

## Appendix R

### Provider Claim Report Messages

Edit Number	Description
<b>0101</b>	<i>Duplicate claim</i>
<b>0102</b>	<i>Duplicate claim suspected</i>
<b>0103</b>	<i>This is a duplicate item that was previously processed and paid, possibly to another provider.</i>
<b>0104</b>	<i>Multiple surgery requires review</i>
<b>0105</b>	<i>There is no additional benefit for this service. Payment for this service was included in the payment for the inpatient/outpatient claim.</i>
<b>0109</b>	<i>Surgery follow-up covers service.</i>
<b>0111</b>	<i>The dates of service span the end of the year. Claim must be split by year.</i>
<b>0112</b>	<i>The dates of service span the end of the month. Claim must be split</i>
<b>0113</b>	<i>The admission date is after from date. The admission date cannot be after the from date. Correct the admission/ from date.</i>
<b>0114</b>	<i>The source of admission is missing or invalid. Enter/correct the source of admission. Refer to the UB04 Provider Manual or Help Screens for valid source of admission codes.</i>
<b>0117</b>	<i>The procedure modifier 1 is invalid. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS for a listing of valid modifiers.</i>
<b>0118</b>	<i>The coinsurance/deductible is billed incorrectly. The deductible/coinsurance on the claim must match the deductible/coinsurance on the Medicare explanation of benefits or the other insurance explanation of benefits.</i>
<b>0119</b>	<i>The tooth surface is missing. Enter the tooth surface.</i>
<b>0120</b>	<i>The Billing Provider number or the NPI are in conflict. Verify the Medicaid billing provider number, the National Provider Identification (NPI), the taxonomy code, and the 9-digit zip code are entered correctly and have been registered with the fiscal agent.</i>
<b>0121</b>	<i>The procedure modifier 2 is invalid. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS for a listing of valid modifiers</i>
<b>0122</b>	<i>Provider type requires procedure code modifier</i>
<b>0123</b>	<i>The procedure modifier 3 is invalid. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS for a listing of valid modifiers</i>
<b>0124</b>	<i>The from date of service is missing or invalid. Enter/Correct the from date of service</i>
<b>0125</b>	<i>The procedure modifier 4 is invalid. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS for a listing of valid modifiers</i>
<b>0126</b>	<i>The from date of service is after the last date of service. The from date of service must be before the last date of service. Correct the from date of service or the last date of service</i>
<b>0127</b>	<i>The claim was received before the service was rendered. Services must be rendered before claims are submitted. Correct the date of service.</i>
<b>0128</b>	<i>The date of service date is out of timely filing. Complete the late bill override date information and maintain documentation to prove timely filing continuity.</i>
<b>0129</b>	<i>Client ID is missing or invalid</i>
<b>0130</b>	<i>The client's birth date is missing. Enter the client's birth date.</i>
<b>0131</b>	<i>The provider's signature is missing. Complete signature field indicator, or include signature certification page for the dental or UB04 forms</i>
<b>0132</b>	<i>The submitted charge is missing. Complete the submitted charge field.</i>
<b>0133</b>	<i>Modifier not valid for date of service.</i>

<b>Edit Number</b>	<b>Description</b>
<b>0134</b>	<i>The attending physician number is missing. Enter the attending physician's 8-digit Medicaid provider number.</i>
<b>0135</b>	<i>Only one waiver modifier may be billed on a claim</i>
<b>0136</b>	<i>Only one waiver modifier can be billed on line one</i>
<b>0142</b>	<i>Family planning indicator invalid</i>
<b>0147</b>	<i>The type of admission is missing or invalid. Enter/Correct the type of admission. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0148</b>	<i>The revenue code is missing. Enter the revenue code. Refer to the current revenue code table for valid revenue codes.</i>
<b>0149</b>	<i>Reimbursement limit to skilled nursing</i>
<b>0150</b>	<i>Place of service is missing or invalid</i>
<b>0155</b>	<i>The last date of service is missing or invalid. Enter/Correct the last date of service.</i>
<b>0160</b>	<i>Total claim charge conflict</i>
<b>0162</b>	<i>The service is included in the FQHC/ RHC encounter rate. This service is not a separate benefit.</i>
<b>0163</b>	<i>The detail date of service is missing or invalid. Enter/Correct the detail date of service. The detail dates of service must fall within the header dates of service.</i>
<b>0165</b>	<i>Medicare provider ID missing or invalid</i>
<b>0167</b>	<i>The admission date is missing or invalid. Enter/Correct the admission date.</i>
<b>0169</b>	<i>Medicare paid amount is missing or invalid</i>
<b>0172</b>	<i>The procedure code is missing. Enter the procedure code. Refer to the CPT or HCPCS listing for valid procedure codes.</i>
<b>0181</b>	<i>First condition code invalid</i>
<b>0182</b>	<i>The covered/non-covered days are missing or invalid. Enter/Correct the number of covered/non-covered days.</i>
<b>0183</b>	<i>The medical leave days/non-covered days are missing or invalid. Enter/Correct the number of medical leave days and/or the non-covered days.</i>
<b>0184</b>	<i>The hospice units of service are invalid. Recalculate and enter the hospice units of service.</i>
<b>0185</b>	<i>The line item units of service exceed the total number of days. The line item units cannot be greater than the total number of days. Re-calculate and enter the units of service/total number of days.</i>
<b>0186</b>	<i>The total units of service cannot exceed the total number of days. Re-calculate and enter the total units of service/total number of days.</i>
<b>0188</b>	<i>The patient status is invalid. Correct the patient status code. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0189</b>	<i>The units of service are missing or invalid. Enter/Correct the units of service.</i>
<b>0193</b>	<i>The 2nd occurrence span code is invalid. Correct the 2nd occurrence span code. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0194</b>	<i>Fifth Occurrence Code/Date Missing or Invalid.</i>
<b>0197</b>	<i>Principal Surgical Procedure Code/Date Missing or Invalid</i>
<b>0198</b>	<i>1st Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>0199</b>	<i>2nd Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>0201</b>	<i>The TCN to credit is missing or invalid. Enter/Correct the TCN of the original claim to be credited.</i>
<b>0203</b>	<i>The client is in the Locked-in program. The Lock-in provider number must be either the billing, rendering, referring or supervising provider number on the claim.</i>
<b>0205</b>	<i>Referring provider required</i>

<b>Edit Number</b>	<b>Description</b>
<b>0206</b>	<i>The total non-covered charges do not balance with the submitted charges.Re-calculate and enter the non-covered charges/submitted charges.</i>
<b>0208</b>	<i>First occurrence span date missing or invalid</i>
<b>0209</b>	<i>Second occurrence span date missing or invalid</i>
<b>0210</b>	<i>First Occurrence Code Invalid.</i>
<b>0211</b>	<i>First Occurrence Code/Date Missing or Invalid.</i>
<b>0212</b>	<i>First occurrence code invalid</i>
<b>0213</b>	<i>The CDAS service and the administration fee must be submitted on the same claim.</i>
<b>0216</b>	<i>Five Occurrence Code Invalid.</i>
<b>0222</b>	<i>The 1st value code or amount is missing. Enter the first value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0223</b>	<i>The 1st value code or amount is missing. Enter the first value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes</i>
<b>0225</b>	<i>Sixth Occurrence Code/Date Missing or Invalid.</i>
<b>0226</b>	<i>Sixth Occurrence Code Invalid.</i>
<b>0227</b>	<i>Seventh Occurrence Code/Date Missing or Invalid.</i>
<b>0228</b>	<i>Seventh Occurrence Code Invalid.</i>
<b>0229</b>	<i>The dates of service overlap eligibility span. Client is not eligible on each date of the span billed on the claim. Refer to the eligibility dates on the eligibility inquiry and split the claim.</i>
<b>0231</b>	<i>PETI amount is greater than patient pay amount</i>
<b>0232</b>	<i>PETI greater than \$0.00 requires occurrence span code 76</i>
<b>0233</b>	<i>PETI must be billed with accommodation revenue code</i>
<b>0234</b>	<i>PETI revenue code requires line item date of service</i>
<b>0235</b>	<i>Eighth Occurrence Code/Date Missing or Invalid.</i>
<b>0237</b>	<i>The client has Medicare. Charges must bill to Medicare before billing Medicaid. Complete the Medicare payment information fields on the claim and retain a copy of the explanation of benefits.</i>
<b>0238</b>	<i>Service not covered by Medicare</i>
<b>0240</b>	<i>The line was denied by Medicare. If the service is not a Medicare benefit, it can be billed as a Medicaid claim.</i>
<b>0243</b>	<i>Eighth Occurrence Code Invalid.</i>
<b>0248</b>	<i>The birth date does not match client's State ID number. Correct the birth date/State ID number. If billing for newborn care with the mother's DOB and State ID number for DOS after 10/01/2011 use modifier UK.</i>
<b>0250</b>	<i>The client's State ID is not on file. Check for missing/reversed numbers and/or illegible/incorrect letter prefix. Enter the client's State ID number as it appears on the eligibility inquiry.</i>
<b>0252</b>	<i>The Breast and Cervical Cancer Program (BCCP) is for women between the ages of 40-64. The edit will if the client's age calculated from the date of birth on the client master database indicates that the client turns 65 years of age. The client is no longer eligible to receive BCCP services after age 65.</i>
<b>0262</b>	<i>The client has other insurance. Bill the charges to the other insurance before billing Medicaid. Complete the other insurance payment information fields on the claim and retain a copy of the explanation of benefits.</i>
<b>0263</b>	<i>The client has other insurance. Bill the charges to the other insurance before billing Medicaid. Complete the other insurance payment information fields on the claim and retain a copy of the explanation of benefits.</i>
<b>0264</b>	<i>The client has other insurance. (TPL)</i>

<b>Edit Number</b>	<b>Description</b>
<b>0265</b>	<i>Third party liability resource denied</i>
<b>0266</b>	<i>Third party liability resource paid</i>
<b>0267</b>	<i>(TPL) Other insurance, excluded service.</i>
<b>0268</b>	<i>Client has other insurance (TPL)</i>
<b>0269</b>	<i>Client has other insurance (TPL)</i>
<b>0271</b>	<i>The client is ineligible on the date of service. Check the eligibility inquiry and verify the date of service.</i>
<b>0272</b>	<i>The admit date on the claim is prior to the client's date of birth. Re-submit claim with an admit date equal to or greater than the client's date of birth</i>
<b>0273</b>	<i>Claim DRG indicates newborn. Client age is greater than three years old and is not considered a newborn</i>
<b>0275</b>	<i>The major program code is invalid for the date of service.</i>
<b>0276</b>	<i>Waiver program - Service conflict</i>
<b>0282</b>	<i>The 2nd condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0286</b>	<i>The Medicare paid date is missing. Enter the Medicare paid date from the Medicare explanation of benefits and retain the explanation of benefits.</i>
<b>0287</b>	<i>Other provider not on database</i>
<b>0288</b>	<i>Referring provider not on database</i>
<b>0289</b>	<i>Supervising provider not on database</i>
<b>0290</b>	<i>Other Physician 1 must contain the Nursing Facility Provider number for payment of Hospice Room and Board services.</i>
<b>0296</b>	<i>Claim processed with closest eligibility span</i>
<b>0300</b>	<i>Billing provider not on database</i>
<b>0301</b>	<i>Billing provider/service conflict: Verify Provider Number, Procedure/Revenue/Special Program/Condition codes (as applicable). If correct, please call Medicaid Provider Services at 1-800-237-0757.</i>
<b>0302</b>	<i>The attending provider number is not on file. Verify the 8-digit Medicaid provider number of the attending provider.</i>
<b>0303</b>	<i>The attending provider number is not on file. Verify the 8-digit Medicaid provider number of the attending provider.</i>
<b>0305</b>	<i>Claim type not assigned - Type of bill invalid</i>
<b>0307</b>	<i>Client enrolled in Children's Health Plan Plus Major Program</i>
<b>0308</b>	<i>The services must be billed to the HMO/PHP listed on the eligibility inquiry.</i>
<b>0310</b>	<i>Type of bill/Claim type conflict</i>
<b>0311</b>	<i>Institutional type of bill/Claim type conflict</i>
<b>0313</b>	<i>The service is not within the scope of the provider's licensure/certification or services are billed on the incorrect claim form at.</i>
<b>0320</b>	<i>For the CLIA number on record or provided; certification has lapsed, or the certification type does not cover the procedure, or the DOS is not covered by the certification.</i>
<b>0321</b>	<i>The emergency indicator is invalid. Correct the emergency indicator. Refer to the Provider Manual or Help Screens for valid indicators.</i>
<b>0322</b>	<i>The EPSDT indicator is invalid. Correct the EPSDT indicator. Refer to the Provider Manual or Help Screens for valid indicators</i>
<b>0325</b>	<i>Claim has accident related diagnosis code</i>
<b>0332</b>	<i>The ICD-9-CM diagnosis code is missing. Enter the ICD-9-CM diagnosis code.</i>

<b>Edit Number</b>	<b>Description</b>
<b>0347</b>	<i>The revenue code is not on file. Refer to the current revenue code table for valid codes.</i>
<b>0351</b>	<i>High variance</i>
<b>0352</b>	<i>Low variance</i>
<b>0353</b>	<i>HMO copayment exceeds state standard</i>
<b>0354</b>	<i>Claim needs to have a PCM provider number in the following fields: UB04: Billing OR Attending, CO 1500: Billing, Rendering, OR Referring, EPSDT: Billing or Rendering</i>
<b>0359</b>	<i>Provider types 10 and 34 must be assigned a waiver specialty code = 'EA' - 'EZ', 'E0' - 'E9', or 'IA' - 'IJ' at the claim header level</i>
<b>0360</b>	<i>The procedure code billed by the provider must be certified under at least one of the waiver provider's specialty codes/certifications</i>
<b>0361</b>	<i>Tooth number required</i>
<b>0362</b>	<i>Tooth surface required</i>
<b>0363</b>	<i>The 1st modifier is invalid for procedure code. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS listing for valid modifiers.</i>
<b>0364</b>	<i>Procedure Code/Tooth Number Conflict - Tooth number on claim is not valid with the submitted procedure code. Please correct and resubmit your claim.</i>
<b>0365</b>	<i>The place of service code is invalid for procedure code. Correct the place of service code. Refer to the Provider Manual or Help Screens for valid place of service codes.</i>
<b>0366</b>	<i>The rendering provider's specialty is invalid for the procedure code. The procedure is not within the scope of the provider's specialty.</i>
<b>0367</b>	<i>The rendering provider type is invalid for procedure code. The provider is not authorized to provide the billed procedure.</i>
<b>0369</b>	<i>Surgical assist not allowed</i>
<b>0371</b>	<i>The 2nd modifier is invalid for procedure code. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS listing for valid modifiers.</i>
<b>0372</b>	<i>The procedure code is invalid for the claim type. Correct the procedure code or bill the procedure code on the correct claim type.</i>
<b>0373</b>	<i>The revenue code is invalid for type of bill. Correct the revenue code/type of bill. Refer to the Provider Manual or Help Screens for valid types of bill.</i>
<b>0374</b>	<i>Procedure code, revenue code, modifier combination is invalid</i>
<b>0375</b>	<i>Family planning modifier required. Family planning modifier = FP</i>
<b>0376</b>	<i>Procedure requires modifier</i>
<b>0377</b>	<i>Professional/Technical component cannot be priced. Enter/Correct the procedure modifier. Refer to the Provider Manual or Help Screens for valid modifiers.</i>
<b>0380</b>	<i>Relative value scale pricing/relative value scale conversion factor conflict</i>
<b>0381</b>	<i>Rate record not found</i>
<b>0382</b>	<i>No co-pay accumulation span for date of service</i>
<b>0383</b>	<i>PRTF line item not paid on discharge date</i>
<b>0386</b>	<i>Procedure code modifier 3 inclusion/exclusion conflicts</i>
<b>0388</b>	<i>Procedure code modifier 4 inclusion/exclusion conflicts</i>
<b>0390</b>	<i>The National Drug Code (NDC) is missing. The NDC is required for physician- administered drugs. Please reference the provider billing manuals and the following bulletins for more information: December 2007 #B070024, June 2008 #B0800249, May 2009 #B0900266.</i>
<b>0391</b>	<i>NDC/Procedure Code Conflict</i>
<b>0392</b>	<i>NDC/ Date of Service Conflict</i>

<b>Edit Number</b>	<b>Description</b>
<b>0393</b>	<i>The revenue code and procedure code are in conflict. Please verify whether a HCPC can be used with this revenue code and ensure the procedure code is appropriate for the revenue code used.</i>
<b>0394</b>	<i>The revenue code and procedure code are in conflict. Please verify whether a HCPC can be used with this revenue code and ensure the procedure code is appropriate for the revenue code used. If the revenue code is 250 the procedure code must be blank.</i>
<b>0396</b>	<i>CO 1500 auto accident indicator invalid</i>
<b>0397</b>	<i>CO 1500 other accident indicator invalid</i>
<b>0398</b>	<i>Inpatient hospital claims submitted within 48 hours of a previous hospital admission must be submitted on one claim with continuous dates of service.</i>
<b>0410</b>	<i>Attending provider is under review</i>
<b>0411</b>	<i>Billing provider is under review</i>
<b>0412</b>	<i>Rendering provider not on database</i>
<b>0413</b>	<i>Rendering Provider is under review</i>
<b>0414</b>	<i>Billing provider is not eligible to bill for NHVP specific procedures</i>
<b>0422</b>	<i>The rendering provider is not enrolled on the date(s) of service.</i>
<b>0423</b>	<i>The rendering provider is not a group member. Verify the rendering provider number/group number.</i>
<b>0424</b>	<i>The billing provider is not eligible on date(s) of service.</i>
<b>0429</b>	<i>Date of service spans reimbursement</i>
<b>0430</b>	<i>The procedure code is invalid. Correct the procedure code. Refer to the CPT or the HCPCS listing for valid procedure codes.</i>
<b>0431</b>	<i>The procedure currently is not a Medicaid benefit.</i>
<b>0432</b>	<i>The procedure cannot be billed electronically. Submit a paper claim for this procedure with the required attached documentation</i>
<b>0433</b>	<i>This is not an EPSDT benefit. The client is older than 20 years of age.</i>
<b>0434</b>	<i>The client's age is invalid for this procedure code. Verify the client's birth date/procedure code.</i>
<b>0435</b>	<i>The client's sex is invalid for this procedure code. Verify the sex indicator/procedure code.</i>
<b>0436</b>	<i>The procedure requires prior authorization. Submit a PAR for this service. When approved, enter the prior authorization number on the claim.</i>
<b>0437</b>	<i>The procedure code is invalid for date of service. Correct the procedure code. Refer to the CPT or the HCPCS listing for valid procedure codes.</i>
<b>0438</b>	<i>The procedure cannot be processed as billed. Submit a paper claim with the required attached documentation.</i>
<b>0439</b>	<i>The procedure code currently is not a benefit for date of service billed. Refer to the CPT or the HCPCS listing for valid procedure codes.</i>
<b>0440</b>	<i>5th Other Diagnosis Code Not On Database or Invalid</i>
<b>0441</b>	<i>5th Other Diagnosis Not Covered</i>
<b>0443</b>	<i>5th Other Diagnosis is invalid for client's age.</i>
<b>0444</b>	<i>5th Other Diagnosis Code/Sex Code Conflict</i>
<b>0446</b>	<i>6th Other Diagnosis Code Not On Database or Invalid</i>
<b>0447</b>	<i>6th Other Diagnosis Not Covered</i>
<b>0449</b>	<i>6th Other Diagnosis is invalid for client's age</i>
<b>0450</b>	<i>Principal Diagnosis (Institutional), 1st Diagnosis (Professional) Code Not On Database or Invalid</i>
<b>0451</b>	<i>Principal Diagnosis Code Not Covered</i>
<b>0452</b>	<i>6th Other Diagnosis Code/Sex Code Conflict</i>

<b>Edit Number</b>	<b>Description</b>
<b>0454</b>	<i>Principal Diagnosis (Institutional), 1st Diagnosis Code (Professional) is invalid for client's age.</i>
<b>0455</b>	<i>Principal Diagnosis Code (Institutional), 1st Diagnosis Code (Professional)/Sex Code Conflict</i>
<b>0458</b>	<i>7th Other Diagnosis Code Not On Database or Invalid+</i>
<b>0459</b>	<i>7th Other Diagnosis Not Covered</i>
<b>0460</b>	<i>1st Other Diagnosis Code (Professional), 2nd Diagnosis (Professional) Not On Database or Invalid</i>
<b>0461</b>	<i>1st Other Diagnosis Not Covered</i>
<b>0464</b>	<i>1st Other Diagnosis (Institutional), 2nd Diagnosis Code (Professional) is invalid for client's age</i>
<b>0465</b>	<i>1st Other Diagnosis Code (Institutional), 2nd Diagnosis Code (Professional)/Sex Code Conflict</i>
<b>0467</b>	<i>7th Other Diagnosis is invalid for client's age</i>
<b>0468</b>	<i>7th Other Diagnosis Code/Sex Code Conflict</i>
<b>0470</b>	<i>2nd Other Diagnosis Code (Institutional), 3rd Diagnosis (Professional) Not On Database or Invalid</i>
<b>0471</b>	<i>2nd Other Diagnosis Not Covered</i>
<b>0472</b>	<i>8th Other Diagnosis Code Not On Database or Invalid</i>
<b>0474</b>	<i>2nd Other Diagnosis (Institutional), 3rd Diagnosis (Professional) is invalid for client's age</i>
<b>0475</b>	<i>2nd Other Diagnosis Code (Institutional), 3rd Diagnosis Code (Professional) /Sex Code Conflict</i>
<b>0477</b>	<i>8th Other Diagnosis Not Covered</i>
<b>0479</b>	<i>8th Other Diagnosis is invalid for client's age</i>
<b>0480</b>	<i>3rd Other Diagnosis (Institutional), 4th Diagnosis (Professional) Code Not On Database or Invalid</i>
<b>0481</b>	<i>3rd Other Diagnosis Not Covered</i>
<b>0482</b>	<i>8th Other Diagnosis Code/Sex Code Conflict</i>
<b>0484</b>	<i>3rd Other Diagnosis (Institutional), 4th Diagnosis (Professional) is invalid for client's age</i>
<b>0485</b>	<i>3rd Other Diagnosis Code (Institutional), 4th Diagnosis Code (Professional)/Sex Code Conflict</i>
<b>0488</b>	<i>The admitting diagnosis code is missing or invalid. Enter/Correct the admitting diagnosis code.</i>
<b>0489</b>	<i>The admitting diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.</i>
<b>0490</b>	<i>4th Other Diagnosis Code Not On Database or Invalid</i>
<b>0491</b>	<i>4th Other Diagnosis Not Covered</i>
<b>0494</b>	<i>4th Other Diagnosis is invalid for client's age</i>
<b>0495</b>	<i>4th Other Diagnosis Code/Sex Code Conflict</i>
<b>0499</b>	<i>The admitting diagnosis code is invalid for client's age. Correct the diagnosis code/client's birth date.</i>
<b>0500</b>	<i>The procedure requires prior authorization. Submit a PAR for this service. When approved, enter the prior authorization number on the claim.</i>
<b>0501</b>	<i>The Prior Authorization Request (PAR) is pending review.</i>
<b>0502</b>	<i>Services have not been prior authorized for this client. Submit a PAR for the services for this client.</i>
<b>0503</b>	<i>Valid PAR is not on file for this client and service.</i>
<b>0504</b>	<i>There is no PAR on file for the procedure with the billed modifier. Check the approved PAR and verify the procedure and modifier.</i>
<b>0506</b>	<i>The 2nd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0507</b>	<i>The 2nd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0508</b>	<i>Missing 3rd Value Code Or Amount. Enter the appropriate value code and/or the amount.</i>
<b>0509</b>	<i>The 3rd value code is invalid. Correct the value code. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0510</b>	<i>There is no PAR on file for this provider and procedure code. Submit a PAR for this procedure.</i>

<b>Edit Number</b>	<b>Description</b>
<b>0511</b>	<i>The prior authorization does not match the services billed on your claim. Please correct services or submit a new prior authorization for the services billed.</i>
<b>0514</b>	<i>The PAR for this item is pending review. Resubmit the item when the PAR has been approved.</i>
<b>0515</b>	<i>The type of prior authorization needed is missing or is not for this claim type. Submit a PAR for services on the correct format.</i>
<b>0518</b>	<i>There is no valid PAR on file for this item. The PAR is denied, inactive, or rejected. Submit a PAR for this service. When approved, enter the prior authorization number on the claim.</i>
<b>0519</b>	<i>The Nursing Facility (NF) oxygen provider is not a NF contracted supplier. NF oxygen must be billed by a contracted supplier.</i>
<b>0521</b>	<i>3rd Other Surgical Procedure Not on Database or Invalid</i>
<b>0522</b>	<i>3rd Other Surgical Procedure Not Covered</i>
<b>0523</b>	<i>PA inactivated after pricing</i>
<b>0526</b>	<i>4th Other Surgical Procedure Not on Database or Invalid</i>
<b>0527</b>	<i>4th Other Surgical Procedure Not Covered</i>
<b>0536</b>	<i>The revenue code billed is not valid for this provider type.</i>
<b>0541</b>	<i>The revenue code is not a benefit for this date of service. Refer to the current revenue code table for valid codes.</i>
<b>0544</b>	<i>The revenue code is not valid for this date of service. Refer to the current revenue code table for valid codes.</i>
<b>0545</b>	<i>Bill the revenue code on a paper claim with required attached documentation.</i>
<b>0546</b>	<i>The attending provider is not authorized to bill this revenue code. Refer to the current revenue code table for valid codes.</i>
<b>0550</b>	<i>Principal Surgical Procedure Not on Database or Invalid.</i>
<b>0551</b>	<i>Principal Surgical Procedure Not Covered</i>
<b>0552</b>	<i>5th Other Surgical Procedure Not on Database or Invalid</i>
<b>0560</b>	<i>1st Other Surgical Procedure Not on Database or Invalid.</i>
<b>0561</b>	<i>1st Other Surgical Procedure Not Covered</i>
<b>0562</b>	<i>5th Other Surgical Procedure Not Covered</i>
<b>0570</b>	<i>2nd Other Surgical Procedure Not on Database or Invalid</i>
<b>0571</b>	<i>2nd Other Surgical Procedure Not Covered</i>
<b>0578</b>	<i>Principal Diagnosis POA is missing or invalid.</i>
<b>0579</b>	<i>All inpatient hospital claims require a valid POA indicator for the principle and other diagnosis codes (1-8) unless the provider or diagnosis code(s) are exempt from POA reporting. See System Lists 4889 and 4887, respectively.</i>
<b>0582</b>	<i>The DRG assigned is not on file. Note: The CMS DRG V24 has not been updated with the new DX codes. If a new ICD-9-CM DX code was submitted, no action is required. The claim payment will automatically be adjusted upon completion of the DX code cross walk. See provider bulletin for more info.</i>
<b>0583</b>	<i>The DX cannot be submitted as principle. Note: The CMS DRG V24 has not been updated with the new DX codes. If a new ICD-9 -CM DX code was submitted, no action is required. The claim payment will automatically be adjusted upon completion of the DX code cross walk. See provider bulletin for more info.</i>
<b>0584</b>	<i>Return Code 2 - No DRG in MDC for Principal DX. Note: The CMS DRG V24 has not been updated with the new DX codes. If a new ICD-9-CM DX code was submitted, no action is required. The claim payment will automatically be adjusted upon completion of the DX code cross walk. See provider bulletin for more info.</i>

<b>Edit Number</b>	<b>Description</b>
<b>0585</b>	<i>DRG pricing span not found. Note: The CMS DRG V24 has not been updated with the new DX codes. If a new ICD-9-CM DX code was submitted, no action is required. The claim payment will automatically be adjusted upon completion of the DX code cross walk. See provider bulletin for more info.</i>
<b>0587</b>	<i>DRG return code 3 - Invalid client age</i>
<b>0588</b>	<i>DRG relative value/Length of stay missing</i>
<b>0589</b>	<i>The DRG is invalid for the client's sex. Verify the DRG and the sex indicator.</i>
<b>0590</b>	<i>The discharge status is invalid. Correct the discharge status. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0592</b>	<i>The principle DX is illogical. Note: The CMS DRG V24 has not been updated with the new DX codes. If a new ICD-9-CM DX code was submitted, no action is required. The claim payment will automatically be adjusted upon completion of the DX code cross walk. See provider bulletin for more info.</i>
<b>0593</b>	<i>The principle DX is invalid. Note: The CMS DRG V24 has not been updated with the new DX codes. If a new ICD-9-CM DX code was submitted, no action is required. The claim payment will automatically be adjusted upon completion of the DX code cross walk. See provider bulletin for more info.</i>
<b>0596</b>	<i>The diagnosis indicator is missing or invalid. Enter/Correct the diagnosis indicator. Refer to the Provider Manual or Help Screens for valid indicators</i>
<b>0605</b>	<i>The date of service does not match the PAR. The date of service on the claim must match the date on the PAR. Verify/Correct the date of service.</i>
<b>0607</b>	<i>The serial number does not match the PAR. The serial number on the claim must match the serial number on the PAR. Verify/Correct the serial number.</i>
<b>0608</b>	<i>The tooth number does not match the tooth number on the PAR. Verify the tooth number on the PAR and correct the claim.</i>
<b>0609</b>	<i>The tooth surface does not match the tooth surface on the PAR. Verify the tooth surface on the PAR and correct the claim.</i>
<b>0617</b>	<i>The number of units on the claim exceeds the number authorized. Correct the number of units on the claim.</i>
<b>0618</b>	<i>The amount on the claim exceeds the amount authorized. Correct the amount on the claim.</i>
<b>0633</b>	<i>The dental occupational related code is invalid. Correct the occupational related code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>0634</b>	<i>The dental occupational date is missing or invalid. Enter/Correct the occupational date.</i>
<b>0635</b>	<i>Dental auto accident indicator invalid</i>
<b>0636</b>	<i>The dental auto accident date is missing or invalid. Enter/Correct the dental auto accident date.</i>
<b>0637</b>	<i>The dental other accident code is invalid. Correct the other accident code. Refer to the Provider Manual or Help Screens for valid codes</i>
<b>0638</b>	<i>The dental other accident date is missing or invalid. Enter/Correct the dental other accident date.</i>
<b>0670</b>	<i>Sterilization form missing or invalid. Submit a paper claim with the completed Med-178 attached.</i>
<b>0675</b>	<i>Claims for hysterectomies must be submitted on paper. Submit a paper claim with the required attachment.</i>
<b>0696</b>	<i>The 3rd condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0697</b>	<i>The 4th condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes</i>
<b>0700</b>	<i>EPSDT nutritional/gastrointestinal code is invalid</i>

<b>Edit Number</b>	<b>Description</b>
<b>0701</b>	<i>The cardio/pulmonary assessments screening code is invalid. Correct the screening code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>0702</b>	<i>The dental assessments screening code is invalid. Correct the screening code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>0703</b>	<i>The medical history assessments screening code is invalid. Correct the screening code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>0704</b>	<i>The physical examination assessments screening code is invalid. Correct the screening code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>0705</b>	<i>The genital/urinary assessments screening code is invalid. Correct the screening code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>0706</b>	<i>The diabetes assessments screening code is invalid. Correct the screening code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>0707</b>	<i>The vision assessments screening code is invalid. Correct the screening code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>0708</b>	<i>The hearing assessments screening code is invalid. Correct the screening code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>0709</b>	<i>The developmental assessments screening code is invalid. Correct the screening code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>0710</b>	<i>EPSDT immunization code is invalid</i>
<b>0711</b>	<i>The urinalysis lab screening code is invalid. Correct the screening code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>0712</b>	<i>The blood lead lab screening code is invalid. Correct the screening code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>0713</b>	<i>EPSDT education code is invalid</i>
<b>0714</b>	<i>The sickle cell lab screening code is invalid. Correct the screening code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>0715</b>	<i>The HBG/HCT lab screening code is invalid. Correct the screening code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>0716</b>	<i>EPSDT TB lab code is invalid</i>
<b>0717</b>	<i>The other assessments screening code is invalid. Correct the screening code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>0718</b>	<i>The other lab screening code is invalid. Correct the screening code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>0800</b>	<i>The 5th condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0801</b>	<i>The 6th condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0802</b>	<i>The 7th condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0803</b>	<i>The 4th value code or amount is missing. Enter the value code/amount.</i>
<b>0804</b>	<i>The 4th value code or amount is missing. Enter the value code/amount.</i>
<b>0805</b>	<i>The 5th value code or amount is missing. Enter the value code/amount.</i>
<b>0806</b>	<i>The 5th value code is invalid. Correct the value code. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0807</b>	<i>The 6th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>

<b>Edit Number</b>	<b>Description</b>
<b>0808</b>	<i>The 6th value code is invalid. Correct the value code. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0809</b>	<i>The 7th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0810</b>	<i>The 7th value code is invalid. Correct the value code. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0811</b>	<i>The 8th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0818</b>	<i>5th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>0821</b>	<i>3rd Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>0822</b>	<i>4th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>0823</b>	<i>The TPL amount cannot be more than the total charge. Correct the TPL amount/total charge. Enter the TPL amount shown on the explanation of benefits.</i>
<b>0824</b>	<i>CO-1500 Employment Related Code Is Invalid. Correct code and resubmit</i>
<b>0825</b>	<i>The net claim charge is missing or invalid. Recalculate and correct the net claim charge.</i>
<b>0834</b>	<i>The net charge must equal the coinsurance plus the deductible. Verify the coinsurance and the deductible and recalculate the net charge. The deductible and coinsurance on the claim must match the deductible and coinsurance on the explanation of benefits.</i>
<b>0835</b>	<i>The net claim charge is invalid. Recalculate and correct the net claim charge.</i>
<b>0843</b>	<i>The billing provider number does not match the claim in history. Check for missing/reversed numbers. Enter the provider number as it appears on the original claim.</i>
<b>0849</b>	<i>The 8th value code is invalid. Correct the value code. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0851</b>	<i>The 9th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0852</b>	<i>The 9th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0860</b>	<i>Second Occurrence Code Invalid.</i>
<b>0861</b>	<i>Second Occurrence Code/Date Missing or Invalid.</i>
<b>0862</b>	<i>Third Occurrence Code Invalid.</i>
<b>0863</b>	<i>Third Occurrence Code/Date Missing or Invalid.</i>
<b>0864</b>	<i>Fourth Occurrence Code Invalid.</i>
<b>0865</b>	<i>Fourth Occurrence Code/Date Missing or Invalid.</i>
<b>0868</b>	<i>The tooth number is invalid. Correct the tooth number.</i>
<b>0869</b>	<i>The 10th value code or amount is missing/invalid. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0870</b>	<i>The type of bill is missing or invalid. Enter/Correct the type of bill. Refer to the UB04 Provider Manual or Help Screens for valid codes</i>
<b>0882</b>	<i>The 10th value code or amount is missing/invalid. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0883</b>	<i>The 11th value code or amount is missing/invalid. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0884</b>	<i>The 11th value code or amount is missing/invalid. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes</i>
<b>0885</b>	<i>The 12th value code or amount is missing/invalid. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>

<b>Edit Number</b>	<b>Description</b>
<b>0886</b>	<i>The 12th value code or amount is missing/invalid. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.</i>
<b>0899</b>	<i>More than 99 exceptions</i>
<b>1001</b>	<i>The number of hospital visits exceeds the guidelines for the procedure billed. Refer to the CPT or current HCPCS for billing guidelines.</i>
<b>1002</b>	<i>Only one office visit is allowed per day. Additional office visits are not a benefit.</i>
<b>1003</b>	<i>EPSDT services are not a benefit with office visits.</i>
<b>1005</b>	<i>Only one Nursing Facility (NF) visit is allowed per day. Additional NF visits are not a benefit</i>
<b>1007</b>	<i>A Tooth Extraction was previously paid for this Tooth Number. Only one Tooth Extraction for the Same Tooth Number is Allowed.</i>
<b>1008</b>	<i>The tooth filling procedure codes were billed incorrectly. Please submit a claim adjustment request using the appropriate bundled procedure code with the correct number of tooth surfaces.</i>
<b>1012</b>	<i>A new patient office/OP visit is limited to one. A new patient office/OP was previously paid to this provider. Bill the appropriate established patient code.</i>
<b>1013</b>	<i>New patient visit already paid to this provider - Use appropriate established patient code.</i>
<b>1015</b>	<i>A new patient Nursing Facility (NF) visit is limited to one. A new NF visit was previously paid to this provider. Bill the appropriate established patient code.</i>
<b>1016</b>	<i>A family planning visit is limited to one per calendar year. One family planning visit for this calendar year was paid previously.</i>
<b>1019</b>	<i>The number of procedures for the calendar month is invalid. The number of procedures exceeds the calendar month maximum allowed. Correct the number of procedures.</i>
<b>1025</b>	<i>Pap smears are limited to one per year. One routine Pap smear was paid during this 12-month period. Additional Pap smears must be billed with a diagnosis code justifying the additional tests.</i>
<b>1026</b>	<i>The OB services are billed incorrectly. Refer to the OB billing instructions in the Provider Manual.</i>
<b>1028</b>	<i>Only one collection fee is allowed per day. One was paid previously for this date of service.</i>
<b>1029</b>	<i>Antepartum care was processed previously.</i>
<b>1030</b>	<i>An antepartum visit was processed previously.</i>
<b>1031</b>	<i>Counseling is not a benefit with EPSDT screening. Counseling is included in the screening charge.</i>
<b>1032</b>	<i>Screening is included in counseling. No additional payment allowed.</i>
<b>1033</b>	<i>The service is not a benefit with a partial screening and other services.</i>
<b>1034</b>	<i>Full Mouth debridement is not a benefit on the same date of service as prophylaxis and other surgical periodontal procedures.</i>
<b>1035</b>	<i>Only one initial EPSDT screening is a benefit. An initial EPSDT screening visit was processed previously. Bill appropriate established patient procedure code.</i>
<b>1036</b>	<i>The units exceed the lifetime benefit for the procedure. Decrease the number of units to the maximum.</i>
<b>1037</b>	<i>Claim Denied - Units Exceed Fiscal Year Benefit</i>
<b>1038</b>	<i>The units exceed the fiscal year benefit for the procedure. Decrease the number of units to the maximum.</i>
<b>1039</b>	<i>The units exceed the fiscal year benefit for the procedure. Decrease the number of units to the maximum.</i>
<b>1040</b>	<i>This is a duplicate of a treatment that was billed previously. The treatment was processed on a prior claim.</i>
<b>1041</b>	<i>This is a duplicate of a treatment that was billed previously. The treatment was processed on a prior claim.</i>
<b>1042</b>	<i>Only one exam is allowed per day</i>

<b>Edit Number</b>	<b>Description</b>
<b>1043</b>	<i>The lab panel is billed incorrectly. Refer to the CPT, HCPCS listing or the Provider Manual for laboratory billing instructions</i>
<b>1044</b>	<i>Non-sterile gloves are limited to two boxes per calendar month. One unit of service is equal to one box. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.</i>
<b>1046</b>	<i>The service is limited to one unit of service per day. The service for this date of service was processed previously.</i>
<b>1047</b>	<i>The procedure is not a benefit with this diagnosis.</i>
<b>1048</b>	<i>Risk Assessment is limited to one per seven months. A Risk Assessment for this time period was processed previously.</i>
<b>1049</b>	<i>One unit of service was previously paid. The maximum number of units allowed for this procedure code is one in every three state fiscal years. This edit sets when one unit was previously reimbursed and additional units are being billed within a three year time period (three state fiscal years).</i>
<b>1050</b>	<i>The supply procedure was billed and processed on a prior claim.</i>
<b>1051</b>	<i>Limit one visit per month</i>
<b>1052</b>	<i>Limit One Service Per Pregnancy</i>
<b>1053</b>	<i>The service is not a benefit with an eye exam.</i>
<b>1054</b>	<i>The service is not a benefit with an eye exam.</i>
<b>1055</b>	<i>A vision lens is not a benefit with a polycarb lens.</i>
<b>1056</b>	<i>A polycarb lens is not a benefit with a vision lens.</i>
<b>1057</b>	<i>The procedure for the orthodontics diagnosis was previously paid.</i>
<b>1058</b>	<i>The orthotic treatment was processed on a prior claim.</i>
<b>1059</b>	<i>The orthotic treatment was processed on a prior claim.</i>
<b>1060</b>	<i>The orthotic treatment was processed on a prior claim.</i>
<b>1061</b>	<i>Services for this orthotic diagnosis were processed on a prior claim.</i>
<b>1062</b>	<i>Post removal is not a benefit with retreatment of a previous root canal.</i>
<b>1063</b>	<i>Post removal not a benefit with root canal therapy</i>
<b>1064</b>	<i>The maximum number of units allowed for this procedure code is two units per state fiscal year. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.</i>
<b>1065</b>	<i>The maximum number of units allowed for this procedure code is one unit per state fiscal year (July - June). You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.</i>
<b>1066</b>	<i>The maximum number of units allowed for this procedure code is five units per calendar month. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.</i>
<b>1067</b>	<i>The maximum number of units allowed for this procedure code is sixteen units per Fiscal Year (July - June). You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.</i>
<b>1068</b>	<i>The maximum number of units allowed for this code is two units within three state fiscal years (fiscal year is July - June). You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.</i>
<b>1070</b>	<i>Home health revenue code /condition code conflict.</i>
<b>1071</b>	<i>Acute HH and Long Term HH services cannot be billed the same day.</i>
<b>1072</b>	<i>Acute HH over daily limit</i>

<b>Edit Number</b>	<b>Description</b>
<b>1073</b>	<i>Long Term HH over daily limit</i>
<b>1074</b>	<i>PDN services are limited to 24 units per day.</i>
<b>1075</b>	<i>Acute HH and Long Term HH services cannot be billed the same day.</i>
<b>1077</b>	<i>Home Health evaluation for modification limit</i>
<b>1078</b>	<i>PDN limited to 16 units per day</i>
<b>1079</b>	<i>Exceeded acute home health daily limit</i>
<b>1082</b>	<i>Calendar year benefit has been exceeded for purchase. Item(s) are limited to \$750.00 per calendar year per client.</i>
<b>1083</b>	<i>Diapers are limited to 240 per calendar month. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.</i>
<b>1084</b>	<i>Chux are limited to 150 per calendar month. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.</i>
<b>1085</b>	<i>Occupational therapy services limited to a maximum of 24 units per 366 days without PAR. See Procedure/Revenue List 1085</i>
<b>1086</b>	<i>Occupational therapy services limited to maximum of 5 units per date of service. See Procedure/Revenue List 1086</i>
<b>1087</b>	<i>Occupational therapy evaluations limited to a maximum of 1 service per date of service</i>
<b>1088</b>	<i>Exceeded home modification limit \$10000</i>
<b>1089</b>	<i>Limit prefabricated caps to five (5) - Per date of service, Bypass if PAR is checked</i>
<b>1090</b>	<i>Maximum benefit met 3 units per day/month 30 units maximum for parent (G9006) (10 Months) 75-unit maximum for child (T1017) (25 Months)</i>
<b>1092</b>	<i>Maximum parent benefit for NHVP has been reached - 30 Units for 10 months</i>
<b>1093</b>	<i>Child maximum benefit for NHVP has been reached - 75 Units over 25 months</i>
<b>1094</b>	<i>Exceeded LTC home health daily limit</i>
<b>1095</b>	<i>Physical Therapy services are limited to a maximum of 24 units per 366 days without PAR. See Procedure/Rev List 1095</i>
<b>1096</b>	<i>Physical therapy active treatment services limited to maximum of 5 units per date of service. See Procedure/Rev List 1096</i>
<b>1097</b>	<i>Physical therapy evaluations and passive treatment services limited to a maximum of one service per date of service</i>
<b>1098</b>	<i>Claim exceeds daily limit</i>
<b>1099</b>	<i>Client exceeds annual limit</i>
<b>1105</b>	<i>The diagnosis is invalid for this procedure. Correct the diagnosis/ procedure code.</i>
<b>1120</b>	<i>The pregnancy indicator is invalid for the client's age/sex. Verify the client's birth date/sex indicator.</i>
<b>1128</b>	<i>The accident date is after last date of service. Correct the accident date/dates of service.</i>
<b>1149</b>	<i>The transportation certification is missing or invalid. Enter/Correct the transportation certification.</i>
<b>1152</b>	<i>The Administrative Service and the Personal Support Service must be submitted on the same claim.</i>
<b>1166</b>	<i>The date the plan of care was established is missing. Enter the date the plan of care was established.</i>
<b>1183</b>	<i>Inpatient claim units/Covered days/Non-covered days conflict</i>
<b>1186</b>	<i>The admission hour is missing or invalid. Enter the admission hour.</i>
<b>1187</b>	<i>The IP principal or NF admitting diagnosis is missing.</i>
<b>1188</b>	<i>Discharge date/destination conflict. Correct discharge date or patient status.</i>
<b>1189</b>	<i>The PRTF claim is missing key data - Revenue code 911 or type of bill 89X</i>
<b>1194</b>	<i>Facility class/type is missing or invalid</i>

<b>Edit Number</b>	<b>Description</b>
<b>1209</b>	<i>The professional component, modifier -26 is missing. Enter modifier -26.</i>
<b>1211</b>	<i>The Medicare deductible on the claim is greater than annual amount. The deductible amount must match the amount on the Medicare explanation of benefits. Correct the deductible amount.</i>
<b>1224</b>	<i>The units are not equal to the calculated units from the hours &amp; minutes. Re-calculate units and resubmit.</i>
<b>1225</b>	<i>Medicare associated Medicaid claim type conflict</i>
<b>1245</b>	<i>The discharge date is before the through date. Correct the discharge/through date.</i>
<b>1247</b>	<i>The special program code is missing or invalid. Enter/Correct the special program code. Refer to the Provider Manual or Help Screens for valid codes.</i>
<b>1249</b>	<i>The patient payment is greater than the pro-rated amount. Re-calculate and enter the patient payment amount.</i>
<b>1253</b>	<i>Possible client death. Check the eligibility inquiry.</i>
<b>1255</b>	<i>The client is over 65 years old. Bill the charges to Medicare before billing Medicaid. Complete the Medicare fields on the claim.</i>
<b>1265</b>	<i>Claim indicates TPL or TPL payment, no resource on file</i>
<b>1274</b>	<i>Claim indicates client death or discharge from NF.</i>
<b>1277</b>	<i>Services auto related</i>
<b>1279</b>	<i>The claim date of service is over 4 years old. Submit the claim on paper to the fiscal agent's Medicaid Exceptions Unit with documentation supporting the processing request.</i>
<b>1295</b>	<i>No eligibility for authorized claim (eligibility verif)</i>
<b>1296</b>	<i>Eligibility dates mismatch authorization (eligibility verif)</i>
<b>1307</b>	<i>Paraprofessionals require a supervising/billing provider. Complete the supervising/billing provider number field.</i>
<b>1347</b>	<i>The billing provider is a non-physician practitioner. Enter the supervising physician's Medicaid provider number in the billing provider field</i>
<b>1348</b>	<i>The billing provider specified is not a fully active provider because they are enrolled in an active/non-billable status of '62, '63', '64', or '65 for the first date of service on the claim. These active/non-billable providers can't receive payment directly. The provider must be in a fully active enrollment status of '60' or '61'</i>
<b>1350</b>	<i>Manual price greater than submitted charge</i>
<b>1353</b>	<i>There is no rate on file for the date of service. Charges cannot be processed.</i>
<b>1355</b>	<i>A rendering provider number is required. Complete the rendering provider number field.</i>
<b>1363</b>	<i>Medicare Coinsurance is greater than the annual limit. Verify and correct coinsurance amount</i>
<b>1367</b>	<i>The primary care physician provider number is invalid/missing. Correct/Enter the primary care physician provider number.</i>
<b>1369</b>	<i>The PCP provider number is invalid for the date of service. Check the eligibility inquiry for the PCP. Contact the PCP for the provider number and enter it on the claim.</i>
<b>1371</b>	<i>Non-emergency service is not a benefit with triage.</i>
<b>1376</b>	<i>Units or charge too large</i>
<b>1378</b>	<i>Referring or supervising provider not eligible for date of service</i>
<b>1379</b>	<i>Provider category of service eligibility not in date of service</i>
<b>1396</b>	<i>Dates of service span calendar year</i>
<b>1420</b>	<i>Independent lab must bill</i>
<b>1427</b>	<i>The programmatic leave days are exceeded. Bill excess programmatic leave days as medical leave days.</i>
<b>1436</b>	<i>Acute and Long Term Home Health Revenue Code conflict - must be billed on separate claims.</i>

<b>Edit Number</b>	<b>Description</b>
<b>1437</b>	<i>Medicare non-assigned lab is not a benefit.</i>
<b>1447</b>	<i>Interim DRG bills cannot be processed.</i>
<b>1448</b>	<i>Cutback days for DRG based on client eligibility</i>
<b>1451</b>	<i>The charges are not a benefit. The client has Medicare QMB only.</i>
<b>1453</b>	<i>The dates of service overlap the Medicare QMB eligibility. Check the eligibility inquiry for effective dates and split the claim.</i>
<b>1454</b>	<i>The client has QMB benefits only. Medicaid benefits are paid for crossover claims only.</i>
<b>1457</b>	<i>Client enrolled in Behavior Health Organization.</i>
<b>1458</b>	<i>Member is enrolled in Dental ASO.</i>
<b>1459</b>	<i>Member is not enrolled in Dental ASO.</i>
<b>1461</b>	<i>The client aid category spans Old Age Pension. Check the eligibility inquiry and split the claim.</i>
<b>1462</b>	<i>The service is not a benefit for the recipient aid category (OAP).</i>
<b>1464</b>	<i>Inpatient mental hospital services are not a benefit for the recipient aid category. (OAP)</i>
<b>1470</b>	<i>The revenue code must be a radiology code. Refer to the current revenue code table for valid codes.</i>
<b>1471</b>	<i>The revenue code/HCPCS code combination is invalid. Refer to the UB04 Provider Manual for instructions.</i>
<b>1476</b>	<i>The service is a Medicare benefit only.</i>
<b>1479</b>	<i>The Medicare bilateral procedure requires a review by the fiscal agent. Submit the claim on paper with a copy of the surgeon's report.</i>
<b>1483</b>	<i>This service is not a benefit of presumptive eligibility.</i>
<b>1484</b>	<i>Services for undocumented aliens are limited to emergencies. The billed service is not a benefit.</i>
<b>1501</b>	<i>The service is a duplicate of an EPSDT screening service processed previously.</i>
<b>1505</b>	<i>Services with this diagnosis must be billed on the EPSDT claim format.</i>
<b>1524</b>	<i>The detail units of service are greater than the covered days. Recalculate detail units of service/covered days.</i>
<b>1532</b>	<i>Previous rehab claim &lt;= 30 days</i>
<b>1533</b>	<i>The principal diagnosis is invalid for DRG claims. Correct the principal diagnosis.</i>
<b>1534</b>	<i>The principal diagnosis is invalid for DRG claims. Correct the principal diagnosis.</i>
<b>1535</b>	<i>DRG not a benefit for billing provider</i>
<b>1582</b>	<i>The number of tooth surfaces is invalid for the procedure. Correct the number of tooth surfaces/procedure.</i>
<b>1597</b>	<i>The abortion ICD-9-CM surgical procedure(s) is not a benefit of the Colorado Medicaid Program. Submit a paper claim with appropriate documentation.</i>
<b>1598</b>	<i>The abortion procedure code(s) is not a benefit of the Colorado Medicaid Program. Submit a paper claim with appropriate documentation.</i>
<b>1599</b>	<i>The abortion ICD-9- CM diagnosis code(s) is not a benefit of the Colorado Medicaid Program. Submit a paper claim with appropriate documentation..</i>
<b>1699</b>	<i>The claim must be submitted electronically.</i>
<b>1700</b>	<i>Revenue code must be laboratory when HCPCS is laboratory</i>
<b>1701</b>	<i>The HCPCS code must be a laboratory code. Enter the laboratory HCPCS code. Refer to the current HCPCS listing for valid codes.</i>
<b>1702</b>	<i>The ICD-9-CM surgical procedure date is not within the header dates of service. The procedure must fall within these dates. Correct the surgical procedure/header dates.</i>
<b>1703</b>	<i>Revenue code must be transportation when HCPCS code is transportation</i>

<b>Edit Number</b>	<b>Description</b>
<b>1704</b>	<i>The HCPCS code must be a transportation code. Enter the transportation HCPCS code. Refer to the current HCPCS listing for valid codes.</i>
<b>1706</b>	<i>Service dates overlap MHASA contract</i>
<b>1707</b>	<i>The service dates overlap the HMO/PHP contract. Refer to the eligibility inquiry for effective dates and split the claim.</i>
<b>1710</b>	<i>Please reference the most recent Bulletin containing information for the CLIA Certification requirements. This edit sets for HOSPITALS when there is no CLIA # on record with the Fiscal Agent, and for 837P/1500 PROVIDERS when the CLIA # provided is not in the CLIA master file.</i>
<b>1711</b>	<i>You did not provide a CLIA number with the claim or claim line. Please resubmit the claim or claim line with a CLIA number that certifies you to perform these procedures on the date(s) of service.</i>
<b>1712</b>	<i>Reconcile your Tax ID and resubmit the claim. HOSPITALS -Your Tax ID is different from the CMS Master File or your CLIA #(s) on file with the fiscal agent is not valid for this procedure code and date of service.837P/1500 PROVIDERS- the Tax ID for the CLIA # submitted does not match the CMS master file Tax ID.</i>
<b>1786</b>	<i>The services are over 1 year old and must be submitted on paper. Attach documentation to justify the request and to prove timely filing continuity.</i>
<b>1787</b>	<i>Medicare Part D Benefit Only. There is No Additional Medical Benefit for this Service.</i>
<b>2001</b>	<i>Benefit is limited to one per day</i>
<b>2002</b>	<i>Individual/Family Therapy limited to four units per day</i>
<b>2003</b>	<i>Group Therapy limited to 2 per day</i>
<b>2004</b>	<i>Targeted Case Management (TCM) is limited to 4 units a day</i>
<b>2005</b>	<i>Benefit is limited to 3 units a day</i>
<b>2006</b>	<i>Assessment Limited to Three per State Fiscal Year</i>
<b>2007</b>	<i>Individual/Family Therapy is limited to 100 units per State Fiscal Year (25 Sessions)</i>
<b>2008</b>	<i>Benefit is Limited to 36 Units per State fiscal Year</i>
<b>2009</b>	<i>Benefit is Limited to 21 Units per State Fiscal Year</i>
<b>2010</b>	<i>The maximum number of units allowed for this procedure code is 1 unit per calendar month.</i>
<b>2011</b>	<i>A National Corrective Coding Initiative (NCCI) procedure to procedure edit that is comprised of three scenarios: Comprehensive/Component (Column 1/Column 2) edits, Mutually Exclusive edits, and Action on History. These three scenarios are edits that compare procedure code pairs to identify coding logic conflicts.</i>
<b>2012</b>	<i>A National Corrective Coding Initiative (NCCI) Medically Unlikely Edit (MUE) that sets when the units of service are billed in excess of established standards for services that a client would receive on a single date of service for a given HCPCS/CPT code.</i>
<b>2016</b>	<i>This procedure code is limited to one (1) unit per date of service for School Health Services.</i>
<b>2017</b>	<i>This procedure code is limited to six (6) units per date of service for School Health Services.</i>
<b>2018</b>	<i>This procedure code is limited to 24 units per date of service for School Health Services.</i>
<b>2019</b>	<i>This procedure code is limited to 40 units per date of service for School Health Services.</i>
<b>2021</b>	<i>A National Correct Coding Initiative (NCCI) procedure to procedure edit that is comprised of three scenarios: Comprehensive/Component (Column I/Column II) edits, Mutually Exclusive edits, and Action on History. These three scenarios are edits that compare procedure code pairs to identify coding logic conflicts.</i>
<b>2022</b>	<i>A National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) that sets when the units of service are billed in excess of established standards for services that a client would receive on a single date of service for a given HCPCS/CPT code.</i>
<b>2122</b>	<i>Individual and Family Therapy limited to 8 units per day.</i>
<b>2123</b>	<i>Group Therapy limited to 3 units per day.</i>

<b>Edit Number</b>	<b>Description</b>
<b>2124</b>	<i>Benefit is limited to 108 units per state fiscal year.</i>
<b>2125</b>	<i>Screening is limited to 52 units per state fiscal year.</i>
<b>2126</b>	<i>Safety limit 15 per state fiscal year.</i>
<b>2127</b>	<i>Procedure code limited to 45 units per state fiscal year.</i>
<b>2128</b>	<i>FFS Primary Care Depression Screening limited to 1 per state fiscal year.</i>
<b>3200</b>	<i>9th Occurrence Code is an Invalid Code.</i>
<b>3201</b>	<i>9th Occurrence Code/Date Missing or Invalid.</i>
<b>3202</b>	<i>10th Occurrence Code is an Invalid Code.</i>
<b>3203</b>	<i>10th Occurrence Code/Date Missing or Invalid.</i>
<b>3204</b>	<i>11th Occurrence Code is an Invalid Code.</i>
<b>3205</b>	<i>11th Occurrence Code/Date Missing or Invalid.</i>
<b>3206</b>	<i>12th Occurrence Code is an Invalid Code.</i>
<b>3207</b>	<i>12th Occurrence Code/Date Missing or Invalid.</i>
<b>3208</b>	<i>13rd Occurrence Code is an Invalid Code.</i>
<b>3209</b>	<i>13th Occurrence Code/Date Missing or Invalid</i>
<b>3210</b>	<i>14th Occurrence Code is an Invalid Code.</i>
<b>3211</b>	<i>14th Occurrence Code/Date Missing or Invalid.</i>
<b>3212</b>	<i>15th Occurrence Code is an Invalid Code.</i>
<b>3213</b>	<i>15th Occurrence Code/Date Missing or Invalid.</i>
<b>3214</b>	<i>16th Occurrence Code is an Invalid Code.</i>
<b>3215</b>	<i>16th Occurrence Code/Date Missing or Invalid.</i>
<b>3216</b>	<i>17th Occurrence Code is an Invalid Code.</i>
<b>3217</b>	<i>17th Occurrence Code/Date Missing or Invalid.</i>
<b>3218</b>	<i>18th Occurrence Code is an Invalid Code.</i>
<b>3219</b>	<i>18th Occurrence Code/Date Missing or Invalid.</i>
<b>3220</b>	<i>19th Occurrence Code is an Invalid Code.</i>
<b>3221</b>	<i>19th Occurrence Code/Date Missing or Invalid.</i>
<b>3222</b>	<i>20th Occurrence Code is an Invalid Code.</i>
<b>3223</b>	<i>20th Occurrence Code/Date Missing or Invalid.</i>
<b>3224</b>	<i>21st Occurrence Code is an Invalid Code.</i>
<b>3225</b>	<i>21st Occurrence Code/Date Missing or Invalid.</i>
<b>3226</b>	<i>22nd Occurrence Code is an Invalid Code.</i>
<b>3227</b>	<i>22nd Occurrence Code/Date Missing or Invalid.</i>
<b>3228</b>	<i>23rd Occurrence Code is an Invalid Code.</i>
<b>3229</b>	<i>23rd Occurrence Code/Date Missing or Invalid.</i>
<b>3230</b>	<i>24th Occurrence Code is an Invalid Code.</i>
<b>3231</b>	<i>24th Occurrence Code/Date Missing or Invalid.</i>
<b>3232</b>	<i>6th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3233</b>	<i>6th Other Surgical Procedure Not on Database or Invalid</i>
<b>3234</b>	<i>6th Other Surgical Procedure Not Covered</i>
<b>3235</b>	<i>7th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3236</b>	<i>7th Other Surgical Procedure Not on Database or Invalid</i>
<b>3237</b>	<i>7th Other Surgical Procedure Not Covered</i>

<b>Edit Number</b>	<b>Description</b>
<b>3238</b>	<i>8th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3239</b>	<i>8th Other Surgical Procedure Not on Database or Invalid</i>
<b>3240</b>	<i>8th Other Surgical Procedure Not Covered</i>
<b>3241</b>	<i>9th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3242</b>	<i>9th Other Surgical Procedure Not on Database or Invalid</i>
<b>3243</b>	<i>9th Other Surgical Procedure Not Covered</i>
<b>3244</b>	<i>10th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3245</b>	<i>10th Other Surgical Procedure Not on Database or Invalid</i>
<b>3246</b>	<i>10th Other Surgical Procedure Not Covered</i>
<b>3247</b>	<i>11th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3248</b>	<i>11th Other Surgical Procedure Not on Database or Invalid</i>
<b>3249</b>	<i>11th Other Surgical Procedure Not Covered</i>
<b>3250</b>	<i>12th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3251</b>	<i>12th Other Surgical Procedure Not on Database or Invalid</i>
<b>3252</b>	<i>12th Other Surgical Procedure Not Covered</i>
<b>3253</b>	<i>13th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3254</b>	<i>13th Other Surgical Procedure Not on Database or Invalid</i>
<b>3255</b>	<i>13th Other Surgical Procedure Not Covered</i>
<b>3256</b>	<i>14th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3257</b>	<i>14th Other Surgical Procedure Not on Database or Invalid</i>
<b>3258</b>	<i>14th Other Surgical Procedure Not Covered</i>
<b>3259</b>	<i>15th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3260</b>	<i>15th Other Surgical Procedure Not on Database or Invalid</i>
<b>3261</b>	<i>15th Other Surgical Procedure Not Covered</i>
<b>3262</b>	<i>16th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3263</b>	<i>16th Other Surgical Procedure Not on Database or Invalid</i>
<b>3264</b>	<i>16th Other Surgical Procedure Not Covered</i>
<b>3265</b>	<i>17th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3266</b>	<i>17th Other Surgical Procedure Not on Database or Invalid</i>
<b>3267</b>	<i>17th Other Surgical Procedure Not Covered</i>
<b>3268</b>	<i>18th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3269</b>	<i>18th Other Surgical Procedure Not on Database or Invalid</i>
<b>3270</b>	<i>18th Other Surgical Procedure Not Covered</i>
<b>3271</b>	<i>19th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3272</b>	<i>19th Other Surgical Procedure Not on Database or Invalid</i>
<b>3273</b>	<i>19th Other Surgical Procedure Not Covered</i>
<b>3274</b>	<i>20th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3275</b>	<i>20th Other Surgical Procedure Not on Database or Invalid</i>
<b>3276</b>	<i>20th Other Surgical Procedure Not Covered</i>
<b>3277</b>	<i>21st Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3278</b>	<i>21st Other Surgical Procedure Not on Database or Invalid</i>
<b>3279</b>	<i>21th Other Surgical Procedure Not Covered</i>
<b>3280</b>	<i>22nd Other Surgical Procedure Code/Date Missing or Invalid</i>

<b>Edit Number</b>	<b>Description</b>
<b>3281</b>	<i>22nd Other Surgical Procedure Not on Database or Invalid</i>
<b>3282</b>	<i>22nd Other Surgical Procedure Not Covered</i>
<b>3283</b>	<i>23rd Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3284</b>	<i>23rd Other Surgical Procedure Not on Database or Invalid</i>
<b>3285</b>	<i>23rd Other Surgical Procedure Not Covered</i>
<b>3286</b>	<i>24th Other Surgical Procedure Code/Date Missing or Invalid</i>
<b>3287</b>	<i>24th Other Surgical Procedure Not on Database or Invalid</i>
<b>3288</b>	<i>24th Other Surgical Procedure Not Covered</i>
<b>3289</b>	<i>The Principal Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3290</b>	<i>The Principal Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3291</b>	<i>The 1st Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3292</b>	<i>The 1st Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3293</b>	<i>The 2nd Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3294</b>	<i>The 2nd Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3295</b>	<i>The 3rd Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3296</b>	<i>The 3rd Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3297</b>	<i>The 4th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3298</b>	<i>The 4th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3299</b>	<i>The 5th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3300</b>	<i>The 5th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3301</b>	<i>The 6th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3302</b>	<i>The 6th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3303</b>	<i>The 7th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3304</b>	<i>The 7th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3305</b>	<i>The 8th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3306</b>	<i>The 8th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3307</b>	<i>9th Other Diagnosis Code Not on Database or Invalid</i>
<b>3308</b>	<i>The 9th Other Diagnosis is Not Covered.</i>

<b>Edit Number</b>	<b>Description</b>
<b>3309</b>	<i>The 9th Other Diagnosis is invalid for client's age.</i>
<b>3310</b>	<i>9th Other Diagnosis Code/Sex Code Conflict</i>
<b>3311</b>	<i>The 9th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3312</b>	<i>The 9th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3313</b>	<i>10th Other Diagnosis Code Not on Database or Invalid</i>
<b>3314</b>	<i>The 10th Other Diagnosis is Not Covered.</i>
<b>3315</b>	<i>The 10th Other Diagnosis is invalid for client's age.</i>
<b>3316</b>	<i>10th Other Diagnosis Code/Sex Code Conflict</i>
<b>3317</b>	<i>The 10th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3318</b>	<i>The 10th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3319</b>	<i>11th Other Diagnosis Code Not on Database or Invalid</i>
<b>3320</b>	<i>The 11th Other Diagnosis is Not Covered.</i>
<b>3321</b>	<i>The 11th Other Diagnosis is invalid for client's age.</i>
<b>3322</b>	<i>11th Other Diagnosis Code/Sex Code Conflict</i>
<b>3323</b>	<i>The 11th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3324</b>	<i>The 11th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3325</b>	<i>12th Other Diagnosis Code Not on Database or Invalid</i>
<b>3326</b>	<i>The 12th Other Diagnosis is Not Covered.</i>
<b>3327</b>	<i>The 12th Other Diagnosis is invalid for client's age.</i>
<b>3328</b>	<i>12th Other Diagnosis Code/Sex Code Conflict</i>
<b>3329</b>	<i>The 12th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3330</b>	<i>The 12th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3331</b>	<i>13th Other Diagnosis Code Not on Database or Invalid</i>
<b>3332</b>	<i>The 13th Other Diagnosis is Not Covered.</i>
<b>3333</b>	<i>The 13th Other Diagnosis is invalid for client's age.</i>
<b>3334</b>	<i>13th Other Diagnosis Code/Sex Code Conflict</i>
<b>3335</b>	<i>The 13th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3336</b>	<i>The 13th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3337</b>	<i>14th Other Diagnosis Code Not on Database or Invalid</i>
<b>3338</b>	<i>The 14th Other Diagnosis is Not Covered.</i>
<b>3339</b>	<i>The 14th Other Diagnosis is invalid for client's age.</i>
<b>3340</b>	<i>14th Other Diagnosis Code/Sex Code Conflict</i>
<b>3341</b>	<i>The 14th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>

<b>Edit Number</b>	<b>Description</b>
<b>3342</b>	<i>The 14th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3343</b>	<i>15th Other Diagnosis Code Not on Database or Invalid</i>
<b>3344</b>	<i>The 15th Other Diagnosis is Not Covered.</i>
<b>3345</b>	<i>The 15th Other Diagnosis is invalid for client's age.</i>
<b>3346</b>	<i>15th Other Diagnosis Code/Sex Code Conflict</i>
<b>3347</b>	<i>The 15th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3348</b>	<i>The 15th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3349</b>	<i>16th Other Diagnosis Code Not on Database or Invalid</i>
<b>3350</b>	<i>The 16th Other Diagnosis is Not Covered.</i>
<b>3351</b>	<i>The 16th Other Diagnosis is invalid for client's age.</i>
<b>3352</b>	<i>16th Other Diagnosis Code/Sex Code Conflict</i>
<b>3353</b>	<i>The 16th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3354</b>	<i>The 16th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3355</b>	<i>17th Other Diagnosis Code Not on Database or Invalid</i>
<b>3356</b>	<i>The 17th Other Diagnosis is Not Covered.</i>
<b>3357</b>	<i>The 17th Other Diagnosis is invalid for client's age.</i>
<b>3358</b>	<i>17th Other Diagnosis Code/Sex Code Conflict</i>
<b>3359</b>	<i>The 17th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3360</b>	<i>The 17th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3361</b>	<i>18th Other Diagnosis Code Not on Database or Invalid</i>
<b>3362</b>	<i>The 18th Other Diagnosis is Not Covered.</i>
<b>3363</b>	<i>The 18th Other Diagnosis is invalid for client's age.</i>
<b>3364</b>	<i>18th Other Diagnosis Code/Sex Code Conflict</i>
<b>3365</b>	<i>The 18th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3366</b>	<i>The 18th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3367</b>	<i>19th Other Diagnosis Code Not on Database or Invalid</i>
<b>3368</b>	<i>The 19th Other Diagnosis is Not Covered.</i>
<b>3369</b>	<i>The 19th Other Diagnosis is invalid for client's age.</i>
<b>3370</b>	<i>19th Other Diagnosis Code/Sex Code Conflict</i>
<b>3371</b>	<i>The 19th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3372</b>	<i>The 19th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3373</b>	<i>20th Other Diagnosis Code Not on Database or Invalid</i>
<b>3374</b>	<i>The 20th Other Diagnosis is Not Covered.</i>
<b>3375</b>	<i>The 20th Other Diagnosis is invalid for client's age.</i>

<b>Edit Number</b>	<b>Description</b>
<b>3376</b>	<i>20th Other Diagnosis Code/Sex Code Conflict</i>
<b>3377</b>	<i>The 20th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3378</b>	<i>The 20th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3379</b>	<i>21st Other Diagnosis Code Not on Database or Invalid</i>
<b>3380</b>	<i>The 21st Other Diagnosis is Not Covered.</i>
<b>3381</b>	<i>The 21st Other Diagnosis is invalid for client's age.</i>
<b>3382</b>	<i>21th Other Diagnosis Code/Sex Code Conflict</i>
<b>3383</b>	<i>The 21st Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3384</b>	<i>The 21st Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3385</b>	<i>22nd Other Diagnosis Code Not on Database or Invalid</i>
<b>3386</b>	<i>The 22nd Other Diagnosis is Not Covered.</i>
<b>3387</b>	<i>The 22nd Other Diagnosis is invalid for client's age.</i>
<b>3388</b>	<i>22nd Other Diagnosis Code/Sex Code Conflict</i>
<b>3389</b>	<i>The 22nd Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3390</b>	<i>The 22nd Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3391</b>	<i>23rd Other Diagnosis Code Not on Database or Invalid</i>
<b>3392</b>	<i>The 23rd Other Diagnosis is Not Covered.</i>
<b>3393</b>	<i>The 23rd Other Diagnosis is invalid for client's age.</i>
<b>3394</b>	<i>23rd Other Diagnosis Code/Sex Code Conflict</i>
<b>3395</b>	<i>The 23rd Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3396</b>	<i>The 23rd Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3397</b>	<i>24th Other Diagnosis Code Not on Database or Invalid</i>
<b>3398</b>	<i>The 24th Other Diagnosis is Not Covered.</i>
<b>3399</b>	<i>The 24th Other Diagnosis is invalid for client's age.</i>
<b>3400</b>	<i>24th Other Diagnosis Code/Sex Code Conflict</i>
<b>3401</b>	<i>The 24th Other Diagnosis is not included in the determination of APR-DRG because it is a CMS-defined Health Care Acquired Condition (HCAC) with a POA=N or U.</i>
<b>3402</b>	<i>The 24th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3404</b>	<i>The Admitting Diagnosis is Not Covered.</i>
<b>3408</b>	<i>The Admitting Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.</i>
<b>3409</b>	<i>1st Other Diagnosis POA is missing or invalid.</i>
<b>3410</b>	<i>2nd Other Diagnosis POA is missing or invalid.</i>
<b>3411</b>	<i>3rd Other Diagnosis POA is missing or invalid.</i>
<b>3412</b>	<i>4th Other Diagnosis POA is missing or invalid.</i>
<b>3413</b>	<i>5th Other Diagnosis POA is missing or invalid.</i>

<b>Edit Number</b>	<b>Description</b>
<b>3414</b>	<i>6th Other Diagnosis POA is missing or invalid.</i>
<b>3415</b>	<i>7th Other Diagnosis POA is missing or invalid.</i>
<b>3416</b>	<i>8th Other Diagnosis POA is missing or invalid.</i>
<b>3417</b>	<i>9th Other Diagnosis POA is missing or invalid.</i>
<b>3418</b>	<i>10th Other Diagnosis POA is missing or invalid.</i>
<b>3419</b>	<i>11th Other Diagnosis POA is missing or invalid.</i>
<b>3420</b>	<i>12th Other Diagnosis POA is missing or invalid.</i>
<b>3421</b>	<i>13th Other Diagnosis POA is missing or invalid.</i>
<b>3422</b>	<i>14th Other Diagnosis POA is missing or invalid.</i>
<b>3423</b>	<i>15th Other Diagnosis POA is missing or invalid.</i>
<b>3424</b>	<i>16th Other Diagnosis POA is missing or invalid.</i>
<b>3425</b>	<i>17th Other Diagnosis POA is missing or invalid.</i>
<b>3426</b>	<i>18th Other Diagnosis POA is missing or invalid.</i>
<b>3427</b>	<i>19th Other Diagnosis POA is missing or invalid.</i>
<b>3428</b>	<i>20th Other Diagnosis POA is missing or invalid.</i>
<b>3429</b>	<i>21st Other Diagnosis POA is missing or invalid.</i>
<b>3430</b>	<i>22nd Other Diagnosis POA is missing or invalid.</i>
<b>3431</b>	<i>23rd Other Diagnosis POA is missing or invalid.</i>
<b>3432</b>	<i>24th Other Diagnosis POA is missing or invalid.</i>
<b>3433</b>	<i>1st Patient Reason for Visit is Invalid</i>
<b>3434</b>	<i>2nd Patient Reason for Visit is Invalid</i>
<b>3435</b>	<i>3rd Patient Reason for Visit is Invalid</i>
<b>3436</b>	<i>APR-DRG No Price on File - [L]</i>
<b>3437</b>	<i>APR-DRG Not Covered - [H]</i>
<b>3438</b>	<i>APR-DRG Requires Manual Review -[ H]</i>
<b>3439</b>	<i>APR-DRG/Age Conflict - [H]</i>
<b>3440</b>	<i>APR-DRG Not Covered - [L]</i>
<b>3441</b>	<i>APR-DRG Requires Manual Review - [L]</i>
<b>3442</b>	<i>Must bill as a continuous stay</i>
<b>3443</b>	<i>Service must be billed as Outpatient</i>
<b>3444</b>	<i>Abortion service not a benefit</i>
<b>3445</b>	<i>PreAdmission Testing on Outpatient Services</i>
<b>3446</b>	<i>No Hospital Weight Group Located</i>
<b>3448</b>	<i>APR-DRG/Sex Conflict - [H]</i>

**NPI Edits**

<b>Edit Number</b>	<b>Description</b>
<b>1801</b>	<i>No provider match for Billing National Provider Identifier</i>
<b>1809</b>	<i>Unique provider not found for Billing National Provider Identifier</i>
<b>1825</b>	<i>Billing provider's NPI required</i>
<b>1826</b>	<i>Rendering provider's NPI required</i>

**Appendix R Revisions Log**

<b>Revision Date</b>	<b>Appendix</b>	<b>Pages</b>	<b>Made by</b>
02/09/2007	Replaced Provider Claim Report Messages	All	jg
06/22/2007	Added NPI Edits	16	jg
07/17/2007	Added New Edits	15, 16	jg
10/11/2007	Corrected description for 0229	2	jg
07/22/2008	Updated NPI edits	16	jg
06/21/2012	Appendix R – Updated edits 0578 and 0579	8	cc
01/18/2013	Added edits 2016-2019 (School Health Services)	16	jg
12/19/2013	Updated the following edits: 0194, 0197, 0198, 0199, 0210, 0211, 0216, 0225, 0226, 0227, 0228, 0229, 0229, 0235, 0243, 0440-0485, 0490, 0491, 0494, 0495, 0521, 0522, 0526, 0527, 0550-0578, 0818-0822, 0860-0865, and 1187 Added the following edits: 3200-3448	Throughout	cc
01/23/2014	Revised the following edits for Abortion services: 1597, 1598, and 1599	15	cc
03/26/2014	Revised the following edits to differentiate between diagnosis codes on the Professional and Institutional claims: 0450, 0460, 0470, 0480, 0455, 0465, 0475, 0485, 0454, 0464, 0474, 0484	6-7	cc
03/31/2014	Removed edits: 3403, 3405, 3406, 3407	21	mm
04/10/2014	Added NCCI edits 2021 1nd 2022	16	Jg
07/02/2014	Added edit 1458 – Member is enrolled in Dental ASO.	14	Mm
08/28/2014	Removed edit 1091 – No more than 3 visits per month for NHVP	13	MM
02/06/2015	Updated edits 2122, 2123, 2124, 2125, 2126, 2127, and 2128.	16	Bl
4/30/2015	Added edit 1459 and description. Changed font to Tahoma.	16	JH
4/30/15	Added "0" to Edit 354, unbundled the edits and descriptions that combined 34093408 – 34483446.	5, 23, 24	JH
04/30/2015	Minor formatting throughout	All	bl

**Note:** In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above, are the page numbers on which the updates/changes occur.