MHC Claims Editing Update

Please find below the revised Claims edits effective October 2024 for your reference.

EDIT	Category	Description	EOB Remark
00101	Ineffective or Deleted CPT/HCPCS Code	The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be complete and date of service compliant. Therefore, all procedure codes are issued an effective and termination date. This edit uses regulatory-sourced code sets including Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and American Dental Association (ADA) Dental Procedures to determine whether a procedure code is effective on the claim line date of service. When an ineffective or deleted procedure code is submitted, the logic within this edit will apply a recommendation to deny the claim line.	Ineffective or Deleted CPT/HCPCS Code.
00101 (UB)	Ineffective or Deleted CPT/HCPCS Code	The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be complete and date of service compliant. Therefore, all procedure codes are issued an effective and termination date. This edit uses regulatory-sourced code sets including Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and American Dental Association (ADA) Dental Procedures to determine whether a procedure code is effective on the claim line date of service. When an ineffective or deleted procedure code is submitted, the logic within this edit will apply a recommendation to deny the claim line.	Ineffective or Deleted CPT/HCPCS Code.
00102	Invalid CPT/HCPCS Code	The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be complete and date of service compliant. This edit uses regulatory-sourced code sets including Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and American Dental Association (ADA) Dental Procedures to determine whether a code is a valid procedure code. An invalid procedure code is one that never existed on the CPT, HCPCS, or ADA Dental source files. This edit addresses invalid procedure codes. When an invalid procedure code is submitted, the logic within this edit will apply a recommendation to deny the claim line.	Invalid CPT/HCPCS Code.
00102 (UB)	Invalid CPT/HCPCS Code	The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be complete and date of service compliant. This edit uses regulatory-sourced code sets including Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and American Dental Association (ADA) Dental Procedures to determine whether a code is a valid procedure code. An invalid procedure code is one that never existed on the CPT, HCPCS, or ADA Dental source files. This edit addresses invalid procedure codes. When an invalid procedure code is submitted, the logic within this edit will apply a recommendation to deny the claim line.	Invalid CPT/HCPCS Code.

00103	Missing CPT/HCPCS Code	The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be complete and date of service compliant. This edit addresses when a CPT/HCPCS code is not billed on a claim line.	Missing CPT/HCPCS Code.
00103 (UB)	Missing CPT/HCPCS Code	The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be complete and date of service compliant. The National Uniform Billing Committee (NUBC) specifies revenue codes that should be billed with a CPT/HCPCS code on the claim line. This edit addresses outpatient facility claims. When a revenue code requiring a CPT/HCPCS code is billed without a CPT/HCPCS code, the claim line will be denied.	Missing CPT/HCPCS Code.

00402	Inappropriate Use of Modifier	As per guidelines from the Centers for Medicare & Medicaid Services, procedure code and modifier combinations that have been billed inappropriately with regards to modifier 25 (significant, separately identifiable E/M service by same physician on same day of procedure or other service), 50 (bilateral procedures), 51 (Multiple Procedures), 59 (distinct procedural services), XE (separate encounter), XP (separate practitioner), XS (separate structure), and XU (unusual non-overlapping service) will be denied.	Inappropriate Use of Modifier.
00403	Mutually Exclusive Modifier (Anesthia)	As per Centers for Medicare & Medicaid Services and American Medical Association guidelines, modifiers may be appended to HCPCS/CPT codes to provide additional information about services/procedures rendered. However, certain modifier combinations and/or billing of a global charge, are considered mutually exclusive and inappropriate when reported on the same or a subsequent claim for the same patient, same service and on the same date of service. This edit will detect these mutually exclusive scenarios and deny the latter claim line.	Already paid in part, or for the global amount, on another claim/provider.
00501	Separate Procedures	Add-on codes, as defined by the American Medical Association are identified if a provider has performed one without an associated primary procedure code for a member on the same date of service regardless of location.	Add-on Code. Primary procedure not found.
00502	Separate Procedures	Separate procedures should not be reimbursed with a major procedure that includes that procedure. A procedure is considered separate as defined by the American Medical Association. These are allowed reimbursement only when done separately or independently of a major procedure. Other procedures, not defined as separate, are also considered to be inclusive of major procedures. A procedure or group of procedures may also be identified. If more than one is billed, only the procedure with the highest allowed amount is approved.	Not allowed separate payment with procedure {0}.
00901	Patient is Not New to This Provider	The American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) define a new patient as one who has not received any professional services from the physician or physician group practice of the same specialty within the past three years. The American Medical Association defines evaluation and management services as services provided by physicians and other qualified health care professionals to evaluate patients and manage their care.	Patient is Not New to This Provider.

016	Invalid HCPCS Code	HCPCS codes were established by Centers for Medicare & Medicaid Services for unidentified procedure/services for which there is no corresponding CPT code. Typically, these do not carry a Relative Value Unit (RVU) and/or a Reasonable & Customary (R&C) value. As per the American Medical Association, there is a CPT code available that should be used in lieu of the HCPCS code. The CPT code does carry an Relative RVU and R&C value.	Inappropriate use of HCPCS code. CPT code exists.
021X	Fragmented Procedures	Per AMA and CMS, procedures shall be reported with the most comprehensive CPT code that describes the services performed. A physician shall not report multiple HCPCS or CPT codes when a single comprehensive HCPCS or CPT code describes these	Rebundled with other procedure(s) into procedure {0}.
024	Unlisted CPT Code	As per Centers for Medicare & Medicaid Services & American Medical Association guidelines, unlisted CPT/HCPCS codes are only to be used in the event that there is not a more descriptive CPT/HCPCS code available. Providers are required to have documentation to substantiate the use of such code. (i.e. unlisted drug codes, J3490)	Unlisted CPT or HCPCS code.
024 (UB)	Unlisted CPT Code	As per Centers for Medicare & Medicaid Services & American Medical Association guidelines, unlisted CPT/HCPCS codes are only to be used in the event that there is not a more descriptive CPT/HCPCS code available. Providers are required to have documentation to substantiate the use of such code. (i.e. unlisted drug codes, J3490). This edit will target outpatient UB claims.	Unlisted CPT or HCPCS code.
027X	Chemistry Lab Unbundled	The American Medical Association has identified individual lab tests that should be grouped together and paid under one procedure code as a panel. This edit will review for lab procedures billed by the same provider on the same date of service and determine if there are individual components of a disease-oriented panel or an automated chemistry panel code. It will deny the codes billed “a la carte” and the denial will reflect the correct procedure code that should be rebilled.	Rebundled with other procedure(s) into procedure {0}.
03806	Inappropriate Age/Gender Code Use	This edit identifies procedure codes that are inappropriate for a patient’s age as identified by the American Medical Association.	Procedure is inconsistent with the patient's age.
03806 (UB)	Inappropriate Age/Gender Code Use	This edit identifies procedure codes that are inappropriate for a patient’s age as identified by the American Medical Association.	Procedure is inconsistent with the patient's age.
03807	Inappropriate Age/Gender Code Use	This edit identifies procedure codes that are inappropriate for a patient’s gender as identified by the American Medical Association.	Procedure is inconsistent with the patient's gender.
03807 (UB)	Inappropriate Age/Gender Code Use	This edit identifies procedure codes that are inappropriate for a patient’s gender as identified by the American Medical Association.	Procedure is inconsistent with the patient's gender.
03809	Inappropriate Age/Gender Code Use	This edit identifies diagnosis codes that are inappropriate for a patient’s age as identified by the ICD-10 CM.	Diagnosis is inconsistent with the patient's age.
03809 (UB)	Inappropriate Age/Gender Code Use	This edit identifies diagnosis codes that are inappropriate for a patient’s age as identified by the ICD-10 CM.	Diagnosis is inconsistent with the patient's age.
03810	Inappropriate Age/Gender Code Use	This edit identifies diagnosis codes that are inappropriate for a patient’s gender as identified by the ICD-10 CM.	Diagnosis is inconsistent with the patient's gender.
03810 (UB)	Inappropriate Age/Gender Code Use	This edit identifies diagnosis codes that are inappropriate for a patient’s gender as identified by the ICD-10 CM.	Diagnosis is inconsistent with the patient's gender.

04501	Diagnosis Laterality	Per ICD-10 guidelines and CMS policy, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting, some ICD-10 codes indicate laterality specifying whether the condition occurs on the left, right or is bilateral.	Unspecified Laterality Diagnosis Code.
04501 (UB)	Diagnosis Laterality	Per ICD-10 guidelines and CMS policy, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting, some ICD-10 codes indicate laterality specifying whether the condition occurs on the left, right or is bilateral.	Unspecified Laterality Diagnosis Code.
04502	Diagnosis Specificity	As per Centers for Medicare & Medicaid Services & American Medical Association guidelines, incomplete diagnosis codes are only to be used in the event that there is not a more specific diagnosis code available. CMS requires certain diagnosis codes to extend out to a specified number of digits. This edit will target HCFA and ASC UB claims.	Incomplete diagnosis code.
04502 (UB)	Diagnosis Specificity	As per Centers for Medicare & Medicaid Services & American Medical Association guidelines, incomplete diagnosis codes are only to be used in the event that there is not a more specific diagnosis code available. CMS requires certain diagnosis codes to extend out to a specified number of digits. This edit will target outpatient UB claims.	Incomplete diagnosis code.
04503	Manifestation Dx Code Billed as Primary Diagnosis	Manifestation diagnosis codes are ICD-10 Diagnosis (DX) codes that describe the symptoms or signs of an underlying disease, not the disease itself. These codes have a 'code first' distinction in the CPT coding manual instructs a coder to avoid the use of these codes as a primary diagnosis. Therefore, they will deny if they are billed as a primary diagnosis.	Manifestation diagnosis code billed as primary diagnosis.
04503 (UB)	Manifestation Dx Code Billed as Primary Diagnosis	Manifestation diagnosis codes are ICD-10 Diagnosis (DX) codes that describe the symptoms or signs of an underlying disease, not the disease itself. These codes have a 'code first' distinction in the CPT coding manual instructs a coder to avoid the use of these codes as a primary diagnosis. Therefore, they will deny if they are billed as a primary diagnosis.	Manifestation diagnosis code billed as primary diagnosis.
04504	Ineffective or Deleted Diagnosis Code	CMS provides additions and updates to ICD-10-CM diagnosis codes. The source files provided support the effective and termination date of individual diagnosis codes and provide an incomplete and complete diagnosis code indicator.	Ineffective or Deleted Diagnosis Code.
04504 (UB)	Ineffective or Deleted Diagnosis Code	CMS provides additions and updates to ICD-10-CM diagnosis codes. The source files provided support the effective and termination date of individual diagnosis codes and provide an incomplete and complete diagnosis code indicator.	Ineffective or Deleted Diagnosis Code.
04505	Invalid Diagnosis Code	CMS provides additions and updates to ICD-10-CM diagnosis codes. The source files provided support the effective and termination date of individual diagnosis codes and provide an incomplete and complete diagnosis code indicator.	Invalid Diagnosis Code.

04505 (UB)	Invalid Diagnosis Code	CMS provides additions and updates to ICD-10-CM diagnosis codes. The source files provided support the effective and termination date of individual diagnosis codes and provide an incomplete and complete diagnosis code indicator.	Invalid Diagnosis Code.
04506	External Cause of Morbidity Dx Code Billed as Primary Dx	Per the Centers for Medicare and Medicaid Services (CMS) and International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting, external cause of morbidity codes are never to be recorded as a principal diagnosis (first-listed in non-inpatient settings). The appropriate injury code should be sequenced before any external cause codes.	External Cause of Morbidity Dx Code Billed as Primary Dx.
04506 (UB)	External Cause of Morbidity Dx Code Billed as Primary Dx	Per the Centers for Medicare and Medicaid Services (CMS) and International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting, external cause of morbidity codes are never to be recorded as a principal diagnosis (first-listed in non-inpatient settings). The appropriate injury code should be sequenced before any external cause codes.	External Cause of Morbidity Dx Code Billed as Primary Dx.
04507	Sequela Billed as Primary or Principal Diagnosis	There is guidance from the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting, a sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. Coding of sequela generally requires two codes sequenced in the following order: the condition or nature of the sequela is sequenced first. The sequela code is sequenced second. The professional edit addresses when a sequela diagnosis code is submitted in the first or primary diagnosis position or as the only diagnosis code on the claim.	Sequela Dx Code Billed as Primary Dx.
04508 (UB)	Sequela Diagnosis Code Billed as Primary or Principal	There is guidance from the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting, a sequela is a residual effect (condition produced) after the acute phase of an illness or injury has terminated. Coding of sequela generally requires two codes sequenced in the following order: the condition or nature of the sequela is sequenced first. The sequela code is sequenced second.	Sequela Dx Code Billed as Primary Dx.
05202	Ineffective or Deleted Place of Service	CMS maintains and publishes the Place of Service code set. Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the CMS Place of Service code set as the standard for direct billing of Medicare, Medicaid, and private insurance providers. Place of Service is a two-digit code utilized on HCFA/professional claims to indicate where a procedure or service was provided.	Ineffective or Deleted Place of Service.
05203	Invalid Place of Service	CMS maintains and publishes the Place of Service code set. Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the CMS Place of Service code set as the standard for direct billing of Medicare, Medicaid, and private insurance providers. Place of Service is a two-digit code utilized on HCFA/professional claims to indicate where a procedure or service was provided.	Invalid Place of Service.

05204 (UB)	Missing Type of Bill Required on Claim	The National Uniform Billing Committee (NUBC) maintains and publishes the Type of Bill code set. Type of Bill is a required four-digit alphanumeric code utilized on UB/Facility claims that specifies the following information: The leading zero is typically ignored The second digit identifies the type of facility The third digit identifies the type of care The fourth digit/character identifies the sequence or episode of care	Missing Type of Bill Required on Claim.
05205 (UB)	Ineffective or Deleted Type of Bill	The National Uniform Billing Committee (NUBC) maintains and publishes the Type of Bill code set. Type of Bill is a required four-digit alphanumeric code utilized on UB/Facility claims that specifies the following information: The leading zero is typically ignored The second digit identifies the type of facility The third digit identifies the type of care The fourth digit/character identifies the sequence or episode of care	Ineffective or Deleted Type of Bill.
05206 (UB)	Invalid Type of Bill	The National Uniform Billing Committee (NUBC) maintains and publishes the Type of Bill code set. Type of Bill is a required four-digit alphanumeric code utilized on UB/Facility claims that specifies the following information: The leading zero is typically ignored The second digit identifies the type of facility The third digit identifies the type of care The fourth digit/character identifies the sequence or episode of care	Invalid Type of Bill.
05207 (UB)	Federally Qualified Health Center Type of Bill and Taxonomy Mismatch	The National Uniform Billing Committee (NUBC) requires Federally Qualified Health Centers to bill taxonomy and type of bill to be reimbursed by Medicare or Medicare based plans. If a FQHC submits a claim and the taxonomy or type of bill are a mismatch, then the claim is denied.	FQHC Type of Bill and Taxonomy Mismatch.
05208 (UB)	Community Mental Health Center Type of Bill and Taxonomy Mismatch	The National Uniform Billing Committee (NUBC) requires Community Mental Health Centers to bill with taxonomy and type of bill to be reimbursed by Medicare or Medicare based plans. If a CMHC submits a claim and the taxonomy or type of bill are a mismatch, then the claim is denied.	CMHC Type of Bill and Taxonomy Mismatch.
05501	Inappropriate Place of Service for Emergency Department CPT/HCPCS	The CPT/HCPCS to Place of Service edit suite addresses billing an inappropriate Place of Service to specified CPT/HCPCS codes based on guidelines established by American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and other nationally recognized medical societies and organizations. Place of Service codes are two-digit codes utilized on healthcare professional claims to indicate the setting in which the health care service was provided.	Inappropriate Place of Service for Emergency Department CPT/HCPCS.

05502	Inappropriate Place of Service for Critical Care Transport CPT/HCPCS	The CPT/HCPCS to Place of Service edit suite addresses billing an inappropriate Place of Service to specified CPT/HCPCS codes based on guidelines established by American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and other nationally recognized medical societies and organizations. Place of Service codes are two-digit codes utilized on healthcare professional claims to indicate the setting in which the health care service was provided.	Inappropriate Place of Service for Critical Care Transport CPT/HCPCS.
05503	Inappropriate Place of Service for Critical/Intensive Care CPT/HCPCS	The CPT/HCPCS to Place of Service edit suite addresses billing an inappropriate Place of Service to specified CPT/HCPCS codes based on guidelines established by American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and other nationally recognized medical societies and organizations. Place of Service codes are two-digit codes utilized on healthcare professional claims to indicate the setting in which the health care service was provided.	Inappropriate Place of Service for Critical/Intensive Care CPT/HCPCS.
05504	CPT/HCPCS to Place of Service - Hospital Care Services (Initial or Subsequent) (Professional)	The CPT/HCPCS to Place of Service edit suite addresses billing an inappropriate Place of Service to specified CPT/HCPCS codes based on guidelines established by American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and other nationally recognized medical societies and organizations. Place of Service codes are two-digit codes utilized on healthcare professional claims to indicate the setting in which the health care service was provided.	Inappropriate Place of Service for Hospital Care CPT/HCPCS.
05506	CPT/HCPCS to Place of Service - Hospital Care Services (Including Admission and Discharge Services) Services (Professional)	The CPT/HCPCS to Place of Service edit suite addresses billing an inappropriate Place of Service to specified CPT/HCPCS codes based on guidelines established by American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and other nationally recognized medical societies and organizations. Place of Service codes are two-digit codes utilized on healthcare professional claims to indicate the setting in which the health care service was provided.	Inappropriate Place of Service for Hospital Care CPT/HCPCS.
05507	Inappropriate Place of Service for Hospital Observation CPT/HCPCS	The CPT/HCPCS to Place of Service edit suite addresses billing an inappropriate Place of Service to specified CPT/HCPCS codes based on guidelines established by American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and other nationally recognized medical societies and organizations. Place of Service codes are two-digit codes utilized on healthcare professional claims to indicate the setting in which the health care service was provided.	Inappropriate Place of Service for Hospital Observation CPT/HCPCS.

05508	Not Payable CPT/HCPCS for Place of Service Ambulatory Surgical Center	The CPT/HCPCS to Place of Service edit suite addresses billing an inappropriate Place of Service to specified CPT/HCPCS codes based on guidelines established by American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and other nationally recognized medical societies and organizations. Place of Service codes are two-digit codes utilized on healthcare professional claims to indicate the setting in which the health care service was provided. The CMS Ambulatory Surgical Center (ASC) Addendum EE is a list of surgical procedures excluded from Medicare payment in ASCs. The surgical procedures on that exclusionary list are those that are on the OPPS inpatient list, CPT unlisted codes, surgical procedures that are not recognized for payment under Medicare, and those that CMS medical advisors determined pose a significant risk to beneficiary safety or would be expected to require an overnight stay when provided in ASCs. Disallowed POS: 24	Not Payable CPT/HCPCS for Place of Service Ambulatory Surgical Center.
05509	Inappropriate Place of Service for Urgent Care CPT/HCPCS	The CPT/HCPCS to Place of Service edit suite addresses billing an inappropriate Place of Service to specified CPT/HCPCS codes based on guidelines established by American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and other nationally recognized medical societies and organizations. Place of Service codes are two-digit codes utilized on healthcare professional claims to indicate the setting in which the health care service was provided.	Inappropriate Place of Service for Urgent Care CPT/HCPCS.
05510	Inappropriate Place of Service for Home Service CPT/HCPCS	The CPT/HCPCS to Place of Service edit suite addresses billing an inappropriate Place of Service to specified CPT/HCPCS codes based on guidelines established by American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and other nationally recognized medical societies and organizations. Place of Service codes are two-digit codes utilized on healthcare professional claims to indicate the setting in which the health care service was provided.	Inappropriate Place of Service for Home Service CPT/HCPCS.
05511	Inappropriate Place of Service for Home Health CPT/HCPCS	The CPT/HCPCS to Place of Service edit suite addresses billing an inappropriate Place of Service to specified CPT/HCPCS codes based on guidelines established by American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and other nationally recognized medical societies and organizations. Place of Service codes are two-digit codes utilized on healthcare professional claims to indicate the setting in which the health care service was provided.	Inappropriate Place of Service for Home Health CPT/HCPCS.

05512	Inappropriate Place of Service for Newborn Care CPT/HCPCS	The CPT/HCPCS to Place of Service edit suite addresses billing an inappropriate Place of Service to specified CPT/HCPCS codes based on guidelines established by American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and other nationally recognized medical societies and organizations. Place of Service codes are two-digit codes utilized on healthcare professional claims to indicate the setting in which the health care service was provided.	Inappropriate Place of Service for Newborn Care CPT/HCPCS.
05513	Inappropriate Place of Service for Nursing Facility CPT/HCPCS	The CPT/HCPCS to Place of Service edit suite addresses billing an inappropriate Place of Service to specified CPT/HCPCS codes based on guidelines established by American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and other nationally recognized medical societies and organizations. Place of Service codes are two-digit codes utilized on healthcare professional claims to indicate the setting in which the health care service was provided.	Inappropriate Place of Service for Nursing Facility CPT/HCPCS.
05514	Inappropriate Place of Service for Office or Other Outpatient CPT/HCPCS	The CPT/HCPCS to Place of Service edit suite addresses billing an inappropriate Place of Service to specified CPT/HCPCS codes based on guidelines established by American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and other nationally recognized medical societies and organizations. Place of Service codes are two-digit codes utilized on healthcare professional claims to indicate the setting in which the health care service was provided.	Inappropriate Place of Service for Office or Other Outpatient CPT/HCPCS.
05517	Inappropriate Place of Service for Single Dialysis Services	Place of Service codes are two-digit codes utilized on healthcare professional claims to indicate the setting in which the health care service was provided and is a required claim field. This professional edit will look for billing an inappropriate Place of Service for single dialysis services codes 90935, 90937, 90945, 90947 based on guidelines established by American Medical Association (AMA), and Centers for Medicare and Medicaid Services (CMS).	Inappropriate Place of Service for Single Dialysis Services.
030	NCCI Comprehensive Component	The Medicare National Correct Coding Initiative was developed to prevent inappropriate payment of services that should not be reported together. Each edit table contains edits which are pairs of CPT codes and/or HCPCS codes that should not be reported together. Each edit has a Column I and a Column II HCPCS and/or CPT code. If a provider reports the two codes of an edit pair, the Column II code is denied and the Column I code is eligible for payment.	As per NCCI, not allowed separate payment with procedure {0}.
031	NCCI Mutually Exclusive	Mutually exclusive procedures/services are those that cannot be reasonably performed together during the same operative or patient session. According to guidelines from the Centers for Medicare and Medicaid Services (CMS) in the Medicare National Correct Coding Initiative edit table, if a provider bills for multiple services that are considered mutually exclusive, it will recommend allowing the procedure that has the lesser fee schedule amount. This logic is according to the policies established by CMS for the Medicare National Correct Coding Initiative mutually exclusive edits.	As per NCCI, mutually exclusive to procedure {0}.

U0101 (UB)	NCCI PTP	The National Correct Coding Initiative was developed to prevent inappropriate payment of services that should not be reported together. Each edit table contains edits which are pairs of CPT codes and/or HCPCS codes that should not be reported together. Each edit has a Column I and a Column II HCPCS and/or CPT code. If a facility reports the two codes of an edit pair, the Column II code is denied and the Column I code is eligible for payment.	As per NCCI, not allowed separate payment with procedure {0}.
033	Disallowed Multiple Procedures	Certain procedures cannot be performed on the same patient more than a specific number of times (amputation of the right arm twice), or a procedure cannot be billed after another has been performed (delivery after hysterectomy). This edit will also review for Medicare Unlikely Edits, which will monitor the number of units a provider bills per procedure code.	Too many procedures of this type billed.
033 (UB)	Disallowed Multiple Procedures	As per CMS's Medically Unlikely Edit (MUE), there is a max number of units, per beneficiary, per DOS that a provider may bill for. This edit will deny vs. allowing max number of units. This edit will target outpatient UB claims.	Too many procedures of this type billed.
004	Co / Team Surgeon Inappropriate	As per the guidelines from the Centers for Medicare & Medicaid Services, procedures that are not considered complex enough to warrant payment of a co-surgeon (modifier 62) or team surgery (modifier 66) or require a review of the operative report to determine medical necessity of either a co-surgeon or team surgery will be denied.	Co-Surgeon / Team Surgery inappropriate.
006	Assistant Surgeon Inappropriate	As per guidelines from the Centers for Medicare & Medicaid Services, procedures that do not warrant payment for an Assistant Surgeon (modifiers 80, 81, 82 or AS) or require a review of the operative report to determine medical necessity for an Assistant Surgeon.	Assistant surgery not appropriate.
00202	Experimental / Investigational Procedures	Some procedures are considered Experimental / Investigational (E/I) in that there is no clearly determined efficacy associated with them. Any physician/provider visits and/or consultations related to the procedure and billed within the global fee period will also be denied. There are 3 scenarios: 1. A procedure is considered E/I regardless of the diagnosis codes they are billed with. 2. A procedure is considered E/I unless it is billed with a specific qualifying diagnosis code. 3. A procedure is considered E/I when billed with a specific combination of other procedure or diagnosis codes.	Procedure is considered experimental.
00302	Cosmetic / Discretionary Procedures	Procedures, which are not performed to restore function or to improve the health status of an individual, are considered cosmetic or otherwise discretionary (C/D) by Centers for Medicare & Medicaid Services. The system reviews the record and scans history to determine whether the procedure is justified or not. Any physician/provider visits and/or consultations related to the procedure and billed within the global fee period will also be denied. There are 4 scenarios: 1. A procedure in and of itself is considered C/D regardless of the diagnosis codes billed. 2. A procedure is considered C/D unless it is billed with a specific qualifying diagnosis code. 3. A procedure is considered C/D unless it is billed after another procedure has been performed. 4. A procedure is considered C/D when billed with a specific diagnosis code.	Procedure is considered cosmetic or discretionary.

00801	Global Surgery (90 Day) - E/M Service Billed One Day Prior	The Centers for Medicare and Medicaid Services (CMS) define global period as having either “0”, “10” or “90” days. The CMS Global Surgery Package (GSP) suite of edits define time periods of which services or other procedures related to a primary surgical procedure and furnished by the same physician, are included in the payment of the primary surgery code. GSP identifies when evaluation and management services are included in the payment for the surgical code. Evaluation and Management (E&M) services subsequent to the decision for surgery on the day before or day of surgery and follow up care related to both diagnostic and therapeutic procedures, when performed by the same provider, are included in the global period and not separately reimbursed.	E/M Service Billed One Day Prior is Included in 90 Day Global Service.
R0801	Global Surgery (90 Day) - E/M Service Billed One Day Prior	The Centers for Medicare and Medicaid Services (CMS) define global period as having either “0”, “10” or “90” days. The CMS Global Surgery Package (GSP) suite of edits define time periods of which services or other procedures related to a primary surgical procedure and furnished by the same physician, are included in the payment of the primary surgery code. GSP identifies when evaluation and management services are included in the payment for the surgical code. Evaluation and Management (E&M) services subsequent to the decision for surgery on the day before or day of surgery and follow up care related to both diagnostic and therapeutic procedures, when performed by the same provider, are included in the global period and not separately reimbursed.	E/M Service Billed One Day Prior is Included in 90 Day Global Service.
00802	Global Surgery (90 Day) - E/M Service Billed on the Same Day	The Centers for Medicare and Medicaid Services (CMS) define global period as having either “0”, “10” or “90” days. The CMS Global Surgery Package (GSP) suite of edits define time periods of which services or other procedures related to a primary surgical procedure and furnished by the same physician, are included in the payment of the primary surgery code. GSP identifies when evaluation and management services are included in the payment for the surgical code. Evaluation and Management (E&M) services subsequent to the decision for surgery on the same day of surgery and follow up care related to both diagnostic and therapeutic procedures, when performed by the same provider, are included in the global period and not separately reimbursed.	E/M Service Billed on the Same Day is Included in 90 Day Global Service.

R0802	Global Surgery (90 Day) - E/M Service Billed on the Same Day	The Centers for Medicare and Medicaid Services (CMS) define global period as having either “0”, “10” or “90” days. The CMS Global Surgery Package (GSP) suite of edits define time periods of which services or other procedures related to a primary surgical procedure and furnished by the same physician, are included in the payment of the primary surgery code. GSP identifies when evaluation and management services are included in the payment for the surgical code. Evaluation and Management (E&M) services subsequent to the decision for surgery on the same day of surgery and follow up care related to both diagnostic and therapeutic procedures, when performed by the same provider, are included in the global period and not separately reimbursed.	E/M Service Billed on the Same Day is Included in 90 Day Global Service.
00803	Global Surgery (10 Day) - E/M Service Billed on the Same Day	The Centers for Medicare and Medicaid Services (CMS) define global period as having either “0”, “10” or “90” days. The CMS Global Surgery Package (GSP) suite of edits define time periods of which services or other procedures related to a primary surgical procedure and furnished by the same physician, are included in the payment of the primary surgery code. GSP identifies when evaluation and management services are included in the payment for the surgical code. Evaluation and Management (E&M) services subsequent to the decision for surgery on the same day of surgery and follow up care related to both diagnostic and therapeutic procedures, when performed by the same provider, are included in the global period and not separately reimbursed.	E/M Service Billed on the Same Day is Included in 10 Day Global Service.
R0803	Global Surgery (10 Day) - E/M Service Billed on the Same Day	The Centers for Medicare and Medicaid Services (CMS) define global period as having either “0”, “10” or “90” days. The CMS Global Surgery Package (GSP) suite of edits define time periods of which services or other procedures related to a primary surgical procedure and furnished by the same physician, are included in the payment of the primary surgery code. GSP identifies when evaluation and management services are included in the payment for the surgical code. Evaluation and Management (E&M) services subsequent to the decision for surgery on the same day of surgery and follow up care related to both diagnostic and therapeutic procedures, when performed by the same provider, are included in the global period and not separately reimbursed.	E/M Service Billed on the Same Day is Included in 10 Day Global Service.

00804	Global Surgery (0 Day) - E/M Service Billed on the Same Day	The Centers for Medicare and Medicaid Services (CMS) define global period as having either “0”, “10” or “90” days. The CMS Global Surgery Package (GSP) suite of edits define time periods of which services or other procedures related to a primary surgical procedure and furnished by the same physician, are included in the payment of the primary surgery code. GSP identifies when evaluation and management services are included in the payment for the surgical code. Evaluation and Management (E&M) services subsequent to the decision for surgery on the same day of surgery and follow up care related to both diagnostic and therapeutic procedures, when performed by the same provider, are included in the global period and not separately reimbursed	E/M Service Billed on the Same Day is Included in 0 Day Global Service.
R0804	Global Surgery (0 Day) - E/M Service Billed on the Same Day	The Centers for Medicare and Medicaid Services (CMS) define global period as having either “0”, “10” or “90” days. The CMS Global Surgery Package (GSP) suite of edits define time periods of which services or other procedures related to a primary surgical procedure and furnished by the same physician, are included in the payment of the primary surgery code. GSP identifies when evaluation and management services are included in the payment for the surgical code. Evaluation and Management (E&M) services subsequent to the decision for surgery on the same day of surgery and follow up care related to both diagnostic and therapeutic procedures, when performed by the same provider, are included in the global period and not separately reimbursed	E/M Service Billed on the Same Day is Included in 0 Day Global Service.
00805	Global Surgery (90 Day: Postop) - E/M Service Billed During Postop	The Centers for Medicare and Medicaid Services (CMS) define global period as having either “0”, “10” or “90” days. The CMS Global Surgery Package (GSP) suite of edits define time periods of which services or other procedures related to a primary surgical procedure and furnished by the same physician, are included in the payment of the primary surgery code. GSP identifies when evaluation and management services are included in the payment for the surgical code. Evaluation and Management (E&M) services subsequent to the decision for surgery on the day before or day of surgery and follow up care related to both diagnostic and therapeutic procedures, when performed by the same provider, are included in the global period and not separately reimbursed.	E/M Service Billed During Postop Included in 90 Day Global Service.

R0805	Global Surgery (90 Day: Postop) - E/M Service Billed During Postop	The Centers for Medicare and Medicaid Services (CMS) define global period as having either “0”, “10” or “90” days. The CMS Global Surgery Package (GSP) suite of edits define time periods of which services or other procedures related to a primary surgical procedure and furnished by the same physician, are included in the payment of the primary surgery code. GSP identifies when evaluation and management services are included in the payment for the surgical code. Evaluation and Management (E&M) services subsequent to the decision for surgery on the day before or day of surgery and follow up care related to both diagnostic and therapeutic procedures, when performed by the same provider, are included in the global period and not separately reimbursed.	E/M Service Billed During Postop Included in 90 Day Global Service.
00806	Global Surgery (10 Day: Postop) - E/M Service Billed During Postop	The Centers for Medicare and Medicaid Services (CMS) define global period as having either “0”, “10” or “90” days. The CMS Global Surgery Package (GSP) suite of edits define time periods of which services or other procedures related to a primary surgical procedure and furnished by the same physician, are included in the payment of the primary surgery code. GSP identifies when evaluation and management services are included in the payment for the surgical code. Evaluation and Management (E&M) services subsequent to the decision for surgery on the day before or day of surgery and follow up care related to both diagnostic and therapeutic procedures, when performed by the same provider, are included in the global period and not separately reimbursed.	E/M Service Billed During Postop Included in 10 Day Global Service.
R0806	Global Surgery (10 Day: Postop) - E/M Service Billed During Postop	The Centers for Medicare and Medicaid Services (CMS) define global period as having either “0”, “10” or “90” days. The CMS Global Surgery Package (GSP) suite of edits define time periods of which services or other procedures related to a primary surgical procedure and furnished by the same physician, are included in the payment of the primary surgery code. GSP identifies when evaluation and management services are included in the payment for the surgical code. Evaluation and Management (E&M) services subsequent to the decision for surgery on the day before or day of surgery and follow up care related to both diagnostic and therapeutic procedures, when performed by the same provider, are included in the global period and not separately reimbursed.	E/M Service Billed During Postop Included in 10 Day Global Service.
00807	Global Surgery (90 Day:Postop) - Secondary Procedure Billed During 90 day Postop.	The Centers for Medicare and Medicaid Services (CMS) define global period as having either “0”, “10” or “90” days. The CMS Global Surgery Package (GSP) suite of edits define time periods of which services or other procedures related to a primary surgical procedure and furnished by the same physician, are included in the payment of the primary surgery code. Secondary procedures with a 0-, 10-, or 90-day global period are considered included in the global surgical package of a 10- or 90-day primary procedure when billed by the same provider unless modifiers 58, 78, or 79 are appended.	E/M Service Billed During Primary Included in 90 Day Global Service.

R0807	Global Surgery (90 Day:Postop) - Secondary Procedure Billed During 90 day Postop.	The Centers for Medicare and Medicaid Services (CMS) define global period as having either “0”, “10” or “90” days. The CMS Global Surgery Package (GSP) suite of edits define time periods of which services or other procedures related to a primary surgical procedure and furnished by the same physician, are included in the payment of the primary surgery code. Secondary procedures with a 0-, 10-, or 90-day global period are considered included in the global surgical package of a 10- or 90-day primary procedure when billed by the same provider unless modifiers 58, 78, or 79 are appended.	E/M Service Billed During Primary Included in 90 Day Global Service.
00808	Global Surgery (10 Day:Postop) - Secondary Procedure Billed During 10 day Postop.	The Centers for Medicare and Medicaid Services (CMS) define global period as having either “0”, “10” or “90” days. The CMS Global Surgery Package (GSP) suite of edits define time periods of which services or other procedures related to a primary surgical procedure and furnished by the same physician, are included in the payment of the primary surgery code. Secondary procedures with a 0-, 10-, or 90-day global period are considered included in the global surgical package of a 10- or 90-day primary procedure when billed by the same provider unless modifiers 58, 78, or 79 are appended.	E/M Service Billed During Primary Included in 10 Day Global Service.
R0808	Global Surgery (10 Day:Postop) - Secondary Procedure Billed During 10 day Postop.	The Centers for Medicare and Medicaid Services (CMS) define global period as having either “0”, “10” or “90” days. The CMS Global Surgery Package (GSP) suite of edits define time periods of which services or other procedures related to a primary surgical procedure and furnished by the same physician, are included in the payment of the primary surgery code. Secondary procedures with a 0-, 10-, or 90-day global period are considered included in the global surgical package of a 10- or 90-day primary procedure when billed by the same provider unless modifiers 58, 78, or 79 are appended.	E/M Service Billed During Primary Included in 10 Day Global Service.
020	Medical Protocol	This edit incorporates standards and guidelines to identify deviations from protocol as set forth by various professional colleges and societies. The system takes into account the current diagnosis of the patient, as well as past diagnoses and procedures, in order to determine if the procedure is justified, medically necessary and/or improves the function or quality of life.	Not within medical protocol. Dx does not qualify proc or freq of proc.
020AM	Medical Protocol-Ambulance	As per guidelines from the Centers for Medicare & Medicaid Services, the diagnosis code does not qualify for the medical necessity of an ambulance transport. Any incidentals billed in conjunction with transport will also be denied.	Ambulance charge denied due to lack of medical necessity.
02004	Procedure Frequency	This edit will detect claims received for drug screenings, billed over a specified annual limit.	Exceeds clinical guidelines.
02004 (UB)	Procedure Frequency	This edit will detect claims received for drug screenings, billed over a specified annual limit. Similar to 020-04 however this edit targets outpatient UB claims only.	Exceeds clinical guidelines.

041	Procedure - Diagnosis Incompatibility	This edit will fire due to one of 2 scenarios: 1. Correct procedure code, incorrect diagnosis code. 2. Correct diagnosis code, incorrect procedure code. In either of the above scenarios, medical records will need to be reviewed in order to determine what would be approved for payment. CMI: This edit targets procedures billed for Carpal Tunnel, Morton's Neuroma or Intra-articular injections with a non-payable diagnosis. RXSC: This edit targets procedures billed for drug screenings with a non-payable diagnosis. VSDXH: This edit targets procedures billed for vascular studies with a non-payable diagnosis.	Procedure not compatible with diagnosis.
041 (UB)	Procedure - Diagnosis Incompatibility	This edit will fire due to one of 2 scenarios: 1. Correct procedure code, incorrect diagnosis code. 2. Correct diagnosis code, incorrect procedure code. In either of the above scenarios, medical records will need to be reviewed in order to determine what would be approved for payment. CMI (UB): This edit targets procedures billed for Carpal Tunnel, Morton's Neuroma or Intra-articular injections with a non-payable diagnosis. Similar to 041 (CMI) however this edit targets outpatient UB claims only. RXSC (UB): This edit targets procedures billed for drug screenings with a non-payable diagnosis. Similar to 041 (RXSC) however this edit targets outpatient UB claims only. VSDXH (UB): This edit targets procedures billed for vascular studies with a non-payable diagnosis. Similar to 041 (VSDXH) however this edit targets outpatient UB claims on	Procedure not compatible with diagnosis.
04601	Procedure - DME Diagnosis Incompatibility	This edit targets DME claims where there are inappropriate diagnosis and procedure code combinations at the header level.	Procedure not compatible with diagnosis.
04602	DME Non-Covered Procedure/Service	As the Centers for Medicare & Medicaid Services, these are deemed a non-covered procedure/service, either by definition of the code or guideline.	Non-covered DME service/supply.
04603	DME Place of Service	If any of the designated DME procedures are billed without one of the designated Place of Service codes, the edit will be applied.	Procedure inconsistent with the place of service.
04604	DME Required Modifiers	If any of the designated DME procedures are billed without one of the designated modifiers, the edit will be applied.	Procedure inconsistent with the modifier used or a required modifier is missing.
04605	DME Rental Period	If any of the designated DME procedures are billed longer than the rental period, the edit will be applied.	Billing exceeds the rental period.
04606	DME Procedure Frequency	If any of the designated DME procedures are billed more than the number of times allowed within a specified time period, the edit will apply.	Exceeds number/frequency allowed within time period.
04608	DME Requires Additional Modifier	CMS Local Coverage Determination (LCD) and Local Coverage Article's (LCA) require two separate modifiers for a claim line where specific DME codes are billed.	DME Requires Additional Modifier.

04701	Telehealth	When a telehealth modifier is billed with a CPT that is not in the list of Telehealth Services, then deny the line.	Inappropriate Use of Modifier.
04702	Telehealth	When a telehealth POS is billed with a procedure code that is not in the list of Telehealth Services, then deny the line.	Procedure inconsistent with the place of service.
04703	Telehealth	When a procedure code that is in the list of Telehealth Services is billed with a telehealth POS, but without a required telehealth modifier, then deny the line.	Missing required modifier.
04704	Telehealth	When a procedure code that is in the list of Telehealth Services is billed with a required telehealth modifier, but without a telehealth POS, then deny the line.	Inappropriate or invalid Place of Service.
04705	Telehealth	When processing a telephone service, if the telephone service is billed within 7 days of an E/M service, then deny the telephone service. When processing an E/M service, if the telephone service is billed within 7 days of an E/M service, then reduce the E/M service by the amount of the telephone service. (Cap at zero so we are not suggesting a negative paid amount).	Telephone Service Billed Within 7 Days After EM is Included in EM Service.
04706	Telehealth	When processing a telephone service, if the telephone service is billed within 1 day prior to an E/M service, then deny the telephone service. When processing an E/M service, if the telephone service is billed within 1 day prior to an E/M service, then reduce the E/M service by the amount of the telephone service. (Cap at zero so we are not suggesting a negative paid amount).	Telephone Service Billed Within 1 Day Before EM is Included in EM Service.
04707 (UB)	Telehealth	As per the Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners; 190.5 - Originating Site Facility Fee Payment Methodology, Q3014 submitted claim with Type of Bill (TOB) 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, or 85X is payable in a facility (UB form).	Q3014 was submitted with an inappropriate type of bill.
04708 (UB)	Telehealth	As per the Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners; 190.5 - Originating Site Facility Fee Payment Methodology, Q3014 submitted claim with Type of Bill (TOB) 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, or 85X is payable in a facility (UB form). All Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) must use revenue code 078X when billing for the originating site facility fee.	Q3014 was Submitted with an Inappropriate Revenue Code.
04709	Inappropriate Use of Audio-Only Telehealth/Telemedicine Modifier 93	Modifier 93 (telehealth modifier) is not appropriate to appended to a procedure code that is not eligible for audio-only telehealth.	Inappropriate Use of Modifier.
04710	Inappropriate Use of Audio-Only Telehealth Modifier FQ	Modifiers give additional information about the procedure or service on a claim. The audio-only telehealth modifier is not appropriate for use with the CPT/HCPCS code billed.	Inappropriate Use of Modifier.
04801	Genetic Testing	Some procedures are considered investigational in that there is no clearly determined efficacy associated with them. There are 3 scenarios: 1. A procedure is considered investigational regardless of the diagnosis codes it is billed with. 2. A procedure is considered investigational unless it is billed with a specific qualifying diagnosis code. 3. A procedure is considered investigational when billed with a specific combination of other procedure or diagnosis codes.	Genetic test is considered investigational.

04802	Genetic Testing	This edit identifies specific procedures that are inappropriate for a patient's age based on current guidelines from professional societies and/or evidence from published literature.	Genetic test is inconsistent with the patient's age.
04803	Genetic Testing	As per International Classification of Diseases (ICD)-10 Manual guidelines, incomplete diagnosis codes are only to be used in the event that there is not a more specific diagnosis code available. Oftentimes a specific diagnosis code is required to determine the appropriateness of a procedure.	Incomplete diagnosis code.
04804	Genetic Testing	Based on the Centers for Medicare & Medicaid Services National Correct Coding Initiative (NCCI) and the American Medical Association Current Procedural Terminology (CPT®) publications, certain procedures are unlikely or inappropriate to be billed more than a certain number of units per claim line or per date of service. This edit will review for unlikely procedures or procedures where the units of service are restricted, which will monitor the number of units a provider bills per procedure code. There are 3 scenarios: The CPT/HCPCS code exceeds the maximum number of units identified as billable by a provider on a single date of service per specimen for a member. The CPT/HCPCS code exceeds the maximum number of units identified as billable by a provider on a single date of service for a member. The CPT/HCPCS code exceeds the maximum number of units identified as billable by a provider for the lifetime of a single member.	Too many procedures of this type billed.
04805	Genetic Testing	Per the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA), Healthcare Common Procedure Coding System (HCPCS) codes are utilized to report services performed on patients. HCPCS codes consist of Level I Current Procedural Terminology (CPT) codes and Level II HCPCS codes. CPT codes are defined within the AMA CPT Manual which is updated and published annually; HCPCS Level II codes are defined by CMS and are updated throughout the year as necessary. The annual and quarterly updated files consist of new, deleted and revised codes.	Genetic procedure code has been deleted.
04806	Genetic Testing	Based on the American Medical Association Current Procedural Terminology (CPT®) publications, certain procedure codes are assigned to represent specific tests or algorithms proprietary to specific providers. This edit will review for proprietary procedure codes billed by laboratories who are not known to provide the proprietary genetic test or algorithm billed.	Procedure code restricted for proprietary tests or algorithms.
04807	Genetic Testing	Per the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA), procedures should be billed with the most comprehensive CPT/HCPCS code available. Genetic tests which represent a panel test should be billed with the appropriate panel CPT/HCPCS code rather than with unbundled codes representing component services. This edit will review for claims billed with unbundled codes when a panel code exists.	Unstacked procedure code(s) billed when panel code exists.
04809	Genetic Testing	This edit identifies procedure-diagnosis incompatibility that may occur because the procedures or services are not appropriate for a member’s diagnosis based on industry standard guidelines and/or evidence from published literature.	Genetic test is incompatible with the diagnosis provided.

04901	Therapy	Per CMS, “Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively. Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered: GN Services delivered under an outpatient speech-language pathology plan of care; GO Services delivered under an outpatient occupational therapy plan of care; or, GP Services delivered under an outpatient physical therapy plan of care. Because the GN, GO, GP therapy modifier is specific to the SLP, OT, PT plan of care, respectively, only one of these modifiers is allowed.	Therapy code was received with more than one therapy modifier.
04901 (UB)	Therapy	Per CMS, “Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively. Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered: GN Services delivered under an outpatient speech-language pathology plan of care; GO Services delivered under an outpatient occupational therapy plan of care; or, GP Services delivered under an outpatient physical therapy plan of care. Because the GN, GO, GP therapy modifier is specific to the SLP, OT, PT plan of care, respectively, only one of these modifiers is allowed.	Therapy code was received with more than one therapy modifier.
04902	Therapy	Per CMS, “Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively. Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy. Modifiers GN, GO, and GP refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. They should never be used with codes that are not on the list of applicable therapy services. For example, respiratory therapy services, or nutrition therapy services shall not be represented by therapy codes which require GN, GO, and GP modifiers.” CMS payment policies related to the use of CQ and CO modifier on applicable claims for PT and OT services when those services are furnished in whole or in part by PTAs and OTAs: The CQ modifier is paired to the GP therapy modifier and the CO modifier is paired with the GO therapy modifier, and claims not so paired are rejected/returned as unprocessable.	Assistant therapy code requires additional modifier.

04902 (UB)	Therapy	Per CMS, “Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively. Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy. Modifiers GN, GO, and GP refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. They should never be used with codes that are not on the list of applicable therapy services. For example, respiratory therapy services, or nutrition therapy services shall not be represented by therapy codes which require GN, GO, and GP modifiers.” CMS payment policies related to the use of CQ and CO modifier on applicable claims for PT and OT services when those services are furnished in whole or in part by PTAs and OTAs: The CQ modifier is paired to the GP therapy modifier and the CO modifier is paired with the GO therapy modifier, and claims not so paired are rejected/returned as unprocessable.	Assistant therapy code requires additional modifier.
04903	Therapy	Per CMS, “Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively. Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy. Modifiers GN, GO, and GP refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. They should never be used with codes that are not on the list of applicable therapy services. For example, respiratory therapy services, or nutrition therapy services shall not be represented by therapy codes which require GN, GO, and GP modifiers.” CMS payment policies related to the use of CQ and CO modifier on applicable claims for PT and OT services when those services are furnished in whole or in part by PTAs and OTAs: The CQ modifier is paired to the GP therapy modifier and the CO modifier is paired with the GO therapy modifier, and claims not so paired are rejected/returned as unprocessable.	Assistant therapy code requires additional modifier.
04903 (UB)	Therapy	Per CMS, “Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively. Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy. Modifiers GN, GO, and GP refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. They should never be used with codes that are not on the list of applicable therapy services. For example, respiratory therapy services, or nutrition therapy services shall not be represented by therapy codes which require GN, GO, and GP modifiers.” CMS payment policies related to the use of CQ and CO modifier on applicable claims for PT and OT services when those services are furnished in whole or in part by PTAs and OTAs: The CQ modifier is paired to the GP therapy modifier and the CO modifier is paired with the GO therapy modifier, and claims not so paired are rejected/returned as unprocessable.	Assistant therapy code requires additional modifier.

04904	Therapy	Per CMS, “Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively. Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered: GN Services delivered under an outpatient speech-language pathology plan of care; GO Services delivered under an outpatient occupational therapy plan of care; or, GP Services delivered under an outpatient physical therapy plan of care. On professional claims, each code designated as “always therapy” must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them; and, as such, must always be accompanied by one of the therapy modifiers.	Always therapy code missing required modifier
04904 (UB)	Therapy	Per CMS, “Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively. Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered: GN Services delivered under an outpatient speech-language pathology plan of care; GO Services delivered under an outpatient occupational therapy plan of care; or, GP Services delivered under an outpatient physical therapy plan of care. Institutional (facility) claims should ensure the following: GN, GO or GP modifier is present for all lines reporting revenue codes 042X, 043X, or 044X. No more than one GN, GO or GP modifier is reported on the same service line. Revenue codes and modifiers are reported only in the following combinations: Revenue code 42x (physical therapy) lines may only contain modifier GP Revenue code 43x (occupational therapy) lines may only contain modifier GO Revenue code 44x (speech-language pathology) lines may only contain modifier GN	Always therapy code missing required modifier

04905	Therapy	Per CMS, “Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively. Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered: GN Services delivered under an outpatient speech-language pathology plan of care; GO Services delivered under an outpatient occupational therapy plan of care; or, GP Services delivered under an outpatient physical therapy plan of care. On professional claims, each code designated as “always therapy” must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them; and, as such, must always be accompanied by one of the therapy modifiers. In addition, several “always therapy” codes have been identified as discipline specific.	Always ST code missing required modifier
04906	Therapy	Per CMS, “Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively. Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered: GN Services delivered under an outpatient speech-language pathology plan of care; GO Services delivered under an outpatient occupational therapy plan of care; or, GP Services delivered under an outpatient physical therapy plan of care. On professional claims, each code designated as “always therapy” must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them; and, as such, must always be accompanied by one of the therapy modifiers. In addition, several “always therapy” codes have been identified as discipline specific.	Always OT code missing required modifier
04907	Therapy	Per CMS, “Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively. Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered: GN Services delivered under an outpatient speech-language pathology plan of care; GO Services delivered under an outpatient occupational therapy plan of care; or, GP Services delivered under an outpatient physical therapy plan of care. On professional claims, each code designated as “always therapy” must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them; and, as such, must always be accompanied by one of the therapy modifiers. In addition, several “always therapy” codes have been identified as discipline specific.	Always PT code missing required modifier.

04908 (UB)	Therapy	Per CMS, “Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively. Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered: • GN Services delivered under an outpatient speech-language pathology plan of care; • GO Services delivered under an outpatient occupational therapy plan of care; or, • GP Services delivered under an outpatient physical therapy plan of care. Institutional (facility) claims should ensure the following: • GN, GO or GP modifier is present for all lines reporting revenue codes 042X, 043X, or 044X. • No more than one GN, GO or GP modifier is reported on the same service line. • Revenue codes and modifiers are reported only in the following combinations: • Revenue code 42x (physical therapy) lines may only contain modifier GP • Revenue code 43x (occupational therapy) lines may only contain modifier GO • Revenue code 44x (speech-language pathology) lines may only contain modifier GN.	Always therapy rev code with inappropriate modifier pairing.
04909 (UB)	Therapy	Per CMS, “Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively. Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered: • GN Services delivered under an outpatient speech-language pathology plan of care; • GO Services delivered under an outpatient occupational therapy plan of care; or, • GP Services delivered under an outpatient physical therapy plan of care. On professional claims, each code designated as “always therapy” must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them; and, as such, must always be accompanied by one of the therapy modifiers. In addition, several “always therapy” codes have been identified as discipline specific. Institutional (facility) claims should ensure the following: • GN, GO or GP modifier is present for all lines reporting revenue codes 042X, 043X, or 044X. • No more than one GN, GO or GP modifier is reported on the same service line. • Revenue codes and modifiers are reported only in the following combinations: • Revenue code 42x (physical therapy) lines may only contain modifier GP • Revenue code 43x (occupational therapy) lines may only contain modifier GO	Always ST code with inappropriate modifier/REV code pairing.

04910 (UB)	Therapy	Per CMS, “Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively. Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered: • GN Services delivered under an outpatient speech-language pathology plan of care; • GO Services delivered under an outpatient occupational therapy plan of care; or, • GP Services delivered under an outpatient physical therapy plan of care. On professional claims, each code designated as “always therapy” must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them; and, as such, must always be accompanied by one of the therapy modifiers. In addition, several “always therapy” codes have been identified as discipline specific. Institutional (facility) claims should ensure the following: • GN, GO or GP modifier is present for all lines reporting revenue codes 042X, 043X, or 044X. • No more than one GN, GO or GP modifier is reported on the same service line. • Revenue codes and modifiers are reported only in the following combinations: • Revenue code 42x (physical therapy) lines may only contain modifier GP • Revenue code 43x (occupational therapy) lines may only contain modifier GO	Always OT code with inappropriate modifier/REV code pairing.
04911 (UB)	Therapy	Per CMS, “Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively. Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered: • GN Services delivered under an outpatient speech-language pathology plan of care; • GO Services delivered under an outpatient occupational therapy plan of care; or, • GP Services delivered under an outpatient physical therapy plan of care. On professional claims, each code designated as “always therapy” must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them; and, as such, must always be accompanied by one of the therapy modifiers. In addition, several “always therapy” codes have been identified as discipline specific. Institutional (facility) claims should ensure the following: • GN, GO or GP modifier is present for all lines reporting revenue codes 042X, 043X, or 044X. • No more than one GN, GO or GP modifier is reported on the same service line. • Revenue codes and modifiers are reported only in the following combinations: • Revenue code 42x (physical therapy) lines may only contain modifier GP • Revenue code 43x (occupational therapy) lines may only contain	Always PT code with inappropriate modifier/REV code pairing
04912 (UB)	Therapy	Per CMS, “Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under a SLP, OT, or PT plan of care, respectively. Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy.	Sometimes therapy modifier and REV code pairing is missing or inappropriate.

05801	Drug Waste	Modifier JW is used on a claim line to indicate that a drug or biologic has been discarded or not administered to a patient. If a provider submits a claim for drug waste with a JW Modifier, there should be a corresponding claim line for the drug code without the JW modifier. If there is no corresponding claim line without a JW Modifier, the edit will deny the claim line with the JW Modifier.	Drug Waste Billed Without Identical HCPCS Code.
05801 (UB)	Drug Waste	Modifier JW is used on a claim line to indicate that a drug or biologic has been discarded or not administered to a patient. If a provider submits a claim for drug waste with a JW Modifier, there should be a corresponding claim line for the drug code without the JW modifier. If there is no corresponding claim line without a JW Modifier, the edit will deny the claim line with the JW Modifier.	Drug Waste Billed Without Identical HCPCS Code.
05802	Drug Waste	Modifier JW is used on a claim line to indicate that a drug or biologic has been discarded or not administered to a patient. This edit will look for the original administration drug code and the billing of the same code with the JW Modifier. When the original administration of the same drug is either missing or denied, the claim line with the JW modifier will be denied.	Drug Waste Billed and HCPCS Code for Amount Administered Not Payable.
05802 (UB)	Drug Waste	Modifier JW is used on a claim line to indicate that a drug or biologic has been discarded or not administered to a patient. This edit will look for the original administration drug code and the billing of the same code with the JW Modifier. When the original administration of the same drug is either missing or denied, the claim line with the JW modifier will be denied.	Drug Waste Billed and HCPCS Code for Amount Administered Not Payable.
05803	Drug Waste	The Centers for Medicare and Medicaid Services (CMS) requires providers and suppliers to include a JW modifier and the corresponding units wasted on all claims where drug waste occurs. Per the U.S. Food and Drug Administration (FDA) and CMS policy, certain drugs do not warrant any waste due to the approved dosage, drug form, and/or preparation requirements. Any of these specific drugs billed with a JW modifier will be denied reimbursement for all corresponding drug wastage lines.	Inappropriate Drug Waste Submitted for Drug or Biological.
05804 (UB)	Drug Waste	The Centers for Medicare and Medicaid Services (CMS) requires providers and suppliers to include a JW modifier and the corresponding units wasted on all claims where drug waste occurs. Per the U.S. Food and Drug Administration (FDA) and CMS policy, certain drugs do not warrant any waste due to the approved dosage, drug form, and/or preparation requirements. Any of these specific drugs billed with a JW modifier will be denied reimbursement for all corresponding drug wastage lines.	Inappropriate Drug Waste Submitted for Drug or Biological.
00504	Bundled Procedures	Procedure codes with a Status indicator of 'B' by the Centers for Medicare & Medicaid Services (CMS) are not eligible for reimbursement, even when billed alone, and will be denied. These codes are always considered an integral part of some other service. Additionally, procedure codes with a Status indicator of 'T' by CMS will be denied if they are billed in conjunction with a qualifying charge, on the same DOS, by the same provider. Lastly, Ambulatory Surgery Center charges will be denied for those that are assigned an indicator of 'N1' by CMS.	Incidental to proc/svc and is bundled, no separate payment warranted.
00507	Bundled Procedures	On any ASC classified claims, per OPPS/ASC Final Rule, a Revenue Code billed with no corresponding CPT code is deemed not separately payable.	Packaged item/service, separate payment not allowed.
013	Physician Visit Frequency	Based on Medicare part B guidance and industry standards, a provider may see the same patient more than once on the same day. However, this does not mean that payment is allowed for every visit. This edit looks for visits with related diagnoses billed on the same day of service. Any record without a listed diagnosis, or with a blank diagnosis, will be considered related to all diagnosis listed for a member. Only the primary and secondary diagnosis codes are reviewed. Exceptions occur when a physician bills for multiple unrelated diagnosis visits on the same day of service.	Other office visit ({0}) on same service date.

05001	NCCI Modifier Review	The American Medical Association (AMA) defines Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Level II codes for medical and surgical procedures performed on patients. Additionally, the AMA defines modifiers that may be appended to HCPCS/CPT codes to provide additional information about the services rendered. CPT/HCPCS codes that are deemed bundled must be supported by an appropriately applied modifier. Per AMA and CPT guidelines, Modifier 25 should be applied when a Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Professional on the Same Day of the Procedure or Other Service when an E/M service occurs at the same time as another minor procedure or service. Any E/M service separately reported must be “above and beyond” the minimal evaluation and management normally included in a procedure or other service.	As per NCCI, Inappropriate Use of Modifier.
05001 (UB)	NCCI Modifier Review	The American Medical Association (AMA) defines Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Level II codes for medical and surgical procedures performed on patients. Additionally, the AMA defines modifiers that may be appended to HCPCS/CPT codes to provide additional information about the services rendered. CPT/HCPCS codes that are deemed bundled must be supported by an appropriately applied modifier. Per AMA and CPT guidelines, Modifier 25 should be applied when a Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Professional on the Same Day of the Procedure or Other Service when an E/M service occurs at the same time as another minor procedure or service. Any E/M service separately reported must be “above and beyond” the minimal evaluation and management normally included in a procedure or other service.	As per NCCI,Inappropriate Use of Modifier.
05002	NCCI Modifier Review	The American Medical Association (AMA) defines Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Level II codes for medical and surgical procedures performed on patients. Additionally, the AMA defines modifiers that may be appended to HCPCS/CPT codes to provide additional information about the services rendered. CPT/HCPCS codes that are deemed bundled must be supported by an appropriately applied modifier. Modifier 59 should be applied for a Distinct Procedure Service to identify procedures that are distinctly separate from any other procedure provided on the same date of service by the same provider.	As per NCCI,Inappropriate Use of Modifier.
05002 (UB)	NCCI Modifier Review	The American Medical Association (AMA) defines Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Level II codes for medical and surgical procedures performed on patients. Additionally, the AMA defines modifiers that may be appended to HCPCS/CPT codes to provide additional information about the services rendered. CPT/HCPCS codes that are deemed bundled must be supported by an appropriately applied modifier. Modifier 59 should be applied for a Distinct Procedure Service to identify procedures that are distinctly separate from any other procedure provided on the same date of service by the same provider.	As per NCCI,Inappropriate Use of Modifier.

05701	Professional Component (PC)/Technical Component (TC) Indicator	Centers for Medicare and Medicaid Services (CMS) PC/TC indicators are set forth under the Medicare Physician Fee Schedule (MPFS) to distinguish whether a CPT or HCPCS code is eligible for separate professional and/or technical reimbursement. The Professional Component (PC)/Technical Component (TC) Indicator suite of edits will address professional, technical, and global services billed inappropriately. When the provider renders the professional component or PC portion of a service only, the CPT/HCPCS code is appended with modifier 26. Modifier 26 is allowed with CPT/HCPCS represented by PC/TC indicators 1, 6, or 8 only per the CMS Medicare Physician Fee Schedule.	Inappropriate CPT/HCPCS Billed with Modifier 26 for Professional Component.
05702	Professional Component (PC)/Technical Component (TC) Indicator	Centers for Medicare and Medicaid Services (CMS) PC/TC indicators are set forth under the Medicare Physician Fee Schedule (MPFS) to distinguish whether a CPT or HCPCS code is eligible for separate professional and/or technical reimbursement. The Professional Component (PC)/Technical Component (TC) Indicator suite of edits will address professional, technical, and global services billed inappropriately. When the provider renders the technical component or TC portion of a service only, the CPT/HCPCS code is appended with modifier TC. Modifier TC is allowed with CPT/HCPCS represented by PC/TC indicator 1 only per the CMS Medicare Physician Fee Schedule.	Inappropriate CPT/HCPCS Billed with Modifier TC for Technical Component.
05703	Professional Component (PC)/Technical Component (TC) Indicator	Centers for Medicare and Medicaid Services (CMS) PC/TC indicators are set forth under the Medicare Physician Fee Schedule (MPFS) to distinguish whether a CPT or HCPCS code is eligible for separate professional and/or technical reimbursement. The Professional Component (PC)/Technical Component (TC) Indicator suite of edits will address professional, technical, and global services billed inappropriately. PC/TC Indicator 8 CPT/HCPCS codes are only allowed to be performed in a hospital inpatient setting (Place of Service 21) per the CMS Medicare Physician Fee Schedule.	Inappropriate Place of Service for CPT/HCPCS with PC/TC Indicator 8.
05704	Professional Component (PC)/Technical Component (TC) Indicator	Centers for Medicare and Medicaid Services (CMS) PC/TC indicators are set forth under the Medicare Physician Fee Schedule (MPFS) to distinguish whether a CPT or HCPCS code is eligible for separate professional and/or technical reimbursement. The Professional Component (PC)/Technical Component (TC) Indicator suite of edits will address professional, technical, and global services billed inappropriately.	Professional and/or Technical Component Billed with Global Service.
05705	Professional Component (PC)/Technical Component (TC) Indicator	Centers for Medicare and Medicaid Services (CMS) PC/TC indicators are set forth under the Medicare Physician Fee Schedule (MPFS) to distinguish whether a CPT or HCPCS code is eligible for separate professional and/or technical reimbursement. The Professional Component (PC)/Technical Component (TC) Indicator suite of edits will address professional, technical, and global services billed inappropriately.	CPT/HCPCS Professional and Technical Component Billed and Requires the Global Service.
05706	Professional Component (PC)/Technical Component (TC) Indicator	Centers for Medicare and Medicaid Services (CMS) PC/TC indicators are set forth under the Medicare Physician Fee Schedule (MPFS) to distinguish whether a CPT or HCPCS code is eligible for separate professional and/or technical reimbursement. The Professional Component (PC)/Technical Component (TC) Indicator suite of edits will address professional, technical, and global services billed inappropriately.	Inappropriate Global Service Billed in a Hospital Setting.
05707	Professional Component (PC)/Technical Component (TC) Indicator	Centers for Medicare and Medicaid Services (CMS) PC/TC indicators are set forth under the Medicare Physician Fee Schedule (MPFS) to distinguish whether a CPT or HCPCS code is eligible for separate professional and/or technical reimbursement. The Professional Component (PC)/Technical Component (TC) Indicator suite of edits will address professional, technical, and global services billed inappropriately.	Inappropriate Technical Component Billed in a Hospital Setting.

07401	Billed Charges Inconsistent with Zero Units of Service	This edit considers claim lines with charges that are inconsistent with the zero units reported. The edit applies a recommendation to deny when a claim line is submitted with zero Units of Service, and with Charges and Allowed Amount greater than $0.00.	Billed Charges Inconsistent with Zero Units of Service.
07402 (UB)	Billed Charges Inconsistent with Zero Units of Service	This edit considers claim lines with charges that are inconsistent with the zero units reported. The edit applies a recommendation to deny when a CPT/HCPCS procedure code is submitted with zero Units of Service, and with Charges and Allowed Amount greater than $0.00.	Billed Charges Inconsistent with Zero Units of Service.
07501	Inpatient Only Service Billed with Inappropriate Place of Service	There is guidance from the Centers for Medicare and Medicaid Services (CMS) that defines services for which payment under the Outpatient Prospective Payment System (OPPS) is appropriate. Services designated as “inpatient only” are not appropriate to be furnished in an outpatient setting and are not paid under the CMS Outpatient Prospective Payment System (OPPS). The “inpatient only” code list is included in the CMS Outpatient Prospective Payment System (OPPS) Addendum B, with a Status Indicator (SI) C. Status Indicator C indicates they are “Inpatient Procedures Not paid under OPPS”. This edit will fire when a service code from CMS OPPS Addendum B with a Status Indicator of C=Inpatient Only is billed and the Place of Service is 19 (Off-Campus Outpatient Hospital) or 22 (On Campus Outpatient Hospital) AND modifier CA is not submitted on the claim line.	Inpatient Only CPT/HCPCS Billed with Inappropriate POS.
08101	Not Otherwise Classified Code on Professional Claim	Non-specific procedure codes include descriptors such as, Not Otherwise Classified (NOC), Unlisted, Unspecified, Unclassified, Other, or Miscellaneous. Billing a non-specific procedure code requires a description or documentation of the service, per Health Insurance Portability and Accountability Act (HIPAA) guidelines. The Centers for Medicare and Medicaid Services (CMS) publishes a list of NOC HCPCS codes. If an NOC code is billed, the logic within this edit will deny the claim line.	HCPCS Code Submitted is Not Otherwise Classified.
08102 (UB)	Not Otherwise Classified Code on Facility Claim	Non-specific procedure codes include descriptors such as, Not Otherwise Classified (NOC), Unlisted, Unspecified, Unclassified, Other, or Miscellaneous. Billing a non-specific procedure code requires a description or documentation of the service, per Health Insurance Portability and Accountability Act (HIPAA) guidelines. The Centers for Medicare and Medicaid Services (CMS) publishes a list of NOC HCPCS codes. If an NOC code is billed, the logic within this edit will deny the claim line.	HCPCS Code Submitted is Not Otherwise Classified.
08301	Maximum Dosage for Professional Claims	Per Drugs and Biologicals policy, each drug or biological HCPCS code has an expected maximum number of units that are medically likely per day. The maximum is based on expert clinical analysis of industry guidelines, pharmaceutical standards, and drug literature. When the units billed on a claim line exceed the medically likely units threshold per day, the claim line will be denied. Durable Medical Equipment (DME) and pharmacy suppliers are excluded.	Drug Units of Service Exceed the Daily Maximum.

08304 (UB)	Maximum Dosage for Outpatient Facility Claims	Per Drugs and Biologicals policy, each drug or biological HCPCS code has an expected maximum number of units that are medically likely per day. The maximum is based on expert clinical analysis of industry guidelines, pharmaceutical standards, and drug literature. When the units billed on a claim line exceed the medically likely units threshold per day, the claim line will be denied. Durable Medical Equipment (DME) and pharmacy suppliers are excluded.	Drug Units of Service Exceed the Daily Maximum.
08306	Frequency of Service for Drugs and Biologicals on Professional Claims	Per Drugs and Biologicals policy, drug or biological HCPCS codes submitted should not exceed the expected frequency within a time period. The expected frequency is based on expert clinical analysis of industry guidelines, pharmaceutical standards, and drug literature. When a drug or biological HCPCS code is billed earlier than expected, the claim line will be denied. Durable Medical Equipment (DME) and pharmacy suppliers are excluded from editing.	Drug Frequency of Service Limit Exceeded.
08307 (UB)	Frequency of Service for Drugs and Biologicals on Facility Claims	Per Drugs and Biologicals policy, drug or biological HCPCS codes submitted should not exceed the expected frequency within a time period. The expected frequency is based on expert clinical analysis of industry guidelines, pharmaceutical standards, and drug literature. When a drug is billed earlier than expected, the claim line will be denied. Durable Medical Equipment (DME) and pharmacy suppliers are excluded from editing.	Drug Frequency of Service Limit Exceeded.