Advanced Care Planning as Preventive	An Advanced Care Planning (ACP) procedure code <1> with a modifier 33 appended has previously been reported in history within the last year. Do not waive co-pay and deductible more than once per year.
22937	Medicare Waive Deductible and Co-pay for Preventive Advanced Care Planning	Per Medicare when CPT code <1> is billed with modifier 33 waive the deductible and co-pay for this service.
22965	HCPCS Home Health and Hospice Codes Reported on a Professional Claim	Procedure code <1> found on claim ID <2> is a facility service code. This service is not to be reported on a professional claim.
23103	Timely Filing	The statement covers period through date of service, <1>, is past the timely filing limit.
23162	ASC Skin Substitute Application Procedure Without Appropriate Skin Substitute Product Code	Skin substitute product procedure code <1> must be submitted with the appropriate skin substitute application procedure code on the same date of service.
23163	Inappropriate Diagnosis Combination - Definitive - Facility	Per the ICD-10-CM Excludes1 note guideline, diagnosis codes <1> identify two conditions that cannot be reported together except when the two conditions are unrelated.
23256	Type of Admission Frequency	Type of Admission Code 4 (newborn), cannot be billed more than once in a lifetime.
23271	ASC Incorrect Billing of Modifier FB or FC	Incorrect billing of modifier FB or FC.
23272	ASC Incorrect Billing of Modifier FB and FC	Incorrect billing of modifiers <1> and <2>.
23356	ASC Procedure Submitted With Modifier 59	A procedure code has been submitted with modifier 59. Per AMA guidelines, use of modifier 59 may require supporting documentation.
23388	Medicare Post-Op Unrelated Service by Provider HIstory - 10 Day	Per Medicare guidelines, procedure code <1> exists in history on claim ID <2> and line ID <3> with a different diagnosis by the same provider as submitted procedure code <4> during the global period.
23400	Unbundle	History Procedure Code <2> on Claim <3> on line <4> has an exclusive relationship with the Procedure Code <1>.
23757	CCM and Services Found in History Included During Same Month	Procedure Code <1> on History Claim ID <2>, Line ID <3> is included in chronic care management service Procedure Code <4> on Claim ID <5> when reported in the same calendar month.
23761	CCM and Services included During Same Month	Procedure Code <1> is included in chronic care management service Procedure Code <2> reported on Claim ID <3>, Line ID <4> when reported in the same calendar month.
23762	Psychiatric Collaborative Care Management Episode	Procedure code 99492 may only be reported once in an episode of care. A period of 6 calendar months has not passed since Procedure code <1> found on history Claim ID <2>, Line ID <3> was reported.
23763	HCPCS Codes for RHCs and FQHCs Reported on a Professional Claim	Procedure code <1> found on claim ID <2> is a facility service code. This service is not to be reported on a professional claim.
23765	Medicare Global Follow-Up by Provider History - 90 Day	Per Medicare guidelines, E/M code <1> exists in history on claim ID <2>, line ID <3>, with the same diagnosis code, by the same provider as procedure code <4>, on the current claim line billed by the same provider during the global period.
23768	TCM and Services Included During Same 30 Day Period	Procedure Code <1> is included in transitional care management service Procedure Code <2> on Claim ID <3>, Line ID <4> when reported in the same 30 day period.

23769	Psychiatric Collaborative Care Management Services During Same Month	Procedure Code 99493 may not be reported with Procedure Code 99492 on Claim ID <1>, Line ID <2> when reported in the same calendar month.
23770	TCM and Services Found in History Included During Same 30 Day Period	Procedure Code <1> found in history on Claim ID <2>, Line ID <3> is included in transitional care management Procedure Code <4> on Claim ID <5> when reported in the same 30 day period.
23790	Behavioral Health Integration Care Management	Procedure Code <1> may not be reported with Procedure Code <2> on Claim ID <3>, Line ID <4> in the same calendar month.
23835	ASC Bilateral Modifier 50 Rule	Modifier 50 is not recognized in an Ambulatory Surgical Center (ASC).
23837	ASC TOB 083x Not Typical for Procedure	Procedure code <1> is not typically performed in an ASC setting.
23838	Screening Digital Breast Tomosynthesis Required Diagnosis	Screening digital breast tomosynthesis HCPCS code <1> requires the appropriate diagnosis code.
23839	Screening Digital Breast Tomosynthesis Required Diagnosis	Screening digital breast tomosynthesis HCPCS code <1> requires the appropriate diagnosis code.
23840	Screening Digital Breast Tomosynthesis Must Be Billed With Primary Mammogram Code	Screening digital breast tomosynthesis HCPCS code <1> requires the appropriate primary mammogram code.
23842	Discharge Status Code 20 Cannot be Used on Hospice Claims	Patient discharge status 20 cannot be submitted on Hospice claims.
23843	Occurrence Code 42 Cannot be Submitted with Condition Code 52 or Discharge Status Codes 50 or 51 on Hospice Claims	Occurrence code 42 cannot be submitted with condition code 52 or discharge status codes 50 or 51 on Hospice claims.
23846	Telehealth Place of Service	Per Medicare guidelines telehealth procedure code <1> must be performed in POS 02.
23870	Modifier Pairing Not Allowed on the Same Line	Modifier codes <1> and <2> can not be submitted on the same claim line.
23883	Federally Qualified Health Clinics (FQHC) Payment Code Not Reported for FQHC Claim	A FQHC claim must contain a required FQHC payment code.
23897	Only Incidental Services Reported	Only incidental services are billed on this claim.
23899	Medicare Telehealth Frequency Inpatient Services	Per Medicare guidelines, the frequency does not meet policy requirements for the procedure code.
23900	Medicare Telehealth Frequency Subsequent Nursing Home Care	Per Medicare guidelines, the frequency does not meet policy requirements for the procedure code.
23906	Acute Kidney Injury (AKI) Claims Cannot Report HCPCS Codes J0604 and J0606	Per Medicare guidelines, HCPCS code <1> is not allowed on an Acute Kidney Injury (AKI) claim.
23917	Acute Kidney Injury (AKI) Claims Cannot Report Modifier AX	Per Medicare guidelines, Modifier code <1> is not allowed on an Acute Kidney Injury (AKI) claim.
23926	Chronic Care Management (CCM) Frequency Rule for RHC and FQHC Claims	Per Medicare guidelines, chronic care management (CCM) code <1> is only billed once per month.

23927	340B Drug Reduction	A 22.5% reduction should be taken from the average sales price (ASP) on drug code <1> which has a status indicator of K and modifier JG.
23928	Condition Code 85 Reported on Type of Bill (TOB) Other Than Hospice	Per Medicare guidelines, condition code 85 is not allowed on Type of Bill (TOB) code <1>.
23955	Medicare Always Therapy - Speech, Language Therapy Only	Per Medicare CPT/HCPCS code <1> on line <2> must have modifier GN.
24039	Modifier GT Only Allowed on Critical Access Hospital Claims	Modifier GT can only be billed on Critical Access Hospital (TOB 085X) claims.
24063	Global Surgical Days for Critical Access Hospitals	Evaluation and Management code <1> is within the global period of surgical procedure code <2> on claim ID <3>.
24066	Service Not Billable to the Medicare Administrative Contractor	Service is not billable to an FI or MAC.
24071	Diagnostic Imaging Multiple Procedure Reduction (MPR) for Critical Access Hospital (CAH)	Per CMS guidelines, a multiple procedure reduction should be applied to HCPCS code <1>.
24074	Condition Code 44 Reported on Type of Bill (TOB) Other Than 013X or 085X	Per Medicare guidelines, condition code 44 is not allowed on Type of Bill (TOB) code <1>.
24077	Item or Service Not Covered Under FQHC PPS or for RHC	Items or services are not covered under the FQHC PPS and RHC claims.
24078	Medicare CCI Unbundle	Per Medicare CCI Guidelines, history procedure code <2> on history line ID <4> and claim ID <3> has an unbundle relationship with procedure code <1>.
24079	Medicare Other Unbundle	Per Medicare Guidelines, procedure code <1> has an unbundle relationship with history procedure code <2>, on line ID <4>, on claim ID <3>.
24110	Medicare Always Therapy - Occupational Therapy Only	Per Medicare CPT/HCPCS code <1> on line <2> must have modifier GO.
24111	Medicare Always Therapy - Physical Therapy Only	Per Medicare CPT/HCPCS code <1> on line <2> must have modifier GP.
24122	Skilled Nursing Facility Date Span	Per Medicare guidelines, the statement covers period From and Through dates cannot span the annual update effective date of October 1.
24129	Skilled Nursing Facility HIPPS Charge Amount	Revenue code 0022 cannot be billed with charges greater than $1.00.
24262	Medicare Terminated Procedure Reduction	The surgical procedure code <1> contains a terminated modifier and should be reviewed for a 50% reduction.
24266	Skilled Nursing Facility Type of Bill	Revenue code 0022 can only be billed on TOB 021X or 018X.
24267	Home Health Revenue Code and TOB	Revenue code 0023 can only be billed on a Home Health TOB (032X).
24353	Stationary Oxygen Delivery at Less Than 1 LPM	Per Medicare guidelines, when procedure code <1> for stationary oxygen is billed with modifier QA or QE appended, the fee schedule amount for stationary oxygen is decreased by 50 percent.
24458	Home Health Non Covered Revenue Codes	Revenue code <1> cannot be submitted with covered charges on Home Health claims, Type of Bill 032X.
24918	Type I Add-On Procedure Without Primary Procedure	Add-on procedure code <1> has been submitted without an appropriate primary procedure code.

25048	Inpatient Procedure	Per CMS, procedure code <1> is designated as an inpatient only procedure performed in an outpatient hospital setting.
25117	ASC MUE Medicare By Line	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2>.
25118	ASC MUE Medicare Per Date Of Service	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2> <3>.
25119	ASC MUE Medicare Per Date Of Service	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2> <3>.
25277	Ambulatory Surgical Center Invalid Age	Patient's age must be between 0 and 124 years.
25292	Invalid Revenue Code For Acute Kidney Injury Claims	Revenue code <1> is not valid for Acute Kidney Injury Claims.
25307	Inpatient Questionable Obstetric Admission	Procedure code <1> indicates a questionable obstetric admission.
25539	Transfer Rebundle	Retain Procedure Code <1>. The Transfer relationship is <4>. The Grouper ID is <5>.
25604	Code2 of a Code Pair That Is Not Allowed by NCCI Even if Appropriate Modifier is Present - CAH Professional	History procedure code <1> on history claim <2> on history line <3> is considered to be a component of the comprehensive procedure code <4> on the current line and the history line may be denied. A modifier will not override this edit.
25627	Code2 of a Code Pair That Is Not Allowed by NCCI Even if Appropriate Modifier is Present - CAH Professional - Same Claim	Procedure code <1> is considered to be a component of the comprehensive code <2> on claim ID <3> Line ID <4> and this line should be denied. A modifier will not override this edit.
25629	Code2 of a Code Pair That Is Not Allowed by NCCI Even if Appropriate Modifier is Present - CAH Facility - Same Claim	Procedure code <1> is considered to be a component of the comprehensive code <2> on claim ID <3> Line ID <4> and this line should be denied. A modifier will not override this edit.
25632	Code2 of a Code Pair That Is Not Allowed by NCCI Even if Appropriate Modifier is Present - CAH Facility	History procedure code <1> on history claim <2> on history line <3> is considered to be a component of the comprehensive procedure code <4> on the current line and the history line may be denied. A modifier will not override this edit.
25633	Code2 of a Code Pair That Would Be Allowed by NCCI if Appropriate Modifier Were Present - CAH Professional	History procedure code <1> on history claim <2> on history line <3> is considered to be a component of the comprehensive procedure code <4> and the history line may be denied. Review the medical record to determine if an appropriate modifier should be assigned.
25634	Code2 of a Code Pair That Would Be Allowed by NCCI if Appropriate Modifier Were Present - CAH Facility	History procedure code <1> on history claim <2> on history line <3> is considered to be a component of the comprehensive procedure code <4> and the history line may be denied. Review the medical record to determine if an appropriate modifier should be assigned.
25635	Code2 of a Code Pair That Would Be Allowed by NCCI if Appropriate Modifier Were Present - CAH Facility - Same Claim	Procedure code <1> is considered to be a component of the comprehensive code <2> on claim ID <3> Line ID <4> and this line should be denied. Review documentation to determine if a modifier is appropriate.

25636	Code2 of a Code Pair That Would Be Allowed by NCCI if Appropriate Modifier Were Present - CAH Professional - Same Claim	Procedure code <1> is considered to be a component of the comprehensive code <2> on claim ID <3> Line ID <4> and this line should be denied. Review documentation to determine if a modifier is appropriate.
25647	Code2 of a Code Pair That Is Not Allowed by NCCI Even if Appropriate Modifier is Present - CAH Professional - Different Claim	Procedure code <1> is considered to be a component of the comprehensive code <2> on claim ID <3> Line ID <4> and this line should be denied. A modifier will not override this edit.
25648	Code2 of a Code Pair That Would Be Allowed by NCCI if Appropriate Modifier Were Present - CAH Facility - Different Claim	Procedure code <1> is considered to be a component of the comprehensive code <2> on claim ID <3> Line ID <4> and this line should be denied. Review documentation to determine if a modifier is appropriate.
25649	Code2 of a Code Pair That Would Be Allowed by NCCI if Appropriate Modifier Were Present - CAH Professional - Different Claim	Procedure code <1> is considered to be a component of the comprehensive code <2> on claim ID <3> Line ID <4> and this line should be denied. Review documentation to determine if a modifier is appropriate.
25650	Code2 of a Code Pair That Is Not Allowed by NCCI Even if Appropriate Modifier is Present - CAH Facility - Different Claim	Procedure code <1> is considered to be a component of the comprehensive code <2> on claim ID <3> Line ID <4> and this line should be denied. A modifier will not override this edit.
25834	Medicare Non-Covered Chiropractic Services	Per Medicare guidelines, procedure code <1> is not covered when billed by a provider with specialty 35, Chiropractor.
25859	Inpatient Skilled Nursing Facility and Swing Bed Requirements for Occurrence Code 22	Inpatient Skilled Nursing Facility (SNF) or Swing Bed type of bill (TOB) code <1> requires discharge disposition 30 when occurrence code 22 is present on the claim and the occurrence code date is equal to the through date of the claim.
25874	Home Health Non Covered Revenue Codes	Revenue code <1> cannot be submitted on Home Health claims, Type of Bill 032X.
25921	Medicare Pneumococcal Vaccine Frequency	Per Medicare guidelines, the frequency does not meet policy requirements for the procedure code.
25988	Supply Code Not Reported with an Always Injection Procedure	The injection or infusion procedure code <2> performed in POS <1> has been reported without an appropriate drug or substance code.
26014	Unclassified Drug or Biological Not Allowed on AKI Claim	Per Medicare guidelines, HCPCS code <1> is not allowed on an Acute Kidney Injury (AKI) claim.
26057	NDC Information Required for ESRD Claim	The NDC information is required for HCPCS code <1>.
26063	Laboratory Test in Hospital	Per Medicare guidelines, procedure code <1> describes a laboratory procedure that is not eligible for separate reimbursement in place of service <2>.
26064	Laboratory Interpretation in Hospital	Per Medicare guidelines, procedure code <1> describes a diagnostic procedure that requires a professional component modifier in POS <2>.
26065	Technical Component in Hospital	Per Medicare guidelines, procedure code <1> describes a diagnostic procedure that is not eligible for separate reimbursement in place of service <2>.

26070	Medicare Subsequent Annual Wellness Visit Without Initial Annual Wellness Visit Code in History	Per Medicare guidelines, a subsequent wellness visit code has been billed without an initial wellness visit code in history.
26106	Non-ESRD HCPCS is Not Permitted on ESRD Claims	Non-ESRD HCPCS code <1> is not permitted on ESRD claims.
26188	Inappropriate Age for Procedure	Procedure Code <1> is not typical for a patient whose age is <2> <3>.
26197	Code First Diagnosis Present Without Mental Health Diagnosis as the First Secondary Diagnosis	A mental health diagnosis code is required in the first secondary diagnosis position when a code first diagnosis is submitted as the principal diagnosis on a Partial Hospitalization claim.
26246	Duplicate Diagnosis Code	Diagnosis code(s) <1> may only be reported once per claim line.
26265	Inpatient Procedure	Per CMS, procedure code <1> is designated as an inpatient only procedure performed in an outpatient hospital setting.
26266	Service Provided Prior to Initial Marketing Date	The HCPCS code <1> on this line is billed prior to the initial marketing date.
26291	Medicare Prior Authorization Required for DMEPOS	Per Medicare guidelines, DMEPOS code <1> requires prior authorization.
26302	Facility Outpatient Partial Hospitalization Service For Non-Mental Health Diagnosis	Claims for partial hospitalization must have a mental health principal diagnosis.
26308	ASC Facility - Claim With Pass-Through Device Lacks Required Procedure	This claim contains a pass-through device code <1>, but lacks the required associated procedure.
26370	Modifier 53 - Incomplete Colonoscopy for Critical Access Hospital (CAH)	Per Medicare guidelines, procedure code <1> when billed with modifier 53 is paid at a specific rate established in the Medicare Physician Fee Schedule (MPFS).
26377	Inconsistency Between Implanted Device or Administered Substance and Implantation or Associated Procedure	Inconsistency between implanted device and implantation procedure.
26408	Outpatient Services Reduction for Modifier PO	A reduction should be applied to HCPCS code <1> when reported with modifier PO.
26410	Medicare Inappropriate Modifier - Professional/Technical Component	Per Medicare guidelines, modifier <1> is not appropriate for procedure code <2>.
26411	Medicare Inappropriate Modifier - Follow Up Days	Per Medicare guidelines, modifier <1> is not appropriate for procedure code <2>.
26413	Medicare Inappropriate Modifier - Team Surgery	Per Medicare guidelines, modifier <1> is not appropriate for procedure code <2>.
26414	Medicare Inappropriate Modifier - Assistant Surgeon	Per Medicare guidelines, modifier <1> is not appropriate for procedure code <2>.
26423	Maximum Frequency Exceeded Once For Same Period - HCPCS codes G0333, Q0513 and Q0514	The maximum frequency for the procedure code has been exceeded. Only one dispensing fee payment (HCPCS code G0333, Q0513 or Q0514) will be made for the same period.

26488	Professional Services for Home Infusion Therapy Drug	Professional home infusion therapy services code <1> has been reported without an associated drug code. The professional visit claim should be reviewed with a 30-day look back period for a total of 15 business days. After 15 business days, if no J-code claim is found in claims history, the G-code claim will receive an edit.
26530	Mammography Required Revenue Code for RHC and FQHC	Per Medicare guidelines, the required revenue code is missing or inappropriate.
26531	Mammography Required Revenue Code	Per Medicare guidelines, the required revenue code is missing or inappropriate.
26537	Modifier Pairing Not Allowed on the Same Line	Modifier codes <1> and <2> can not be submitted on the same claim line.
26538	Modifier Pairing Not Allowed on the Same Line	Modifier codes <1> and <2> can not be submitted on the same claim line.
26551	Professional Services for Home Infusion Therapy	Professional home infusion therapy services code <1> is reported on the same date of service as another professional home infusion therapy service code. Only one visit is allowed to be reported per date of service.
26574	Professional Services for Home Infusion Therapy in History	A professional home infusion therapy services code <1> on History Claim ID <2>, Line ID <3> was reported. The professional home infusion therapy services code <4> on the Current Claim ID <5>, Line ID <6> is reported on the same date of service and should not be allowed. Only one professional home infusion therapy service visit is allowed per date of service.
26616	Only Incidental Services Reported	Only incidental services are billed on this claim.
26617	Behavioral Health Integration Care Management in History	Procedure Code <1> on Claim ID <2>, Line ID <3> may not be reported with Procedure Code <4>, found on the current line, in the same calendar month.
26627	Modifier Pairing Not Allowed on the Same Line	Modifier codes <1> and <2> can not be submitted on the same claim line.
26628	Modifier Pairing Not Allowed on the Same Line	Modifier codes <1> and <2> can not be submitted on the same claim line.
26629	Modifier Pairing Not Allowed on the Same Line	Modifier codes <1> and <2> can not be submitted on the same claim line.
26631	Initial Preventive Physical Examination (IPPE) Frequency Rule	Per Medicare, IPPE is only covered once a lifetime.
26640	Psychiatric Collaborative Care Management Services in History During Same Month	Procedure Code 99493 found in history on Claim ID <1>, Line ID <2> may not be reported with Procedure Code 99492 when reported in the same calendar month.
26656	HH PPS (TOB 0327,0328,0329) and RAP (TOB 0322) Claims Must Report Value Codes 61 and 85 to Report Location and County	Value Codes 61 and 85 must be reported on all Home Health PPS and RAP claims to report location and county.
26662	Medicare Surgical Separate Procedure	Per Medicare guidelines, procedure code <1> has been billed with a related procedure code <2> on history line ID <3> and claim ID <4>.
26689	Missing Patient ID - Inpatient	No patient ID was submitted on the claim.
26696	Missing Provider ID - Inpatient	The provider ID is missing from the claim.
26699	Patient DOB is Invalid - Inpatient	Patient's Date of Birth <1> is invalid on the claim.

26745	Modifier Not Appropriate	Use of modifier(s) <1> is not typical for procedure code <2>.
26746	Transfer Rebundle Facility	Retain Procedure Code <1>. The Transfer relationship is <4>. The Grouper ID is <5>.
26765	Bilateral Modifier 50 Billed With More Than 1 Unit	Per Medicare guidelines, a bilateral procedure code <1> submitted with modifier 50 and billed with more than 1 unit of service is inappropriate. Bilateral procedures billed with a modifier 50 should be billed with one unit of service.
26792	Mammography Required Revenue Code for CAH	Per Medicare guidelines, the required revenue code is missing or inappropriate.
26839	Home Health Span Date Must be Equal to or Less Than 30	Per CMS policy, the span of days between the from and through dates on a home health claim (TOBs 0327, 0329, 032Q) should not exceed 30 days.
26841	Home Health Claims Occurrence Code 50	Per CMS policy, occurrence code 50 must be present on a home health claim type of bill 032X.
26844	Home Health HIPPS Code Charge	Revenue code 0023 cannot be billed with charges greater than $1.00.
26876	Initial Preventive Physical Examination Frequency	Per Medicare guidelines, the frequency does not meet policy requirements for the procedure code.
26893	Modifier JE Required for Drug Administered Via Dialysate on ESRD Claim	Modifier JE is required on a drug administered via dialysate when submitted on an ESRD claim (Type of Bill 072X).
26987	Medicare Initial Preventive Physical Examination and Annual Wellness Visit Dates of Service Policy	Per Medicare guidelines, the initial preventive physical examination HCPCS code G0402 must be billed prior to the annual wellness visit code G0438 or G0439.
27049	Modifier 33 with Moderate Sedation Services	A moderate sedation service <1> was reported in conjunction with a screening colonoscopy service <2> without modifier 33. When moderate sedation services are performed in conjunction with screening colonoscopy services, coinsurance and deductible are waived when modifier 33 is entered on the moderate sedation claim line.
27083	Invalid Procedure Code	Invalid HCPCS code, <1> based on the date of service on the claim.
27148	Bundled Into Biological	The service submitted on claim ID <1> and line ID <2> is considered bundled into the biological.
27164	Bundled Into Biological	The service submitted on claim ID <1> and line ID <2> is considered bundled into the biological.
27165	Medicare Pneumococcal Vaccine Lifetime Frequency	Per Medicare guidelines, the frequency does not meet policy requirements for the procedure code.
27184	Medicare Deductible and Coinsurance Waiver	Per Medicare guidelines, the deductible and co-insurance are waived for CPT code <1>.
27186	Facility Only Modifiers	Per Medicare guidelines, it is inappropriate to report modifier <1> for a procedure that is discontinued on a professional claim. This modifier is used by the facility to indicate that a procedure was terminated.
27215	Medicare Hospital Acquired Condition - Principal Diagnosis - HAC Category 2	HAC: Air Embolism - The POA indicator and principal diagnosis code <1> indicate that Hospital Acquired Condition (HAC) has been met.
27223	Medicare Hospital Acquired Condition - Principal Diagnosis - HAC Category 3	HAC: Blood Incompatibility - The POA indicator and principal diagnosis code <1> indicate that Hospital Acquired Condition (HAC) has been met.
27228	Medicare Hospital Acquired Condition - Principal Diagnosis - HAC Category 4	HAC: Stage III and IV Pressure Ulcers - The POA indicator and principal diagnosis code <1> indicate that Hospital Acquired Condition (HAC) has been met.
27232	Medicare Hospital Acquired Condition - Principal Diagnosis - HAC Category 5	HAC: Falls and Trauma - The POA indicator and principal diagnosis code <1> indicate that Hospital Acquired Condition (HAC) has been met.

27285	Negative Pressure Wound Therapy (NPWT) Inappropriate Modifier	Per Home Health plan of care, Negative Pressure Wound Therapy (NPWT) CPT code <1> should not be submitted with a plan of care modifier <2>.
27287	Medicare Hospital Acquired Condition - Principal Diagnosis - HAC Category 7	HAC: Vascular Catheter-Associated Infection - The POA indicator and principal diagnosis code <1> indicate that Hospital Acquired Condition (HAC) has been met.
27289	Medicare Hospital Acquired Condition - Principal Diagnosis - HAC Category 9	HAC: Manifestations of Poor Glycemic Control - The POA indicator and principal diagnosis code <1> indicate that Hospital Acquired Condition (HAC) has been met.
27358	Revenue Codes 0860 and 0861 Must Be Submitted on TOB 011x	Revenue code 0860 or 0861 is submitted with inappropriate type of bill.
27413	Medicare Surgical Separate Procedure History	Per Medicare guidelines, history procedure code <1> on history line ID <2> and claim ID <3> is related to procedure code <4>.
27442	Medicare Hospital Acquired Condition - Other Diagnosis - HAC Category 2	HAC: Air Embolism - The POA indicator and diagnosis code <1> found on the claim indicate that Hospital Acquired Condition (HAC) has been met. Code is by-passed when calculating reimbursement.
27444	Monthly Enhanced Oncology Services (MEOS) Frequency	Per Medicare guidelines, the frequency does not meet policy requirements for the procedure code.
27446	Medicare Hospital Acquired Condition - Other Diagnosis - HAC Category 3	HAC: Blood Incompatibility - The POA indicator and diagnosis code <1> found on the claim indicate that Hospital Acquired Condition (HAC) has been met. Code is by-passed when calculating reimbursement.
27468	Medicare Hospital Acquired Condition - Other Diagnosis - HAC Category 4	HAC: Stage III and IV Pressure Ulcers - The POA indicator and diagnosis code <1> found on the claim indicate that Hospital Acquired Condition (HAC) has been met. Code is by-passed when calculating reimbursement.
27469	Medicare Hospital Acquired Condition - Other Diagnosis - HAC Category 5	HAC: Falls and Trauma - The POA indicator and diagnosis code <1> found on the claim indicate that Hospital Acquired Condition (HAC) has been met. Code is by-passed when calculating reimbursement.
27470	Medicare Hospital Acquired Condition - Other Diagnosis - HAC Category 7	HAC: Vascular Catheter-Associated Infection - The POA indicator and diagnosis code <1> found on the claim indicate that Hospital Acquired Condition (HAC) has been met. Code is by-passed when calculating reimbursement.
27471	Medicare Hospital Acquired Condition - Other Diagnosis - HAC Category 9	HAC: Manifestations of Poor Glycemic Control - The POA indicator and diagnosis code <1> found on the claim indicate that Hospital Acquired Condition (HAC) has been met. Code is by-passed when calculating reimbursement.
27736	New Patient Code in History for Established Patient	New patient E/M Code <1> found in history on Claim ID <2>, Line ID <3> on Date of Service <4> is within three years of code <5> on current line. An established patient E/M code should have been used.
27741	Facility Reason For Visit Diagnosis Maternity Age Conflict	The reason for visit diagnosis code <1> is for maternity and is not typical for the patient's age <2> years.
27742	Facility Principal Diagnosis Maternity Age Conflict	The principal diagnosis code <1> is for maternity and is not typical for the patient's age <2> years.
27743	Facility Other Diagnosis Maternity Age Conflict	The other diagnosis code <1> is for maternity and is not typical for the patient's age <2> years.
27754	Home Health Revenue Code 0023 Units Greater than Zero	Per Medicare guidelines revenue code 0023 must be submitted with units greater than zero on Home Health claims.
27833	Home Health Claims Occurrence Code 50	Per CMS policy, occurrence code 50 should only be submitted once on a home health claim, type of bill 032X except 0322.
27835	Home Health Claims Occurrence Codes 61 and 62	Per CMS policy, only one instance of occurrence code 61 or 62 should be reported on a home health claim, type of bills 0327, 0329, or 032Q.

27838	Home Health Claims Occurrence Codes 61 and 62	Per CMS policy, occurrence codes 61 and 62 should not be reported together on a home health claim, type of bills 0327, 0329, or 032Q.
27839	Home Health Principal Diagnosis	Per CMS policy, the principal diagnosis <1> is not sufficient to determine the home health resources group (HHRG).
28149	Outpatient Rehabilitation Biofeedback Training of Urinary Incontinence Type of Bill	Inappropriate type of bill for outpatient rehabilitation service.
28155	Biofeedback HCPCS Reported Without Appropriate Revenue Code	Inappropriate revenue code for outpatient rehabilitation service.
28158	ICD-10-CM Outpatient Code Editor (OCE) Age	The diagnosis code(s) is not typical for age of the patient.
28165	ASC Inappropriate age for Diagnosis Rule	Diagnosis not typical for age.
28170	Type I Add-On Procedure Without Primary Procedure	Add-on procedure code <1> has been submitted without an appropriate primary procedure code.
28171	Type I Add-On Procedure Without Primary Procedure	Add-on procedure code <1> has been submitted without an appropriate primary procedure code.
28232	Maximum Frequency - One Per Day Professional	Maximum frequency per day for procedure code <1> has exceeded the allowed number of units of <2>.
28244	Maximum Frequency - Two Per Day Professional	Maximum frequency per day for procedure code <1> has exceeded the allowed number of units of <2>.
28245	Maximum Frequency - Three Per Day Professional	Maximum frequency per day for procedure code <1> has exceeded the allowed number of units of <2>.
28246	Maximum Frequency - 96 Per Day Professional	Maximum frequency per day for procedure code <1> has exceeded the allowed number of units of <2>.
28247	Maximum Frequency - Four Per Day Professional	Maximum frequency per day for procedure code <1> has exceeded the allowed number of units of <2>.
28256	Medicare Glaucoma Screening Services Frequency	Per Medicare guidelines, the frequency does not meet policy requirements for the procedure code.
28259	Unbundle Interrogation Device Evaluation In Person and Remote by the Same Provider in a 90 Day Period (0576T)	A remote interrogation device evaluation code <1> on History Claim ID <2>, Line ID <3> was reported with an in person interrogation device evaluation code <4> on the Current Claim ID <5>, Line ID <6> of the same device during the same period. Only the remote service may be reported.
28260	In Person Interrogation Device Evaluation (0576T) Reported in 90 Day History of a Remote Evaluation (0578T, 0579T) by the Same Provider	An in person interrogation device evaluation code <1> on History Claim ID <2>, Line ID <3> was reported with a remote interrogation device evaluation code <4> on the Current Claim ID <5>, Line ID <6> of the same device during the same period. Only the remote service may be reported.
28261	Medicare Glaucoma Screening Services Medical Necessity	Per Medicare guidelines, procedure code <1> has been reported without the appropriate ICD 10 CM screening diagnosis code Z13.5.
28286	New Patient Ophthalmology Code in History for Established Patient	New patient E/M Code <1> found in history on Claim ID <2>, Line ID <3> on Date of Service <4> is within three years of code <5> on current line. An established patient E/M code should have been used.

28321	Interprofessional Telehealth Consultations and Face-To-Face Service Reported in 14 Days	Procedure code <1> reported on <2> is within 14 days of procedure code <3> reported on Claim ID <4>, Line ID <5> by the same physician.
28322	Interprofessional Telehealth Consultation Found in History with a Face-To-Face Service Reported in 14 Days	Procedure code <1> reported on <2> found on history Claim ID <3>, Line ID <4> is within 14 days of procedure code <5> on the current line by the same physician.
28354	Therapy Modifiers for Therapy Assistant	For claim lines billing therapy assistant services, modifier CQ must be submitted with modifier GP and modifier CO must be submitted with modifier GO.
28501	Type I Add-On Procedure Without Primary Procedure Drug Administration	Add-on procedure code <1> has been submitted without an appropriate primary procedure code.
28515	Informational Only Service	HCPCS code <1> is non-covered and is for informational reporting purposes only.
28633	ASC Facility - Claim With Pass-Through Device Lacks Required Procedure	This claim contains a pass-through device code <1>, but lacks the required associated procedure.
28675	Interrupted Stay Policy for Skilled Nursing Facility (SNF) and Swing Bed (SB)	History claim <1> is found in the paid claim history for the same SNF provider within 3 consecutive days of this readmission.
28683	Medicare Evaluation and Management Service Billed by a Physical or Occupational Therapist	Per Medicare guidelines, evaluation and management code <1> is not covered when reported by provider specialty code <2>.
28692	Medicare Diabetes Screening Frequency - Pre Diabetics	Per Medicare guidelines, the frequency does not meet policy requirements for the procedure code.
28693	Medicare Diabetes Screening Frequency - Non Pre Diabetics	Per Medicare guidelines, the frequency does not meet policy requirements for the procedure code.
28811	Duplicative Radiology Facility and Professional Procedures	This claim line has a duplicate radiology procedure code <1> on facility Claim ID <2><4>, Line ID <3><5> for the same date of service. This procedure code submitted should be reviewed for potential overpayment.
28895	Prolonged Care Without Direct Contact with Care Management Services - Same Month	Procedure Code 99358 may not be reported with procedure code <1> on Claim ID <2>, Line ID <3> in the same month.
28896	Prolonged Care Without Direct Contact in History with Care Management Services - Same Month	Procedure Code 99358 found on History Claim ID <1>, Line ID <2> may not be reported with procedure code <3> in the same month.
28901	Type I Add-On Procedure Without Primary Procedure Drug Administration	Add-on procedure code <1> has been submitted without an appropriate primary procedure code.
28944	Revenue Codes Not Allowed On Part B Hospital TOB 012X - A/B Rebill Claims	Revenue code <1> is not allowed on TOB 012X A/B Rebill claims.
29082	Add-On Procedure - Primary Procedure Flagged	Add-on procedure code <1> is reported with primary procedure code <2><3> that received an edit with a Review or Deny status.

29183	Type I Add-On Procedure Primary Procedure Flagged	Add-on procedure code <1> has been submitted with a primary procedure code that received a deny or review edit.
29185	Type I Add-On Procedure Primary Procedure Flagged	Add-on procedure code <1> has been submitted with a primary procedure code that received a deny or review edit.
29195	Type I Add-On Procedure Primary Procedure Flagged	Add-on procedure code <1> has been submitted with a primary procedure code that received a deny or review edit.
29197	Type I Add-On Procedure Primary Procedure Flagged	Add-on procedure code <1> has been submitted with a primary procedure code that received a deny or review edit.
29198	Type I Add-On Procedure with Primary Procedure Drug Administration Flagged	Add-on procedure code <1> has been submitted with a primary procedure code that received a deny or review edit.
29203	Medicare Medical Nutrition Therapy	Per Medicare guidelines, reassessment nutrition therapy code 97803 has been billed without the initial assessment nutrition therapy code 97802 in history.
29209	Type I Add-On Procedure With Primary Procedure Drug Administration Flagged	Add-on procedure code <1> has been submitted with a primary procedure code that received a deny or review edit.
29391	Medicare Implantable Tissue Markers and Radiation Dosimeters Rule	Per Medicare guidelines, HCPCS code <1> requires an additional procedure code to meet the CMS billing requirements.
29508	Ambulance During Inpatient Stay-CCT	Ambulance services are not separately payable when reported with a date of service within an admission and discharge date of an inpatient claim. The service is considered bundled to the inpatient stay and cannot be billed separately.
29820	Qualifying Stay Edit For Skilled Nursing Facility (SNF) and Swing Bed (SB)	Per Medicare, qualified stay requirements have not been met.
29855	Inappropriate Use of Repeat Radiology Modifier-1	Inappropriate use of a repeat procedure modifier 76 or 77 with a radiology procedure code. The procedure code <1> is reported with repeat procedure modifier 77 or 76 along with the same procedure code on Claim ID <2><4><6><8><10><12>, Line ID <3><5><7><9><11><13> or with any of these repeat procedure modifiers when there is no previous radiology procedure, submitted for the same date of service.
29923	Incorrect Billing of Blood and Blood Products	Incorrect billing of blood and blood products.
29973	Post-Operative Care Modifier Rule	Per Medicare guidelines, procedure code <1> with modifier 55 submitted on claim ID <2>, line ID <3> is within the global period of procedure code <4> found in history on claim ID <5>, line ID <6>, for the same date of service by a different provider without modifier 54. When physicians agree on the transfer of care during the global period, the same date of service and surgical procedure code should be reported on the bill for the surgical care only with modifier 54 and post-operative care only with modifier 55.
30005	Hepatitis C Virus Screening Frequency	Per Medicare guidelines, the frequency does not meet policy requirements for the procedure code.
30064	Duplicate Kidney Disease Education Service Facility and Professional Claim	This claim line has a duplicate procedure code on facility Claim ID <1><3>, Line ID <2><4> for the same date of service. This procedure code submitted should be reviewed for potential overpayment.
30101	Federally Qualified Health Clinics (FQHC) Payment Code Not Reported for FQHC Claim	A FQHC claim must contain a required FQHC payment code.

30171	History Post-Operative Care Modifier Rule	Per Medicare guidelines, procedure code <1> without modifier 54 submitted on claim ID <2>, line ID <3> is within the global period of procedure code <4> found in history on claim ID <5>, line ID <6> for the same date of service by a different provider with modifier 55. When physicians agree on the transfer of care during the global period, the same date of service and surgical procedure code should be reported on the bill for the surgical care only with modifier 54 and post-operative care only with modifier 55.
30172	Medicare Hepatitis C Screening Services	Per Medicare guidelines, HCPCS code G0472 is not a covered service when submitted without ICD-10 CM code Z72.89 or F19.20 for a Medicare beneficiary born prior to 1945 or after 1965.
30242	Duplicative Laboratory Procedure Reported By Provider and Independent/Reference Laboratory	A duplicate laboratory procedure code <1> is reported with modifier 90. The same laboratory procedure code is reported by an independent or reference laboratory on Claim ID <2>, Line ID <3> for the same date of service. Only one provider may report a reference laboratory procedure.
30243	Kidney Disease Education Service Frequency Rule	Per Medicare guidelines, the frequency does not meet policy requirements for the procedure code.
30244	Medicare Kidney Disease Education Service Medical Necessity Rule	Per Medicare guidelines, procedure code <1> has been reported without the appropriate ICD-10-CM diagnosis code N18.4.
30246	Medicare Lung Cancer Screening Service Frequency Rule	Per Medicare guidelines, the frequency does not meet policy requirements for the procedure code.
30350	Type of Bill Not Allowed for Telehealth Site Origination Facility Fee	Procedure code <1>, telehealth site origination facility fee, cannot be billed on type of bill <2>.
30352	Multiple Gestation Delivery	A vaginal or cesarean delivery procedure code <1> has been reported on Claim ID, <2> Line ID <3> without a diagnosis code for multiple gestation and an outcome of delivery code from diagnosis code category Z37.
30421	Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Rule - Educational Period	Per Medicare guidelines, procedure code <1> reported with modifier <2> should have an additional Clinical Decision Support Mechanism (CDSM) HCPCS code reported for the same date of service
30443	Duplicative Laboratory Procedure Reported By Provider in History and Independent/Reference Laboratory	A duplicate laboratory procedure code <1> reported with modifier 90 is found in history on Claim ID <2>, Line ID <3> for the same date of service. The same laboratory procedure code is reported on the current line. Only one provider may report a reference laboratory procedure.
30447	Maximum Frequency ESRD Related Services for Home Dialysis Based on Age of Patient	It is inappropriate to report an ESRD related service code for home dialysis (based on patient's age) more than once per month.
30455	Modifier KX Only Allowed On Revenue Code 0023 On A RAP Claim	Modifier KX can only be submitted on revenue code 0023 on a home health RAP claim.
30550	Medicare Manual Wheelchair Accessories with Modifiers KU & KE Rule	Per Medicare guidelines, HCPCS code <1> reported with modifiers KU and KE will be denied.
30551	Medicare Manual Wheelchair Accessories with Modifier KU Rule	Per Medicare guidelines, procedure code <1> reported with modifier KU should have a manual wheelchair HCPCS code reported in the history for the same patient.
30613	Federally Qualified Health Clinics (FQHC) Payment Code Not Reported for FQHC Claim	A FQHC claim must contain a required FQHC payment code.

30614	Incorrect Revenue Code Reported for Federally Qualified Health Clinics (FQHC) Payment Code	The FQHC payment code requires specific revenue codes.
30615	Incorrect Revenue Code Reported for Federally Qualified Health Clinics (FQHC) Payment Code	The FQHC payment code requires specific revenue codes.
30616	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code New Patient	A FQHC claim requires both the FQHC payment code and a qualifying visit code.
30617	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code Established Patient	A FQHC claim requires both the FQHC payment code and a qualifying visit code.
30619	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code IPPE/AWV	A FQHC claim requires both the FQHC payment code and a qualifying visit code.
30620	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code Mental Health New Patient	A FQHC claim requires both the FQHC payment code and a qualifying visit code.
30621	Federally Qualified Health Clinics (FQHC) Claim Lacks Required Qualifying Visit Code Mental Health Established Patient	A FQHC claim requires both the FQHC payment code and a qualifying visit code.
30631	Item or Service Not Covered Under FQHC PPS or for RHC	Items or services are not covered under the FQHC PPS and RHC claims.
30677	Professional Services for Home Infusion Therapy Drug	Professional home infusion therapy services code <1> has been reported without an associated drug code. The professional visit claim should be reviewed with a 30-day look back period for a total of 15 business days. After 15 business days, if no J-code claim is found in claims history, the G-code claim will receive an edit.
30678	Professional Services for Home Infusion Therapy	Professional home infusion therapy services code <1> is reported on the same date of service as another professional home infusion therapy service code. Only one visit is allowed to be reported per date of service.
30679	Professional Services for Home Infusion Therapy in History	A professional home infusion therapy services code <1> on History Claim ID <2>, Line ID <3> was reported. The professional home infusion therapy services code <4> on the Current Claim ID <5>, Line ID <6> is reported on the same date of service and should not be allowed. Only one professional home infusion therapy service visit is allowed per date of service.
30684	Professional Services for Home Infusion Therapy Specialty	A professional home infusion therapy service must be reported by specialty Home Infusion Supplier (D6).

30695	Professional Services for Home Infusion Therapy - 60 days	A professional home infusion therapy services code <1> on History Claim ID <2>, Line ID <3> was reported within 60 days of an initial professional home infusion therapy service code <4> on the current line. It is not appropriate to report an initial professional home infusion therapy service code within 60 days of a prior reported professional home infusion therapy service.
30699	Supplementary or Additional Code Not Allowed as Principal Diagnosis	Principal diagnosis code <1> is considered supplementary or an additional code and cannot be used as the principal diagnosis.
30735	Annual Wellness Subsequent Visit Rule - CCT Facility/Professional	Per Medicare Guidelines, HCPCS code G0439 reported on a professional claim is not a covered service as HCPCS code <1> is previously reported in history within 12 months on an institutional claim.
30737	Item or Service Not Allowed with Modifier CS	Procedure code <1> is not allowed with modifier CS as it is not eligible for a coinsurance and deductible waiver.
30789	Osteoporosis Drugs Must be Submitted on TOB 34X for Home Health Claims	Osteoporosis drug HCPCS code <1> must be submitted on type of bill 034X for home health claims.
30794	Osteoporosis Drugs Must be Submitted with Revenue Code 0636 for Home Health Claims	Osteoporosis drug HCPCS code <1> must be submitted with revenue code 0636 for home health claims.
30797	Osteoporosis Drugs Can Only be Submitted for Female Beneficiaries on Home Health Claims	Osteoporosis drug HCPCS code <1> can only be submitted for female beneficiaries on home health claims.
30847	Osteoporosis Drugs Must be Submitted with Post-Menopausal Diagnosis on Home Health Claims	When osteoporosis drug HCPCS code <1> is submitted on a home health claim, diagnosis for post-menopausal osteoporosis must be present.
31204	Duplicative Laboratory Professional and Facility Procedures	This claim line has a possible duplicate procedure <1> with professional history Claim ID <2><4>, Line ID <3><5> for the same date of service. Please review professional claim for potential duplicate billing.
31274	Modifier JE Required for Drug Administered Via Dialysate on ESRD Claim	Modifier JE is required on a drug administered via dialysate when submitted on an ESRD claim (Type of Bill 072X).
31324	Hospice Notice of Termination/Revocation Can Only be Submitted After Notice of Election Claim	A Notice of Election claim must be submitted prior to a Notice of Termination/Revocation claim.
31471	Covid-19 Lab Add-On Code Reported Without Required Primary Procedure	COVID-19 lab add-on procedure code <1> has been submitted without an appropriate primary procedure code.
31472	Opioid Treatment Program Service Not Payable Outside Opioid Treatment Program	Procedure code <1> is for opioid treatment program and cannot be submitted on this type of bill.
31486	Inappropriate Use of Repeat Radiology Modifier-2	Inappropriate use of a repeat procedure modifier 76 or 77 with a radiology procedure code. The procedure code <1> is reported with repeat procedure modifier 77 or 76 along with the same procedure code on Claim ID <2><4><6><8><10><12>, Line ID <3><5><7><9><11><13> or with any of these repeat procedure modifiers when there is no previous radiology procedure, submitted for the same date of service.
31498	Critical Access Hospital (CAH) Bilateral Procedures Rule	Per CMS guidelines, bilateral procedure code <1> shall be returned when submitted with modifiers LT and RT on a critical access hospital (CAH) claim under revenue code 096x, 097x, or 098x.

31499	Critical Access Hospital (CAH) Bilateral Procedures Rule	Per CMS guidelines, bilateral procedure code <1> shall be returned when submitted with modifiers LT and RT on a critical access hospital (CAH) claim under revenue code 096x, 097x, or 098x.
31605	Duplicative Radiology Professional and Facility Procedures	This claim line has a possible duplicate procedure <1> with professional history Claim ID <2><4>, Line ID <3><5> for the same date of service. Please review professional claim for potential duplicate billing.
31670	ASC Item or Service Not Allowed with Modifier CS	Procedure code <1> is not allowed with modifier CS as it is not eligible for a coinsurance and deductible waiver.
31703	ASC Separate Payment For Services Is Not Provided By Medicare	Separate payment for procedure code <1> is not provided by Medicare.
31719	Opioid Treatment Program Missing Revenue Code or HCPCS	The Opioid Treatment Program (OTP) claim is missing a required revenue code.
31736	Opioid Treatment Program Missing Revenue Code or HCPCS	The Opioid Treatment Program (OTP) claim is missing a required HCPCS code.
31738	Supplementary or Additional Code Not Allowed as Principal Diagnosis	Principal diagnosis code <1> is considered supplementary or an additional code and cannot be used as the principal diagnosis.
31740	ASC Separate Payment For Services Is Not Provided By Medicare	Separate payment for procedure code <1> is not provided by Medicare.
31957	Federally Qualified Health Clinics (FQHC) Payment Code Not Reported for FQHC Claim	A FQHC claim must contain a required FQHC payment code.
31974	Only Incidental Services Reported	Only incidental services are billed on this claim.
31982	Osteoporosis Drug Edit - Prevent Duplicate Payment for Home Health Claims	Per Medicare guidelines, osteoporosis drug HCPCS code <1> is a possible duplicate of another osteoporosis drug HCPCS code <2>, on history claim ID <3>, history line ID <4> for the same date of service.
32023	Medicare Telehealth Frequency Subsequent Nursing Home Care	Per Medicare guidelines, the frequency does not meet policy requirements for the procedure code.
32024	Opioid Treatment Program Frequency Per Seven Days	Per Medicare, the frequency does not meet policy requirements for Opioid Treatment Program (OTP) procedure code <1>.
32027	Opioid Treatment Program Frequency Per Four Weeks	Per Medicare, the frequency does not meet policy requirements for Opioid Treatment Program (OTP) procedure code <1>.
32033	Opioid Treatment Program Frequency Per Six Months	Per Medicare, the frequency does not meet policy requirements for Opioid Treatment Program (OTP) procedure code <1>.
32234	Opioid Treatment Program Frequency Per One Month	Per Medicare, the frequency does not meet policy requirements for Opioid Treatment Program (OTP) procedure code <1>.
32235	Modifier 51 Inappropriate	Procedure code <1> has been billed with modifier 51 on claim <2>, line ID <3>, either the procedure code has the highest RVU on the claim or the use of modifier 51 is not appropriate with the procedure code.
32254	Opioid Treatment Program Frequency Per Thirty Days	Per Medicare, the frequency does not meet policy requirements for Opioid Treatment Program (OTP) procedure code <1>.
32297	Opioid Treatment Program Add-On	An Opioid Treatment Program add-on procedure code has been submitted without an appropriate primary procedure code.
32766	Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Rule - Educational Period	Per Medicare guidelines, procedure code <1> reported with modifier <2> should have an additional Clinical Decision Support Mechanism (CDSM) HCPCS code reported for the same date of service.

32873	Observation Code G0378 Not Allowed to be Reported More Than Once Per Claim	Observation HCPCS code G0378 can only be submitted once per claim.
32881	Token Charge Less Than $1.01 Billed By Provider	The charge amount for HCPCS code <1> must be equal to or greater than $1.01.
32895	Modifier 63 Age	Modifier 63 was reported with Procedure Code <1>. Modifier 63 may only be reported for infants less than 1 year of age.
32998	Home Health Value Code	Value Codes 61 and 85 must be reported on all Home Health PPS and RAP claims to report location and county.
33001	Modifier KX Only Allowed On Revenue Code 0023 On Home Health Claims	Modifier KX can only be submitted on revenue code 0023 on a home health RAP claim.
33002	Home Health HIPPS and Revenue Codes	Revenue code 0023 must be billed with a Home Health HIPPS code.
33007	Home Health Claims Must Submit Revenue Code 0023	All Home Health claims must be submitted with revenue code 0023.
33018	Medicare Manual Wheelchair Accessories with Modifier KU Rule	Per Medicare guidelines, procedure code <1> reported with modifier KU should have a manual wheelchair HCPCS code reported in the history for the same patient.
33125	Modifier Not Appropriate - PO	Use of modifier(s) <1> is not typical for procedure code <2>.
33243	Medicare Medical Visit on Same Day as a Type T or S Procedure Without Modifier 25 - Same Claim	Medical visit is on the same day as a procedure <1> with a status indicator of T or S without modifier 25, on claim ID <2> line ID <3>.
33260	Medicare Medical Visit on Same Day as a Type T or S Procedure Without Modifier 25 - Different Claim	Medical visit is on the same day as a procedure <1> with a status indicator of T or S without modifier 25, on claim ID <2> line ID <3>.
33262	Medicare Medical Visit on Same Day as a Type S Procedure Without Modifier 25 - Same Claim	Medical visit is on the same day as a procedure <1> with a status indicator of S without modifier 25, on claim ID <2> line ID <3>.
33264	Medicare Medical Visit on Same Day as a Type S Procedure Without Modifier 25 - Different Claim	Medical visit is on the same day as a procedure <1> with a status indicator of S without modifier 25, on claim ID <2> line ID <3>.
33265	Modifier Not Appropriate - PO	Use of modifier(s) <1> is not typical for procedure code <2>.
33294	Medicare Manual Wheelchair Accessories with Modifier KU Rule	Per Medicare guidelines, procedure code <1> reported with modifier KU should have a manual wheelchair HCPCS code reported in the history for the same patient.
33305	Home Health HIPPS Code Charge	Revenue code 0023 cannot be billed with charges greater than $1.00.
33332	Home Health Claims Occurrence Code 50	Per CMS policy, occurrence code 50 must be present on a home health claim type of bill 032X.
33375	Home Health Dates Must Match On NOA Claims	For Type of Bill 032A, the admission, from and through date must all match,
33389	Admission, From, and Through Dates Cannot be Future Date on Home Health NOA Claims	The admission, from, and through dates cannot be a future date on a home health NOA claim.

33409	26/TC Split Billed without Global Procedure	The procedure code submitted on claim id, line id includes professional componet (modifier 26) and a technical component (modifier TC) on separate claim lines for the same procedure code, on the same date of service, by the same physician. Please review history and currrent claim lines for the procedure code to report a a global procedure
33411	Online Digital E/M or Assessment Group Frequency in Previous 7 Days	Only 1 Online Digital E/M or Assessment code may be reported by the same provider in a 7-day period. Procedure Code <1> was reported on Claim ID <2>, Line ID <3> by the same Provider.
33930	ASC Bilateral Procedures Rule	Bilateral procedure code <1> shall be returned when submitted on two claim lines with the same date of service and both lines have the same modifier RT or LT.
34503	Appropriate Claim Change Reason Code Required on Adjusted Claims	Type of bill <> requires an appropriate claim change reason code
34525	Ambulance Service Requires Mileage HCPCS Code Rule	Ambulance mileage HCPCS code requires an ambulance service HCPCS code.
34558	Bilateral Procedure Reduction - Modifiers 54, 55, 56	Per Medicare guidelines, the presence of modifier 54,55 or 56 appended to bilateral surgical procedure code on claim id indicates bilateral reductions may apply to the surgical care only, posoperative management only, or preoperative management only services
34591	TPNIES and CRA TPNIES Cannot be Submitted with More than One Unit	TPNIES and CRA TPNIES cannot be submitted with more than 1 unit.
34710	Unspecified Code	Diagnosis codes <> is an unspecified diagnosis code
34829	RAP TOB 0322 No Longer Valid for Home Health Claims	Request for Anticpated Payment (RAP) claims (TOB 0322) are no longer valid for Home Health. Please submit a notice of admission (NOA) on TOB 032A
34975	Possible Duplicate Line Different Provider Anatomic Modifier	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <>. Line ID <> reported by a different provider in the same group and specialty using anatomic modifiers
34976	Possible Duplicate Line in History Different Provider Anatomic Modifier	Procedure code <1> is a possible duplicate of the same procedure code found on Claim ID <>. Line ID <> reported without an anatomic modifier in history, is a possible duplicate of the current line reported by a different provider in the same group and specialty on the same date using anatomic modifiers.
4057 -replaces 97	Hysterectomy Following a C/S Delivery	A hysterectomy following a c/section delivery may not be reported by any specialty other than Obstetrics/Gynecology (16).
11 - replaced 24	Skilled Nursing Facility Date Span	Per Medicare guidelines, the statement covers period From and Through dates cannot span the annual update effective date of October 1 or the through date cannot equal October 1 with a pateint discharge status of 30..
34265	Medicare Vaccine Services Reported Prior to Medicare Effective Date	The edit identifies claim lines that include procedure code 90677 with a date of service falling within the date range of 07/01/2021 to 09/30/2021. Medicare does not provide coverage for CPT code 90677 during this period.
549 -replaced 11	Ambulance Required Modifiers for Ambulance Service HCPCS Code Rule	Invalid or missing required ambulance modifier(s).
4450	Telehealth Modifier Not Appropriate	Use of modifier(s) <1> is not typical for procedure code <2>.
iLOG	(030PHI) Facility Insufficient Services on Day of Partial Hospitalization	Insufficient Services on day of Partial Hospitalization.