Optum

OptumCare ACE Smart Edits

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Rejection	009NCS	Per Medicare, the item, service, or code is a non-covered service. Please update as applicable.	**Facility Non Covered Codes** The 009NCS edit will fire when an outpatient claim contains a HCPCS/CPT code that is designated as non- covered based on other than statute. The services in this list are a subset of the services assigned to payment status of "E" or the revenue code is 099x with status indicator of "E" submitted without a HCPCS/CPT code for OPPS. The edit will also fire on claim lines submitted with revenue code 0760 without a HCPCS code. This is based on guidelines from the Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 4, Section 10.1.1 - Payment Status Indicators state "The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule." Addendum D1 - Payment Status Indicators published by CMS defines status indicator of "E" as "Items, Codes and Services that are covered by Medicare for reasons other than statutory exclusion." Medicare has a list of HCPCS codes that are considered to be non- covered under Medicare's outpatient benefit for reason other than statute. The Integrated Outpatient Code Editor contains an edit which will deny the claim line when a service is submitted with a status indicator of "E" indicating the service is non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion for OPPS and Non-OPPS. In addition, per the OCE V20.2, edit 009NCS will also fire when revenue code 760 is submitted with a blank HCPCS. In summary, the 009NCS edit will fire when a HCPCS code is on the 'non-covered HCPCS codes' list for OPPS and Non-OPPS or when revenue code 099x or 0760 is submitted without a HCPCS code for OPPS. This edit applies to both OPPS and non- OPPS claims.	Medicare	5/11/2023	Institutional
Return	017IBP	HCPCS code <1> is inherently bilateral and should not be billed more than once for the same date of service. Please update as applicable.	**Inappropriate Specification of Bilateral Procedure Same Claim** The 017IBP edit fires when an inherently bilateral procedure code occurs on more than one line or with more than one unit for the same date of service. This edit applies unless modifier 76 or 77 is submitted on the second or subsequent line or units Condition code G0 will override edit 17 for inherently bilateral codes with a status indicator of "V." This edit is based on a requirement from the Centers for Medicare and Medicaid Services (CMS). The Integrated Outpatient Editor (IOCE) supports this requirement. It states, "The same inherent bilateral procedure code occurs two or more times (based on units and/or lines) on the same date of service with the exception if modifier 76 or 77 is submitted on the second and subsequent line(s) or unit(s) the claim is returned to the provider. Also, for codes with status indicator of "V" that are also on the inherently bilateral list, condition code G0 will take precedence over the bilateral edit and these claims will not receive edit 17 nor be returned to provider." Example: CPT code 11010 Debridement of Skin appearing on two different claim lines for the same service date. Both claim lines will be flagged with edit 017.	Medicare	6/20/2024	Institutional
Return	01ODID	The other diagnoses codes <1> are invalid due to having an incomplete number of digits. Please update as applicable.	**Inpatient Incomplete Other Diagnosis** The 01ODID edit identifies an inpatient claim when the secondary diagnosis code does not have the required additional digits. The Medicare Code Editor checks each diagnosis including the admitting diagnosis against a table of valid ICD codes. If an entered code does not agree with any code on the internal list, it is assumed to be invalid.	Medicare	5/11/2023	Institutional
Rejection	023BDS	The service date <1> on line <2>, is not within the From and Through dates of service on the claim. Please update as applicable.	**Invalid Date** The 023BDS edit identifies when the service date falls outside the range of the From and Through dates.	Medicare	3/20/2023	Institutional
Rejection	023BDS	The service date <1> on line <2>, is not within the From and Through dates of service on the claim. Please update as applicable.	**Invalid Date** The 023BDS edit identifies when the service date falls outside the range of the From and Through dates.	Medicaid	12/14/2023	Institutional
Rejection	048RRH	Claim line revenue code <1> requires submission of a HCPCS code.	**Revenue Center Requires HCPCS** The 048RRH edit identifies claim lines containing bill types 13x, 74x, 75x, 76x, or 12x/14x without condition code 41, HCPCS is blank, and the revenue center status indicator is not N or F. This edit is bypassed when the revenue code is 100x, 210x, 310x, 099x, 0905-0907, 0500, 0509, 0583, 0660-0663, 0669, 0931, 0932, 0521, 0522, 0524, 0525, 0527, 0528, 0637, or 0948. Per the Outpatient Code Editor (OCE) V20.2, this edit should be bypassed when revenue code 760 is submitted with a blank HCPCS.	Medicare	3/30/2023	Institutional
Rejection	049SIP	Ancillary service billed on the same day as an inpatient only procedure. Please update as applicable.	**Service on Same Day as Inpatient Procedure** The 049SIP edit identifies when a claim line has a C status indicator and is not on the 'separate procedure' list or a claim line has a C status indicator and is on the 'separate procedure' list, and there are no type T lines on the same day and Modifier CA is not present.	Medicare	4/6/2023	Institutional
Return	04PAGE	Age conflict; the Principal diagnosis <1> is not permissible for the patient's age. Please update as applicable.	**Principal Diagnosis - Age Conflict** Edit 04PAGE is triggered when an inpatient claim contains a principal diagnosis code that is inconsistent with the patient's age. This edit looks at the principal diagnosis code that is submitted on an inpatient claim and determine if the diagnosis have an age designation for the code and calculates the age of the patient using the patient's date of birth and the "through" date on the claim. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS). The Medicare Claim Processing Manual - Chapter 3, "Inpatient Hospital Billing" Section 20.2.1 - Age Conflict supports this requirement. The MCE detects inconsistencies between a patient's age and any diagnosis on the patient's record. Examples are: â€¢A 5 year old patient with benign prostatic hypertrophy â€¢A 78 year old delivery In the above cases, the diagnosis is clinically impossible in a patient of the stated age. Therefore, either the diagnosis or age is presumed to be incorrect. There are four age categories in determining the diagnosis is appropriate for the patient's age as described below: â€¢A subset of diagnoses is intended only for newborns and neonates. These are "Newborn" diagnoses. For "Newborn" diagnoses, the patient's age must be 0 years. â€¢Certain diagnoses are considered reasonable only for children between the ages of 0 and 17. These are "Pediatric" diagnoses. â€¢Diagnoses identified as "Maternity" are coded only for patients between the ages of 12 and 55 years. â€¢A subset of diagnoses is considered valid only for patients over the age of 14. These are "Adult" diagnoses. For "Adult" diagnoses the age range is 15 through 124. The Medicare Code Editor (MCE) is consistent with CMS. The MCE will return the claim to the provider when it detects inconsistencies between a patient's age and any diagnosis on the patient's record.	Medicare	6/6/2024	Institutional
Rejection	092DDP	A device-dependent procedure <1> requires that a device HCPCS code be submitted on the same day. Please update as applicable.	**Device-Intensive Procedure Reported Without Device Code** The 092DDP edit identifies when a device-dependent procedure is submitted without the device HCPCS code on the same date of service. Effective January 1, 2015, the submission of a device-dependent procedure also requires that a device be submitted on the same day. If any device-dependent procedure is submitted without a code for a device on the same date of service, the claim will be returned. Discontinued procedures (indicated by the presence of modifier 52, 73 or 74 on the line) are not returned for a missing device code. Effective 1/1/2019, certain device-intensive procedures codes are applicable for bypass if an insertion of a device is not completed (e.g., revised only). For this edit to be bypassed a device procedure on the "Edit 92 Modifier Bypass" list is reported with modifier CG.	Medicare	3/20/2023	Institutional
Return	092DDP	A device-dependent procedure <1> requires that a device HCPCS code be submitted on the same day. Please update as applicable.	**Device-Intensive Procedure Reported Without Device Code** The 092DDP edit identifies when a device-dependent procedure is submitted without the device HCPCS code on the same date of service. Effective January 1, 2015, the submission of a device-dependent procedure also requires that a device be submitted on the same day. If any device-dependent procedure is submitted without a code for a device on the same date of service, the claim will be returned. Discontinued procedures (indicated by the presence of modifier 52, 73 or 74 on the line) are not returned for a missing device code. Effective 1/1/2019, certain device-intensive procedures codes are applicable for bypass if an insertion of a device is not completed (e.g., revised only). For this edit to be bypassed a device procedure on the "Edit 92 Modifier Bypass" list is reported with modifier CG.	Medicaid	12/14/2023	Institutional
Rejection	099LPP	This claim contains a pass- through or non- pass-through drug or biological HCPCS code <1> but lacks the associated payable procedure that must be submitted on the same claim. Please update as applicable.	**Claim With Pass-Through or Non-Pass-Through Drug or Biological Lacks Payable Procedure** The 099LPP edit identifies when a pass-through or non-pass-through drug or biological is billed without an associated payable procedure on the same claim. Pass-through drugs and biologicals include radiopharmaceuticals, contrast agents, skin substitute products and stress agents. Claims containing drugs and biological HCPCS codes with pass-through status (SI = G) or non-pass-through status (SI = K) that are reported without an OPPS payable procedure (SI = J1, J2, P, Q1, Q2, Q3, R, S, T, U, V) are returned to the provider.	Medicare	3/20/2023	Institutional
Return	099LPP	This claim contains a pass- through or non- pass-through drug or biological HCPCS code <1> but lacks the associated payable procedure that must be submitted on the same claim. Please update as applicable.	**Claim With Pass-Through or Non-Pass-Through Drug or Biological Lacks Payable Procedure** The 099LPP edit identifies when a pass-through or non-pass-through drug or biological is billed without an associated payable procedure on the same claim. Pass-through drugs and biologicals include radiopharmaceuticals, contrast agents, skin substitute products and stress agents. Claims containing drugs and biological HCPCS codes with pass-through status (SI = G) or non-pass-through status (SI = K) that are reported without an OPPS payable procedure (SI = J1, J2, P, Q1, Q2, Q3, R, S, T, U, V) are returned to the provider.	Medicaid	12/14/2023	Institutional

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Return	16DSC	The patient status is not valid. Please update as applicable.	**Facility Inpatient Invalid Patient Discharge Status** The 16DSC edit is triggered when a claim is submitted with an invalid Patient Discharge Status Code. When an invalid discharge status is reported, the patient is presumed to have been discharged alive for the purpose of performing the non- specific principal diagnosis check. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS)and the National Uniform Billing Committee (NUBC). The Medicare Claims Processing Manual, Chapter 25 Completing and Processing the Form CMS-1450 Data Set, Section 75.2 Form Locators 16-30 is consistent with this requirement and states that Field Locator 17 is required to indicate the patient's discharge status as of the "Through" date of the billing period. It is required for all Part A inpatient, SNF, hospice, home health agency (HHA) and outpatient hospital services. The Medicare Code Editor (MCE) is consistent with CMS. The MCE Manual states, "Discharge status must be coded according to the UB-04 conventions". The National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual defines the Patient Discharge Status as a code indicating the disposition or discharge status of the patient at the end of service for the period covered on the bill. Field Locator 17 is a required field for all institutional claims.	Medicare	6/6/2024	Institutional
Return	18OWPP	The Other diagnosis code <1> indicates that a wrong procedure was performed.	**Wrong Procedure Performed Other Diagnosis** The 18iOWPP edit is triggered when an inpatient claim contains a designated ICD-10-CM other diagnosis code which indicates that a wrong procedure was performed on the patient. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS). The Medicare Code Editor (MCE) is consistent with CMS. The MCE Manual states, "Certain external causes of morbidity codes indicate that the wrong procedure was performed. The following list contains the codes with corresponding english descriptions, that indicate the wrong procedure was performed". Y6551-Performance of wrong procedure (op) on correct patient Y6552-Perform of proc (op) on patient not scheduled for surgery Y6553- Perform of correct procedure (op) on wrong side or body part	Medicare	6/20/2024	Institutional
Return	18PWPP	The Principal diagnosis code <1> indicates that a wrong procedure was performed.	**Wrong Procedure Performed Principal Diagnosis** The 18iPWPP edit is triggered when an inpatient claim contains a designated ICD-10-CM principal diagnosis code which indicates that a wrong procedure was performed on the patient. This edit is based on a requirement from The Centers for Medicare and Medicaid Services (CMS). The Medicare Code Editor (MCE) is consistent with CMS. The MCE Manual states, "Certain external causes of morbidity codes indicate that the wrong procedure was performed. The following list contains the codes with corresponding english descriptions, that indicate the wrong procedure was performed". Y6551-Performance of wrong procedure (op) on correct patient Y6552-Perform of proc (op) on patient not scheduled for surgery Y6553- Perform of correct procedure (op) on wrong side or body part	Medicare	6/20/2024	Institutional
Return	19LOS	Procedure code 5A1955Z should not be reported when the patient's length of stay is less than or equal to four days. Please update as applicable.	**Facility Inpatient Procedure Inconsistent with Length of Stay** The 19LOS edit identifies when ICD-10 procedure code 5A1955Z (Respiratory Ventilation, Greater than 96 Consecutive Hours) is reported with a length of stay less than or equal to four days, after subtracting number of days reported with Occurrence Span Code 74, effective for date of service on or after October 1, 2015. For original inpatient claims received on or after October 1, 2016, the contractor shall determine the consecutive day count as previously instructed by using the procedure code date for mechanical ventilation (ICD-9-CM procedure code 96.72 or ICD-10-CM procedure code 5A1955Z) instead of the claim 'from' date. The following procedure code should only be coded on claims when the respiratory ventilation is provided for greater than four consecutive days during the length of stay: Effective October 1, 2015, ICD-10-PCS code, 5A1955Z - Respiratory Ventilation, Greater than 96 Consecutive Hours.	Medicare	3/20/2023	Institutional
Return	19LOS	Procedure code 5A1955Z should not be reported when the patient's length of stay is less than or equal to four days. Please update as applicable.	**Facility Inpatient Procedure Inconsistent with Length of Stay** The 19LOS edit identifies when ICD-10 procedure code 5A1955Z (Respiratory Ventilation, Greater than 96 Consecutive Hours) is reported with a length of stay less than or equal to four days, after subtracting number of days reported with Occurrence Span Code 74, effective for date of service on or after October 1, 2015. For original inpatient claims received on or after October 1, 2016, the contractor shall determine the consecutive day count as previously instructed by using the procedure code date for mechanical ventilation (ICD-9-CM procedure code 96.72 or ICD-10-CM procedure code 5A1955Z) instead of the claim 'from' date. The following procedure code should only be coded on claims when the respiratory ventilation is provided for greater than four consecutive days during the length of stay: Effective October 1, 2015, ICD-10-PCS code, 5A1955Z - Respiratory Ventilation, Greater than 96 Consecutive Hours.	Medicaid	12/14/2023	Institutional
Rejection	AKIPf	The Acute Kidney Injury (AKI) claim is missing the required procedure code. Please update as applicable.	**Acute Kidney Injury Claim Without Required Procedure** The AKIPXf edit will fire when an Acute Kidney Injury (AKI) claim is billed with condition code 84 without the required Current Procedural Terminology (CPT) code G0491. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS). CMS Transmittal R1725OTN, Changes to the End-Stage Renal Disease (ESRD) Facility Claim (Type of Bill 72X) to Accommodate Dialysis Furnished to Beneficiaries with Acute Kidney Injury (AKI), dated October 13, 2016 supports this requirement. It states, "Contractors shall create an edit for AKI claims submitted by ESRD facilities on TOB 72x with condition code 84 and the following are not on the claim: CPT code G0491.." In summary, the AKIPXf edit will fire on an AKI claim that is submitted without the required CPT code G0491.	Medicare	10/26/2023	Institutional
Return	ARGf	Argatroban, HCPCS code J0883 can not be submitted on TOB 072X. Please update as applicable.	**Argatroban, HCPCS J0883, Can Not Be Submitted On TOB 072X** The ARGf edit will fire when an End Stage Renal Disease (ESRD) claim, type of bill 072X, is billed with HCPCS code J0883. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS). CMS Transmittal R231BP, Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2017, dated November 4, 2016 supports this requirement. It states, "Medicare contractors shall return to the provider type of bill 072X (ESRD) when non-ESRD HCPCS are reported on the claim: J0883 - Injection, Argatroban, 1mg (for non-ESRD use). Note: There is a new HCPCS J0883 for argatroban for non-ESRD use. This code will not be permitted on the ESRD type of bill 072x." In summary, the ARGf edit will fire on an ESRD claim that is submitted with HCPCS code J0883.	Medicare	10/26/2023	Institutional
Return	ARMf	Invalid or missing required ambulance modifier(s). Please update as applicable.	**Ambulance Required Service Provided Under Arrangement or Directly Modifier Rule** Criteria - For claims with dates of service on or after April 1, 2002, A/MACs perform the following edit to assure proper reporting: 1. Edit to assure the presence of an origin, destination modifier, and a QM or QN modifier for every line item containing revenue code 540; Two of the following letters submitted together create the origin/destination modifier that must be present. Each alpha character, with the exception of "X" represents an origin code and a destination code. The pair of alpha codes creates one modifier. D = Diagnostic or therapeutic site other than P or H when these are used as origin codes; E = Residential, domiciliary, custodial facility (other than 1819 facility); G = Hospital based ESRD facility; H = Hospital; I = Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport; J = Freestanding ESRD facility; N = Skilled nursing facility; P = Physician's office; R = Residence; S = Scene of accident or acute event; X = Intermediate stop at physician's office on way to hospital (destination code only) Applicable Bill Types. The appropriate type of bill (12X, 13X, 22X, 23X, 83X, and 85X) must be reported. For SNFs, ambulance cannot be reported on a 21X type of bill.	Medicaid	4/25/2024	Institutional
Return	ARMf	Invalid or missing required ambulance modifier(s). Please update as applicable.	**Ambulance Required Modifiers for Ambulance Mileage HCPCS Code Rule** Criteria - For claims with dates of service on or after April 1, 2002, A/MACs perform the following edit to assure proper reporting: 1. Edit to assure the presence of an origin, destination modifier, and a QM or QN modifier for every line item containing revenue code 540; Two of the following letters submitted together create the origin/destination modifier that must be present. Each alpha character, with the exception of "X" represents an origin code and a destination code. The pair of alpha codes creates one modifier. D = Diagnostic or therapeutic site other than P or H when these are used as origin codes; E = Residential, domiciliary, custodial facility (other than 1819 facility); G = Hospital based ESRD facility; H = Hospital; I = Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport; J = Freestanding ESRD facility; N = Skilled nursing facility; P = Physician's office; R = Residence; S = Scene of accident or acute event; X = Intermediate stop at physician's office on way to hospital (destination code only) Applicable Bill Types The appropriate type of bill (12X, 13X, 22X, 23X, 83X, and 85X) must be reported. For SNFs, ambulance cannot be reported on a 21X type of bill.	Medicaid	4/25/2024	Institutional

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Return	ARMf	Invalid or missing required ambulance modifier(s). Please update as applicable.	**Ambulance Required Origin and Destination Modifier Rule** Criteria - For claims with dates of service on or after April 1, 2002, A/MACs perform the following edit to assure proper reporting: 1. Edit to assure the presence of an origin, destination modifier, and a QM or QN modifier for every line item containing revenue code 540; Two of the following letters submitted together create the origin/destination modifier that must be present. Each alpha character, with the exception of "X" represents an origin code and a destination code. The pair of alpha codes creates one modifier. Providers report modifier QL (Patient pronounced dead after ambulance called) in "HCPCS/Rates" instead of the origin and destination modifier. In addition to the QL modifier, providers report modifier QM or QN. D = Diagnostic or therapeutic site other than P or H when these are used as origin codes; E = Residential, domiciliary, custodial facility (other than 1819 facility); G = Hospital based ESRD facility; H = Hospital; I = Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport; J = Freestanding ESRD facility; N = Skilled nursing facility; P = Physician's office; R = Residence; S = Scene of accident or acute event; X = Intermediate stop at physician's office on way to hospital (destination code only) Applicable Bill Types The appropriate type of bill (12X, 13X, 22X, 23X, and 85X) must be reported. For SNFs, ambulance cannot be reported on a 21X type of bill.	Medicaid	4/25/2024	Institutional
Return	ASRf	Assistant at surgery modifiers are only payable by Medicare in Method II Critical Access Hospitals (CAHs). Please update as applicable.	**Assistant at Surgery Rule** The ASRf edit will fire when a claim is submitted with an "Assistant at Surgery" modifier 80, 81, 82, or AS and the bill type is other than 085X along with the revenue code is other than 96X, 97X, or 98X. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS). Medicare Claim Processing Manual, Chapter 4, Section 250.9 - Coding Assistant at Surgery Services Rendered in a Method II CAH states an assistant at surgery is a physician or non-physician practitioner who actively assists the physician in charge of the case in performing a surgical procedure. Medicare makes payment for an assistant at surgery when the procedure is authorized for an assistant and the person performing the service is a physician, physician assistant (PA), nurse practitioner (NP) or a clinical nurse specialist (CNS). Assistant at surgery services rendered by a physician or non-physician practitioner that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedure is billed on type of bill 85X with revenue code (RC) 96X, 97X or 98X and an appropriate assistant at surgery modifier. Modifier 80 (assistant surgeon), 81 (minimum assistant surgeon), or 82 (when qualified resident surgeon not available) is used to bill for assistant at surgery services. When billed without modifier AS (PA, NP or CNS services for assistant at surgery) the use of these modifiers indicate that a physician served as an assistant at surgery. In summary, these modifiers are not appropriate in any other outpatient hospital setting and should not be allowed to suppress any edit(s) on any other TOBs or claim lines with any other revenue codes.	Medicare	5/23/2024	Institutional
Rejection	BDS	The beginning or ending Date of Service is invalid or missing. Please update as applicable.	**Missing or Invalid Date of Service** The rule identifies claim lines that have a missing or invalid Beginning or Ending Date Of Service (DOS). If either the Beginning DOS or the Ending DOS is missing or invalid, the line is dropped and the BDS flag is fired.	Medicare	11/16/2023	Professional
Return	BDS	The beginning or ending Date of Service is invalid or missing. Please update as applicable.	**Missing or Invalid Date of Service** The beginning or ending Date of Service is invalid or missing. Please update as applicable.	Medicaid	5/2/2024	Professional
Rejection	BICCL	CLIA ID <1> does not meet the certification level for procedure code <1>. Please update as applicable.	**Invalid CLIA Billing Provider Certification Level** The lab certification level must support the billed service code. Laboratory service providers who do not meet the reporting requirements and/or do not have the appropriate level of CLIA certification for the services reported will not be reimbursed. If the code is under waiver a modifier will be required.	Medicare	5/25/2023	Professional
Rejection	BPS	The place of service (<1>) is missing or invalid. Please update as applicable.	**Missing or Bad POS** The BPS System Rule verifies the place of service (POS) code submitted on each claim line against the Centers for Medicare & Medicaid Services (CMS) Place of Service list found in the Code Repository.	Medicare	5/11/2023	Professional
Rejection	CAG	Procedure Code <1> is not typical for a patient whose age is <2> <3>. Please update as applicable.	**Procedure Age** The code submitted is invalid due to the age of the member at time of service. This edit applies when procedure codes are reported for the inappropriate patient's age.	Medicare	11/16/2023	Professional
Return	CCDf	Condition codes H3, H4 and H5 must be submitted on end stage renal disease claims. Please update as applicable.	**Condition Codes H3, H4, H5 Can Only Be Submit on TOB 072x** The CCDf edit will fire on a line that is submitted with a condition code H3, H4, or H5 and the claim Type of Bill is not 072X. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS) and The National Uniform Billing Committee (NUBC). The Medicare Claims Processing Manual, Chapter 8, Section 50.3 - Required Information for In-Facility Claims Paid Under the Composite Rate and the ESRD PPS list H3, H4 and H5 as condition codes that are completed by hospital based and independent renal facilities. The CMS Transmittal R2134CP, dated January 14, 2011 states that condition codes H3, H4, and H5 will be accepted when submitted on 072X bill type effective January 01, 2011. In addition, The National Uniform Billing Committee (NUBC) states condition codes H3, H4 and H5 indicates a comorbid category limited for use in conjunction with ESRD PPS and applicable to 072X types of bill only.	Medicare	5/23/2024	Institutional
Rejection	CCIPS	Provider state <1> submitted on the claim does not match the state registered with CLIA <2>. Please update claim as applicable.	**CLIA Invalid Provider State Code** CLIA Certificate Identification number and their associated state will be required for reimbursement of clinical laboratory services reported on a 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronicequivalent. Any claim that does not contain the CLIA ID, invalid ID, and/or the complete servicing provider demographic information will be considered incomplete and rejected or denied. Please refer to Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (CLIA) at https://www.cms. gov/ regulations- and-guidance/ legislation/CLIA.	Medicare	5/25/2023	Professional
Rejection	CCIPZ	Provider ZIP Code <1> submitted on the claim does not match ZIP code registered with CLIA <2>. Please update claim as applicable.	**Commercial CLIA Invalid Provider ZIP Code** CLIA Certificate Identification number and their associated state will be required for reimbursement of clinical laboratory services reported on a 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronicequivalent. Any claim that does not contain the CLIA ID, invalid ID, and/or the complete servicing provider demographic information will be considered incomplete and rejected or denied.Please refer to Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (CLIA) at https:// www.cms.gov/regulations-and- guidance/ legislation/CLIA.	Medicare	5/25/2023	Professional
Rejection	CCRCf	Type of bill <1> requires an appropriate claim change reason code. Please update as applicable.	**Appropriate Claim Change Reason Code Required on Adjusted Claims** The edit will fire when a correct claim change reason code is not present on an adjusted claim with TOB XX7 or XX8. For reason codes D0-D4 and D7-D9, and E0 the biller submits a debit-only adjustment request, bill type xx7. For reason codes D5 and D6, it submits a cancel-only adjustment request, bill type xx8.	Medicare	1/5/2023	Institutional
Return	CDL	Procedure code <1> is no longer active. Please review and update as applicable.	**Deleted Procedure Code** CMS maintain and annually updates a list of Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Codes. The AMA develops and manages CPT codes on a rigorous and transparent process which ensures codes are issued and updated regularly to reflect current clinical practice and innovation in medicine. For any additional questions, please review the current applicable code list.	Medicare	1/18/2024	Professional
Rejection	COVDX	ICD-10 U072 is for international reporting only and should not be used to indicate a medical COVID-19 diagnosis. Please update as applicable.	**Inappropriate COVID Diagnosis** CMS and the AMA have developed new procedure codes specifically for COVID vaccination administration and products. Vaccine administration is to be billed primary to Medicare, and should not be sent to OptumCare Medicare Advantage plans for reimbursement. Since ACE only processes primary claims, any claim with an admin code should be rejected.This edit will follow global exclusions such as $03 or less to accommodate practice management system limitations.	Medicare	1/11/2024	Professional
Rejection	COVDXf	ICD-10 U072 is for international reporting only and should not be used to indicate a medical COVID-19 diagnosis. Please update as applicable.	**Inappropriate COVID Diagnosis** CMS and the AMA have developed new procedure codes specifically for COVID vaccination administration and products. Vaccine administration is to be billed primary to Medicare, and should not be sent to OptumCare Medicare Advantage plans for reimbursement. Since ACE only processes primary claims, any claim with an admin code should be rejected.This edit will follow global exclusions such as $03 or less to accommodate practice management system limitations.	Medicare	1/11/2024	Institutional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Rejection	DCCf	Per CMS guidelines, one condition code 59, 71, 72, 73, 74, 76, 80 or 87 must be present on End Stage Renal Disease (ESRD) type of bill 072x claims. Please update as applicable.	**Condition Code Must Be Present On All TOB 072X ERSD Claims** The DCCf edit will fire on an ESRD claim Type of Bill (TOB) 072X when there is not a valid ESRD condition code submitted on the claim. The Medicare Claims Processing Manual, Chapter 8, Section 50.3 - Required Information for In- Facility Claims Paid Under the Composite Rate and the ESRD PPS states, "for hospital-based and independent renal facilities, one of the condition codes 71-76 is applicable for every ESRD bill." Section 80.2.1 - Required Billing Information for Method I Claims has the same requirements as 50.3 with the addition of condition codes 74 and 80. In addition, CMS transmittal R1715OTN, dated September 16, 2016, states that "Medicare Contractors shall add condition code 87 to the list of acceptable condition codes for dialysis treatments submitted on ESRD claims type of bill (TOB) 72x." Condition Code; 59 - Non-primary ESRD Facility - Code indicates that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility. 71 - Full Care in Unit - Providers enter this code to indicate the billing is for a patient who received staff- assisted dialysis services in a hospital or renal dialysis facility 72 - Self-Care in Unit - Providers enter this code to indicate the billing is for a patient who managed his own dialysis in a hospital or renal dialysis facility 73 - Self-Care in Training - Providers enter this code to indicate the billing is for special dialysis services where a patient and his/her helper (if necessary) were learning to perform dialysis 74 - Home - Code indicates the billing is for a patient who received dialysis services at home, but where code 75 below does not apply 76 - Back-up In- facility Dialysis - Providers enter this code to indicate the billing is for a home dialysis patient who received back-up dialysis in a facility 80 - Home Dialysis - Nursing Facility - Home dialysis furnished in a SNF or nursing facility. 87 - ESRD Self Care Retraining. In summary, DCCf will fire when an ESRD claim TOB 072X is submitted without a valid ESRD condition code.	Medicare	11/9/2023	Institutional
Return	DOB	Patient's Date of Birth is missing or invalid. Pease update as applicable.	**Missing Patient's Date of Birth** The DOB System Rule identifies claim lines where the Date of Birth is missing or is prior to the date of service.	Medicare	3/7/2023	Professional
Return	DOBf	Patient's Date of Birth is missing on the claim. Pease update as applicable.	**Patient DOB is missing** The DOB System Rule identifies claim lines where the Date of Birth is missing or is prior to the date of service.	Medicare	3/7/2023	Institutional
Return	FTDf	Missing admission date or invalid Statement Covers Period "From" or "Through" dates. Please update as applicable.	**Missing or Invalid Admission Date** The FTDf edit identifies claims that are missing a required admission date or an admission date that is after the Through date. Per the National Uniform Billing Committee (NUBC) the Admission/Start of Care Date is required on outpatient claims 012x, 022x, 032x, 034x, 081x, and 082x.	Medicare	1/18/2024	Institutional
Return	HIPDXf	Invalid principal diagnosis code <1> for hospice bill type 081x and 082x. Please update as applicable.	**Hospice Invalid Principal Diadnosis Codes - I-10** New editing for principal diagnoses that are not appropriate for reporting on hospice claims. The principal diagnosis reported on the claim is the diagnosis most contributory to the terminal prognosis. ICD-10-CM Coding Guidelines state that codes listed under the classification of Symptoms, Signs, and Ill-defined Conditions are not to be used as principal diagnoses when a related definitive diagnosis has been established or confirmed by the provider. Hospice providers may not report diagnosis codes that cannot be used as the principal diagnosis according to ICD-10-CM Coding Guidelines and require further compliance with various ICD-10-CM coding conventions, such as those that have principal diagnosis code sequencing or etiology/manifestation guidelines.	Medicare	5/16/2024	Institutional
Return	IAG	Diagnosis code(s) <1> is not typical for a patient whose age is <2> <3>. Please update as applicable.	**Diagnosis Age** The edit identifies line items where the listed diagnosis code(s) is not typically performed for a person of the patient's age. This rule is to be used in place of the system diagnosis age (IAG) edit.	Medicare	4/25/2024	Professional
Return	IAGf	Diagnosis code(s) <1> is not typical for a patient whose age is <2> <3>. Please update as applecable.	**Inappropriate Diagnosis Age** The IAGf edit indicates that the patient's age is outside the valid age range specified for that diagnosis code (i.e) The patient's age is less than the beginning age or greater than the ending age for the diagnosis.	Medicaid	4/25/2024	Institutional
Rejection	IBC	Billing CLIA ID submitted on the claim is not valid based on QIES and CDC database. Please resubmit claim with a valid CLIA ID.	**Invalid Billing CLIA ID** A valid CLIA Certificate Identification number will be required for reimbursement of clinical laboratory services reported on a 1500 Health Insurance Claim Form (a/k/a CMS1500) or its electronic equivalent. Any claim that does not contain the CLIA ID, invalid ID, and/or the complete servicing provider demographic information will be considered incomplete.	Medicare	5/25/2023	Professional
Rejection	ICD	The diagnosis code(s) <1> are invalid.	**Invalid Diagnosis Code** The ICD System Rule identifies diagnosis codes that are not valid. This edit looks for blank diagnosis fields as well as a diagnosis code that is not present in the KnowledgeBase.	Medicare	9/28/2023	Professional
Return	ICM	There is no Primary Diagnosis listed for this procedure. Please update as applicable.	**Missing Diagnosis Code** This rule identifies line items with no diagnosis code listed in the primary diagnosis field.	Medicare	1/18/2024	Professional
Return	ICMf	The principal diagnosis code is missing. Please update as applicable.	**Missing Principal Diagnosis Code - I -10** The ICMf rule indicates there is no principal diagnosis code on the current claim (outpatient) since it is a required field.	Medicare	1/18/2024	Institutional
Return	IDDMf	The discharge date is missing. Please update as applicable.	**Inpatient Facility Discharge Date Missing** The IDDMf edit will fire on an inpatient claim when the discharge date is missing. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS). CMS Transmittal R2627CP, Fiscal Year (FY) 2013 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS Changes, dated January 4, 2013 supports this requirement as it states if no discharge date is entered, it is also invalid. The Medicare Code Editor (MCE) reports when an invalid discharge date is entered. In summary, the IDDMf edits indicate the discharge date is missing from an inpatient claim.	Medicaid	5/9/2024	Institutional
Return	IDNR	Per ICD-10-CM guidelines, diagnosis code(s) <1> is only for use on the maternal record, never on the newborn record. Please update as applicable.	**Inappropriate Diagnosis Code(s) on Newborn Record** This edit identifies when a maternal delivery diagnosis code(s) is reported on a newborn record. The obstetric diagnosis codes for this rule are identified as Chapter 15 codes O00-O9A and category codes Z3A and Z37. Per ICD- 10-CM guidelines "Chapter 15 codes are to be used only on the maternal record, never on the record of the newborn" and "Codes from Chapter 15, the obstetric chapter, are never permitted on the newborn record." The guidelines for Z37 category codes state, "The outcome of delivery codes, category Z37, should be included on all maternal delivery records. It is always a secondary code. Codes in category Z37 should not be used on the newborn record." In addition, the guidelines for Z3A category state, "Codes from category Z3A are for use, only on the maternal record, to indicate the weeks of gestation of the pregnancy, if known." A newborns' age (perinatal period) is defined as 0- 28 days per ICD 10- CM guidelines.	Medicare	10/26/2023	Professional
Rejection	IIRA	Per CMS, between May 1, 2023 and June 30, 2023 J1817 can only be billed with modifier JK. J1817, J1811, J1813 cannot be billed without modifier JK or JL after July 1, 2023. Please update as applicable.	**Insulin Inflation Reduction Act** Section 1833(b) of the Social Security Act (the Act) is amended by Section 11407 of the Inflation Reduction Act, which waives the Medicare Part B deductible beginning July 1, 2023 for insulin furnished through an item of DME covered under section 1861(n) of the Act. Also, Section 1833(a) of the Act is amended by Section 11407 of the Inflation Reduction Act, which requires that beneficiary coinsurance for a month's supply of insulin furnished through an item of durable medical equipment is not to exceed $35 beginning July 1, 2023. The supplier payment is to be adjusted as necessary so that Medicare pays for the rest of the amount for the month's supply of insulin. The Shared Systems Maintainers (SSMs) shall implement necessary changes to their respective systems in order to ensure their systems are programmed to adjudicate Medicare Part B claims containing HCPCS for insulin administered via DME pump, ensuring the beneficiary coinsurance for a month's supply of insulin is not to exceed $35. The supplier payment is to be adjusted as necessary, so that Medicare pays for the rest of the amount for the month's supply of insulin. The following modifiers are effective April 1, 2023: JK – Short Descriptor: Drug supply 1 month or less; Long Descriptor: One month supply or less of drug or biological JL - Short Descriptor: Drug 3-month supply; Long Descriptor: Three-month supply of drug or biological.	Medicare	7/27/2023	Professional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Rejection	IIRAf	Per CMS, between May 1, 2023 and June 30, 2023 J1817 can only be billed with modifier JK. J1817, J1811, J1813 cannot be billed without modifier JK or JL after July 1, 2023. Please update as applicable.	**Insulin Inflation Reduction Act** Section 1833(b) of the Social Security Act (the Act) is amended by Section 11407 of the Inflation Reduction Act, which waives the Medicare Part B deductible beginning July 1, 2023 for insulin furnished through an item of DME covered under section 1861(n) of the Act. Also, Section 1833(a) of the Act is amended by Section 11407 of the Inflation Reduction Act, which requires that beneficiary coinsurance for a month's supply of insulin furnished through an item of durable medical equipment is not to exceed $35 beginning July 1, 2023. The supplier payment is to be adjusted as necessary so that Medicare pays for the rest of the amount for the month's supply of insulin. The Shared Systems Maintainers (SSMs) shall implement necessary changes to their respective systems in order to ensure their systems are programmed to adjudicate Medicare Part B claims containing HCPCS for insulin administered via DME pump, ensuring the beneficiary coinsurance for a month's supply of insulin is not to exceed $35. The supplier payment is to be adjusted as necessary, so that Medicare pays for the rest of the amount for the month's supply of insulin. The following modifiers are effective April 1, 2023: JK - Short Descriptor: Drug supply 1 month or less; Long Descriptor: One month supply or less of drug or biological JL - Short Descriptor: Drug 3-month supply; Long Descriptor: Three-month supply of drug or biological.	Medicare	7/27/2023	Institutional
Return	IMO	Per Medicare guidelines, procedure code <1> is inappropriate with Modifier TC. Performance of the test is paid under the lab fee schedule. Please update as applicable.	**Invalid Modifier Code** The IMO edit identifies the claim line which has one or more invalid modifier code(s). All modifiers are validated to verify if they are present in the Modifier Edits table and valid for the date of service. If there is a modifier on the claim line which is not present in the system, has been disabled, or is not effective or valid for the date of service the IMO flag is fired.	Medicare	5/11/2023	Professional
Return	IMO	The modifier code(s) <1> are invalid. Please update as applicable.	**Invalid Modifier Code** This rule identifies the claim line which has one or more invalid modifier code(s). All modifiers are validated to verify if they are present in the Modifier Edits table and valid for the date of service. If there is a modifier on the claim line which is not present in the system, has been disabled, or is not effective or valid for the date of service the IMO flag is fired.	Medicaid	4/18/2024	Professional
Rejection	ISC	Servicing CLIA ID submitted on the claim is not valid based on QIES and CDC database. Please resubmit claim with a valid CLIA ID.	**Invalid Servicing CLIA ID** A valid CLIA Certificate Identification number will be required for reimbursement of clinical laboratory services reported on a 1500 Health Insurance Claim Form (a/k/a CMS1500) or its electronic equivalent. Any claim that does not contain the CLIA ID, invalid ID, and/or the complete servicing provider demographic information will be considered incomplete.	Medicare	5/25/2023	Professional
Rejection	mAM	Per CMS guidelines, HCPCS Code <1> is identified as an ambulance code and requires an ambulance modifier appended. Please update as applicable.	**Medicare Ambulance Origin and Destination Modifiers** For ambulance service claims, Facility-based providers and suppliers must report an origin and destination modifier for each ambulance trip provided in HCPCS/Rates. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, except for X, represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. The mAM edit identifies claim lines that contain an ambulance HCPCS code without an ambulance modifier appended that has a first character of D, E, G, H, I, J, N, P, R or S and a second character of D, E, G, H, I, J, N, P, R, S or X. When an ambulance HCPCS code without an appropriate ambulance modifier is on the current claim, the mAM edit is triggered. Please refer to the Centers for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual, Chapter 15, 30 - General Billing Guidelines, Page 25 for further information.	Medicare	4/20/2023	Professional
Rejection	mANM	Per Medicare guidelines, anesthesia code <1> on claim line ID <2> requires an appropriate modifier. Please update as applicable.	**Medicare Anesthesia Modifier** The mANM edit uses the CMS Medicare Claims Processing Manual to identify anesthesia services that were submitted without an anesthesia modifier. This edit fires on all claim lines that contain an anesthesia code, excluding CPT code 01996, submitted without modifier AA, AD, QK, QX, QY or QZ appended. Physicians must append the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed, or medically supervised. Payment for the service is determined by the use of these modifiers. Please refer to the Anesthesia Services Reimbursement Policy on UHCprovider.com.	Medicare	5/11/2023	Professional
Rejection	mAS	Procedure code <1> is not appropriate when billed by an assistant surgeon. Please update codes as applicable.	**No Payment for Assistant Surgeons Procedure Edits** All codes in the NPFS with the status code indicator "1" for "Assistant Surgeons" are considered to not be reimbursable for Assistant Surgeon services, as indicated by an Assistant Surgeon or surgical assistant modifier (80, 81, 82, or AS), and will not be allowed for payment. Please refer to the National Physician Fee Schedule Relative Value File for further information.	Medicare	4/27/2023	Professional
Return	mB50	A bilateral procedure code <1> submitted with modifier 50 and billed with more than 1 unit of service is inappropriate Please update as applicable.	**Bilateral Modifier 50 Billed With More Than 1 Unit** The mB50 edit identifies claim lines that contain a procedure code with modifier 50 appended and billed with more than 1 unit of service. These codes are identified by indicators "1" or "3" in the bilateral column of the Medicare Physician Fee Schedules (MPFS). "Modifier 50 applies to bilateral procedures performed on both sides of the body during the same operative session. When a procedure is identified by the terminology as bilateral or unilateral, the 50 modifier is not reported. If a procedure is authorized for the 150 percent payment adjustment for bilateral procedures (payment policy indicator 1), the procedure shall be reported on a single line item with the 50 modifier and one service unit. Whenever the 50 modifier is appended, the appropriate number of service units is one."	Medicare	4/27/2023	Professional
Rejection	mBC	Per CMS guidelines, payment for procedure code <1> is always bundled into payment for other services not specified and no separate payment is made. Please update as applicable.	**Medicare Bundled Code** Consistent with CMS, UnitedHealthcare will not separately reimburse for specific CPT/HCPCS codes assigned a status code "B" on the NPFS Relative Value File indicating a bundled procedure. B Bundle Codes are not reimbursable services regardless of whether they are billed alone or in conjunction with other services. Please refer to Section 20.3 of the Medicare Claims Processing Manual (cms.gov).	Medicare	5/11/2023	Professional
Return	mBI	Per Medicare guidelines procedure code <1> is an item or service that has no separate payment under the physician fee schedule. Please update as applicable.	**Medicare Bundling Item Or Service** The mBI edit utilizes the Centers for Medicare and Medicaid Services' (CMS) Medicare Physician Fee Schedule (MPFS) to identify CPTÂ® codes with the indicator "P" in the Status Code column of the MPFS as Bundled or Excluded for which no separate payment should be made under the MPFS. Attachment A of the MPFS defines the indicator or "P" in the Status Code column as follows: "P = Bundled/Excluded Codes. There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule. --If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.) --If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act." As stated within the Medicare Claims Processing Manual, "There are a number of services/supplies that are covered under Medicare and that have HCPCS codes, but they are services for which Medicare bundles payment into the payment for other related services. If carriers receive a claim that is solely for a service or supply that must be mandatorily bundled, the claim for payment should be denied by the carrier." The mBI edit identifies items or services that are covered as incidental to a physician service or are bundled into the payment for the physician service and will not be separately reimbursed under the MPFS.	Medicare	4/18/2024	Professional
Rejection	MCID	CLIA ID was not submitted on the claim. Please resubmit claim with a valid CLIA ID.	**Missing CLIA ID** A valid CLIA Certificate Identification number will be required for reimbursement of clinical laboratory services reported on a 1500 Health Insurance Claim Form (a/k/a CMS1500) or its electronic equivalent. Any claim that does not contain the CLIA ID, invalid ID, and/or the complete servicing provider demographic information will be considered incomplete. Please refer to Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (CLIA) at https://www.cms.gov/ regulations-and- guidance/legis lation/CLIA.	Medicare	5/25/2023	Professional
Return	mCO	Per Medicare guidelines, billing for co-surgeons is not permitted for procedure code <1>. Please update as applicable.	**Co-Surgeons Not Permitted Procedure** The mCO edit identifies claim lines that contain procedure codes with modifier 62 appended inappropriately under CMS guidelines. CMS has designated codes that are identified by the indicator of "0" in the co- surgeon column of the National Physician Fee Schedule (NPFS) as ineligible for modifier 62.The NPFS defines the indicator "0" in the co- surgery column as follows: "0=Co- Surgeons not permitted for this procedure."	Medicare	4/20/2023	Professional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Rejection	mCVAXA	COVID-19 vaccine administration code <1> should be billed to Original Medicare. Please update as applicable.	**Medicare COVID-19 Vaccine Admin Code** CMS and the AMA have developed new procedure codes specifically for COVID vaccination administration and products. Vaccine administration is to be billed primary to Medicare, and should not be sent to OptumCare Medicare Advantage plans for reimbursement. Since ACE only processes primary claims, any claim with an admin code should be rejected.This edit will follow global exclusions such as $03 or less to accommodate practice management system limitations.	Medicare	1/11/2024	Professional
Rejection	mCVAXAf	COVID-19 vaccine administration code <1> should be billed to Original Medicare. Please update as applicable.	**Medicare COVID-19 Vaccine Admin Code** CMS and the AMA have developed new procedure codes specifically for COVID vaccination administration and products. Vaccine administration is to be billed primary to Medicare, and should not be sent to OptumCare Medicare Advantage plans for reimbursement. Since ACE only processes primary claims, any claim with an admin code should be rejected.This edit will follow global exclusions such as $03 or less to accommodate practice management system limitations.	Medicare	1/11/2024	Institutional
Rejection	mDT	Per Medicare guidelines, procedure code <1> describes a diagnostic procedure that requires a professional component modifier in this place of service	**Diagnostic Test in Hospital** The mDT edit identifies claim lines which have procedure codes that are diagnostic tests performed in an Inpatient or Outpatient hospital or skilled nursing setting. When a provider is billing these services in an Inpatient or Outpatient hospital or skilled nursing setting, only the professional component should be billed (modifier 26).	Medicare	5/4/2023	Professional
Rejection	MFLf	REJECT - A diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid. Please update as applicable.	**Medicare Influenza Vaccine Requires Diagnosis** Effective January 1, 2011, Vaccines and their administration are reported using separate codes. Applicable bill types are: 12x, 13x, 22x, 23x, 34x, 72x, 83x, 75x and 85x. One of the following diagnosis codes must be reported as appropriate. If the sole purpose for the visit is to receive a vaccine or if a vaccine is the only service billed on a claim the applicable following diagnosis code may be used. * V04.81 - Influenza vaccination with dates of services 10/1/2003 and later * V06.6 - Influenza and pneumococcal (Effective October 1, 2006, providers must report diagnosis code V06.6 on claims when the purpose of the visit was to receive both vaccines during the same visit. ICD-10-CM diagnosis code Z23 may be used for an encounter for immunizations effective with the implementation of ICD-10.	Medicare	5/9/2024	Institutional
Return	mGT	Per Medicare guidelines, modifier <1> is inappropriately appended to procedure code <2>. Please update as applicable.	**Modifier 26 or TC applied inappropriately - Global Service** This edit identifies claim lines that contain codes that have the modifier 26 or TC appended inappropriately. The concept of professional and technical component splits (PC/TC) does not apply since global test only codes identified by the indicator of "4" in the PC/TC column of the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) cannot be split into professional and technical components under CMS rules. Modifier 26 and TC cannot be used with these codes. The CMS NPFS PCTC indicator "4" is defined as follows: "4 = Global Test Only Codes--This indicator identifies stand-alone codes that describe selected diagnostic tests for which there are associated codes that describe (a) the professional component of the test only, and (b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined."	Medicare	1/18/2024	Professional
Return	mHB	Per Medicare guidelines, a diagnosis code(s), which meets medical necessity for procedure code G0010, is missing or invalid. Please update as applicable.	**Medicare Hepatitis B Vaccine Rule** New rule to capture the submission of Hepatitis B administration and vaccine procedure codes without the required diagnosis code per CMS guidelines.	Medicare	4/18/2024	Professional
Rejection	MHBf	A diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid. Please update as applicable.	**Medicare Hepatitis Vaccine Requires Diagnosis** The MMHBf and MHBf edits utilizes the Centers for Medicare and Medicaid Services (CMS) guidelines found in the Medicare Claims Processing Manual, Medicare Benefit Policy Manual, and The Guide to Medicare Preventive Services to identify Hepatitis B procedures. This edit fires on all claim lines that contain a Hepatitis B vaccine code and a Hepatitis B administration code is not found or a Hepatitis B administration code and a Hepatitis B vaccine code is not found for the same patient and same date of service. This edit will also fire when a Hepatitis B vaccine code or a Hepatitis B administration code is found on the claim without the required diagnosis code for the same patient on the same date of service. All providers bill the FIs/AB MACs for hepatitis B on Form CMS-1450. Hepatitis B Vaccine guidelines: Medicare pays for the Hepatitis B virus (HBV) vaccine and administration for patients determined to be at intermediate or high risk for HBV infection. Medicare has defined persons at high risk as: Individuals with End Stage Renal Disease (ESRD), Individuals with hemophilia who received Factor VIII or IX concentrates, Clients of institutions for the developmentally disabled, Individuals who live in the same household as an HBV carrier, Homosexual men, and Illicit injectable drug users. Persons at intermediate risk are defined as: Staff in institutions for the developmentally disabled, and workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work. A physician order and supervision is required for the hepatitis B vaccine to be administered. A CPT® code for the vaccine (90740, 90743, 90744, 90746, or 90747) is required to be submitted with the administration code (G0010) along with a specific diagnosis code (V05.3). CMS Transmittal R3329CP, dated August 14, 2015, states ICD- 10-CM diagnosis code Z23 may be used for an encounter for immunizations effective with the implementation of ICD- 10. The MMHBf and MHBf edits identifies a claim line that contains a Hepatitis B vaccine, and a valid Hepatitis B administration code is not found, or a Hepatitis B administration code and a valid Hepatitis B vaccine code is not found for the same patient on the same date of service. This edit will also fire when a Hepatitis B vaccine code or a Hepatitis B administration code is found on the claim without the required diagnosis code.	Medicare	5/11/2023	Institutional
Return	MI10f	Per CMS guidelines, ICD-10 codes cannot be billed for dates of service prior to October 1, 2015. Please update as applicable.	**Facility Medicare ICD-10 Code Rule** The MI10f edit is triggered when an outpatient claim contains an ICD-10 code type and the "through" date of service is prior to October 1, 2015. This edit is also triggered when an inpatient claim contains an ICD-10 code type and the "through" date of service is prior to October 1, 2015. The MI10SCf edit is triggered when an outpatient claim contains an ICD-10 code type and the "from" date is less than or equal to September 30, 2015 and the "through" date is greater than or equal to October 1, 2015. These edits are based on SE1408 requirements from The Centers for Medicare and Medicaid Services (CMS). CMS MLN Matters SE1408, Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) - A Re-Issue of MM7492, dated February 5, 2014 states	Medicaid	6/20/2024	Institutional
Return	MI9f	ICD-9 code types cannot be billed for dates of service greater than September 30, 2015. Please update as applicable.	**Facility Medicare ICD-9 Code Rule** The MI9f edit is triggered when an outpatient claim contains an ICD-9 code type and the "through" date of service is greater than September 30, 2015. This edit is also triggered when an inpatient claim contains an ICD-9 code type and the "through" date of service is greater than September 30, 2015. The MI9SCf edit is triggered when an outpatient claim contains an ICD-9 code type and the "from" date is less than or equal to September 30, 2015 and the "through" date is greater than or equal to October 1, 2015. These edits are based on SE1408 requirements from The Centers for Medicare and Medicaid Services (CMS). CMS MLN Matters SE1408, Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) - A Re-Issue of MM7492dated February 5, 2014 states	Medicaid	6/20/2024	Institutional
Return	mIC	Per Medicare guidelines, procedure code <1> is a service covered incident to a physician's service and modifier 26 or TC is not appropriate. Please update as applicable.	**Medicare Incident to Codes** Incident to a physician's professional services means the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. As a condition for OptumCare Medicare Advantage payment all "incident to" services and supplies must be furnished in accordance with applicable state law and the individual furnishing "incident to" services must meet any applicable state requirements to provide such services.	Medicare	1/18/2024	Professional
Rejection	mIM	Modifier is not appropriate for procedure code. Please update as applicable.	**Medicare Inappropriate Modifier - Follow Up Days** This edit utilizes the Centers for Medicare and Medicaid Services' (CMS) Medicare Physician Fee Schedule (MPFS) to determine whether a procedure code billed on a Medicare claim is submitted with an inappropriate modifier. This edit identifies claims submitted with modifier 22 with MPFS follow up days of MMM,XXX, or ZZZ. If the current line has the modifier 22, and if the follow up days for the procedure in the MPFS is MMM, XXX, or ZZZ the mIM edit will trigger. The Medicare Claims Processing Manual states, Modifier -22 should only be reported with procedure codes that have a global period of 0, 10 or 90 days." It would be inappropriate to bill modifier 22 with procedure codes that have a global day indicator of MMM, XXX and ZZZ. Global day indicators found within the "Glob Days" column of the MPFS are defined as follows: MMM=Maternity codes; usual global period does not apply. XXX=The global concept does not apply to the code. ZZZ=The code is related to another service and is always included in the global period of the other service. The global period provides time frames that apply to each surgical procedure.	Medicare	7/27/2023	Professional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Rejection	MIT2f	I21.A1 is an inappropriate principal diagnosis per ICD-10 guidelines and will not be forwarded for claim adjudication. Please resubmit claim with an appropriate principal diagnosis.	**Myocardial Infarction Type 2 Reporting** According to Medicare ICD-10-CM Official Coding Guidelines it states- "Type 2 Myocardial Infarction is assigned to I21.A1 with the underlying cause coded first." Please refer to ICD-10-CM Official Guidelines for Coding and Reporting found on www.cms.gov.	Medicare	11/16/2023	Institutional
Rejection	mLP	Per Medicare guidelines, procedure code <1> is inappropriate with Modifier TC. Performance of the test is paid under the lab fee schedule. Please update as applicable.	**Laboratory Physician Interpretation** The mLP Medicare Rule identifies claim lines which have clinical laboratory codes that are interpreted by laboratory physicians, for which separate payment may be made, and the modifier TC is attached. Modifier -TC (technical component) cannot be used with these codes.	Medicare	10/26/2023	Professional
Rejection	mLTH	REJECT - Per Medicare guidelines, procedure code <1> describes a laboratory procedure that is not eligible for separate reimbursement in place of service <2>. Please update as applicable.	**Laboratory Testing in Hospital** The edit identifies claim lines that contain laboratory codes identified by the indicator of "9" in the PC/TC column of the CMS Physician Fee Schedule (MPFS), are also within the CPT code range of 80047 through 89398 or on the Clinical Laboratory Fee Schedule, and are submitted inappropriately with an inpatient hospital or outpatient hospital place of service code in the system list Diagnostic Test POS Codes. Following the MPFS and the Code of Federal Regulations, laboratory services provided under arrangement to hospital patients are only billable by the hospital. Attachment A of the MPFS defines the indicator 9 in the PC/TC column as follows: "9 = Not Applicable--Concept of a professional/technical component does not apply" The edit excludes Advanced Diagnostic Laboratory Tests (ADLTs) and molecular pathology tests with an outpatient hospital place of service code. The CMS Laboratory Date of Service (DOS) Policy excludes these tests from OPPS packaging when performed after discharge and all requirements from the policy are met. The CMS Laboratory DOS policy allows three exceptions from the rule, if all policy requirements are met, that the date of service must be the date the specimen is collected: Tests performed on stored specimens 14 days or more after discharge; Chemotherapy Sensitivity Tests performed on live tissue 14 days or more after discharge; Advanced Diagnostic Laboratory Tests and Molecular Pathology Tests performed after discharge.	Medicare	5/16/2024	Professional
Rejection	mM54	Per CMS Guidelines, the presence of modifier 54 indicates that only the intraoperative portion of the global fee should be reimbursed. Please update as applicable.	**Intra-Operative Care Only Reduction** The mM54 rule utilizes the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) and the Medicare Claims Processing Manual to identify when a code with modifier 54 appended is eligible for a reduction. This flag fires on all claim lines that contain a code submitted with modifier 54 appended and have a number, other than zero, in the Intra Op column of the NPFS. The NPFS defines the Intra Op column as follows: "Intraoperative Percentage = Percentage for intraoperative portion of global package, including postoperative work in the hospital." Modifier 54 indicates that only intraoperative care was provided by the physician. The Claims Processing Manual instructs that when a physician performs surgery and relinquishes care at the time of discharge, he or she needs to indicate the date of surgery and bill with modifier 54. The NPFS designates procedures that are appropriate for appendage of modifier 54. When a procedure code is listed in the NPFS with a number other than zero in the Intra Op column it indicates those procedure codes are eligible for an intraoperative care only reduction and are eligible for modifier 54. Per CMS Guidelines, the presence of modifier 54 indicates that only the intraoperative portion of the global fee should be reimbursed. The mM54 rule will fire on all claim lines when the modifier 54 is present and a number, other than zero, is listed in the Intra Op column in the NPFS. The mM54 rule will review a primary surgical procedure code to determine if it is eligible for a reduction. When the modifier 54 is present and a zero is listed in the Intra Op column in the NPFS the line will not receive the flag. Also when modifier 54 is not present and a number, other than zero, is listed in the Intra Op column in the NPFS the line will not receive the flag.	Medicare	9/28/2023	Professional
Return	mM56	Per CMS Guidelines, the presence of modifier 56 indicates that only the preoperative portion of the global fee should be reimbursed. Please update as applicable.	**Pre-Operative Care Only Reduction** The mM56 rule utilizes the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) and the Medicare Claims Processing Manual to identify when a code with modifier 56 appended is eligible for a reduction. This flag fires on all claim lines that contain a code submitted with modifier 56 appended and have a number, other than zero, in the Pre Op column of the NPFS. The NPFS defines the Pre Op column as follows: "Preoperative Percentage = Percentage for preoperative portion of global package." The NPFS designates procedures that are appropriate for appendage of modifier 56. When a procedure code is listed in the NPFS with a number other than zero in the Pre Op column it indicates those procedure codes are eligible for a preoperative care only reduction and are eligible for modifier 56. The mM56 rule will fire on all claim lines when the modifier 56 is present and a number, other than zero, is listed in the Pre Op column in the NPFS. The mM56 rule will review a primary surgical procedure code to determine if it is eligible for a reduction. When the modifier 56 is present and a zero is listed in the Pre Op column in the NPFS the line will not receive the flag. Also when modifier 56 is not present and a number, other than zero, is listed in the Pre Op column in the NPFS the line will not receive the flag.	Medicare	10/26/2023	Professional
Return	mM66	Modifier 66 is not present on procedure code <1>. The same procedure code with modifier 66 appended was reported by a different provider on claim ID <2> and line id <3>. Please update as applicable.	**Medicare Team Surgeon Rule- Modifier 66** Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. In these cases, the additional physicians are not acting as assistants-at-surgery. The following billing procedures apply when billing for a surgical procedure or procedures that required the use of two surgeons or a team of surgeons: If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-62." Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Documentation of the medical necessity for two surgeons is required for certain services identified in the MFSDB. (See §40.8.C.5.); If a team of surgeons (more than 2 surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-66." Field 25 of the MFSDB identifies certain services submitted with a "-66" modifier which must be sufficiently documented to establish that a team was medically necessary. All claims for team surgeons must contain sufficient information to allow pricing "by report." If surgeons of different specialties are each performing a different procedure (with specific CPT codes), neither co-surgery nor multiple surgery rules apply (even if the procedures are performed through the same incision). If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services. (See §40.6 for multiple surgery payment rules.) For co-surgeons (modifier 62), the fee schedule amount applicable to the payment for each co-surgeon is 62.5 percent of the global surgery fee schedule amount. Team surgery (modifier 66) is paid for on a "By Report" basis.	Medicare	10/26/2023	Professional
Rejection	mMAC	COVID-19 monoclonal antibody code <1> should be billed to Original Medicare for dates of service prior to 1/1/22. This claim has been rejected and will not be processed.	**Medicare Monoclonal Antibody Codes** For Medicare health plans, the CMS Medicare Administrative Contractor will reimburse claims for Medicare beneficiaries with no cost share (copayment, coinsurance or deductible) through 2021. Charges for monoclonal antibody infusions or injects should be submitted to Original Medicare and not a United Healthcare Medicare Advantage plan.	Medicare	11/16/2023	Professional
Rejection	mMACf	COVID-19 monoclonal antibody code <1> should be billed to Original Medicare for dates of service prior to 1/1/22. This claim has been rejected and will not be processed.	**Medicare Monoclonal Antibody Codes** For Medicare health plans, the CMS Medicare Administrative Contractor will reimburse claims for Medicare beneficiaries with no cost share (copayment, coinsurance or deductible) through 2021. Charges for monoclonal antibody infusions or injects should be submitted to Original Medicare and not a United Healthcare Medicare Advantage plan.	Medicare	11/16/2023	Institutional
Rejection	mMAT	Per Medicare guidelines, modifier AT is required when billing procedure code <1> for active treatment. Medicare does not pay for maintenance therapy. Please update as applicable.	**Medicare Modifier AT For Chiropractic Services** The mMAT edit utilizes the Centers for Medicare and Medicaid Services (CMS) guidelines to identify when procedure codes 98940, 98941, and 98942 are billed without modifier AT (Acute Treatment) for chiropractic services. CMS MLN 1602 states, "The Active Treatment (AT) modifier defines the difference between active treatment and maintenance treatment. Effective October 1, 2004, the AT Modifier is required under Medicare billing to receive reimbursement for CPT codes 98940- 98942. For Medicare purposes, the AT modifier is used only when chiropractors bill for active/corrective treatment (acute and chronic care). The policy requires the following: 1. Every chiropractic claim for 98940/98941/98942, with a date of service on or after October 1, 2004, should include the AT modifier if active/corrective treatment is being performed; and 2. The AT modifier should not be used if maintenance therapy is being performed. MACs deny chiropractic claims for 98940/98941/98942, with a date of service on or after October 1, 2004, that does not contain the AT modifier." The mMAT edit will fire on all claim lines with procedure codes 98940, 98941, and 98942 without modifier AT appended .	Medicare	7/27/2023	Professional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Rejection	mMOD	Per Medicare guidelines use of modifier <1> is not typical for procedure code <2>. Please update as applicable.	**Medicare Modifier Code Not Typical for Procedure Code** The mMOD edit validates whether the Modifier Codes on a claim line may be billed with the procedure code on the claim line, based on the Centers for Medicare and Medicaid Services (CMS). Modifiers that are covered by other Medicare rules and modifiers that do not have a specific national CMS source or a source that addresses specific codes that these modifiers should be appended to are excluded from this rule. All modifiers are validated to determine whether they may be billed with the procedure code on the claim line.	Medicare	3/23/2023	Professional
Return	mMSP	Per Medicare guidelines the diagnosis code(s) billed does not support the medical necessity of G0101.	**Medicare Screening Pelvic** Per Medicare guidelines the diagnosis code(s) billed does not support the medical necessity of G0101. Please update as applicable.	Medicare	10/26/2023	Professional
Rejection	mNC	Per Medicare guidelines, the HCPCS code or modifier billed is a non-covered HCPCS code or modifier. Please update as applicable.	**Medicare Non Covered HCPCS Codes and Modifiers Rule** The mNC edit utilizes the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) file to determine a non covered service code. This edit will fire on all claim lines containing HCPCS codes and HCPCS modifiers that have an indicator of "I", "M", or "S" in the coverage column of the HCPCS file. The record layout for the HCPCS file defines the indicator "I", "M", and "S" in the coverage column as follows: " I = Not payable by Medicare M = Non-covered by Medicare S = Non-covered by Medicare statute " The mNC edit identifies claim lines that contain codes that are non covered service codes under Medicare rules based on having been assigned the coverage indicator of "I", "M" or "S" in the coverage column of the HCPCS file.	Medicare	5/11/2023	Professional
Rejection	mNS	Procedure code <1> is not covered by Medicare. Please update as applicable.	**Medicare Non-Covered Services** The mNS edit utilizes the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine a non covered service code. This edit will fire on all claim lines containing codes that have an indicator of "N" in the status indicator column of the NPFS. Attachment A of the NPFS defines the indicator "N" in the status indicator column as follows: "N - Non covered services. These services are not covered by Medicare." The mNS edit identifies claim lines that contain codes that are non covered service codes under Medicare rules based on having been assigned the indicator of "N" in the status indicator column of the NPFS.	Medicare	9/21/2023	Professional
Rejection	mNV	REJECT - Procedure code <1> is not valid for Medicare purposes. Please update as applicable.	**Medicare Not Valid For Payment** The mNV edit utilizes the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine if a CPTÂ® code is valid for Medicare purposes. This edit will fire on all claim lines containing codes that have an indicator of "I" in the status indicator column of the NPFS. Attachment A of the NPFS defines the indicator "I" in the status indicator column as follows: "I - Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code NOT subject to a 90 day grace period.)" The mNV edit identifies claim lines that contain codes that are not valid for Medicare purposes based on having been assigned the indicator of "I" in the status indicator column of the NPFS.	Medicare	4/25/2024	Professional
Rejection	MODf	Use of modifier(s) <1> is not typical for procedure code <2>. Please update as applicable.	**Modifier Not Appropriate** The MODf edit identifies claim lines that contain a modifier that is not appropriate for the procedure code. Please refer to the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative Policy Manual, Chapter 1.	Medicare	4/27/2023	Institutional
Rejection	mORM	Ordering or Referring physician NPI is not found for service code <1>. Per CMS, physicians must be enrolled with a valid NPI. Please verify physician record and resubmit the claim with a valid NPI.	**Ordering and Referring Physician Missing NPI** CMS regulations require physicians or other eligible professionals to be enrolled or validly opted-out for the Medicare Program to order or refer items and services for Medicare beneficiaries. The submitted CPT code requires a valid NPI submitted in either the Ordering Provider NPI found in 2420E/NM109 or Line Level Referring Provider NPI found in 2420F/NM109 or Claim Level Referring Provider NPI found in 2310A/NM109. See the Medicare Claims Processing Manual, Chapter 26, Page 11 at cms.gov for more information about services that require an ordering/referring physician, including services/ situations where the ordering physician is also the performing physician, as often is the case with in-office clinical laboratory tests. For additional information please refer to: Physicians and non-physician practitioners who opt out of Medicare and/or elect to order and certify services to Medicare beneficiaries is available in https://www.cms.gov/Outreach-and- Education/ Medicare-Learning-Network- MLN/MLNMattersArticles/Downloads /SE1311.pdf on the CMS website or Medicare Benefit Policy Manual Chapter 15, section 40. (https://www.cms.gov/Regulations-and-Guidance/ Guidance /Manuals/downloads/bp102c15.PDF)For the complete list of providers who can order/refer beneficiary services for HHAs see SE 1305 (Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856) at http://www.cms.gov/Outreach- and-Education/Medicare-Learning Network-MLN/MLNMatters Articles/Downloads/se1305.pdf on the CMS website.	Medicare	11/16/2023	Professional
Rejection	mPC	Per Medicare guidelines, procedure code <1> describes the physician work portion of a diagnostic test. Modifier 26 or TC on current line ID <2> is not appropriate. Please update as applicable.	**Professional Component Only** This edit utilizes the Centers for Medicare & Medicaid Services Physician Fee Schedule (NPFS) to determine if a procedure code is submitted with modifier 26 or TC inappropriately.This edit identifies claim lines that contain codes that have the modifier 26 or TC appended inappropriately. The concept of professional and technical components splits (PC/TC) does not apply since professional component only codes identified by the indicator of "2" in the PC/TC column of the NPFS cannot be split into professional and technical components under Medicare rules. Modifiers 26 and TC can not be used with these codes. If a provider bills a claim containing codes that have an indicator of "2" in the PC/TC column of the NPFS that are submitted with modifier 26 or TC appended then deny payment for procedure code because the submitted procedure cannot be split into professional and technical components per CMS guidelines. Centers for Medicare & Medicaid Services Physician Fee Schedule National Physician Fee Schedule Relative Value File - PCTC Indicator 2 = Professional Component Only Codes - This indicator identifies stand- alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test.	Medicare	10/26/2023	Professional
Rejection	mPI	Per Medicare guidelines, Procedure Code <1> describes a physician interpretation for this service and is inappropriate in Place of Service <2>. Please update as applicable.	**Physician Interpretation Only Policy** The mPI edit identifies claim lines that contain codes that are billed with a place of service other than inpatient. The concept of professional and technical component splits (PC/TC) does not apply since these codes describe professional inpatient services. Centers for Medicare and Medicaid Services (CMS) has designated place of service "21" as inpatient and it is the only recognized place of service designation when the PC/TC indicator is "8." All other place of service designations are inappropriate.	Medicare	3/23/2023	Professional
Rejection	mPS	Per Medicare guidelines, procedure code <1> is inappropriate with Modifier TC. Performance of the test is paid under the lab fee schedule. Please update as applicable.	**Physician Service Policy** The mPS flag identifies the claim lines which have codes that describe physician services, PC/TC indicator is '0' and a 26 or TC modifier is present. The concept of professional and technical components splits (PC/TC) does not apply since physician services cannot be split into professional and technical components. Modifiers -26 (Professional), and TC (Technical) cannot be used with these codes.	Medicaid	10/12/2023	Professional
Return	mSE	Per Medicare guidelines the procedure code billed is an item or service that is excluded from the National Physician Fee Schedule by regulation. Please update as applicable.	**Medicare Excluded from Physician Fee Schedule** The 015MSEX edit is triggered when a claim is submitted and the sex code is missing on the claim. This is based on requirements from the Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual - Chapter 3, "Inpatient Hospital Billing" Section 20.2.1 - Medicare Code Editor - Supports this requirement. The manual states," The sex code reported must be either 1 (male) or 2 (female)". The Medicare Code Editor (MCE) is consistent with CMS. The MCE Manual states, "The sex code reported must be either 1 (male) or 2 (female)".	Medicare	4/27/2023	Professional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Rejection	mSM	Per Medicare guidelines the procedure code billed is an item or service that Medicare considers a measurement code and is used for reporting purposes only. Please update as	**Medicare Measurement Code** The mSM edit utilizes the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to identify CPTÂ® codes with the indicator "M" in the Status Code column of the NPFS as measurement codes. These codes are only utilized for reporting purposes. Attachment A of the NPFS defines the indicator or "M" in the Status Code column as follows: "M = Measurement codes. Used for reporting purposes only." The mSM edit identifies items or services that have been identified as measurement codes per the NPFS.	Medicare	9/21/2023	Professional
Rejection	mTC	Per Medicare guidelines, procedure code <1> describes only the technical portion of a service or diagnostic test. Modifier 26 or TC is not appropriate. Please update as applicable.	**Technical Component Only Policy** If the procedure code has modifier 26 or modifier TC on it and the Medicare MPFS PC/TC indicator for the procedure code = 3, then CES will generate this flag If the procedure code has modifier 26 or modifier TC on it and the Medicare MPFS PC/TC indicator for the procedure code = 3, then CES will generate this flag. Please refer to the Professional/Technical Component reimbursement policy at UHCprovider.com.	Medicare	5/11/2023	Professional
Rejection	mTCH	REJECT - Per Medicare guidelines, procedure code <1> describes a diagnostic procedure that is not eligible for separate reimbursement in place of service <2>. Please update as applicable.	**Technical Component in Hospital** The edit identifies claim lines that contain procedure codes identified by the indicator of "3" in the PC/TC column of the CMS Physician Fee Schedule (MPFS) and are submitted inappropriately with an inpatient or outpatient hospital place of service code in the system list Diagnostic Tests POS Codes. Following the MPFS and the Code of Federal Regulations, the technical component for diagnostic services provided under arrangement to hospital patients are only billable by the hospital. The MPFS assigns the indicator of "3" in the PC/TC column for codes that represent only the technical component of a service. The professional component cannot be reimbursed using these procedure codes. Attachment A of the MPFS defines the indicator "3" in the PC/TC column as follows: "3 = Technical Component Only Codes--This indicator identifies stand- alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic test only. An example of a technical component only code is CPT code 93005--Electrocardiogram; Tracing Only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only."	Medicare	5/16/2024	Professional
Return	mTS	Per Medicare guidelines, team surgery is not permitted for procedure code <1>. Please update as applicable.	**Medicare Team Surgeons Not Allowed** If the claim is for a team surgery and the procedure code indicates that team surgery is not permitted, CES will generate this flag. This is based on the TEAM SURG = 0 on the CMS National Fee Schedule.	Medicare	1/18/2024	Professional
Rejection	NPD	Diagnosis code <1> describes an external cause or requires the diagnosis code for the first underlying disease, and should never be listed as the primary diagnosis for a procedure. Please update as applicable.	**Not A Primary Diagnosis Code** The NPD edit identifies codes that are not recommended for reporting alone or as a primary diagnosis (i.e., sequenced first). Please refer to ICD- 10-CM Official Guidelines for Coding and Reporting at https://www.cms.gov/medicare/icd-10/2022-icd-10-cm and American Hospital Association (AHA) Coding Clinic guidelines.	Medicaid	12/14/2023	Professional
Rejection	NPM	Per Medicare guidelines, modifier <> is a nonpayable modifier. Please update as applicable.	**NonPayable Modifiers** According to the definition of the modifier, the code billed with the modifier is not payable. Please refer to the CMS HCPCS Release Code Sets quarterly update at https://www.cms.gov/medicare/coding/ hcpcsreleasecodesets/hcpcs-quarterly-update.	Medicare	11/9/2023	Professional
Rejection	NPMf	Per Medicare guidelines, modifier <> is a nonpayable modifier. Please update as applicable.	**NonPayable Modifiers** According to the definition of the modifier, the code billed with the modifier is not payable. Please refer to the CMS HCPCS Release Code Sets quarterly update at https://www.cms.gov/medicare/coding/ hcpcsreleasecodesets/hcpcs-quarterly-update.	Medicare	11/9/2023	Institutional
Rejection	OPINf	The date of service of this outpatient service falls with an inpatient confinement for this member. Please update as	**Outpatient During Inpatient Confinement** Out-Patient claim dates are falling within date span of inpatient confinement. Services performed in an inpatient setting should not be submitted separately as outpatient services.	Medicare	1/11/2024	Institutional
Return	OUEDf	Codes Q4081 and J0882 must be submitted with code G0257. Please update as applicable.	**EPO and Aransep Should Not Be Submitted Without HCPCS Code G0257** The OUEDf edit will fire on a line with HCPCS J0882 or Q4081 and the Type of Bill is 013X or 085X and HCPCS G0257 is not submitted on the same claim. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 8, Sections 60.4.3.2 - Epoetin Alfa (EPO) Provided in the Hospital Outpatient Department, and Section 60.7.3.2 - Payment for Darbepoetin Alfa (Aranesp) in the Hospital Outpatient Department state when ESRD patients come to the hospital for an unscheduled or emergency dialysis treatment they may also require the administration of EPO and Aranesp. Hospitals use type of bill 13X (or 85X for Critical Access Hospitals) and report charges under the respective revenue code. The CMS Transmittal R1503CP, dated May 16, 2008 states the definition for HCPCS code G0257 is as follows: Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility. Medicare allows for reimbursement of ESRD-related EPO and Aranesp provided during an unscheduled or emergency dialysis treatment in the outpatient hospital setting. It contains requirements that state Medicare contractors shall only make payment for ESRD-related EPO or Aranesp in the outpatient hospital setting (13x and 85x bill types) and when HCPCS code G0257 appears on the same claim for dates of service on or after October 1, 2008. In addition, claims will be returned to the provider when outpatient hospital claims contain ESRD-related EPO or Aranesp and HCPCS code G0257 does not appear on the same claim. In summary, OUEDf will fire when HCPCS J0882 or Q4081 is submitted on a claim with TOB 013X or 085X and HCPCS G0257 is not present.	Medicare	10/26/2023	Institutional
Rejection	PDIf	Principal ICD-10 diagnosis N18.6 is required on all 072X ESRD claims. Please update as applicable.	**Principal Diagnosis Required for End Stage Renal Disease - ICD-10** The PDIf edit will fire on an ESRD claim with Type of Bill (TOB) 072X with a principal diagnosis code other than 585.6 (ICD-9) or N18.6 (ICD-10) End Stage Renal Disease. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 8 - Section 50.3 - Required Information for In-Facility Claims Paid Under the Composite Rate and the ESRD PPS states that the principal diagnosis code for hospital-based and independent renal facilities must include a diagnosis of end stage renal disease. In summary, PDIf will fire when an ESRD claim is submitted with TOB 072X without diagnosis code	Medicare	5/11/2023	Institutional
Rejection	PDO	The ICD-10-CM code <1> may only be used as first- listed or primary diagnosis position. Please update as applicable.	**ICD-10-CM Primary Diagnosis Only** Per ICD-10-CM Official Guidelines for Coding and Reporting certain Z codes/categories may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined. Please refer to ICD-10-CM Official Guidelines for Coding and Reporting at https://www.cms.gov/medicare/icd- 10/2022-icd-10-cm.	Medicare	4/6/2023	Professional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Return	POAf	The Present on Admission (POA) indicator <1> is invalid. Please update as applicable.	**Invalid Present on Admission (POA) Indicator** POAf edit is triggered when an inpatient claim contains an invalid Present on Admission (POA) indicator. CMS POA Indicator Options and Definitions CodeReason for Code YDiagnosis was present at time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as "Y" for the POA Indicator. NDiagnosis was not present at time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "N" for the POA Indicator. UDocumentation insufficient to determine if the condition was present at the time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "U" for the POA Indicator. WClinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as "W" for the POA Indicator. 1Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the 4010A.CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list. General Reporting Requirements This list provides some POA general reporting requirements: • Include the POA indicator on all claims that involve Medicare inpatient admissions to general IPPS acute care hospitals or other facilities, and you are subject to a law or regulation that mandates the collection of POA indicator information. • POA is defined as being present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter (including emergency department, observation, or outpatient surgery) are considered POA. • Assign the POA indicator to principal and all secondary diagnoses as defined in Section II of the "Official Guidelines." • Resolve issues related to inconsistent, missing, conflicting, or unclear documentation. • Do not report the POA indicator if a condition is not coded and reported based on Uniform Hospital Discharge Data Set definitions and current "Official Guidelines." • CMS does not require a POA indicator for the external cause of injury code unless you are reporting it as an "other diagnosis."	Medicare	5/16/2024	Institutional
Informational	RCT	Modifier Q1 indicates a routine clinical trial. The National Clinical Trial ID was not sent in loop 2300, REF02 with a P4 qualifier in REF01. Original Medicare COB data is also missing. Please update as applicable.	**Routine Clinical Trial** In order to adjudicate Clinical Trial claims, the Medicare EOB and/or clinical number is required. Please refer to NCD 310.1 Routine Costs in Clinical Trials and Medicare Managed Care Manual Chapter 4 section 10.7. for additional information.	Medicare	5/16/2024	Professional
Informational	RCTf	Modifier Q1 indicates a routine clinical trial. The National Clinical Trial ID was not sent in loop 2300, REF02 with a P4 qualifier in REF01. Original Medicare COB data is also missing. Please update as applicable.	**Routine Clinical Trial** In order to adjudicate Clinical Trial claims, the Medicare EOB and/or clinical number is required. Please refer to NCD 310.1 Routine Costs in Clinical Trials and Medicare Managed Care Manual Chapter 4 section 10.7. for additional information.	Medicare	5/16/2024	Institutional
Rejection	ROAM	Per Medicare guidelines, HCPCS code <1> must be billed with either modifier JA or JB. Please update as applicable.	**Route of Administration Modifier** The use of the JA and JB modifiers is required for drugs which have one HCPCS Level II (J or Q) code but multiple routes of administration. Drugs that fall under this category must be billed with JA Modifier for the intravenous infusion of the drug or billed with JB Modifier for subcutaneous injection of the drug.	Medicare	11/9/2023	Professional
Rejection	ROAMf	Per Medicare guidelines, HCPCS code <1> must be billed with either modifier JA or JB. Please update as applicable.	**Route of Administration Modifier** The use of the JA and JB modifiers is required for drugs which have one HCPCS Level II (J or Q) code but multiple routes of administration. Drugs that fall under this category must be billed with JA Modifier for the intravenous infusion of the drug or billed with JB Modifier for subcutaneous injection of the drug.	Medicare	11/9/2023	Institutional
Return	sAG	Per Medicaid guidelines, the patient's age does not meet policy requirements for the procedure code and/or a diagnosis code. Please update as applicable.	**Vaccines Free From DOH - Age Restriction** The sAG edit uses Medicaid policies and guidelines to identify claim lines when the patient's age does not meet policy requirements for a procedure code and/or a diagnosis code. Optum bases coding relationships and edits on guidelines from generally accepted third-party industry sources such as the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), published ICD-10-CM Official Guidelines for Coding and Reporting and specialty specific coding rules, when these rules and/or guidelines are available. Individual states establish and administer their own Medicaid programs and determine the type, amount, duration and scope of services within broad federal guidelines. For example, a code may have a specified maximum age limit benefit of eighteen years old. If a claim is submitted for a patient that is over eighteen years old, the sAG edit will fire. The sAG edit will identify Medicaid claim lines when the patient's age does not meet policy requirements for a procedure code and/or a diagnosis code.	Medicaid	3/14/2024	Professional
Rejection	sANM	Per Medicaid guidelines, anesthesia code <1> on claim line ID <2> requires an appropriate modifier. Please update as applicable.	**Medicaid Anesthesia Modifiers** All anesthesia codes in the range of 00100 – 01999 are included with the exception of code 01996 (Daily hospital management of epidural or subarachnoid continuous drug administration). Category II and category III codes are excluded as well. The required modifiers indicate the conditions under which the service was rendered, and this edit will fire on all claim lines that contain anesthesia codes submitted without modifier AA, AD, QK, QX, QY, or QZ. Physicians must append the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed, or medically supervised; payment for the service is determined by the use of these	Medicaid	11/30/2023	Professional
Return	sB50	Per Medicaid guidelines, a bilateral procedure code <1> submitted with modifier 50 and billed with more than 1 unit of service is inappropriate. Please update as applicable.	**Bilateral Modifier 50 Billed With More than 1 Unit** The edit identifies claim lines that contain a procedure code with modifier 50 appended and billed with more than 1 unit of service. These codes are identified by indicators "1" or "3" in the bilateral column of the MPFS. "Modifier 50 applies to bilateral procedures performed on both sides of the body during the same operative session. When a procedure is identified by the terminology as bilateral or unilateral, the 50 modifier is not reported. If a procedure is authorized for the 150 percent payment adjustment for bilateral procedures (payment policy indicator 1), the procedure shall be reported on a single line item with the 50 modifier and one service unit. Whenever the 50 modifier is appended, the appropriate number of service units is one."	Medicaid	12/14/2023	Professional
Return	sBUN	Per Medicaid guidelines, payment for this procedure code is always bundled into payment for other services not specified; no separate payment is made. Please update as applicable.	**Physician-Related or Professional Healthcare - Bundled Services** The sBUN edit uses Medicaid policies and guidelines to identify claim lines that report procedures and/or services that are inherently bundled into another procedure rendered on the same date of service. Optum bases coding relationships and edits on guidelines from generally accepted third-party industry sources such as the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), published ICD-10 Official Guidelines for Coding and Reporting and specialty- specific coding rules when these rules and/or guidelines are available. Individual states establish and administer their own Medicaid programs and determine the type, amount, duration and scope of services within broad federal guidelines. This edit will use scenarios disclosed in a state's Medicaid manual that indicates that a specified or unspecified procedure and/or service is considered bundled or incidental to another procedure and/or service rendered on the same date of service. The sBUN edit will identify Medicaid claim lines that report a procedure and/or service that is bundled or incidental to another procedure and/or service rendered on the same	Medicaid	10/12/2023	Professional
Return	sCC	Per Medicaid guidelines, an additional procedure code is needed to meet policy requirements. Please update as applicable.	**Oral Anti-Emetic Drugs With Chemotherapy** The sCC edit uses Medicaid policies and guidelines to identify Medicaid claim lines that do not meet code-to-code policy requirements. Optum bases coding relationships and edits on guidelines from generally accepted third-party industry sources such as the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), published ICD-10 Official Guidelines for Coding and Reporting and specialty-specific coding rules when these rules and/or guidelines are available. Individual states establish and administer their own Medicaid programs and determine the type, amount, duration and scope of services within broad federal guidelines. For example, Medicaid policy may state "For billing, use HCPCS code J2430 (injection, pamidronate disodium, per 30 mg). Pamidronate must be billed in conjunction with CPT-4 codes 96365 (intravenous infusion for therapy prophylaxis or diagnosis; initial, up to one hour) and 96366." The sCC edit identifies Medicaid claim lines when a code-to-code policy requirement is not met per Medicaid policies and guidelines.	Medicaid	6/6/2024	Professional
Return	sCO	Per Medicaid guidelines, billing for co-surgeons is not permitted for procedure code <1>. Please update as	**Co-Surgeons Not Permitted Procedure** The edit identifies claim lines that contain procedure codes with modifier 62 appended inappropriately under CMS guidelines. CMS has designated codes that are identified by the indicator of "0" in the co-surgeon column of the NFPS as ineligible for modifier 62. The NPFS defines the indicator "0" in the co-surgery column as follows: "0=Co-Surgeons not permitted for this procedure "	Medicaid	12/14/2023	Professional
Rejection	sDT	Per Medicaid guidelines, procedure code <1> describes a diagnostic procedure that requires a professional component modifier in place of service <2>. Please update as applicable.	**Diagnostic Test in Hospital** The edit identifies claim lines that contain codes that do not have the modifier 26 appended appropriately when submitted with a place of service of inpatient hospital, outpatient hospital, or skilled nursing facility under CMS guidelines. The concept of professional and technical component splits (PC/TC) does apply to these codes that are identified by the indicator of "1" in the PC/TC column of the NPFS. When billing these services in an inpatient hospital, outpatient hospital, or skilled nursing facility, only the professional component should be billed by the physician. Billing of the technical component is inappropriate by the physician as the facility should be responsible for submitting it. Modifiers 26 and TC can be used with these codes. Attachment A of the NPFS defines the indicator "1" in the PC/TC column as follows: "1 = Diagnostic Tests for Radiology Services--Identifies codes that describe diagnostic tests. Examples are pulmonary function tests or therapeutic radiology procedures, e.g., radiation therapy. These codes have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier include values for physician work, practice expense, and malpractice expense."	Medicaid	12/14/2023	Professional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Return	sGT	Per Medicaid guidelines, modifier <1> is inappropriately appended to procedure code <2>. Please update as applicable.	**Global Test Only Rule** This edit identifies claim lines that contain codes that have the modifier 26 or TC appended inappropriately. The concept of professional and technical component splits (PC/TC) does not apply since global test only codes identified by the indicator of "4" in the PC/TC column of the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) cannot be split into professional and technical components under CMS rules. Modifier 26 and TC cannot be used with these codes. The CMS NPFS PCTC indicator "4" is defined as follows: "4 = Global Test Only Codes--This indicator identifies stand-alone codes that describe selected diagnostic tests for which there are associated codes that describe (a) the professional component of the test only, and (b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined."	Medicaid	4/18/2024	Professional
Rejection	SICCL	CLIA ID <1> does not meet the certification level for procedure code <2>. Please update as applicable.	**CLIA Servicing Provider Certification Level** The lab certification level must support the billed service code. Laboratory service providers who do not meet the reporting requirements and/or do not have the appropriate level of CLIA certification for the services reported will not be reimbursed. If the code is under waiver a modifier will be required. Please update as	Medicare	5/25/2023	Professional
Return	sIM	Per Medicaid guidelines, modifier <1> is not appropriate for procedure code <2>. Please update as applicable.	**Medicaid Inappropriate Modifier - Co-Surgeon** This edit utilizes the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine whether a procedure code billed on a Medicaid claim is submitted with an inappropriate modifier. This edit identifies claims submitted with modifier 62 with an NPFS Co-Surgeon indicator of "9".	Medicaid	5/2/2024	Professional
Return	SIP	Sequential intravenous push code 96376 reported on Claim ID <1>, Line ID <2> may only be reported by facilities. This service is not to be reported on a professional claim. Please update as applicable.	**Sequential Intravenous Push Reported by a Physician** Current Procedural Terminology (CPT®) code 96376 may not be reported on a professional claim. This code is to be reported by a facility only. The CPT codebook states, "96376 may be reported by facilities only." The Centers for Medicare and Medicaid Services (CMS) Transmittal 2636 states, "96376 - may be reported by facilities only."	Medicare	10/26/2023	Professional
Return	sLP	Per Medicaid guidelines, procedure code <1> is inappropriate with Modifier TC. Performance of the test is paid under the lab fee schedule. Please update as applicable.	**Laboratory Physician Interpretation** The sLP edit uses the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPTÂ® code to be split into professional and technical components. This edit will fire on all claim lines containing codes that have an indicator of "6" or "8" in the PC/TC column of the NPFS that are submitted with modifier TC appended. The Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, 50.6 - Physician Fee Schedule Payment Policy Indicator File Record Layout, defines the indicator "6" and "8" in the PC/TC column as follows: "6 = Laboratory Physician Interpretation Codes-This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the test is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense." "8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate. No payment is recognized for code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test." The sLP edit identifies Medicaid claim lines that contain codes that have the modifier TC appended inappropriately per Medicaid policies and guidelines.	Medicaid	4/18/2024	Professional
Rejection	sLTH	REJECT - Per Medicaid guidelines, procedure code <1> describes a laboratory procedure that is not eligible for separate reimbursement in place of service <2>. Please update as applicable.	**Laboratory Testing in Hospital** The edit identifies claim lines that contain laboratory codes identified by the indicator of "9" in the PC/TC column of the CMS Physician Fee Schedule (MPFS), are also within the CPT code range of 80047 through 89398 or on the Clinical Laboratory Fee Schedule, and are submitted inappropriately with an inpatient hospital or outpatient hospital place of service code in the system list Diagnostic Test POS Codes. Following the MPFS and the Code of Federal Regulations, laboratory services provided under arrangement to hospital patients are only billable by the hospital. Attachment A of the MPFS defines the indicator 9 in the PC/TC column as follows: "9 = Not Applicable--Concept of a professional/technical component does not apply" The edit excludes Advanced Diagnostic Laboratory Tests (ADLTs) and molecular pathology tests with an outpatient hospital place of service code. The CMS Laboratory Date of Service (DOS) Policy excludes these tests from OPPS packaging when performed after discharge and all requirements from the policy are met. The CMS Laboratory DOS policy allows three exceptions from the rule, if all policy requirements are met, that the date of service must be the date the specimen is collected: Tests performed on stored specimens 14 days or more after discharge; Chemotherapy Sensitivity Tests performed on live tissue 14 days or more after discharge; Advanced Diagnostic Laboratory Tests and Molecular Pathology Tests performed after discharge.	Medicaid	5/16/2024	Professional
Return	sMN	Per Medicaid guidelines, a diagnosis code which meets medical necessity is missing or invalid for procedure code <1> on Claim ID <2>, Line ID <3>. Please update as applicable.	**HIV/AIDS Case Management requires HIV or AIDS Codes** The sMN edit uses state Medicaid policies and guidelines to identify claim lines that contain a diagnosis code that does not meet medical necessity. Optum bases coding relationships and edits on guidelines from generally accepted third- party industry sources such as the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), published ICD-10-CM Official Guidelines for Coding and Reporting and specialty specific coding rules, when these rules and/or guidelines are available. Individual states establish and administer their own Medicaid programs and determine the type, amount, duration and scope of services within broad federal guidelines. The Centers for Medicare and Medicaid Services defines medical necessity as services that are: "Reasonable and necessary, for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member, and not excluded under another provision of the Medicare Program". Per CMS Policy, if the diagnoses provided do not support medical necessity, the items or services will be denied. The sMN edit will identify Medicaid claim lines that do not contain a valid diagnosis code that meets medical necessity as defined by Medicaid policy.	Medicaid	7/11/2024	Professional
Return	sMN	Per Medicaid guidelines, a diagnosis code which meets medical necessity is missing or invalid for procedure code <1> on Claim ID <2>, Line ID <3>. Please update as applicable.	**HIV/AIDS Case Management-Program Intake Assessment T1023** The sMN edit uses state Medicaid policies and guidelines to identify claim lines that contain a diagnosis code that does not meet medical necessity. Optum bases coding relationships and edits on guidelines from generally accepted third- party industry sources such as the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), published ICD-10-CM Official Guidelines for Coding and Reporting and specialty specific coding rules, when these rules and/or guidelines are available. Individual states establish and administer their own Medicaid programs and determine the type, amount, duration and scope of services within broad federal guidelines. The Centers for Medicare and Medicaid Services defines medical necessity as services that are: "Reasonable and necessary, for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member, and not excluded under another provision of the Medicare Program". Per CMS Policy, if the diagnoses provided do not support medical necessity, the items or services will be denied. The sMN edit will identify Medicaid claim lines that do not contain a valid diagnosis code that meets medical necessity as defined by Medicaid policy.	Medicaid	7/11/2024	Professional
Return	sNP	Per Medicaid guidelines, procedure code <1> does not typically require performance by a physician in place of service <2>. Please update as applicable.	**Medicaid Non-Physician Service** The sNP edit uses the Centers for Medicare and Medicaid Services' (CMS) Medicare Physician Fee Schedule (MPFS) to determine eligibility of a CPTÂ® code to be covered under incident to guidelines. The edit will fire on all Medicaid claim lines containing codes that have an indicator of "5" in the PC/TC column of the MPFS that are submitted with a location of skilled nursing facility, hospital inpatient or hospital outpatient. Attachment A of the MPFS defines the indicator "5" in the PC/TC column as follows: "5 = Incident To Codes -This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct personal supervision. Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes." The sNP edit identifies Medicaid claim lines that contain codes that represent services submitted under incident to guidelines with an inappropriate place of service. Following MPFS and Centers for Medicare and Medicaid Services' guidelines, codes that have a PC/TC indicator of "5" will not be eligible for payment if the service was provided by auxiliary personnel under physician supervision and done in a skilled nursing facility, hospital inpatient or hospital outpatient.	Medicaid	7/11/2024	Professional
Return	sNS	Per Medicaid guidelines, this procedure is considered a non- covered service. Please update as applicable.	**Anesthesia Services with Modifier 47 - Non-Covered** The sNS edit uses Medicaid policies and guidelines to identify claim lines that contain codes specified as "non-covered services". Optum bases coding relationships and edits on guidelines from generally accepted third-party industry sources such as the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), published ICD-10-CM Official Guidelines for Coding and Reporting and specialty specific coding rules, when these rules and/or guidelines are available. Individual states establish and administer their own Medicaid programs and determine the type, amount, duration and scope of services within broad federal guidelines. For example, a policy may state, "The following are Non-Covered Services: 0314T - Laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator, 0315T Removal of pulse generator." The sNS edit identifies Medicaid claim lines that contain codes specified as "non-covered services".	Medicaid	4/18/2024	Professional
Rejection	sPI	Per Medicaid guidelines, procedure code <1> describes a physician interpretation for a service and is not appropriate in place of service <2>. Please update as applicable.	**Physician Interpretation Only Policy** This edit identifies claim lines that contain codes that are billed with a place of service other than inpatient. The concept of professional and technical component splits (PC/TC) does not apply since these codes describe professional inpatient services. CMS has designated place of service "21" as inpatient and it is the only recognized place of service designation when the PC/TC indicator is "8." All other place of service designations are inappropriate.	Medicaid	12/14/2023	Professional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Return	sRM	Per Medicaid guidelines, the required modifier is missing or the modifier is inappropriate for the procedure code. Please update as applicable.	**HIV/AIDS Case Management requires modifier** The sRM edit uses Medicaid policies and guidelines to identify claim lines that include a CPTÂ® or HCPCS procedure code that is missing the required modifier or the modifier is inappropriate for the code. Optum bases coding relationships and edits on guidelines from generally accepted third-party industry sources such as the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), published ICD-9-CM or ICD-10-CM Official Guidelines for Coding and Reporting and specialty specific coding rules, when these rules and/or guidelines are available. Individual states establish and administer their own Medicaid programs and determine the type, amount, duration and scope of services within broad federal guidelines. The AMA CPT Manual and the Medicaid NCCI program define modifiers that may be appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers consist of two characters which can be alpha, numeric or alphanumeric. Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an edit if the clinical circumstances do not justify its use. The Centers for Medicare and Medicaid Services (CMS) internet policy for HCPCS modifier code guidelines states, "A modifier provides the means by which the reporting physician or provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code." The sRM edit identifies Medicaid claim lines that are missing the required modifier or the modifier appended is invalid or inappropriate for the procedure code.	Medicaid	7/11/2024	Professional
Return	sRM	Per Medicaid guidelines, the required modifier is missing or the modifier is inappropriate for the procedure code. Please update as applicable.	**Ambulance Modifiers Requirement** The sRM edit uses Medicaid policies and guidelines to identify claim lines that include a CPTÂ® or HCPCS procedure code that is missing the required modifier or the modifier is inappropriate for the code. Optum bases coding relationships and edits on guidelines from generally accepted third-party industry sources such as the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), published ICD-9-CM or ICD-10-CM Official Guidelines for Coding and Reporting and specialty specific coding rules, when these rules and/or guidelines are available. Individual states establish and administer their own Medicaid programs and determine the type, amount, duration and scope of services within broad federal guidelines. The AMA CPT Manual and the Medicaid NCCI program define modifiers that may be appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers consist of two characters which can be alpha, numeric or alphanumeric. Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an edit if the clinical circumstances do not justify its use. The Centers for Medicare and Medicaid Services (CMS) internet policy for HCPCS modifier code guidelines states, "A modifier provides the means by which the reporting physician or provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code." The sRM edit identifies Medicaid claim lines that are missing the required modifier or the modifier appended is invalid or inappropriate for the procedure code.	Medicaid	7/11/2024	Professional
Rejection	sTC	Per Medicaid guidelines, procedure code <1> describes only the technical portion of a service or diagnostic test. Modifier 26 or TC is not appropriate. Please update as applicable.	**Technical Component Only Policy** This edit identifies claim lines that contain codes that have the modifier 26 or TC appended inappropriately. The concept of professional and technical components splits (PC/TC) does not apply since technical component only codes identified by the indicator of "3" in the PC/TC column of the NPFS cannot be split into professional and technical components under Medicare rules. Modifiers 26 and TC cannot be used with these codes. If a provider bills a claim containing codes that have an indicator of "3" in the PC/TC column of the NPFS that are submitted with modifier 26 or TC appended then deny payment for procedure code because the submitted procedure cannot be split into professional and technical components per CMS and Medicaid guidelines	Medicaid	11/30/2023	Professional
Rejection	sTCH	REJECT - Per Medicaid guidelines, procedure code <1> describes a diagnostic procedure that is not eligible for separate reimbursement in place of service <2>. Please update as applicable.	**Technical Component in Hospital** The edit identifies claim lines that contain procedure codes identified by the indicator of "3" in the PC/TC column of the CMS Physician Fee Schedule (MPFS) and are submitted inappropriately with an inpatient or outpatient hospital place of service code in the system list Diagnostic Tests POS Codes. Following the MPFS and the Code of Federal Regulations, the technical component for diagnostic services provided under arrangement to hospital patients are only billable by the hospital. The MPFS assigns the indicator of "3" in the PC/TC column for codes that represent only the technical component of a service. The professional component cannot be reimbursed using these procedure codes.Attachment A of the MPFS defines the indicator "3" in the PC/TC column as follows: "3 = Technical Component Only Codes--This indicator identifies stand- alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic test only. An example of a technical component only code is CPT code 93005--Electrocardiogram; Tracing Only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only."	Medicaid	5/16/2024	Professional
Return	sTS	Per Medicaid guidelines, team surgery is not permitted for procedure code <1>. Please update as applicable.	**Team Surgeons Not Permitted** This edit utilizes the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to determine eligibility of a CPT® code for the team surgery modifier 66. This edit will fire on all claim lines containing codes that have an indicator of "0" in the team surgery column of the NPFS that are submitted with modifier 66 appended inappropriately. CMS and Medicaid has designated codes that are identified by the indicator of "0" in the team surgery column of the NPFS as ineligible for modifier 66. If a provider submits a procedure code that have an indicator of "0" in the team surgeon column of the NPFS, with modifier 66 improperly attached, then payment will be denied per	Medicaid	4/25/2024	Professional
Return	TOBf	The type of bill code is invalid. Please update as applicable.	**Missing or Invalid Type of Bill - Outpatient** The TOBf edit will identify a claim that is submitted with a Type of Bill that is invalid or missing. The first and second positions identify the Type of Facility and Classification; the third position contains an indicator identifying the Frequency of Bill. Not all frequency codes are applicable to all types of facilities. This is based on requirements from the National Uniform Billing Committee (NUBC) and The Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 25 Completing and Processing the Form CMS- 1450 Data Set, Section 75.1 Form Locators 1-15 is consistent with this requirement and states that Field Locator 04 is required to identify three specific pieces of information which are the type of facility, the type of care and the sequence of the bill in the particular episode of care also referred to as a "frequency" code. The Official UB-04 Data Specifications Manual defines the Type of Bill as "A code indicating the specific type of bill (e.g., hospital inpatient, outpatient, replacements, voids, etc.)." Field Locator 04 is a required field for the UB-04 claim. The usage requirements of many data elements are based on this designation. In addition, it also states that patient discharge status code 30 (still patient), is used when a patient is still within the same facility, typically used when billing for leave of absence days or interim bills.	Medicaid	5/9/2024	Institutional
Return	TOBf	The type of bill code is invalid or missing. Please update as applicable.	**Missing or Invalid Type of Bill -Outpatient** The TOBf edit will identify a claim that is submitted with a Type of Bill that is invalid or missing. The first and second positions identify the Type of Facility and Classification; the third position contains an indicator identifying the Frequency of Bill. Not all frequency codes are applicable to all types of facilities. This is based on requirements from the National Uniform Billing Committee (NUBC) and The Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 25 Completing and Processing the Form CMS- 1450 Data Set, Section 75.1 Form Locators 1-15 is consistent with this requirement and states that Field Locator 04 is required to identify three specific pieces of information which are the type of facility, the type of care and the sequence of the bill in the particular episode of care also referred to as a "frequency" code. The Official UB-04 Data Specifications Manual defines the Type of Bill as "A code indicating the specific type of bill (e.g., hospital inpatient, outpatient, replacements, voids, etc.)." Field Locator 04 is a required field for the UB-04 claim. The usage requirements of many data elements are based on this designation. In addition, it also states that patient discharge status code 30 (still patient), is used when a patient is still within the same facility, typically used when billing for leave of absence days or interim bills.	Medicaid	5/9/2024	Institutional
Return	TOBf	The type of bill code is invalid or missing. Please update as applicable.	**Missing or Invalid Type of Bill - Inpatient** The TOBf edit will identify a claim that is submitted with a Type of Bill that is invalid or missing. The first and second positions identify the Type of Facility and Classification; the third position contains an indicator identifying the Frequency of Bill. Not all frequency codes are applicable to all types of facilities. This is based on requirements from the National Uniform Billing Committee (NUBC) and The Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 25 Completing and Processing the Form CMS- 1450 Data Set, Section 75.1 Form Locators 1-15 is consistent with this requirement and states that Field Locator 04 is required to identify three specific pieces of information which are the type of facility, the type of care and the sequence of the bill in the particular episode of care also referred to as a "frequency" code. The Official UB-04 Data Specifications Manual defines the Type of Bill as "A code indicating the specific type of bill (e.g., hospital inpatient, outpatient, replacements, voids, etc.)." Field Locator 04 is a required field for the UB-04 claim. The usage requirements of many data elements are based on this designation. In addition, it also states that patient discharge status code 30 (still patient), is used when a patient is still within the same facility, typically used when billing for leave of absence days or interim bills.	Medicaid	5/9/2024	Institutional
Rejection	TRCf	REJECT - A therapy service revenue code requires a therapy service modifier. Please update as applicable.	**Therapy Service Revenue Code Requires Therapy Service Modifier** The appropriate types of bill for submitting outpatient rehabilitation services are: 12X, 13X, 22X, 23X, 74X, 75X, and 85X. The therapy modifiers (GN, GO, GP) refer only to services provided under plans of care for physical therapy, occupational therapy, and speech-language pathology services. Therapy modifiers must always be present with revenue codes 042X, 043X, or 044X for all claims. Effective for date of service on or after April 1, 2011, Medicare created an edit to ensure that the therapy modifiers are present based on revenue codes 042X, 043X, or 044X. Claims containing revenue codes 042X, 043X, or 044X without a therapy modifier GN, GO, or GP are returned to the provider. Additionally to ensure that revenue codes and modifiers are reported 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 The claim is returned to the provider that contains lines with any other combinations of these revenue codes and modifiers.	Medicare	5/23/2024	Institutional
Rejection	TSMf	REJECT - Therapy service modifier requires therapy service revenue code. Please update as applicable.	**Therapy Service Modifier Requires Therapy Service Revenue Code** The appropriate types of bill for submitting outpatient rehabilitation services are: 12X, 13X, 22X, 23X, 74X, 75X, and 85X. The therapy modifiers (GN, GO, GP) refer only to services provided under plans of care for physical therapy, occupational therapy, and speech-language pathology services. Therapy modifiers must always be present with revenue codes 042X, 043X, or 044X. They should never be used with codes that are not on the list of applicable therapy services, (i.e. respiratory therapy services, or nutrition therapy services). Effective for date of service on or after April 1, 2011, Medicare created an edit to ensure that the therapy modifiers are present based on revenue codes 042X, 043X, or 044X. Claims containing revenue codes 042X, 043X, or 044X without a therapy modifier GN, GO, or GP are returned to the provider. Additionally to ensure that revenue codes and modifiers are reported 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 The claim is returned to the provider that contains lines with any other combinations of these revenue codes and modifiers.	Medicare	5/23/2024	Institutional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Rejection	UCVAX	Vaccine code <1> has not been federally approved on this date of service. Please update as applicable.	**Unapproved COVID-19 Vaccine** CMS and the American Medical Association (AMA) collaborated on a new approach to report use of COVID-19 vaccines. If you plan to administer the COVID-19 vaccines or COVID-19 monoclonal antibody products, especially if you plan to roster bill for codes that describe these services, download and install the newest release of PC-ACE (PDF). This release includes the coding structure for COVID-19 vaccine and monoclonal antibody products, currently comprised of both of these: An AMA-issued HCPCS Level I CPT code structure and A CMS-issued HCPCS Level II code structure together, these codes describe the administration of the COVID-19 vaccines and the monoclonal antibody products, as they become available. CMS and the AMA developed this code structure to make claims processing for administration of COVID-19 vaccines and monoclonal antibody infusions that get FDA EUA or FDA approval more efficient. Many of these codes are placeholders and aren't currently effective until an authorized product is specifically assigned. It's possible that we won't use all codes. We'll issue specific code descriptors in the future. Medicare effective dates for the codes will match with the date of the FDA EUA or FDA approval.	Medicare	1/11/2024	Professional
Rejection	UCVAXf	Vaccine code <1> has not been federally approved on this date of service. Please update as applicable.	**Unapproved COVID-19 Vaccine** CMS and the American Medical Association (AMA) collaborated on a new approach to report use of COVID-19 vaccines. If you plan to administer the COVID-19 vaccines or COVID-19 monoclonal antibody products, especially if you plan to roster bill for codes that describe these services, download and install the newest release of PC-ACE (PDF). This release includes the coding structure for COVID-19 vaccine and monoclonal antibody products, currently comprised of both of these: An AMA-issued HCPCS Level I CPT code structure and A CMS-issued HCPCS Level II code structure together, these codes describe the administration of the COVID-19 vaccines and the monoclonal antibody products, as they become available. CMS and the AMA developed this code structure to make claims processing for administration of COVID-19 vaccines and monoclonal antibody infusions that get FDA EUA or FDA approval more efficient. Many of these codes are placeholders and aren't currently effective until an authorized product is specifically assigned. It's possible that we won't use all codes. We'll issue specific code descriptors in the future. Medicare effective dates for the codes will match with the date of the FDA EUA or FDA approval.	Medicare	1/11/2024	Institutional
Rejection	UPDf	Per CMS ICD-10-CM Guideline, Section II, diagnosis code <1> is not eligible as a primary diagnosis. Refer to MCE for diagnosis codes that are considered acceptable as a principal diagnosis code.	**Unacceptable Principal Diagnosis Inpatient Facility** Per the MCE (Medicare Code Editor) there are selected diagnosis codes that are considered unacceptable as principal diagnosis codes. In accordance with CMS guidelines, OptumCare Medicare Advantage will apply diagnosis coding guidelines that identify codes that should never be billed as a principal diagnosis but should always be coded as a secondary or subsequent diagnosis code to ensure appropriate assignment of Inpatient DRG (Diagnostic Related Group) Payment. Please refer to Section II of the 2021 CMS coding guidelines.	Medicare	11/16/2023	Institutional
Rejection	VCD5f	Value code D5 is required on TOB 072X ESRD claims. Please update as applicable.	**Value Code D5 Not Present on ESRD Claim TOB 072x** All ESRD claims with dates of service on or after July 1, 2010, must indicate the applicable Kt/V reading for the dialysis patient. The reading result and the date of the reading must be reported on the claim Value Code D5 - Result of last Kt/V reading. This code is effective and required on all ESRD claims with dates of service on or after July 1, 2010. For in-center hemodialysis patients, this is the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this may be before the current billing period but should be within 4 months of the claim date of service. If the provider has not performed the Kt/V test for the patient the provider must attest that no test was performed by reporting the value code D5 with a 9.99 value. In addition, requirements also state that contractors shall return to the provider 072x bill types with dates of service on or after July 1, 2010, that do not contain a value code D5. In summary, the VCD5f will fire on a claim with bill type 072x without value code D5 to report the last Kt/V reading.	Medicare	3/23/2023	Institutional
Rejection	VCHf	An appropriate value code is required for HCPCS codes Q4081 or J0882. Please update as applicable.	**HCPCS Codes Q4081 or J0882 Requires Value Code 48 or 49** The VCHf edit will fire on an ESRD claim with Type of Bill (TOB) 72X on a line containing HCPCS codes J0882 or Q4081 and value code 48 or value code 49 is not submitted. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 8 - Section 60.4.1 - Epoetin Alfa (EPO) Facility Billing Requirements and Section 60.7.1 Darbepoetin Alfa (Aranesp) Facility Billing Requirements state the hematocrit reading taken prior to the last administration of EPO during the billing period must also be reported on the UB-04/Form CMS-1450 with value code 49. The hemoglobin reading taken during the billing period must be reported on the UB-04/Form CMS-1450 with value code 48. The hematocrit reading taken prior to the last administration of Aranesp during the billing period must also be reported on the UB-04/Form CMS-1450 with value code 49. A hemoglobin reading may be reported on Aranesp claims using value code 48. In addition it also states Effective January 1, 2012, ESRD facilities are required to report hematocrit or hemoglobin levels on all ESRD claims irrespective of ESA administration. Reporting the value 99.99 is not permitted when billing for an ESA. The CMS Transmittal 1307, date July 20, 2007 states renal dialysis facilities are required to report hematocrit or hemoglobin levels for their Medicare patients receiving erythropoietin products. Hematocrit levels are reported in value code 49 and reflect the most recent reading taken before the start of the billing period. Hemoglobin readings before the start of the billing period are reported in value code 48. In summary the VCHf edit will fire when value codes 48 or 49 are not submitted on an ESRD claim with TOB 72X and codes J0882 or Q4081 is present	Medicare	11/9/2023	Institutional
Rejection	CCRCf	Type of bill <1> requires an appropriate claim change reason code. Please update as applicable.	**Appropriate Claim Change Reason Code Required on Adjusted Claims** The edit will fire when a correct claim change reason code is not present on an adjusted claim with TOB XX7 or XX8. For reason codes D0-D4 and D7-D9, and E0 the biller submits a debit-only adjustment request, bill type xx7. For reason codes D5 and D6, it submits a cancel-only adjustment request, bill type xx8.	Medicaid	12/14/2023	Institutional
Rejection	uSPAM	Surgical code [<1>] requires an anatomical modifier. Please update as applicable.	**Surgical Procedure Anatomical Modifier Required** The uSPAM edit will fire on a surgical procedure claim line when the required anatomical modifier is missing. According to the Medicare Claims Processing Manual Chapter 23 Section 20.9.3.2- Medically Unlikely Edits: "Providers or suppliers shall use anatomic modifiers (e.g. RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) and report procedures with differing modifiers on individual claim lines when appropriate. Many MUEs are based on the assumption that correct modifiers are used." According to the MLN Connects Provider eNews page 3: "On October 1, 2015, ICD-10- CM will replace the ICD-9-CM code set currently used by providers for reporting diagnosis codes. Implementation of ICD- 10-CM will not change the reporting of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, including CPT/HCPCS modifiers for physician services. While ICD-10-CM codes have expanded detail, including specification of laterality for some conditions, providers will continue to follow CPT and CMS guidance in reporting CPT/HCPCS modifiers for laterality." Based on the current CPT® Professional Edition guidelines, "A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code." In addition, the current CPT® Professional Edition guidelines state, modifier 59 should only be used if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances, CPT/HCPCS modifiers for laterality." Per Medicare Claims Processing Manual Chapter 23 Section 40.7: "A. General Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. The terminology for some procedure codes includes the terms "bilateral" (e.g., code 27395; Lengthening of the hamstring tendon; multiple, bilateral.) or "unilateral or bilateral" (e.g., code 52290; cystourethroscopy; with ureteral meatotomy, unilateral or bilateral). The payment adjustment rules for bilateral surgeries do not apply to procedures identified by CPT as "bilateral" or "unilateral or bilateral" since the fee schedule reflects any additional work required for bilateral surgeries. Field 22 of the MFSDB indicates whether the payment adjustment rules apply to a surgical procedure. B. Billing Instructions for Bilateral Surgeries If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral), physicians must report the procedure with modifier "-50." They report such procedures as a single line item. (NOTE: This differs from the CPT coding guidelines which indicate that bilateral procedures should be billed as two-line items.) If a procedure is identified by the terminology as bilateral (or unilateral or bilateral), as in codes 27395 and 52290, physicians do not report the procedure with modifier "-50." C. Claims Processing System Requirements A/B MACs (B) must be able to: 1. Identify bilateral surgeries by the presence on the claim form or electronic submission of the "-50" modifier or of the same code on separate lines reported once with modifier "-LT" and once with modifier "-RT"; 2. Access Field 34 or 35 of the MFSDB to determine the Medicare payment amount; 3. Access Field 22 of the MFSDB: • If Field 22 contains an indicator of "0," "2," or "3," the payment adjustment rules for bilateral surgeries do not apply. Base payment on the lower of the billed amount or 100 percent of the fee schedule amount (Field 34 or 35) unless other payment adjustment rules apply. NOTE: Some codes which have a bilateral indicator of "0" in the MFSDB may be performed more than once on a given day. These are services that would never be considered bilateral and thus should not be billed with modifier "-50." Where such a code is billed on multiple line items or with more than 1 in the units field and A/B MACs (B) have determined that the code may be reported more than once, bypass the "0" bilateral indicator and refer to the multiple surgery field for pricing; • If Field 22 contains an indicator of "1," the standard adjustment rules apply. Base payment on the lower of the billed amount or 150 percent of the fee schedule amount (Field 34 or 35). (Multiply the payment amount in Field 34 or 35 for the surgery by 150 percent and round to the nearest cent.) 4. Apply the requirements §§40 - 40.4 on global surgeries to bilateral surgeries; and 5. Retain the "-50" modifier in history for any bilateral surgeries paid at the adjusted amount. (NOTE: The "-50" modifier is not retained for surgeries which are bilateral by definition such as code 27395.)"	Medicaid	8/15/2024	Professional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Rejection	uSPAM	Surgical code [<1>] requires an anatomical modifier. Please update as applicable.	**Surgical Procedure Anatomical Modifier Required** The uSPAM edit will fire on a surgical procedure claim line when the required anatomical modifier is missing. According to the Medicare Claims Processing Manual Chapter 23 Section 20.9.3.2- Medically Unlikely Edits: "Providers or suppliers shall use anatomic modifiers (e.g. RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) and report procedures with differing modifiers on individual claim lines when appropriate. Many MUEs are based on the assumption that correct modifiers are used." According to the MLN Connects Provider eNews page 3: "On October 1, 2015, ICD-10- CM will replace the ICD-9-CM code set currently used by providers for reporting diagnosis codes. Implementation of ICD- 10-CM will not change the reporting of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, including CPT/HCPCS modifiers for physician services. While ICD-10-CM codes have expanded detail, including specification of laterality for some conditions, providers will continue to follow CPT and CMS guidance in reporting CPT/HCPCS modifiers for laterality." Based on the current CPT® Professional Edition guidelines, "A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code." In addition, the current CPT® Professional Edition guidelines state, modifier 59 should only be used if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances, CPT/HCPCS modifiers for laterality." Per Medicare Claims Processing Manual Chapter 23 Section 40.7: "A. General Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. The terminology for some procedure codes includes the terms "bilateral" (e.g., code 27395; Lengthening of the hamstring tendon; multiple, bilateral.) or "unilateral or bilateral" (e.g., code 52290; cystourethroscopy; with ureteral meatotomy, unilateral or bilateral). The payment adjustment rules for bilateral surgeries do not apply to procedures identified by CPT as "bilateral" or "unilateral or bilateral" since the fee schedule reflects any additional work required for bilateral surgeries. Field 22 of the MFSDB indicates whether the payment adjustment rules apply to a surgical procedure. B. Billing Instructions for Bilateral Surgeries If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral), physicians must report the procedure with modifier "-50." They report such procedures as a single line item. (NOTE: This differs from the CPT coding guidelines which indicate that bilateral procedures should be billed as two-line items.) If a procedure is identified by the terminology as bilateral (or unilateral or bilateral), as in codes 27395 and 52290, physicians do not report the procedure with modifier "-50." C. Claims Processing System Requirements A/B MACs (B) must be able to: 1. Identify bilateral surgeries by the presence on the claim form or electronic submission of the "-50" modifier or of the same code on separate lines reported once with modifier "-LT" and once with modifier "-RT"; 2. Access Field 34 or 35 of the MFSDB to determine the Medicare payment amount; 3. Access Field 22 of the MFSDB: • If Field 22 contains an indicator of "0," "2," or "3," the payment adjustment rules for bilateral surgeries do not apply. Base payment on the lower of the billed amount or 100 percent of the fee schedule amount (Field 34 or 35) unless other payment adjustment rules apply. NOTE: Some codes which have a bilateral indicator of "0" in the MFSDB may be performed more than once on a given day. These are services that would never be considered bilateral and thus should not be billed with modifier "-50." Where such a code is billed on multiple line items or with more than 1 in the units field and A/B MACs (B) have determined that the code may be reported more than once, bypass the "0" bilateral indicator and refer to the multiple surgery field for pricing; • If Field 22 contains an indicator of "1," the standard adjustment rules apply. Base payment on the lower of the billed amount or 150 percent of the fee schedule amount (Field 34 or 35). (Multiply the payment amount in Field 34 or 35 for the surgery by 150 percent and round to the nearest cent.) 4. Apply the requirements §§40 - 40.4 on global surgeries to bilateral surgeries; and 5. Retain the "-50" modifier in history for any bilateral surgeries paid at the adjusted amount. (NOTE: The "-50" modifier is not retained for surgeries which are bilateral by definition such as code 27395.)"	Medicare	8/15/2024	Professional
Rejection	mDDMOD1	Single dose drug <1> billed with NDC <2> should be submitted with JW or JZ modifier. Please update code(s) as applicable	**Discarded Drug Modifier** If adjusted procedure code is found on procedure to NDC list and current line NDC is on same row as procedure code from list and current line does not contain modifier JW or JZ in any position, then fire the edit with the message below.	Medicare	8/15/2024	Professional
Rejection	uSPAMF	Surgical code [<1>] requires an anatomical modifier. Please update as applicable.	**Surgical Procedure Anatomical Modifier Required** The uSPAM edit will fire on a surgical procedure claim line when the required anatomical modifier is missing. According to the Medicare Claims Processing Manual Chapter 23 Section 20.9.3.2- Medically Unlikely Edits: "Providers or suppliers shall use anatomic modifiers (e.g. RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) and report procedures with differing modifiers on individual claim lines when appropriate. Many MUEs are based on the assumption that correct modifiers are used." According to the MLN Connects Provider eNews page 3: "On October 1, 2015, ICD-10- CM will replace the ICD-9-CM code set currently used by providers for reporting diagnosis codes. Implementation of ICD- 10-CM will not change the reporting of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, including CPT/HCPCS modifiers for physician services. While ICD-10-CM codes have expanded detail, including specification of laterality for some conditions, providers will continue to follow CPT and CMS guidance in reporting CPT/HCPCS modifiers for laterality." Based on the current CPT® Professional Edition guidelines, "A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code." In addition, the current CPT® Professional Edition guidelines state, modifier 59 should only be used if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances, CPT/HCPCS modifiers for laterality." Per Medicare Claims Processing Manual Chapter 23 Section 40.7: "A. General Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. The terminology for some procedure codes includes the terms "bilateral" (e.g., code 27395; Lengthening of the hamstring tendon; multiple, bilateral.) or "unilateral or bilateral" (e.g., code 52290; cystourethroscopy; with ureteral meatotomy, unilateral or bilateral). The payment adjustment rules for bilateral surgeries do not apply to procedures identified by CPT as "bilateral" or "unilateral or bilateral" since the fee schedule reflects any additional work required for bilateral surgeries. Field 22 of the MFSDB indicates whether the payment adjustment rules apply to a surgical procedure. B. Billing Instructions for Bilateral Surgeries If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral), physicians must report the procedure with modifier "-50." They report such procedures as a single line item. (NOTE: This differs from the CPT coding guidelines which indicate that bilateral procedures should be billed as two-line items.) If a procedure is identified by the terminology as bilateral (or unilateral or bilateral), as in codes 27395 and 52290, physicians do not report the procedure with modifier "-50." C. Claims Processing System Requirements A/B MACs (B) must be able to: 1. Identify bilateral surgeries by the presence on the claim form or electronic submission of the "-50" modifier or of the same code on separate lines reported once with modifier "-LT" and once with modifier "-RT"; 2. Access Field 34 or 35 of the MFSDB to determine the Medicare payment amount; 3. Access Field 22 of the MFSDB: • If Field 22 contains an indicator of "0," "2," or "3," the payment adjustment rules for bilateral surgeries do not apply. Base payment on the lower of the billed amount or 100 percent of the fee schedule amount (Field 34 or 35) unless other payment adjustment rules apply. NOTE: Some codes which have a bilateral indicator of "0" in the MFSDB may be performed more than once on a given day. These are services that would never be considered bilateral and thus should not be billed with modifier "-50." Where such a code is billed on multiple line items or with more than 1 in the units field and A/B MACs (B) have determined that the code may be reported more than once, bypass the "0" bilateral indicator and refer to the multiple surgery field for pricing; • If Field 22 contains an indicator of "1," the standard adjustment rules apply. Base payment on the lower of the billed amount or 150 percent of the fee schedule amount (Field 34 or 35). (Multiply the payment amount in Field 34 or 35 for the surgery by 150 percent and round to the nearest cent.) 4. Apply the requirements §§40 - 40.4 on global surgeries to bilateral surgeries; and 5. Retain the "-50" modifier in history for any bilateral surgeries paid at the adjusted amount. (NOTE: The "-50" modifier is not retained for surgeries which are bilateral by definition such as code 27395.)"	Medicare	8/29/2024	Institutional
Rejection	mHCS	Per Medicare guidelines, HCPCS code G0472 is not a covered service when submitted without ICD-10 CM code Z72.89 or F19.20 for a Medicare beneficiary born prior to 1945 or after 1965. Please update as applicable.	**Medicare Hepatitis C Screening Service**s The edit identifies claim lines with HCPCS code G0472 for beneficiaries born prior to 1945 or after 1965 who are not at high risk, reported without ICD-10 CM codes Z72.89 or F19.20.	Medicare	8/29/2024	Professional
Rejection	IDUP	Diagnosis code(s) <1> may only be reported once per claim line. Please update as	**Duplicate Diagnosis Code** The ICD-10-CM Official Guidelines for Coding and Reporting state, "Each unique ICD-10-CM diagnosis code may be reported only once for an encounter."	Medicare	8/29/2024	Professional
Rejection	mTHP	Per Medicare guidelines telehealth procedure code <1> must be performed in POS 02. Please update as applicable.	**Telehealth Place of Service** The mTHP edit utilizes the Centers for Medicare and Medicaid Services (CMS) guidelines to identify when procedure codes specific to telehealth services have been submitted without Place of Service (POS) indicator 02.	Medicare	8/29/2024	Professional
Rejection	mLIH	Per Medicare guidelines, procedure code <1> describes a diagnostic procedure that requires a professional component modifier in POS <2>. Please update as applicable.	**Laboratory Interpretation in Hospital** The edit identifies claim lines that contain procedure codes identified by the indicator of "6" in the PC/TC column of the CMS Physician Fee Schedule (MPFS), and the modifier code 26 is not appended appropriately when submitted with an inpatient or outpatient hospital place of service code in the system list Diagnostic Tests POS Codes. Following the MPFS and the Code of Federal Regulations, only the interpretation should be billed by the physician when billed with an inpatient or outpatient hospital, or skilled nursing facility place of service. The MPFS assigns the indicator of "6" in the PC/TC column for laboratory interpretation codes. Modifier code 26 is submitted to identify the laboratory physician's interpretation of tests performed. Attachment A of the MPFS defines the indicator "6" in the PC/TC column as follows: "6 = Laboratory Physician Interpretation Codes--This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense, and malpractice expense."	Medicare	8/29/2024	Professional
Rejection	mHCS	Per Medicare guidelines, HCPCS code G0472 is not a covered service when submitted without ICD-10 CM code Z72.89 or F19.20 for a Medicare beneficiary born prior to 1945 or after 1965. Please update as applicable.	**Medicare Hepatitis C Screening Service**s The edit identifies claim lines with HCPCS code G0472 for beneficiaries born prior to 1945 or after 1965 who are not at high risk, reported without ICD-10 CM codes Z72.89 or F19.20.	Medicaid	8/29/2024	Professional
Rejection	IDUP	Per Medicare guidelines telehealth procedure code <1> must be performed in POS 02. Please update as applicable.	**Duplicate Diagnosis Code** The ICD-10-CM Official Guidelines for Coding and Reporting state, "Each unique ICD-10-CM diagnosis code may be reported only once for an encounter."	Medicaid	8/29/2024	Professional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Rejection	sLIH	Per Medicare guidelines, procedure code <1> describes a diagnostic procedure that requires a professional component modifier in POS <2>. Please update as applicable.	**Laboratory Interpretation in Hospital** The edit identifies claim lines that contain procedure codes identified by the indicator of "6" in the PC/TC column of the CMS Physician Fee Schedule (MPFS), and the modifier code 26 is not appended appropriately when submitted with an inpatient or outpatient hospital place of service code in the system list Diagnostic Tests POS Codes. Following the MPFS and the Code of Federal Regulations, only the interpretation should be billed by the physician when billed with an inpatient or outpatient hospital, or skilled nursing facility place of service. The MPFS assigns the indicator of "6" in the PC/TC column for laboratory interpretation codes. Modifier code 26 is submitted to identify the laboratory physician's interpretation of tests performed. Attachment A of the MPFS defines the indicator "6" in the PC/TC column as follows: "6 = Laboratory Physician Interpretation Codes--This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense, and malpractice expense."	Medicaid	8/29/2024	Professional
Rejection	uCCER	Critical Care Code Current adjusted procedure code is not typical when patient is discharged home from ER. Please evaluate coding.	**Critical Care in an ER Setting when Patient is Discharged Home - PE** The CPT® Professional Edition guidelines state, "Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition." The definition for 99291 states: "Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes." The definition for 99292 states: "Each additional 30 minutes." The CPT®/AMA code critical care code descriptors state, "Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes." Additionally, "Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)." The Medicare Claims Processing Manual Chapter 12 guidelines state, "Critical care is defined as the direct delivery by a physician(s) medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition	Medicare	9/12/2024	Professional
Rejection	uCCER	Critical Care Code Current adjusted procedure code is not typical when patient is discharged home from ER. Please evaluate coding.	**Critical Care in an ER Setting when Patient is Discharged Home - PE** The CPT® Professional Edition guidelines state, "Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition." The definition for 99291 states: "Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes." The definition for 99292 states: "Each additional 30 minutes." The CPT®/AMA code critical care code descriptors state, "Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes." Additionally, "Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)." The Medicare Claims Processing Manual Chapter 12 guidelines state, "Critical care is defined as the direct delivery by a physician(s) medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition	Medicaid	9/12/2024	Professional
Return	sMOD	Use of modifier(s) <1> is not typical for procedure code <2>. Please update as applicable.	**Medicaid Modifier Not Appropriate** The flag fires on a claim line that does not have the appropriate modifier appended for use with a particular CPT® or HCPCS procedure code that does not have an indicator of 2, 3, 4, 5, 6 or 7 in the multiple procedure column of the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) and is submitted with an inappropriate modifier. This flag is sourced to the current CPT® Professional Edition guidelines, which state, "A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code." Additional support for modifier use is found in Coding with Modifiers, published by the American Medical Association (AMA) which states, "The CPT code set nomenclature uses modifiers as an integral part of its structure. A modifier provides a means by which a physician or other qualified health care professional can indicate a service or procedure was altered by specific circumstances but not changed in its definition or code." The Centers for Medicare and Medicaid Services (CMS) internet policy for HCPCS modifier code guidelines state, "A modifier provides the means by which the reporting physician or provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code." Optum bases coding relationships and edits in the KnowledgeBase on generally accepted third-party industry sources like the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), and published specialty specific coding rules when these rules and/or guidelines are available. Both the CPT® Professional Edition and the HCPCS Level II Expert provide a list of place of service codes and a description of the most common locations where these codes would take place.	Medicaid	9/12/2024	Professional
Return	sNBT	Per Medicaid guidelines, procedure code <1> and procedure code <2> on claim ID <3> cannot be billed together. Please update as applicable.	**EPSDT Vaccines and Administration - Not Billed Together** Early Periodic Screening, Diagnosis & Treatment (EPSDT) Program Billing Guide: "What vaccines are free from the Department of Health (DOH) for clients age 18 and younger? No-cost immunizations from DOH are available for clients age 18 and younger. See the Professional Administered Drug Fee Schedule for a list of immunizations that are free from DOH. Therefore, HCA pays only for administering the vaccine. · In a nonfacility setting: Bill for the vaccine by reporting the procedure code for the vaccine given with modifier SL (e.g. 90707 SL). HCA pays for the administrative cost for those vaccines that are free from DOH and are billed with modifier SL (e.g., 90707 SL). DO NOT bill procedure codes 90460-90461 or 90471-90472 for the administration."	Medicaid	9/12/2024	Professional
Return	RFVRf	A patient reason for visit diagnosis code is required. Please update as applicable.	**Patient Reason for Visit Required** Patient's Reason for Visit code required on 013x, 078x and 085x claims when Type of Admission or Visit codes 1, 2 or 5 are reported along with Revenue Codes 045x, 0516, 0526, or 0762.	Medicaid	9/12/2024	Institutional
Return	IDDMf	The discharge date is missing. Please update as applicable.	**Inpatient Facility Discharge Date Missing** An invalid discharge date is a discharge date that does not fall into the acceptable range of numbers to represent, either the month, day or year (e.g., 13/03/01, 12/32/01). If no discharge date is entered, it is also invalid. MCE reports when an invalid discharge date is entered	Medicaid	9/12/2024	Institutional
Return	TOAFf	Type of Admission Code 4 (newborn), cannot be billed more than once in a lifetime. Please update as applicable.	**Type of Admission Frequency** The TOAFf edit will fire when the Type of Admission code 4 (Newborn), is submitted on more than one claim. Per the Official UB-04 Data Specifications Manual 2018, Version 12.00, "Any human should only have a Priority (Type of Admission) (FL 14) = 4 once in their lifetime." In summary, the TOAFf edit is to ensure the Type of Admission code 4 is not submitted on more than one claim	Medicaid	9/19/2024	Institutional
Return	TOAFf	This claim has an invalid type of admission code <1>. Please update as applicable.	**Invalid Type of Admission** The TOAf edit will fire when a claim is submitted with a missing or invalid Type of Admission code. This is based on requirements from the National Uniform Billing Committee (NUBC) and the Centers for Medicare and Medicaid Services (CMS). The Official UB-04 Data Specifications Manual defines the Type of Admission code as "a code indicating the priority of this admission/visit." Form Locator (FL) 14 is a required field. The Medicare Claims Processing Manual, Chapter 25 Completing and Processing the Form CMS-1450 Data Set, Section 75.1 Form Locators 1- 15 is consistent with this requirement and states that FL 14 - Priority (Type) of Admission or Visit is required. CMS Transmittal R2250CP, Non-systems Internet Only Manual (IOM) Changes, dated July 1, 2011 updates the requirement for FL 14. It states, "Per the National Uniform Billing Committee (NUBC), the Priority (Type) of Admission or Visit	Medicaid	9/19/2024	Institutional
Return	sUN	Per Medicaid CCI Guidelines, procedure code <1> has an unbundle relationship with history procedure code <2>, on claim ID <3> and line ID <4>. Please update as applicable.	**Medicaid National Correct Coding Initiative (NCCI) Unbundle** The Medicaid National Correct Coding Initiative Edits history edit, sUH, verifies if the procedure code on a claim line in history is billed with any other procedure for the same patient on the same day by the same provider. If the codes cannot be billed together and the code in history is the deny code and on a separate claim, the sUH edit will apply. The Medicaid National Correct Coding Initiative (NCCI) Policy Manual for Medicaid Services states, "CMS established the National Correct Coding Initiative (NCCI) program to ensure the correct coding of services. The NCCI program includes two types of edits: NCCI Procedure-to-Procedure (PTP) edits and Medically Unlikely Edits (MUEs). NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column One and Column Two HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the Column One code is eligible for payment and the Column Two code is denied. However, if it is clinically appropriate to utilize an NCCI PTP-associated modifier, both the Column One and Column Two codes are eligible for payment. (NCCI PTP-associated modifiers and their appropriate use are discussed in Section E of this chapter.)" The "Mutually Exclusive" procedures are codes which cannot reasonably be performed at the same anatomic site or same patient encounter. The NCCI Manual defines these procedures as, "Pairs of HCPCS/CPT codes that are mutually exclusive of 1 another based either on the HCPCS/CPT code descriptors or the medical impossibility/improbability that the 2 procedures could be performed at the same patient encounter are included in the NCCI PTP edit tables." Accordingly, each NCCI PTP edit has an assigned modifier indicator. Chapter I, section E. Modifiers and Modifier Indicators of the NCCI manual states, "Each NCCI PTP edit has an assigned Correct Coding Modifier Indicator (CCMI). A CCMI of "0" indicates that NCCI PTP-associated modifiers cannot be used to bypass the edit. A CCMI of "1" indicates that NCCI PTP-associated modifiers may be used to bypass an edit under appropriate circumstances. However, if both codes in the edit pair have the same anatomic modifier and neither code has modifier 58, 59, 78, 79, XE, XP, XS, or XU, the PTP edit is not bypassed. A CCMI of "9" indicates that the use of NCCI PTP- associated modifiers is not specified. This indicator is used for all code pairs that have a deletion date that is the same as the effective date. This indicator prevents blank spaces from appearing in the indicator field. The CCMI can be found in the files containing MCD NCCI PTP edits on the CMS webpage." In addition, the NCCI Manual addresses the use of NCCI PTP- associated modifiers which can be used in some code relationships when appropriate to override the edit. In general these circumstances relate to separate patient encounters, anatomic sites or specimens. As stated in the NCCI Manual, "Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier shall not be appended to a HCPCS/CPT code solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use. If a State Medicaid program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI PTP edit if the Medicaid restrictions are fulfilled." "Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: Anatomic modifiers: E1-E4, FA, F1- F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI Global surgery modifiers: 24, 25, 57, 58, 78, 79 Other modifiers: 27, 59, 91, XE, XP, XS, XU" "Modifiers XE, XP, XS, XU: These modifiers were effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.) Although NCCI will eventually require use of these modifiers rather than modifier 59 with certain edits, physicians may begin using them for claims with dates of service on or after January 1, 2015. The modifiers are defined as follows:" XE - "Separate encounter, A service that is distinct because it occurred during a separate encounter" This modifier shall only be used to describe separate encounters on the same date of service. XP - "Separate Practitioner, A service that is distinct because it was performed by a different practitioner" XS - "Separate Structure, A service that is distinct because it was performed on a separate organ/structure" XU - "Unusual Non- Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service" An appropriately used NCCI PTP-associated modifier may be appended to the column one code, column two code or both codes in the NCCI PTP edit pair to bypass the NCCI PTP edit. The Medicaid NCCI Technical Guidance	Medicaid	9/19/2024	Institutional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Rejection	sUNf	Guidelines, procedure code <1> has an unbundle relationship with history procedure code <2>, on claim ID <3> and line ID <4>. Please update as applicable.	**Medicaid Unbundle** The Medicaid unbundle edit sUNhf verifies if the procedure code on a claim line in history is billed with any other procedure for the same patient on the same day by the same provider. If the codes cannot be billed together and the code in history is the deny code and on a separate claim the sUNhf edit will trigger. The National Correct Coding Initiative (NCCI) Policy Manual for Medicaid Services states, "CMS developed the NCCI to prevent inappropriate payment of services that should not be reported together. Medicaid NCCI (MCDNCCI) and Medicare NCCI methodology files differ. The Medicaid NCCI procedure-to-procedure edit file for each of the two Medicaid NCCI methodologies (practitioner/ambulatory surgical center NCCI files and outpatient hospital NCCI file) contain only one column one/column two correct coding edit (CCE) file, rather than separate CCE and mutually exclusive (ME) files. For the Medicaid NCCI methodology files, the CCE and ME files are combined into a single CCE file." Each NCCI edit has an assigned modifier indicator. If the modifier indicator of the edit is "0", the column two code is denied (not payable) regardless of whether an NCCI PTP-associated modifier is appended. These edits cannot be bypassed. If the modifier indicator of the edit is "1" and if no NCCI PTP-associated modifier is correctly appended to either code, the column two code is denied. If the modifier indicator of the edit is "1" and if an NCCI PTP-associated modifier is correctly appended to an appropriate code in the edit, the PTP edit is bypassed and the column two code is eligible for payment. An exception to this rule is that if both codes have the same anatomical modifier (see above) and neither code has modifier 58, 59, 78, 79, XE, XP, XS, or XU, the PTP edit is NOT bypassed and the column two code is denied. If the modifier indicator of the edit is "9", both codes are eligible for payment. The corresponding edit is inactive and was deleted retroactive to its implementation date. In addition, the NCCI Manual addresses the use of NCCI associated modifiers which can be used in some code relationships when appropriate to override the edit. In general these circumstances relate to separate patient encounters, anatomic sites or specimens. As stated in the NCCI Manual, "Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI edit if the clinical circumstances do not justify its use. If a State Medicaid program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI edit if the Medicaid restrictions are fulfilled." NCCI PTP-Associated Modifiers The NCCI PTP-associated modifiers are the following: Anatomical modifiers: RT, LT, E1 - E4, FA, F1 - F9, TA, T1 - T9, LC, LD, LM, RC, RI Non-anatomical modifiers: 24, 25, 27, 57, 58, 59, 78, 79, 91, XE, XP, XS, XU Modifiers XE, XP, XS, XU: These modifiers were effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.) Although NCCI will eventually require use of these modifiers rather than modifier 59 with certain edits, physicians may begin using them for claims with dates of service on or after January 1, 2015. Providers may append an NCCI PTP-associated modifier to either or both of the codes of the code pair. The sUNhf edit reviews if the current claim line procedure code and a procedure code on a separate claim in history have an unbundle relationship per Medicaid.	Medicaid	9/19/2024	Professional
Return	THSf	Procedure code <1> is a telehealth service and must be billed with revenue code 0780 for Rural Health Clinic (RHC) claims. Please update as applicable.	**Telehealth Services RHC Must Be Billed With Revenue Code 0780** The THSf edit will fire on an outpatient claim, type of bills (TOBs) 012X, 013X, 022X, 023X, 071X, 072X, 073X, 076X and 085X, when a CPT/HCPCS code is submitted for Telehealth services without revenue code 0780. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS). CMS transmittal R1637OTN, Required Billing Updates for Rural Health Clinic, dated March 23, 2016 states, "Contractors shall continue to pay for Telehealth services with revenue code 0780 and HCPCS code Q3014." CMS Claim Processing Manual Chapter 12, Section 190.5 and CMS transmittal R3476CP, Telehealth Services, dated March 2016 agrees with this requirement as it states, "To receive the originating facility site fee, the provider submits claims with HCPCS code "Q3014, telehealth originating site facility fee"; short description "telehealth facility fee." It also states, "This benefit may be billed on bill types 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, and 85X. Unless otherwise applicable, report the originating site facility fee under revenue code 078X and include HCPCS code "Q3014, telehealth originating site facility fee." In summary, the THSf edit is to ensure claim lines where Telehealth services are provided, are billed with revenue code 0780 for hospital outpatient claims.	Medicare	10/3/2024	Institutional
Return	THSf	Procedure code <1> is a telehealth service and must be billed with revenue code 0780 for outpatient hospital claims. Please update as applicable.	**Telehealth Services Must Be Billed With Revenue Code 0780** The THSf edit will fire on an outpatient claim, type of bills (TOBs) 012X, 013X, 022X, 023X, 071X, 072X, 073X, 076X and 085X, when a CPT/HCPCS code is submitted for Telehealth services without revenue code 0780. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS). CMS transmittal R1637OTN, Required Billing Updates for Rural Health Clinic, dated March 23, 2016 states, "Contractors shall continue to pay for Telehealth services with revenue code 0780 and HCPCS code Q3014." CMS Claim Processing Manual Chapter 12, Section 190.5 and CMS transmittal R3476CP, Telehealth Services, dated March 2016 agrees with this requirement as it states, "To receive the originating facility site fee, the provider submits claims with HCPCS code "Q3014, telehealth originating site facility fee"; short description "telehealth facility fee." It also states, "This benefit may be billed on bill types 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, and 85X. Unless otherwise applicable, report the originating site facility fee under revenue code 078X and include HCPCS code "Q3014, telehealth originating site facility fee." In summary, the THSf edit is to ensure claim lines where Telehealth services are provided, are billed with revenue code 0780 for hospital outpatient claims.	Medicare	10/3/2024	Institutional
Return	SNSBf	Inpatient Skilled Nursing Facility (SNF) or Swing Bed type of bill (TOB) code <1> requires discharge disposition 30 when occurrence code 22 is on the claim and the occurrence code date is equal to the through date.	**Inpatient Skilled Nursing Facility and Swing Bed Requirements for Occurrence Code 22** The SNSBf edit will fire on a Skilled Nursing Facility (SNF) claim (TOB 021X) or a Swing Bed claim (TOB 018X) when occurrence code 22 is present and the occurrence code 22 date is equal to the through date of the claim and the patient discharge status code is not 30. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS). CMS Transmittal R2146OTN, Update to Common Working File (SWF) Benefit Period Logic for Occurrence Code 22 on Skilled Nursing Facility (SNF) and Swing Bed Inpatient Claims, dated October 5, 2018 supports this requirement. It states, "The Medicare contractor shall create a reason code to return to provider (RTP) SNF claims with type of bill (TOB) 21X or Swing Bed claims with TOB 18X with OC 22 and: OC 22 date is equal to the through date of the claim and the patient discharge status code is not 30." The Medicare Claims Processing Manual, Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing, Section 30 - Billing SNF PPS Services states SNFs and hospital swing bed providers are required to report inpatient Part A Prospective Payment System (PPS) billing using Type of Bill 021X for SNF inpatient services or 018X for hospital swing bed services. The Claims Processing Manual, Chapter 6, Section 10.2, Types of Facilities Subject to the Consolidated Billing Requirement for SNFs, states "consolidated billing applies to short term hospitals, long term hospitals, and rehabilitation hospitals certified as swing bed hospitals except CAHs certified as swing bed hospitals." Chapter 6, Section 100, Part A SNF PPS for Hospital Swing Bed Facilities states, "Part A SNF PPS applies to short-term hospitals, long-term care hospitals, and rehabilitation hospitals that have Medicare swing bed agreements. CAHs with swing beds are exempt from the Part A SNF PPS, and are not affected by these instructions." Per CMS transmittal R1108CP, Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims, dated 11/09/2006, providers billing for their primary facility and its subparts are required to report a taxonomy code on all claims. In addition, it states CAHs that are certified as a swing bed hospital should bill on Type of Bill (TOB) X8X with a taxonomy code of 282NC0060X to define the type of facility. Claims on a 18X TOB with the taxonomy code for a CAH that is certified as a swing bed hospital will be excluded from the rule. In summary, the SNSBf edit will fire on SNF and Swing Bed claims with occurrence code 22 when the date associated with the occurrence code is equal to the through date of the claim and the patient status code is not 30.	Medicare	10/3/2024	Institutional
Return	SNFTf	Revenue code 0022 can only be billed on TOB 021X or 018X. Please update as applicable.	**Skilled Nursing Facility Type of Bill** The SNFTf edit will fire on claims where revenue code 0022 is present and the Type of Bill (TOB) is not a Skilled Nursing Facility (SNF) (TOB 021X) or a Swing Bed (TOB 018X). This is based on guidelines from the Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing, Section 30 - Billing SNF PPS Services states, Revenue code 0022 is required to indicate that the claim is "being paid under the SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS Rate Code(s) and assessment periods." It also states, "Use Type of Bill 21X for SNF inpatient services or 18X for hospital swing bed services." In summary, the SNFTf edit will fire when a claim is submitted with revenue code 0022 and the TOB is not 021X or 018X.	Medicare	10/3/2024	Institutional
Return	sUH	Per Medicaid CCI Guidelines, history procedure code <2> on history line ID <4> and claim ID <3> has an unbundle relationship with the procedure code <1>. Please update as applicable.	**Medicaid Unbundle** The Medicaid National Correct Coding Initiative Edits history edit, sUH, verifies if the procedure code on a claim line in history is billed with any other procedure for the same patient on the same day by the same provider. If the codes cannot be billed together and the code in history is the deny code and on a separate claim, the sUH edit will apply. The Medicaid National Correct Coding Initiative (NCCI) Policy Manual for Medicaid Services states, "CMS established the National Correct Coding Initiative (NCCI) program to ensure the correct coding of services. The NCCI program includes two types of edits: NCCI Procedure-to-Procedure (PTP) edits and Medically Unlikely Edits (MUEs). NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column One and Column Two HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the Column One code is eligible for payment and the Column Two code is denied. However, if it is clinically appropriate to utilize an NCCI PTP-associated modifier, both the Column One and Column Two codes are eligible for payment. (NCCI PTP-associated modifiers and their appropriate use are discussed in Section E of this chapter.)" The "Mutually Exclusive" procedures are codes which cannot reasonably be performed at the same anatomic site or same patient encounter. The NCCI Manual defines these procedures as, "Pairs of HCPCS/CPT codes that are mutually exclusive of 1 another based either on the HCPCS/CPT code descriptors or the medical impossibility/improbability that the 2 procedures could be performed at the same patient encounter are included in the NCCI PTP edit tables." Accordingly, each NCCI PTP edit has an assigned modifier indicator. Chapter I, section E. Modifiers and Modifier Indicators of the NCCI manual states, "Each NCCI PTP edit has an assigned Correct Coding Modifier Indicator (CCMI). A CCMI of "0" indicates that NCCI PTP-associated modifiers cannot be used to bypass the edit. A CCMI of "1" indicates that NCCI PTP-associated modifiers may be used to bypass an edit under appropriate circumstances. However, if both codes in the edit pair have the same anatomic modifier and neither code has modifier 58, 59, 78, 79, XE, XP, XS, or XU, the PTP edit is not bypassed. A CCMI of "9" indicates that the use of NCCI PTP- associated modifiers is not specified. This indicator is used for all code pairs that have a deletion date that is the same as the effective date. This indicator prevents blank spaces from appearing in the indicator field. The CCMI can be found in the files containing MCD NCCI PTP edits on the CMS webpage." In addition, the NCCI Manual addresses the use of NCCI PTP- associated modifiers which can be used in some code relationships when appropriate to override the edit. In general these circumstances relate to separate patient encounters, anatomic sites or specimens. As stated in the NCCI Manual, "Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier shall not be appended to a HCPCS/CPT code solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use. If a State Medicaid program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI PTP edit if the Medicaid restrictions are fulfilled." "Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI Global surgery modifiers: 24, 25, 57, 58, 78, 79 Other modifiers: 27, 59, 91, XE, XP, XS, XU" "Modifiers XE, XP, XS, XU: These modifiers were effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.) Although NCCI will eventually require use of these modifiers rather than modifier 59 with certain edits, physicians may begin using them for claims with dates of service on or after January 1, 2015. The modifiers are defined as follows:" XE - "Separate encounter, A service that is distinct because it occurred during a separate encounter" This modifier shall only be used to describe separate encounters on the same date of service. XP - "Separate Practitioner, A service that is distinct because it was performed by a different practitioner" XS - "Separate Structure, A service that is distinct because it was performed on a separate organ/structure" XU - "Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual	Medicaid	10/10/2024	Professional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Return	sUBh	Per Medicaid Guidelines, History Procedure Code <1> on History line Ext/Int Line ID <2> on Claim <3> has an unbundle relationship with the Procedure Code <4>. Please update as applicable.	**EPSDT Examination - Bundled with Initial Health Evaluation History** The Medicaid unbundle edit (sUBh) uses state Medicaid policies and guidelines to verify that the procedure code on the current line and any other procedure code billed for the same patient within a specified period of time (days/months/years) by any provider can be billed together. If there is a procedure code in the patient's history which should not be billed with the current line's procedure code, the sUBh flag will edit on the claim line. Optum bases coding relationships and edits on guidelines from generally accepted third-party industry sources such as the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), published ICD-10 Official Guidelines for Coding and Reporting, and specialty-specific coding rules when these rules and/or guidelines are available. Individual states establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines. The Medicaid National Correct Coding Initiative (NCCI) Policy Manual and the NCCI Edit Files were developed for the purpose of encouraging consistent and correct coding thereby reducing inappropriate payments. The edits and policies do not include all possible combinations of correct coding edits or unbundling scenarios that may exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. Individual state Medicaid edits may differ from the CMS-published Medicaid NCCI Policy Manual and Edit Table. In this event, state Medicaid policy will supersede national policy. The sUBh edit reviews if the current Medicaid claim line procedure code and a procedure code on a separate claim in history have an unbundle relationship per Medicaid guidelines.	Medicaid	10/10/2024	Professional
Return	sUB	Per Medicaid Guidelines, Procedure Code <1> has an unbundle relationship with history Procedure Code <2>, Ext/Int Line ID <3> on Claim <4>. Please update as applicable.	**EPSDT Examination - Bundled with Initial Health Evaluation** The sUB edit uses state Medicaid policies and guidelines to verify that the procedure code on the current line and any other procedure code billed for the same patient within a specified period of time (days/months/years) by any provider can be billed together. If there is a procedure code in the patient's history which should not be billed with the current line's procedure code, the sUB flag is triggered. Optum bases coding relationships and edits on guidelines from generally accepted third-party industry sources such as the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), published ICD-10 Official Guidelines for Coding and Reporting, and specialty- specific coding rules when these rules and/or guidelines are available. Individual states establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines. The Medicaid National Correct Coding Initiative (NCCI) Policy Manual and the NCCI Edit Files were developed for the purpose of encouraging consistent and correct coding thereby reducing inappropriate payments. The edits and policies do not include all possible combinations of correct coding edits or unbundling scenarios that may exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. Individual state Medicaid edits may differ from the CMS-published Medicaid NCCI Policy Manual and Edit Table. In this event, state Medicaid policy will supersede national policy. The sUB edit will review if the current claim line procedure code and a procedure code on the same claim or a claim line in history have an unbundle relationship per Medicaid guidelines.	Medicaid	10/10/2024	Professional
Rejection	POS	Procedure code <1> is not typically performed by a provider in place of service <2> (<3>). Please update as applicable.	**Place of Service** This rule identifies claim lines where the place of service reported is not typical with the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) procedure code reported. The Centers for Medicare and Medicaid Services (CMS) maintains a list of place of service (POS) codes from the National POS code set. All place of service categories that have no third-party industry source, historical use, policies, or guidelines to direct development of specific coding relationships or edits, are appropriate for all CPT codes and HCPCS codes. The source of these edits will be identified as 'Broad Application'. Optum bases coding relationships and edits in the KnowledgeBase on generally accepted third-party industry sources like the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), and published specialty specific coding rules when these rules and/or guidelines are available. Both the CPT Professional Edition and the HCPCS Level II Expert provide a list of place of service codes and a description of the most common locations where these codes would take place. Unlisted procedure	Medicare	10/24/2024	Professional
Rejection	HDS	Hospital discharge services code 99238 and/or 99239 have been reported more than once per day. Only one individual may report a single hospital discharge service code per patient per day. Please update as applicable.	**Hospital Discharge Services Group Frequency Per Day** This rule identifies when hospital discharge service codes 99238, 99239 are reported more than once per day. The Medicare Claims Processing Manual guidelines regarding codes 99238 and 99239 states, "Only one hospital discharge day management service is payable per patient per hospital stay...Only the attending physician of record reports the discharge day management service." This is also supported by CPT Assistant guidelines stating, "The codes in the Hospital Discharge Services series (99238, 99239) are used by the attending physician or other qualified health care professional who provides care to patients being discharged, as long as the date of discharge is different from the date of admission." The American Medical Association (AMA) publication "Principles of CPT Coding" guidelines further state, "For concurrent care services provided by an individual other than the physician/QHP performing the discharge day management service, report subsequent hospital care codes (99231-99233) on the day of discharge."	Medicare	10/24/2024	Professional
Rejection	mMHB	Per Medicare guidelines, the associated vaccine code for administration procedure code <1>, is missing or invalid. Please update as applicable.	**Medicare Hepatitis Vaccine Administration Requires Drug** The mMHB edit utilizes the Centers for Medicare and Medicaid Services (CMS) guidelines found in the Medicare Claims Processing Manual, Medicare Benefit Policy Manual, and The Guide to Medicare Preventive Services to identify Hepatitis B procedures. This edit fires on all claim lines that contain a Hepatitis B vaccine code and a Hepatitis B administration code is not found for the same patient and same date of service, or on all claim lines that contain a Hepatitis adminstration code and a Hepatitis vaccine code is not found for the same patient and same date of service. Hepatitis B Vaccine guidelines: Medicare pays for the Hepatitis B virus (HBV) vaccine and administration for patients determined to be at intermediate or high risk for HBV infection. Medicare has defined persons at high risk as: •Individuals with End Stage Renal Disease (ESRD), •Individuals with hemophilia who received Factor VIII or IX concentrates, •Clients of institutions for the developmentally disabled, •Individuals who live in the same household as an HBV carrier, •Homosexual men, and •Illicit injectable drug users. Persons at intermediate risk are defined as: •Staff in institutions for the developmentally disabled, and •Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work. A physician order and supervision is required for the hepatitis B vaccine to be administered. A CPT® code for the vaccine (90739, 90740, 90743, 90744, 90746, or 90747) should be submitted with the administration code (G0010) along with a specific diagnosis code (V05.3 or Z23) The mMHB edit will identify if a Hepatitis B vaccine code has been	Medicare	10/24/2024	Professional
Rejection	mONF	Per Medicare Guidelines, HCPCS code <1> has exceeded the allowed frequency. Payment for HCPCS codes G1028, G2215 or G2216 is limited to once every 30 days unless an additional take home supply of the medication is medically reasonable and	**Medicare OTP Naloxone Frequency Rule** The mONF edit identifies claim line(s) where Opioid Treatment Program (OTP) service code G2215, G2216 or G1028 is reported more than the allowed unit of 1 within a span of 30 days as stated in the Medicare billing guidelines for these codes.	Medicare	10/24/2024	Professional
Rejection	POS	Procedure code <1> is not typically performed by a provider in place of service <2> (<3>). Please update as applicable.	**Place of Service** This rule identifies claim lines where the place of service reported is not typical with the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) procedure code reported. The Centers for Medicare and Medicaid Services (CMS) maintains a list of place of service (POS) codes from the National POS code set. All place of service categories that have no third-party industry source, historical use, policies, or guidelines to direct development of specific coding relationships or edits, are appropriate for all CPT codes and HCPCS codes. The source of these edits will be identified as 'Broad Application'. Optum bases coding relationships and edits in the KnowledgeBase on generally accepted third-party industry sources like the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), and published specialty specific coding rules when these rules and/or guidelines are available. Both the CPT Professional Edition and the HCPCS Level II Expert provide a list of place of service codes and a description of the most common locations where these codes would take place. Unlisted procedure	Medicaid	10/24/2024	Professional
Rejection	NDCP	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. Misrouted claim. See the payer's claim submission	**Non-Delegated Claims Processing** OptumCare is not delegated to process claims for this payor/contractor and should be sent to the correct payor/contract for processing.	Medicare	10/24/2024	Professional
Rejection	NDCPf	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. Misrouted claim. See the payer's claim submission	**Non-Delegated Claims Processing** OptumCare is not delegated to process claims for this payor/contractor and should be sent to the correct payor/contract for processing.	Medicare	10/24/2024	Institutional
Rejection	MGAf	REJECT - The presence of modifier GA indicates that a waiver of liability statement is issued and service may deny as beneficiary	**Modifier GA - Facility** This edit will fire on items or services that are submitted with modifier GA signifying that a required Advanced Beneficiary Notice (ABN) has been submitted and line item should deny as beneficiary liable. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).	Medicare	11/14/2024	Institutional
Return	MGZf	The presence of modifier GZ indicates this is not eligible for	**Modifier GZ - Facility** This edit will fire when a line item is submitted with modifier GZ to signify that an ABN is not file. These line items are submitted as non- covered and will be denied as provider liable	Medicare	11/14/2024	Institutional
Rejection	sMGZ	REJECT - Per Medicaid guidelines, the presence of modifier GZ indicates this service/item is not	**Modifier GZ** This edit utilizes the Centers for Medicare and Medicaid Services' (CMS) Medicare Claims Processing Manual to identify an item or service that is expected to be denied as not reasonable and necessary. This edit will fire on all claim lines submitted with a GZ modifier.	Medicaid	11/14/2024	Professional
Return	CAG1	Procedure code 99100 is not typical for age of patient. Please update as applicable.	**Inappropriate Procedure AGE** Procedure code 99100, Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure), is to be reported on a patient younger than 1 year or 70 years and older.	Medicare	2/20/2025	Professional
Return	CSX	Procedure code <1> is not typically performed for a patient whose gender is <2>. Please update as applicable.	**Procedure Not Typical with Patient Gender** This rule identifies line items where the listed service is not typically performed for a person of the patient's gender, unless modifier KX is also reported. The Centers for Medicare and Medicaid Services (CMS) states that, "Contractors shall override any gender specific edits (gender/procedure conflict) that occur for a given procedure code if the KX modifier is billed with that code, and allow the claim to continue normal processing." This rule is to be used in place of the system edit CSX to allow modifier KX to override.	Medicare	2/20/2025	Professional
Return	ISX	Diagnosis code(s) <1> typically would not be reported for a patient whose gender is <2>. Please update as applicable.	**Diagnosis Not Typical for Gender** This rule identifies line items where the listed diagnosis is not typically performed for a person of the patient's gender, unless modifier KX is also reported. The Centers for Medicare and Medicaid Services (CMS) states that, "Contractors shall override any gender specific edits (gender/diagnosis conflict) that occur for a given diagnosis code if the KX modifier is billed with that code, and allow the claim to continue normal processing." This rule is to be used in place of the system edit ISX.	Medicare	2/20/2025	Professional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Rejection	IPCCN	REJECT - Payer Claim Control Number is invalid and is required because the Claim Frequency Type Code - CLM05-3 is 7. Reference the Provider Remittance Advice for Payer Claim Control Number - Claim ID.	**Invalid Payer Control Number** In accordance with HIPAA guidelines, providers are required to submit an accurate "Original Payer Claim Control Number" when submitting a corrected claim (bill type xx7/xx8).	Medicare	1/23/2025	Professional
Rejection	IPCCN	REJECT - Payer Claim Control Number is invalid and is required because the Claim Frequency Type Code - CLM05-3 is 7. Reference the Provider Remittance Advice for Payer Claim Control Number - Claim ID.	**Invalid Payer Control Number** In accordance with HIPAA guidelines, providers are required to submit an accurate "Original Payer Claim Control Number" when submitting a corrected claim (bill type xx7/xx8).	Medicare	1/23/2025	Institutional
Rejection	WMCTF	REJECT - Per CMS timely filing guidelines, the deadline to file a claim for this service has passed and therefore no payment is being made.	**Washington Medicaid Claim Timely Filing** Providers must bill the medicaid agency for covered services provided to eligible clients as follows: (7) Within twenty-four months of the date the service was provided to the client, a provider may resubmit, modify, or adjust an initial claim, other than a prescription drug claim or a claim for major trauma services. (8) After twenty-four months from the date the service was provided to the client, the agency does not accept any claim for resubmission, modification, or	Medicaid	2/27/2025	Professional
Rejection	WMCTF	REJECT - Per CMS timely filing guidelines, the deadline to file a claim for this service has passed and therefore no payment is being made.	**Washington Medicaid Claim Timely Filing** Providers must bill the medicaid agency for covered services provided to eligible clients as follows: (7) Within twenty-four months of the date the service was provided to the client, a provider may resubmit, modify, or adjust an initial claim, other than a prescription drug claim or a claim for major trauma services. (8) After twenty-four months from the date the service was provided to the client, the agency does not accept any claim for resubmission, modification, or	Medicaid	2/27/2025	Institutional
Rejection	MCTF	REJECT - Per CMS timely filing guidelines, the deadline to file a claim for this service has passed and therefore no payment is being made.	**Medicare Claim Timely Filing** The time limit for filing all Medicare fee-for-service claims (Part A and Part B claims) is 12 months, or 1 calendar year from the date services were furnished. This policy is effective for services furnished on or after January 1, 2010. In addition, claims for services furnished prior to January 1, 2010 must be submitted no later than December 31, 2010. Exceptions to the 1 calendar year time limit for filing Medicare claims are as follows: (1) error or misrepresentation by an employee, Medicare contractor, or agent of the Department of HHS that was performing Medicare functions and acting within the scope of its authority; (2) retroactive Medicare entitlement to or before the date of the furnished service; (3) retroactive Medicare entitlement where a State Medicaid Agency recoups money from a provider or supplier 6 months or more after the service was furnished; (4) a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recoups money from a provider or supplier 6 months or more after the service was furnished to a beneficiary who was retroactively disenrolled to or before the date of the furnished service.	Medicare	2/27/2025	Professional
Rejection	MCTF	REJECT - Per CMS timely filing guidelines, the deadline to file a claim for this service has passed and therefore no payment is being made.	**Medicare Claim Timely Filing** The time limit for filing all Medicare fee-for-service claims (Part A and Part B claims) is 12 months, or 1 calendar year from the date services were furnished. This policy is effective for services furnished on or after January 1, 2010. In addition, claims for services furnished prior to January 1, 2010 must be submitted no later than December 31, 2010. Exceptions to the 1 calendar year time limit for filing Medicare claims are as follows: (1) error or misrepresentation by an employee, Medicare contractor, or agent of the Department of HHS that was performing Medicare functions and acting within the scope of its authority; (2) retroactive Medicare entitlement to or before the date of the furnished service; (3) retroactive Medicare entitlement where a State Medicaid Agency recoups money from a provider or supplier 6 months or more after the service was furnished; (4) a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recoups money from a provider or supplier 6 months or more after the service was furnished to a beneficiary who was retroactively disenrolled to or before the date of the furnished service.	Medicare	2/27/2025	Institutional
Rejection	DDWM	REJECT - As of 1/1/2025, OptumCare has been de-delegated for Washington Medicaid. Claims should be sent to the correct payer ID. Please update as applicable.	**De-delegated for Washington Medicaid** As of 1/1/2025, OptumCare is no longer delegated to process Washington Medicaid Claims with a date of service after 12/31/2024. All claims with a date of service after 12/31/2024 will need to be sent to the correct payer ID.	Medicaid	2/27/2025	Professional
Rejection	DDWMf	REJECT - As of 1/1/2025, OptumCare has been de-delegated for Washington Medicaid. Claims should be sent to the correct payer ID. Please update as applicable.	**De-delegated for Washington Medicaid** As of 1/1/2025, OptumCare is no longer delegated to process Washington Medicaid Claims with a date of service after 12/31/2024. All claims with a date of service after 12/31/2024 will need to be sent to the correct payer ID.	Medicaid	2/27/2025	Institutional
Return	HLCf		**Hospice Revenue Code 0652 Cannot Report More Than 96 Units** The HLCf edit will fire on a claim line with Type of Bill 081X or 082X and the revenue code is 0651, 0652, 0655 or 0656 and a type of service location code is not submitted. In addition this edit will fire if revenue code 0652 exceeds 96 units. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 11 Section 30.3 - Data Required on the Institutional Claim to Medicare Contractor states for services provided on or after January 1, 2007, hospices must also report a HCPCS code along with each level of care revenue code (0651, 0652, 0655 or 0656) to identify the type of service location where that level of care was provided. The following HCPCS codes will be used to report the type of service location for hospice services: •Q5001 - HOSPICE CARE PROVIDED IN PATIENT'S HOME/RESIDENCE •Q5002 - HOSPICE CARE PROVIDED IN ASSISTED LIVING FACILITY •Q5003 - HOSPICE CARE PROVIDED IN NURSING LONG TERM CARE FACILITY (LTC) OR NON-SKILLED NURSING FACILITY (NF) •Q5004 - HOSPICE CARE PROVIDED IN SKILLED NURSING FACILITY (SNF) •Q5005 - HOSPICE CARE PROVIDED IN INPATIENT HOSPITAL •Q5006 - HOSPICE CARE PROVIDED IN INPATIENT HOSPICE FACILITY •Q5007 - HOSPICE CARE PROVIDED IN LONG TERM CARE HOSPITAL (LTCH) •Q5008 - HOSPICE CARE PROVIDED IN INPATIENT PSYCHIATRIC FACILITY •Q5009 - HOSPICE CARE PROVIDED IN PLACE NOT OTHERWISE SPECIFIED (NOS) •Q5010 - HOSPICE HOME CARE PROVIDED IN A HOSPICE FACILITY CMS Transmittal R1011CP dated July 28, 2006 states that claims will be returned when service lines are submitted with revenue codes 0651, 0652, 0655 or 0656 that do not contain HCPCS codes in the range Q5001 - Q5009. Payment for continuous home care (CHC), revenue code 0652, will be paid based upon the total number of 15-minute increments and will no longer allow for rounding to the next higher hour. It contains a requirement which states that claims shall be returned to the provider if the number of service units reported with revenue code 0652 exceeds 96.	Medicare	4/3/2025	Institutional
Return	CAGf		**Inappropriate Age for Procedure** Age designations are assigned to selected procedure codes within the KnowledgeBase based on the code descriptor; information from professional specialty societies and/or guidelines from the current CPT® Professional Edition; Food and Drug Administration (FDA); American Medical Association (AMA); International Classification of Diseases, Tenth Revision Clinical Modification (ICD-10-CM); the current HCPCS Level II Expert; the Centers for Medicare & Medicaid Services (CMS) Quality Payment Program (QPP); and the American Hospital Association (AHA) Coding Clinic. If the code descriptor does not contain a specific age or an industry source is not found to support an age assignment, then an age range is not assigned. This indicates the procedure is appropriate for any age. An example of a procedure code descriptor that contains a specific age: CPT code 33822: Repair of patent ductus arteriosus; by division, younger than 18 years. Examples of age as defined by a source: The current CPT® Professional Edition guidelines define newborn as birth through the first 28 days. The ICD-10-CM Newborn guidelines define the perinatal period as before birth through the 28th day following birth. The American Academy of Pediatrics (AAP) guidelines state, "Pediatricians focus on the physical, emotional, and social health of infants, children, adolescents, and young adults from birth to 21 years." The current CPT® Professional Edition Preventive Medicine Services codes (CPT codes 99381-99397) include the age ranges for infant (age younger than 1 year), early childhood (age 1 through 4 years), late childhood (age 5 through 11 years), adolescent (age 12 through 17 years) and adult ages classified as 18-39 years, 40-64 years, and 65 years and older. Regarding CPT vaccine, toxoids codes (90476-90756), the current CPT® Professional Edition guidelines state, "Refer to the product's prescribing information (PI) for the licensed age indication before administering vaccine to a patient." In addition, the CPT 2008 Changes: An Insider's View guidelines state, "These new instructions will help clarify that providers must refer to a vaccines product information for FDA-approved age indications and no rely on the CPT code descriptor for this important information." CPT Category II and certain HCPCS G codes are tracking codes used for performance measurement. These codes have a defined age based on the measure specifications found in the AMA Alphabetical Clinical Topics Listing and the CMS QPP quality measures. If a code is associated to multiple performance measures which have different age ranges, then the broadest age is assigned in the KnowledgeBase. An age range is not assigned if the code descriptor does not specify an age range, or an interpretation is not made. There is no recognized standard age range for maternity codes. Codes that refer to an adult or pediatric dosage of a medication are not assigned an age range. Dosages are calculated based on body weight or mass, and a small adult may receive a pediatric dosage of a medication. An exception to this would be if the FDA provides a specific age range for the drug or vaccine. Codes that have size designations such as wheelchairs and other durable medical equipment (DME-adult size or pediatric size) also do not have an age range assigned. A small adult	Medicare	4/3/2025	Institutional
Return	CAGf		**Inappropriate Age for Procedure** Age designations are assigned to selected procedure codes within the KnowledgeBase based on the code descriptor; information from professional specialty societies and/or guidelines from the current CPT® Professional Edition; Food and Drug Administration (FDA); American Medical Association (AMA); International Classification of Diseases, Tenth Revision Clinical Modification (ICD-10-CM); the current HCPCS Level II Expert; the Centers for Medicare & Medicaid Services (CMS) Quality Payment Program (QPP); and the American Hospital Association (AHA) Coding Clinic. If the code descriptor does not contain a specific age or an industry source is not found to support an age assignment, then an age range is not assigned. This indicates the procedure is appropriate for any age. An example of a procedure code descriptor that contains a specific age: CPT code 33822: Repair of patent ductus arteriosus; by division, younger than 18 years. Examples of age as defined by a source: The current CPT® Professional Edition guidelines define newborn as birth through the first 28 days. The ICD-10-CM Newborn guidelines define the perinatal period as before birth through the 28th day following birth. The American Academy of Pediatrics (AAP) guidelines state, "Pediatricians focus on the physical, emotional, and social health of infants, children, adolescents, and young adults from birth to 21 years." The current CPT® Professional Edition Preventive Medicine Services codes (CPT codes 99381-99397) include the age ranges for infant (age younger than 1 year), early childhood (age 1 through 4 years), late childhood (age 5 through 11 years), adolescent (age 12 through 17 years) and adult ages classified as 18-39 years, 40-64 years, and 65 years and older. Regarding CPT vaccine, toxoids codes (90476-90756), the current CPT® Professional Edition guidelines state, "Refer to the product's prescribing information (PI) for the licensed age indication before administering vaccine to a patient." In addition, the CPT 2008 Changes: An Insider's View guidelines state, "These new instructions will help clarify that providers must refer to a vaccines product information for FDA-approved age indications and no rely on the CPT code descriptor for this important information." CPT Category II and certain HCPCS G codes are tracking codes used for performance measurement. These codes have a defined age based on the measure specifications found in the AMA Alphabetical Clinical Topics Listing and the CMS QPP quality measures. If a code is associated to multiple performance measures which have different age ranges, then the broadest age is assigned in the KnowledgeBase. An age range is not assigned if the code descriptor does not specify an age range, or an interpretation is not made. There is no recognized standard age range for maternity codes. Codes that refer to an adult or pediatric dosage of a medication are not assigned an age range. Dosages are calculated based on body weight or mass, and a small adult may receive a pediatric dosage of a medication. An exception to this would be if the FDA provides a specific age range for the drug or vaccine. Codes that have size designations such as wheelchairs and other durable medical equipment (DME-adult size or pediatric size) also do not have an age range assigned. A small adult	Medicaid	4/3/2025	Institutional
REJECT	OTSf	REJECT - Only one therapy modifier can be reported on a line of service. Please update as applicable.	**Only One Therapy Service Modifier Per Line Rule** The appropriate types of bill for submitting outpatient rehabilitation services are: 12X, 13X, 22X, 23X, 74X, 75X, and 85X. Effective for date of service on or after April 1, 2011, Medicare created an edit to ensure that more than one GN, GO, or GP are not reported on the same service line on all institutional claims. The therapy modifiers refer only to services provided under plans of care for physical therapy, occupational therapy, and speech-language pathology services. Only one therapy modifier should be reported on a line of service.	Medicare	3/13/2025	Institutional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
Return	CRFDf	The capped rental frequency of once per month for 13 months has been exceeded for this code. Please update as applicable.	**Capped Rental Frequency Exceeded Facility** The CRFDf edit will fire on line items that are submitted with a code that is assigned to category "CR" (capped rental) on the DMEPOS Fee Schedule and exceeds the frequency of once per month for over 13 consecutive months. This edit will apply to the Home Health Type of Bills 32x, 33x and 34x with a line item containing revenue code 0291 and modifier RR. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS). The Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule Background File defines capped rentals as items of DME that do not fall under any of the other DME payment categories. They are generally expensive items that have historically been routinely rented. In general, Medicare pays for the rental of these items, when covered, for a period of continuous use not to exceed 13 months, at which point the beneficiary takes over ownership of the equipment. The CMS Transmittal #R1120CP states that after 13 months, the beneficiary owns the capped rental DME item, and after that time, Medicare pays for reasonable and necessary maintenance and servicing (i.e., for parts and labor not covered by a supplier's or manufacturer's warranty) of the item. The beneficiary may not, as in years past, choose to continue to rent the item and leave the supplier with the title to the item. The supplier must follow applicable state and federal laws when transferring title for the item to the beneficiary. This transfer must occur on the first day after the last rental month. The provision applies to items for which the first rental month occurs on or after January 1, 2006. The Final Rule, Volume 72 Number 68, also agrees with this as it states that payment for a capped rental item may not extend over a period of use of longer than 13 months. On the first day that begins after the 13th continuous month during which a payment is made for a capped rental item, the supplier of the capped rental item must transfer title to the item to the beneficiary. These statutory changes apply only to capped rental items whose first rental month occurs on or after January 01, 2006. The Medicare Claim Processing Manual, Chapter 20, Section 130.9 states that claims must specify whether equipment is	Medicare	3/13/2025	Institutional
Return	HHRSPf	Home health services must be reported with an appropriate home health speech language pathology revenue code. Please update as applicable.	**Speech Language Pathology Home Health Revenue Code**s The HHRSPf edit will fire on Home Health claims with Type of Bill (TOB) 032X or 033X (with the exception of 322 or 332), when a Home Health Speech-Language Pathology service HCPCS code is not submitted on the claim with a valid revenue code 044X. Effective October 1, 2013 the Type of Bill 033x is no longer valid. This is based on guidelines from The Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 10, Section 40.2 - HH PPS Claims states home health PPS claims must also report all services provided to the beneficiary within the episode. Each service visit (revenue codes 042X, 043X, 044X, 055X, 056X and 057X) must be reported as a separate line. To report HH visits on episodes beginning on or after January 1, 2011, the HHA reports HCPCS codes as appropriate to that revenue code. In summary, the HHRSPf edit will fire when speech language pathology service HCPCS codes are	Medicare	3/13/2025	Institutional
Return	001ICM	The principal diagnosis code <1> is either not a valid diagnosis or is invalid for the date of service on the claim. Please update as applicable.	**Facility Outpatient Invalid Principal Diagnosis** The 001ICM edit identifies invalid ICD-10-CM diagnosis codes. This edit will look at each ICD-10-CM diagnosis code for completeness and validity. This is based on guidelines from the Center for Medicare and Medicaid Services, Integrated Outpatient Code Editor. The Integrated Outpatient Code Editor (OCE) contains an edit which will return the claim to the provider when an ICD-10-CM diagnosis code is submitted on a claim without the required digits. This edit will also check an ICD-10-CM diagnosis code to ensure it is valid. The Integrated OCE Specifications Version 22.2 updated the edit effective 10/01/2014 to revise the logic for edit 001ICM to examine claims with From-Through dates spanning any quarter boundary (e.g., 09/29-10/01), in order to apply a bypass of edit 001ICM if the diagnosis reported does not exist in at least one of the two quarters. Diagnosis codes that exist/existed within the first quarter, on a spanning quarter boundary claim, have all other diagnosis code editing applied (e.g., edit 002IAG, 003ISX, 005EPD, etc.). However, diagnosis codes that exist only within the second quarter bypass edit 1 as well as all other diagnosis code edits. This logic update is applied across all bill types for OPPS and Non-OPPS. In addition, it states all claims (including 032x) that have From and Through dates that span any quarterly boundary (e.g., 09/29-10/29) bypass edit 001ICM if the diagnosis reported is valid in at least one of the two quarters. If the diagnosis code reported is not valid in either of the two quarters, edit 001ICM is applied. Based on these guidelines edit 001ICM will trigger when	Medicare	4/10/2025	Institutional
Return	002IAG	The principal diagnosis code <1> is for newborns and is not typical for the patient's age <2> years. Please update as applicable.	**Facility Principal Diagnosis Newborn Age Conflict** The 002IAG edit fires when an ICD-9-CM diagnosis code (for services prior to 10/1/15) or an ICD-10-CM diagnosis code (for services on or after 10/1/15) is inconsistent with the patient's age. This is based on guidelines from the Center for Medicare and Medicaid Services. The Integrated Outpatient Code Editor contains an edit which will return the claim to the provider when there are inconsistencies between a patient's age and any diagnosis on the claim. The following are the age categories: Newborn (age = 0), Pediatric (age = 0 to 17 years), Maternity (age = 9 to 64 years), and Adult (age > 14). Effective 01/01/2020, the OCE states, "Update the age range for maternity diagnoses to a low age of 9 and a high age of 64. If reporting a maternity diagnosis with a patient age outside valid range of 9-64, an age conflict exists and edit 2 is returned." Based on these guidelines edit 002IAG will trigger when an ICD-9-CM diagnosis code (for services prior to 10/1/15) or an ICD	Medicare	4/10/2025	Institutional
Return	003ISX	The other diagnosis code <1> is designated for male patients only and this conflicts with the submitted gender of the patient. Please update as applicable.	**Other Diagnosis and Gender Conflict** The 003ISX edit fires when a diagnosis code is inconsistent with the patient's sex. This is based on guidelines from the Center for Medicare and Medicaid Services. The Integrated Outpatient Code Editor contains an edit which will return the claim to the provider when there are inconsistencies between a patient's sex and any diagnosis on the claim. This edit will bypass if condition code 45 (Ambiguous Gender Category) is present on the claim. Based on these guidelines edit 003ISX will trigger when a diagnosis code with a gender designation is submitted that conflicts with the sex of the patient as reported on the claim and condition code 45 is not	Medicare	4/10/2025	Institutional
Return	006IPC	Invalid HCPCS code, <1> for the From date of service on the claim. Please update as applicable.	**Invalid Procedure Code** The 006IPC edit fires when an invalid HCPCS code or a HCPCS code that is invalid for the patient's date of service is submitted on a claim. This edit will look at all the HCPCS codes on the outpatient facility claim and determine if the submitted codes are valid and effective in the Facility Knowledgebase for the "From" date of service on the claim. This is based on guidelines from the Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 4, Section 40.3 - Non-OPPS OCE (Rejected Items and Processing Requirements) is consistent with this guideline as it states that the OCE checks each procedure code against a table of valid HCPCS codes. If the reported code is not found in this table, the code is considered invalid. The Integrated Outpatient Code Editor returns a claim to the provider when a service is submitted using an invalid HCPCS code. This edit applies to both OPPS and Non OPPS hospitals. Example: CPT code 1234 is an invalid HCPCS code because it has only four digits. CPT code 15342 Cultured Skin Grnft 25 cm is invalid for service dates after December 31, 2005. The July 2018 Outpatient Code Editor (OCE), Version 19.2, updated the program logic to include a condition in which lines submitted on a 032x bill type Home Health Agency (HHA) with revenue code 0023 do not have edit 6 applied. This logic is retroactive to the edit activation date.Per the Outpatient Code Editor (OCE) Specifications V20.1 dated 04/01/2019, Home Health Agency (HHA) claims with Type of Bill (TOB) 032X should not hit the edit if the claim dates span the annual (January) release and prior quarter if the service provided is effective for the reported line item date of service. The change is retroactive to the edits inception date. For a list of valid procedure codes for Facility claims, the table FE_PROC_CODE may be used as a read only reference as this table is no longer used in the rule with the integration of the new OCE Software tool. The table is still maintained for other edits.	Medicare	4/10/2025	Institutional
Return	WTRCf	Negative pressure wound therapy CPT codes must be billed with revenue code 042X, 043X, or 559 on a home health claim. Please update as applicable.	**Negative Pressure Wound Therapy (NPWT) CPT Code Missing Appropriate Revenue Code** The WTRCf edit will fire on a Home Health claim, type of bill (TOB) 034X, when a CPT code for Negative Pressure Wound Therapy (NPWT), 97607 or 97608, is present and the revenue code is not 042X, 043X, or 0559. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS). CMS transmittal R3655CP, Implementation of Policy Changes for the CY 2017 Home Health Prospective Payment System, dated November 10, 2016 states, "performing NPWT using a disposable device for a patient under a home health plan of care is separately reimbursed the OPPS amount relating to payment for covered Outpatient Department (OPD) services. In this situation, the HHA bills under type of bill 034x and reports the appropriate revenue code (0559, 042X, 043X), along with the appropriate HCPCS code (97607 or 97608)." In addition, it states, "The contractor shall ensure that if HCPCS codes 97607 or 97608 are billed on TOB 034x the revenue code is 042x, 043x or 0559." In summary, the WTRCf edit will fire when a CPT code for NPWT is present on a home health claim and the	Medicare	4/10/2025	Institutional
Return	mMUR	Per Medicare HCPCS code R0075 was billed without the required UN, UP, UQ, UR, or US modifier. Please update as applicable.	**Medicare Portable X-Ray Modifier Required for Multiple Patients Seen** mMUR looks for HCPCS R0075 (Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen) with one of the following modifiers: UN - Two patients served UP - Three patients served UQ - Four patients served UR - Five patients served US - Six patients or more served When HCPCS code R0075 is not presented with any one of the five modifiers listed above, the mMUR flag will fire. The claim should be denied when the number	Medicare	4/10/2025	Professional
Return	ADDf	Always ESRD related drugs subject to consolidated billing cannot be reported with modifier AY. Please update as applicable.	**Always ESRD Related Drugs With Modifier AY** The ADDf edit will fire on a claim with Type of Bill 072X when a drug that is considered "Always ESRD Related" is submitted with modifier AY or if code J0878 or J3370 is submitted on a claim with modifier AY and a secondary diagnosis is not present to support the use of the drug. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 8, Section 60.2.1.1 - Separately Billable ESRD Drugs states "All drugs reported on the renal dialysis facility claim are considered included in the ESRD PPS. The list of drugs and biologicals for consolidated billing are designated as always ESRD-related and therefore not allowing separate payment to be made to ESRD facilities. However, CMS has determined that some of these drugs may warrant separate payment. The following drugs have been approved for separate payment consideration when billed with the AY modifier attesting to the drug not being used for the treatment of ESRD. The ESRD facility is required to indicate (in accordance with ICD-9 guidelines) the diagnosis code for which the drug is indicated. • Vancomycin, effective January 1, 2012 • Daptomycin, effective January 1, 2013" Per CMS Transmittal R2134CP date January 14, 2011 modifier AY is used to indicate an "Item or service furnished to an ESRD patient that is not for the treatment of ESRD." Due to the fact that the drugs for consolidated billing are designated as always ESRD-related, it would not be appropriate to report the AY modifier on a claim line with one of the drugs from the ESRD consolidated billing list unless it is one of the drugs approved for separate payment consideration and the diagnosis guidelines are met. In summary the ADDf edit will fire on a claim with TOB 072X when a drug that is considered always ESRD related is submitted with modifier	Medicare	5/15/2025	Institutional
Return	ACPf	Advance Care Planning (ACP) procedure code <1> is a packaged service when billed with other OPPS payable services, procedure code <2> and should not be separately paid. Please update as applicable.	**Advance Care Planning** The ACPf edit will fire on Advance Care Planning procedure code 99497 when submitted with other payable Outpatient Prospective Payment System (OPPS) services. This edit is bypassed when advance care planning is submitted with an annual wellness visit. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS). The Integrated Outpatient Code Editor (IOCE), Version 18.0 Advance Care Planning supports this requirement as it states, "Effective January 1, 2016, Advance Care Planning services reported with procedure codes 99497 and 99498, that are also reported with the Medicare annual wellness visit (initial or subsequent), are paid under the Medicare Physician Fee Schedule status indicator (SI) of A (Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS); otherwise, advance care planning is subject to conditional packaging SI of Q1. If advance care planning is reported with no other payable OPPS services, it is paid by APC with SI of V (Clinic or Emergency Department Visit); if reported with other OPPS payable services SI of S, T, V, J1, J2, Q1, Q2, Q3, it is packaged SI of N. Note that procedure code 99498 is an add-on procedure code, and is always packaged with SI of N when not reported with the annual wellness visit." It also states, "Effective January 1, 2017 (v18.0), the conditional APC assignment, fee schedule or packaged processing for Advance Care Planning is processed across the claim if multiple dates of service are present." In summary, the ACPf edit is to ensure that advance care planning	Medicare	5/15/2025	Institutional
Return	CCNAf	Condition code 54 is not allowed on this Type of Bill. Please update as applicable.	**Condition Code 54 Not Allowed on TOB** The CCNAf edit will fire on a claim when the Type of Bill (TOB) is 0322 or any TOB other than 032x and condition code 54 is present. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS). CMS transmittal R3553CP, New Condition Code for Reporting Home Health Episodes With No Skilled Visits, dated June 28, 2016 states, "The contractor shall return claims to the provider if the TOB is 0322 or any TOB other than 032x and condition code 54 is present." In summary, the CCNAf edit is to ensure that condition code 54 is not reported on TOB 0322 or any TOB other than 032x	Medicare	5/15/2025	Institutional
Return	M53f	Per Medicare guidelines, hospitals should not report modifier 53. Please update as applicable.	**Modifier 53 - Discontinued Procedure Rule** The M53f edit identifies a claim line when modifier 53 is submitted on an outpatient hospital or ambulatory surgical center (ASC) claim. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS). The Medicare Claim Processing Manual Chapter 4, Section 20.6.4 states, "Modifier 53 is used to indicate discontinuation of physician services and is not approved for use for outpatient hospital services." In summary, the M53f edit will fire on claim lines with modifier 53 when submitted on an outpatient hospital or ASC claim	Medicare	5/15/2025	Institutional
Return	RAPf	Revenue code 0023 must be billed with a Home Health HIPPS code. Please update as applicable.	**Home Health RAP Claim HIPPS and Revenue Code**s The RAPf edit will fire on Notice of Admission (NOA) claims with Type of Bill (TOB) 032A when a Home Health HIPPS (Health Insurance Prospective Payment System) code is billed without revenue code 0023 as well as when revenue code 0023 is billed without a Home Health HIPPS code. This is based on guidelines from the Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 10, Section 40.1 - Request for Anticipated Payment (RAP) states the HHA must submit a RAP using TOB 0322 or 0328. It also states, "One revenue code line is required on the RAP. This line will be used to report a single HIPPS code that will be the basis of the anticipated payment." The required revenue code for Home Health RAP claims is 0023. In addition, Chapter 10 Section 10.1.9 - Composition of HIPPS Codes for HH PPS states, HIPPS codes are valid only on claim lines with revenue code 0023. Per CMS Transmittal R10839CP, "HHAs shall no longer submit Requests for Anticipated Payment (RAPS -TOB 0322) for any HH period of care with a From date on or after January 1, 2022. Instead, for each admission to home health, the HHA notifies Medicare systems via submission of an NOA." In summary, the RAPf edit will fire when a claim with TOB code 032A is submitted with revenue code 0023 but no Home Health HIPPS code or if a Home Health HIPPS code is submitted on a line with a revenue	Medicare	4/17/2025	Institutional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
REJECT	mAR	REJECT - Per Medicare guidelines apply a <1> reduction to claim lines containing HCPCS code A0425 and A0428 when billed with an origin/destination modifier that contains G or J in any position. Please update as applicable.	**Medicare Ambulance Reduction** The mAR edit utilizes the Centers for Medicare and Medicaid Services (CMS) guidelines found in the Medicare Claims Processing Manual to identify when procedure codes A0425 and A0428 are billed with an origin/destination modifier of "G" or "J". For ambulance services, suppliers and hospital-based ambulance providers must report an accurate origin and destination modifier for each ambulance trip provided. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of "X", represents an origin code or a destination code. The pair of alpha codes creates a modifier. The first position alpha code equals origin; the second position alpha code equals destination. The reduction will be applied on claim lines containing HCPCS code A0428 with modifier code "G" or "J" in either the first position (origin code) or second position (destination code) within the two-digit ambulance modifier code and HCPCS code A0425, which reflects the mileage associated with the transport. According to the Medicare Claims Processing Manual, Chapter 15, Section 20.6, "Section 637 of the American Taxpayer Relief Act of 2012 requires that, effective for transports occurring on and after October 1, 2013, fee schedule payments for non-emergency basic life support (BLS) transports of individuals with end-stage renal disease (ESRD) to and from renal dialysis treatment be reduced by 10%. The payment reduction affects transports (base rate and mileage) to and from hospital-based and freestanding renal dialysis treatment facilities for dialysis services provided on a non-emergency basis. Non-emergency BLS ground transports are identified by Healthcare Common Procedure Code System (HCPCS) code A0428. Ambulance transports to and from renal dialysis treatment are identified by modifier codes "G" (hospital-based ESRD) and "J" (freestanding ESRD facility) in either the first position (origin code) or second position (destination code) within the two-digit ambulance modifier. (See Section 30 (A) for information regarding modifiers specific to ambulance.) . Effective for claims with dates of service on and after October 1, 2013, the 10% reduction will be calculated and applied to HCPCS code A0428 when billed with modifier code "G" or "J". The reduction will also be applied to any mileage billed in association with a non-emergency transport of a beneficiary with ESRD to and from renal dialysis treatment. BLS mileage is identified by HCPCS code A0425." "Section 53108 of the Bipartisan Budget Act of 2018 increased the amount of the reduction described above to 23% for transports occurring on and after October 1, 2018." The mAR edit will fire on all claim lines with HCPCS codes A0425 or A0428 when billed with modifiers "G" or "J" in either the first position (origin code) or second position (destination code) within the two-digit ambulance modifier code. The edit is to assure an ambulance payment reduction of 23% is taken for non-emergency basic	Medicare	4/17/2025	Professional
REJECT	mAR	REJECT - Per Medicare guidelines apply a <1> reduction to claim lines containing HCPCS code A0425 and A0428 when billed with an origin/destination modifier that contains G or J in any position. Please update as applicable.	**Medicare Ambulance Reduction** The mAR edit utilizes the Centers for Medicare and Medicaid Services (CMS) guidelines found in the Medicare Claims Processing Manual to identify when procedure codes A0425 and A0428 are billed with an origin/destination modifier of "G" or "J". For ambulance services, suppliers and hospital-based ambulance providers must report an accurate origin and destination modifier for each ambulance trip provided. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of "X", represents an origin code or a destination code. The pair of alpha codes creates a modifier. The first position alpha code equals origin; the second position alpha code equals destination. The reduction will be applied on claim lines containing HCPCS code A0428 with modifier code "G" or "J" in either the first position (origin code) or second position (destination code) within the two-digit ambulance modifier code and HCPCS code A0425, which reflects the mileage associated with the transport. According to the Medicare Claims Processing Manual, Chapter 15, Section 20.6, "Section 637 of the American Taxpayer Relief Act of 2012 requires that, effective for transports occurring on and after October 1, 2013, fee schedule payments for non-emergency basic life support (BLS) transports of individuals with end-stage renal disease (ESRD) to and from renal dialysis treatment be reduced by 10%. The payment reduction affects transports (base rate and mileage) to and from hospital-based and freestanding renal dialysis treatment facilities for dialysis services provided on a non-emergency basis. Non-emergency BLS ground transports are identified by Healthcare Common Procedure Code System (HCPCS) code A0428. Ambulance transports to and from renal dialysis treatment are identified by modifier codes "G" (hospital-based ESRD) and "J" (freestanding ESRD facility) in either the first position (origin code) or second position (destination code) within the two-digit ambulance modifier. (See Section 30 (A) for information regarding modifiers specific to ambulance.) . Effective for claims with dates of service on and after October 1, 2013, the 10% reduction will be calculated and applied to HCPCS code A0428 when billed with modifier code "G" or "J". The reduction will also be applied to any mileage billed in association with a non-emergency transport of a beneficiary with ESRD to and from renal dialysis treatment. BLS mileage is identified by HCPCS code A0425." "Section 53108 of the Bipartisan Budget Act of 2018 increased the amount of the reduction described above to 23% for transports occurring on and after October 1, 2018." The mAR edit will fire on all claim lines with HCPCS codes A0425 or A0428 when billed with modifiers "G" or "J" in either the first position (origin code) or second position (destination code) within the two-digit ambulance modifier code. The edit is to assure an ambulance payment reduction of 23% is taken for non-emergency basic	Medicare	DRPCC	Professional
Return	DRPCc	This claim line has a possible duplicate procedure <1> with professional history Claim ID <2><4>, Line ID <3><5> for the same date of service. Please review professional claim for potential duplicate billing. Please update as applicable.	**Duplicative Radiology Professional and Facility Procedures** The DRPCc edit identifies facility radiology codes that have a potential duplicate technical service on a professional claim or a Critical Access Hospital (CAH) facility radiology service with a professional revenue code with a potential duplicate on a professional claim submitted on the same date of service. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual Chapter 4 section 20.2 states: "In cases where there are separate codes for the technical component, professional component, and/or complete procedure, hospitals should report the code that represents the technical component for their facility services. If there is no separate technical component code for the service, hospitals should report the code that represents the complete procedure." In summary, the DRPCc edit identifies a facility claim line that contains the same radiology procedure reported on a professional	Medicare	4/24/2025	Professional
Return	DLPCc	This claim line has a possible duplicate procedure <1> with professional history Claim ID <2><4>, Line ID <3><5> for the same date of service. Please review professional claim for potential duplicate billing.	**Duplicative Laboratory Professional and Facility Procedures** The DLPCc edit identifies facility laboratory codes that have a potential duplicate technical service on a professional claim or a Critical Access Hospital (CAH) facility laboratory service with a professional revenue code with a potential duplicate on a professional claim submitted on the same date of service. This is based on a requirement from the Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual Chapter 4 section 20.2 states: "In cases where there are separate codes for the technical component, professional component, and/or complete procedure, hospitals should report the code that represents the technical component for their facility services. If there is no separate technical component code for the service, hospitals should report the code that represents the complete procedure." In summary, the DLPCc edit identifies a facility claim line that contains the same laboratory procedure reported on a	Medicare	4/24/2025	Professional
Return	ICRf	Per Medicare guidelines, procedure code <1> when billed with modifier 53 is paid at a specific rate established in the Medicare Physician Fee Schedule (MPFS). Please update as applicable.	**Modifier 53 - Incomplete Colonoscopy for Critical Access Hospital (CAH)** The edit identifies incomplete colonoscopy code submitted with modifier 53 and a professional revenue code on a Critical Access Hospital (CAH) claim. The Medicare physician fee schedule database has specific values for codes 44388-53, 45378-53, G0105-53 and G0121-53.	Medicare	5/1/2025	Institutional
Return	MEYf	Per Medicare guidelines, payment can not be made for a service or items that does not have a physician order or prescription. Please update as applicable.	**Modifier EY - Order Not supplied** This edit will fire when modifier EY is present on a claim to indicate that the line will be denied as no physician order has been received. Medicare requires orders to support delivery of items and services. This will apply to claim lines submitted on TOBs of 21x, 22x, 32x, 33x, 34x, 74x, 75x, 76x, 81x, 82x, 85x.	Medicare	5/1/2025	Institutional
Return	mMEY	Per CMS guidelines, all claim lines on the same claim must contain the modifier EY. Please update as applicable.	**Modifier EY Required** The edit identifies claims that contain an EY modifier on any line of a claim. Per CMS guidelines, claim lines for which there is "no physician or other licensed health care provider order for this item or service" must be submitted on a claim separate from claim lines for which there is a physician or other licensed health care provider order." The edit will fire on all lines of a claim when any one line of that claim contains an EY modifier, as all claim lines on that claim must contain the EY modifier or the claim will be returned as unprocessable. The edit indicates that either the provider must add the EY modifier to all claim lines on that claim to indicate there is no physician or other licensed health care provider order on file, or submit those unmodified claim lines on a separate claim if there is an order on file. Modifier EY - No physician or other licensed health care provider order for this item or service. Note: The edit is dependent on Data Driven Rule 113 to	Medicare	5/1/2025	Professional
Return	CPO	Only one individual may report a single care plan oversight E/M code per patient in the same month. Please update as applicable.	**Care Plan Oversight** Only one individual may report a Care Plan Oversight (CPO) code in the same calendar month and only one CPO code per patient during the same reporting period. The code descriptor states "...within a calendar month..." The current CPT Professional Edition codebook states "Only one individual may report services for a given period of time to reflect the sole or predominant supervisory role with a particular patient." This is also supported by CPT Assistant July 2009, which states "These are time-based codes and should be reported based on the total time of individual physician supervision within a calendar month." The Medicare Claims Processing Manual states, "The CPO services require recurrent physician supervision of patient involving 30 or more minutes of the physician's time per month.... "Providers billing for CPO must submit the claim with no other services billed on that claim and may bill only after the end of the month in which the CPO services were rendered. CPO services may not be billed across calendar months and should be submitted (and paid) only for one unit of service." CPO codes include: 99374-	Medicare	5/1/2025	Professional
Return	RXDUR	Per FDA and NCCN guidelines, the overall duration limitation for Nivolumab, procedure code <1>, has been exceeded. Please update as applicable.	**Nivolumab Duration Limitation** The Specialty Drug flag identifies possible inappropriate use of a drug based on labeled indications, unlabeled but recommended indications, studied or possibly effective conditions, dose minimum and maximum, dose frequency, duration of treatment, and age minimum & maximum. The edit applies to nivolumab identified with HCPCS code J9299 & nivolumab/relatlimab-rmbw identified with HCPCS code J9298. Resources used in the development of the Specialty Drug Flag include: 1. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2017. Reviewed January 2022. URL: http://www.clinicalpharmacology.com. 2. Opdivo (nivolumab) [prescribing information]. Princeton, NJ: Bristol-Myers Squibb Company; September 2021. 3. NCCN - bladder cancer - https://www.nccn.org/professionals/physician_gls/pdf/bladder.pdf 4. NCCN - colon cancer - https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf 5. NCCN - esophageal cancer - https://www.nccn.org/professionals/physician_gls/pdf/esophageal.pdf 6. NCCN - gastric cancer - https://www.nccn.org/professionals/physician_gls/pdf/gastric.pdf 7. NCCN - head and neck cancer - https://www.nccn.org/professionals/physician_gls/pdf/headneck.pdf 8. NCCN - bladder cancer - https://www.nccn.org/professionals/physician_gls/pdf/esophageal.pdf 9. NCCN - hepatobiliary cancer - https://www.nccn.org/professionals/physician_gls/pdf/hepatobiliary.pdf 10. NCCN - Hodgkin's lymphoma - https://www.nccn.org/professionals/physician_gls/pdf/lymphoma.pdf 11. NCCN - kidney cancer - https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf 12. NCCN - malignant pleural cancer - https://www.nccn.org/professionals/physician_gls/pdf/pleura.pdf 13. NCCN - melanoma - https://www.nccn.org/professionals/physician_gls/pdf/melanoma.pdf 14. NCCN - NSCLC - https://www.nccn.org/professionals/physician_gls/pdf/NSCLC.pdf 15. DailyMed, U.S. National Library of Medicine, Reviewed January 2022. URL: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=0836c6ac-ee37-5640-2fed-a3185a0b16eb. 16. 2021 ICD-10 Medical Codes reference site. URL: http://www.icd10data.com/ICD10CM/Codes. 17. Lexicomp Online, Lexi-Drugs, 2022 Wolters Kluwer Clinical Drug Information, Inc. 18. EncoderPro.com Expert, 2022 Optum 360, Salt Lake City, Utah. 19. Medscape, 2022 20. MediSpan reference file, Wolters Kluwer Clinical Drug Information for NDC and pricing. 21. https://packageinserts.bms.com/pi/pi_opdualag.pdf NOTE: An individual Edit Rationale Statement (ERS) often addresses multiple edits. Each of those edits is sourced to at least one national industry source. There may be multiple national industry sources involved across the whole set of edits that are addressed by a given ERS. Therefore, a specific source may apply to only a	Medicare	5/8/2025	Professional
Return	ESM	It is not appropriate to report an ESRD related service code more than once per month. Please update as applicable.	**ESRD Related Services - Only 1 Face-To-Face Visit Code Monthly Per Age Group** This edit identifies when more than one face-to-face end-stage renal disease (ESRD) related monthly services CPT® codes, 90951-90962, have been reported during the same calendar month from the same age-related code group. The age-related code groups are as follows: younger than 2 years of age (codes 90951-90953); age 2-11 (codes 90954-90956); age 12-19 (codes 90957-90959); 20 years of age and older (codes 90960-90962). According to the Medicare Claims Processing Manual, Chapter 8, "Only one monthly payment is made for any renal disease patient per month."	Medicare	5/8/2025	Professional
Return	AABf	Per Medicare, only one audiology <1> visit is permitted every 12 months. Audiology code <2> was billed on history claim. <3>. Please update as applicable.	**Audiology_AB Modifier Frequency Edit Once Every 12 Months** The AABf edit identifies when an audiology code with modifier AB is submitted more than once within 12 months. This is based on guidelines from the Centers for Medicare and Medicaid Services (CMS). CMS Transmittal R12091OTN, Allowing Audiologists to Furnish Certain Diagnostic Tests Without a Physician Order, dated June 15, 2023, states, "For each beneficiary, only one visit to an audiologist without a physician/NPP order is permitted every 12 months. That is, the audiologist may bill using modifier AB once every 12 months - regardless of the number of applicable CPT codes billed with the modifier on that date of service. For example, if one CPT code is billed with the AB modifier on a certain date, none of the codes on the list of 36 applicable CPT codes will be payable under the PFS for another 12 months without a qualifying order." It also states, "Effective for dates of service (DOS) on or after July 1, 2023, contractors shall process and pay for audiology services when submitted on type of bill 12x, 13x, 22x, 23x, and 85x with the AB modifier and one of the CPT codes provided in the list of applicable 36 CPT codes. Contractors shall create a frequency edit to allow no more than one occurrence/visit on a treatment day (may include multiple services on the same date) per beneficiary for audiologist claims submitted with the AB modifier within 12 months. NOTE: For example, if service(s) is provided with the "AB" modifier	Medicare	5/8/2025	Institutional

Edit Type	ACE Edit	Edit Message	Description	Market	Effective Date	Claim Type
REJECT	027OIS	REJECT - Only incidental services are billed on this claim. Please update as applicable.	**Only Incidental Services Reported** The 027OIS edit will fire when a claim is submitted with only incidental (payment status indictor of "N") services or a combination of claim lines that have a status indicator of N, lines that have an invalid HCPCS code (edit 6), or lines with and invalid revenue code (edit 41). These services are packaged under the outpatient prospective payment system and are paid as part of another primary service or procedure that is performed. When these procedures are submitted on a claim with no other services reported the claim will be rejected with the exception of laboratory procedure codes submitted on bill type 013x or 014x or 012x without condition code W2. This is based on guidelines from the Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 4, Section 10.1.1- Payment Status Indicators contains guidelines that state "Services with status indicator N are paid under the OPPS, but their payment is packaged into payment for a separately paid service." In addition the Medicare Claims Processing Manual, Chapter 4, Section 10.4 - Packaging states "Under the OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items and services is included in the APC payment for the service of which they are an integral part." In regards to packaging it also states "Unconditionally packaged services are services for which separate payment is never made because the payment for the service is always packaged into the payment for other services. Unconditionally packaged services are identified in the OPPS Addendum B with status indictor of N." CMS MLN Matters Article SE1412, Update to 2014 Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing dated May 3, 2014 states, "The January 2014 update to the hospital OPPS, CMS implemented a new policy under the CY 2014 OPPS final rule, providing packaged payment of outpatient lab tests (other than molecular pathology) under the OPPS rather than separate CLFS payment, effective for dates of service on or after January 1, 2014. In the Medicare claims system, packaged payment would apply to all lab tests (other than molecular pathology) billed by OPPS hospitals on a 013X Type of Bill (TOB) (Hospital Outpatient)." As per the OPPS final rule, CMS created very limited exceptions to the packaging policy and instructed hospitals to use the 014X TOB (Hospital Non-Patient) to obtain separate payment only in the following circumstances: (1) Non-patient (referred) specimen; (2) A hospital collects specimen and furnishes only the outpatient labs on a given date of service; or (3) A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day. "Unrelated" means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis. To alleviate this concern, for CY 2014 a new modifier will be used on the 013X TOB (instead of the 014X TOB) when non-referred lab tests are eligible for separate payment under the CLFS for exceptions (2) and (3) listed above. The 014x will only be used for non-patient (meaning referred) laboratory specimens (exception 1 above) and will not include this new modifier. The new modifier will be effective for claims received on or after July 1, 2014 and retroactive for dates of service on or after January 1, 2014. The Integrated Outpatient Code Editor will reject the claim when a service that is considered "incidental" is the only service submitted on the claim. The guidelines state "Certain special HCPCS codes are always packaged when they appear with other specified services on the same day; however, they may be assigned to an APC and paid separately if there is none of the other specified service on the same day. Effective January 1, 2014 packaged laboratory codes (with status indicator of N) that are submitted on a claim with bill type 12x or 14x, or 13x when the L1 modifier is appended to a packaged laboratory code, will have the status indicator changed to A, and will not be subject to edit 27. If packaged laboratory codes are submitted on a claim with bill type 12x and condition code W2 is present, the laboratory codes remain packaged (status indicator N). The Integrated Outpatient Code Editor (IOCE), Version 17.0 added program logic for conditionally packaged laboratory services with new status indicator Q4. Effective January 1, 2016 laboratory codes with status indication of Q4 are subject to conditional packaging criteria in determining the final status indicator assignment, i.e., paid under the clinical lab fee schedule (status indicator A), or packaged (status indicator N): a. For claims with bill type 13x: if the laboratory code(s) with SI Q4 is reported with modifier L1 and is present with other payable OPPS services that have SI = J1, J2, S, T, V, Q1*, Q2, or Q3 on the same claim, the SI is changed to A; otherwise the laboratory code(s) is packaged with SI = N. If there are only laboratory codes present, all laboratory codes with SI = Q4 are changed to SI = A. Effective January 1, 2017 (v18.0), special conditions apply to OPPS services that have a final SI of Q1 due to the presence of line item action flag 2 or 3. When the Q1 service is present as the only OPPS service with laboratory codes with SI = Q4, the laboratory codes are changed to SI = A and processed for payment. Note: Modifier L1 is deactivated as of January 1, 2017 (v18.0), and the provision to change the SI to A if modifier L1 is present is discontinued. If laboratory codes with SI = Q4 are present with other payable OPPS procedures, the laboratory codes are packaged with SI = N. b. For claims with bill type 12x without condition code W2, and for claims with bill type 14x: if a laboratory code(s) is present with SI Q4, the SI is changed to A. Laboratory services on claims with bill type 12x that do contain condition code W2 remain packaged (SI = N). Note: Some laboratory codes (e.g. molecular	Medicare	5/22/2025	Institutional
Return	076TRC	A trauma response critical care code has been submitted without revenue code 068x and CPT code 99291. Please update as applicable.	**Facility Outpatient Trauma Code Without Revenue Code and E/M** The 076TRC edit fires when trauma response critical care code, G0390 (Trauma response team associated with hospital critical care service) is billed without revenue code 068X (Trauma response) and critical care code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) on the same on the dame date of service. This is based on guidelines from the Center for Medicare and Medicaid Services (CMS) and the National Uniform Billing Committee (NUBC). The Official UB-04 Date Specification Manual guidelines states revenue category 068x is used by trauma centers/hospitals licensed designated or authorized by the state or local government authority authorized as a trauma center, or verified by the American College of Surgeons and as a facility with a trauma activation team. In addition they also state, "Only patients for whom there has been pre-hospital notification, who meet either local, state, or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response, can be billed the trauma activation fee charge. Patients who are "drive-by" or arrive without notification cannot be charged for activations." Revenue code 068x is used for patients for whom a trauma activation occurred. A trauma team activation/response is a "Notification of key hospital personnel in response to triage information from pre-hospital caregivers in advance of the patient's arrival." The Medicare Claim Processing Manual Chapter 4 Part B Hospital Including Inpatient Hospital Part B and OPPS Section 160.1 Critical Care Services agree with NUBC guidelines for trauma centers/hospitals licensure and designation criteria. In addition it also states "Hospitals may also bill one unit of code G0390, which describes trauma activation associated with hospital critical care services. Revenue code 068x must be reported on the same date of service. The OCE will edit to ensure that G0390 appears with revenue code 068x on the same date of service and that only one unit of G0390 is billed. CMS believes that trauma activation is a one-time occurrence in association with critical services." The Integrated Outpatient Code Editor (I/OCE) states, "Submission of the trauma response critical care code requires that the trauma revenue code 068x and the critical care evaluation and management code 99291 also be present on the claim for the same date of service. Otherwise, the trauma response critical care code will be rejected." Example: If codes G0390 and 99291 are	Medicare	5/22/2025	Institutional
REJECT	SPCM	REJECT - Subsequent psychiatric CoCM code <1> is reported on <2> and there is no line within the previous 6 months history with initial psychiatric CoCM code 99492. Please update as applicable.	**Subsequent Psychiatric Collaborative Care Management Reported Without Initial Service** The edit identifies subsequent psychiatric collaborative care management (CoCM) code 99493 reported on the current line and an initial psychiatric CoCM, code 99492, is not found in 6 months of claims history. A subsequent service code may not be reported when an initial service code has not been reported. In addition, the edit identifies if there is a break in episode of care of 6 months or more. This is based on coding guidelines from the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS). The description for code 99492 includes that it is reported for the "first 70 minutes in the first calendar month." Code 99493 description states it is reported for the "first 60 minutes in a subsequent month." The guidelines in the current CPT® Professional Edition codebook state that an episode of care begins when the patient initiates services by the behavioral health care manager and ends when either the treatment goals are reached, treatment goals are not met and referred to a psychiatric care provider, or there is a break in the episode of care. "A new episode of care starts after a break in episode of six calendar months or more." The CMS Medical Learning Network (MLN) Booklet "Behavioral Health Integration Services" (MLN909432) reiterates the guidelines from the CPT® codebook including "CoCM First Month (CPT code 99492)" and "CoCM Subsequent Months (CPT code 99493)." The booklet also states, "CoCM is delivered monthly for an episode of care that ends when targeted treatment goals are met or there is failure to meet targeted treatment goals culminating in referral for direct psychiatric care, or there is a break in episode (no CoCM for 6 consecutive months)." The Medicare Claims Processing Manual defines initial and subsequent services as: "An initial service is one that occurs when the patient has not received any professional services from the physician or NPP or another physician or NPP of the same specialty who belongs to the same group practice during the stay. A subsequent service is one that occurs when the patient has received any professional services from the physician or NPP or another physician or NPP of the same specialty who belongs to the same group practice during the stay." Based on the coding guidelines from the AMA and the CMS, it is not appropriate to report subsequent psychiatric CoCM code 99493 without an initial care code 99492 for an episode of care or when there is a break in episode of 6 months or more.	Medicare	5/22/2025	Professional
Informational	WEITIMEf	INFORMATIONAL - <1> does not contain valid time in and out for Washington EVV Home Health in HHMM-HHMM format. Please make updates to prevent future denials.	**Washington Electronic Visit Verification Invalid Time In and Time Out** Per the Washington Health Care Authority, home health care services require that the location of service delivery, the individual practicing the service, and the time the service begins and ends are required for reimbursement. The location of the service delivery (i.e., the client's home) must be submitted in the 2310E loop, NM1 segment. The individual rendering the service's first and last name must be submitted in the 2420C loop, NM1 segment. The start and end times for the service must be submitted in the 2400 loop, SV2, SV202-7 segment. The format for the time in/time out must be submitted as HHMM-HHMM (two digit hour, two digit minutes separated by a dash with no spaces).	Medicaid	4/3/2025	Institutional
Informational	WEMLOCf	INFORMATIONAL - Location where services were rendered is required for Washington EVV Home Health. Please make updates to prevent future denials.	**Washington Electronic Visit Verification Service Location Required** Per the Washington Health Care Authority, home health care services require that the location of service delivery, the individual practicing the service, and the time the service begins and ends are required for reimbursement. The location of the service delivery (i.e., the client's home) must be submitted in the 2310E loop, NM1 segment. The individual rendering the service's first and last name must be submitted in the 2420C loop, NM1 segment. The start and end times for the service must be submitted in the 2400 loop, SV2, SV202-7 segment. The format for the time in/time out must be submitted as HHMM-HHMM (two digit hour, two digit minutes separated by a dash with no spaces).	Medicaid	4/3/2025	Institutional
Informational	WENAMEf	INFORMATIONAL - Rendering provider first and last name are required for Washington EVV Home Health. Please make updates to prevent future denials.	**Washington Electronic Visit Verification Rendering Name Required** Per the Washington Health Care Authority, home health care services require that the location of service delivery, the individual practicing the service, and the time the service begins and ends are required for reimbursement. The location of the service delivery (i.e., the client's home) must be submitted in the 2310E loop, NM1 segment. The individual rendering the service's first and last name must be submitted in the 2420C loop, NM1 segment. The start and end times for the service must be submitted in the 2400 loop, SV2, SV202-7 segment. The format for the time in/time out must be submitted as HHMM-HHMM (two digit hour, two digit minutes separated by a dash with no spaces).	Medicaid	4/3/2025	Institutional
Informational	WENPIf	INFORMATIONAL - Rendering provider NPI is required for Washington EVV Home Health. Please make updates to prevent future denials.	**Washington Electronic Visit Verification Rendering NPI Required** Per the Washington Health Care Authority, home health care services require that the location of service delivery, the individual practicing the service, and the time the service begins and ends are required for reimbursement. The location of the service delivery (i.e., the client's home) must be submitted in the 2310E loop, NM1 segment. The individual rendering the service's first and last name must be submitted in the 2420C loop, NM1 segment. The start and end times for the service must be submitted in the 2400 loop, SV2, SV202-7 segment. The format for the time in/time out must be submitted as HHMM-HHMM (two digit hour, two digit minutes separated by a dash with no spaces).	Medicaid	4/3/2025	Institutional
Informational	WEMTIMEf	INFORMATIONAL - Time In/Time Out is required in the procedure code description for WA EVV Home Health claims. Time should be submitted in HHMM-HHMM format.	**Washington Electronic Visit Verification Missing Time In and Time Out** Per the Washington Health Care Authority, home health care services require that the location of service delivery, the individual practicing the service, and the time the service begins and ends are required for reimbursement. The location of the service delivery (i.e., the client's home) must be submitted in the 2310E loop, NM1 segment. The individual rendering the service's first and last name must be submitted in the 2420C loop, NM1 segment. The start and end times for the service must be submitted in the 2400 loop, SV2, SV202-7 segment. The format for the time in/time out must be submitted as HHMM-HHMM (two digit hour, two digit minutes separated by a dash with no spaces).	Medicaid	4/3/2025	Institutional
