

Edit/Audit Inquiry Results Edit-200 ESC-200

Edit Information

Edit Number	200	esc Number	200	NCPDP Code	
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Short Desc	Pending for Co-pay Calculation				
Long Desc	Pending for Co-pay Calculation				
Edit Criteria	THIS EDIT IS DELETED				
	For Home Health (claim type 03) and Practitioner (claim type 05) payment requests, if co-pay reduction is indicated and the payment equals zero, but the co-pay reduction amount is not equal to zero, set the edit.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

Program	Program Title
CPA100	Adjudication Controller

Exceptions

None

Resolution

This edit is being deleted.

Edit/Audit Inquiry Results Edit-201 ESC-201

Edit Information

Edit Number	201	esc Number	201	NCPDP Code	
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Short Desc	Duplicate Payment Request - Different Provider, Same DOS
Long Desc	Duplicate Payment Request - Different Provider, Same Dates of Service
Edit Criteria	<p>This edit is set when the payment request being processed is a duplicate of another payment request being processed in the same check write cycle, based on the following parameters:</p> <p>INPATIENT (CLAIM TYPE 01): Same enrollee Different base provider ID Same from date of service Same thru date of service</p> <p>NURSING HOME (CLAIM TYPES 02 and 10): Same enrollee Different base provider ID Same from date of service Same thru date of service</p> <p>CORF (CLAIM TYPE 03 - PT 19): Same enrollee Different base provider ID Same from date of service Same thru date of service</p> <p>HOME HEALTH (CLAIM TYPE 03 - PT 58, 59, 94): (Edit 0201/1338) Same enrollee Different base provider ID Same from date of service Same thru date of service Any revenue codes are the same</p>

OUTPATIENT (CLAIM TYPE 03 - other than CORF and Home Health) without therapy revenue codes: (Edit 0201/1339)
Same enrollee
Different base provider ID
Same from date of service
Same thru date of service
Same Patient Account Number
Bypass edit if both claims have revenue code 450 - 459 (ER), both have valid admit hour, and the admit hours are different.
Bypass edit for non-emergency claims if both claims have any of the revenue codes in value set "REVENUE MRI CODES", 'REVENUE CAT SCANS', or 'REVENUE PET SCANS'.
Bypass edit for a combination of non-emergency and emergency claims if both claims have any of the revenue codes in value set "REVENUE MRI CODES", 'REVENUE CAT SCANS', or 'REVENUE PET SCANS'.

OUTPATIENT (CLAIM TYPE 03 - other than CORF and Home Health) with therapy revenue codes (42x, 43x, and 44x): (Edit 0201/1340)
Same enrollee
Different base provider ID
Same from date of service
Same thru date of service
Same Patient Account Number
Any therapy revenue codes are the same

OUTPATIENT (CLAIM TYPE 03 - other than CORF and Home Health) with therapy revenue codes vs. Home Health: (Outpatient is current claim - Edit 0201/1340) (Home Health is current claim - Edit 0201/1341)
Same enrollee
Different base provider ID
Same from date of service
Same thru date of service
Any therapy revenue codes are the same are set to nopay

PERSONAL CARE (CLAIM TYPE 04):
Same enrollee
Different base provider ID
Same from date of service
Same thru date of service

PRACTITIONER - HEALTH DEPT. DRUGS (CLAIM TYPE 05 - PROV TYPE 51 - PROCEDURES J8499, 99070, B4000 - B9999): (Edit 0201/1350)
Same enrollee
Different base provider ID
Same from date of service
Same thru date of service

Same procedure code
Same procedure modifier (any of the modifiers are the same)
Same billed charge

PRACTITIONER - HEALTH DEPT. OTHER (CLAIM TYPE 05 - PROV TYPE 51 - PROCEDURES NOT J8499, 99070, B4000 - B9999): (Edit 0201/1354)

Same enrollee
Different base provider id
Same from date of service
Same thru date of service
Same procedure code
Same procedure modifier (any of the modifiers are the same)

- Bypass dupe check for procedures in Value set "Primary Diag/Procedure Bypass" if primary diagnoses are different

PRACTITIONER - CLAIM TYPE 05 - PROV TYPE NOT 51 - Exception Indicator 'S' (0201/1007):

Same enrollee
Different base provider ID
Same from date of service
Same thru date of service
Same procedure code
Same procedure modifier (any of the modifiers are the same)

- Bypass dupe check for procedures E 1399, H2025, and 97537
- Bypass dupe check for procedures in Value set "Primary Diag/Procedure Bypass" if primary diagnoses are different

- Bypass dupe check for modifiers in Value set "MODIFIERS/PROCEDURE BYPASS" if any exist on the CIP or the PAC claim

PRACTITIONER - ALL OTHER (CLAIM TYPE 05 - PROV TYPE NOT 51 - Exception Indicator not 'S'):

Same enrollee
Different base provider ID
Same from date of service
Same thru date of service
Same procedure code
Same procedure modifier (any of the modifiers are the same)

- Bypass dupe check for procedure E 1399, T1023, T1024
- Bypass dupe check for procedures in Value set "Primary Diag/Procedure Bypass" if primary diagnoses are different

- Bypass dupe check for modifiers in Value set "MODIFIERS/PROCEDURE BYPASS" if any exist on the CIP or the PAC claim

PRACTITIONER - (CLAIM TYPE 05 -Procedure is Jcode): (Edit 0201)

Same enrollee
Different base provider id
Same from date of service
Same thru date of service
Same procedure code (same Jcode)
Same NDC

PHARMACY (CLAIM TYPE 06):

N/A

INDEPENDENT LAB (CLAIM TYPE 08):

Same enrollee
Different base provider ID
Same from date of service
Same thru date of service
Same procedure code
Same NDC (if procedure is Jcode compare the NDCs too; else compare procedure code only)

- Bypass dupe check for procedures in Value set "Primary Diag/Procedure Bypass" if primary diagnoses are different

- Bypass dupe check for modifiers in Value set "MODIFIERS/PROCEDURE BYPASS" if any exist on the CIP or the PAC claim

TITLE XVIII (CLAIM TYPE 09), PART A:

N/A

TITLE XVIII (CLAIM TYPE 09), PART B:

N/A

DENTAL (CLAIM TYPE 11):

Same enrollee
Different base provider ID
Same from date of service
Same thru date of service
Same procedure code
Same tooth number
Same surfaces

- Bypass dupe check for tooth code 33

- Bypass dupe check for quadrant related procedure codes. These procedure codes are

identified as those on the current Geofee File with a value in the quadrant field. See

<p>Value Set "Dental Quadrant Proc Code".</p> <p>TRANSPORTATION (CLAIM TYPE 13): Same enrollee Same from date of service Same thru date of service Different base provider ID Same procedure code Edit only applies if current claim provider type is 81</p> <p>- Bypass dupe check for modifiers in Value set "MODIFIERS/PROCEDURE BYPASSCT13" if any exist on the CIP or the PAC claim</p> <p>ASSESSMENTS (CLAIM TYPE 96): Same enrollee Different base provider ID Same from date of service Same thru date of service Same procedure code Same procedure modifier</p> <p>Different from current system: Some of the dupe logic is different.</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	Y
Type	D	Priority	1	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy		Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	100	PEND	
		DENY	
EMC	100	PEND	
		DENY	
Adjustment	100	PEND	
		DENY	
POS			
Encounter		6	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

All TDO UB claim types that pend will pend to LOC 320 and HCFA claim types will pend to LOC 319. All SLH UB claim types that pend will pend to LOC 308 and HCFA claim types will pend to LOC 310. Pend for Assessments. Pend for CT 03. As of July 1st, 2005, dental encounter severity is changed to 8.

Resolution

All Claim Types:

1. Check for keying/scanning errors.

If errors are found in unprotected fields, correct the field entry.

If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.

2. If the pended claim has a different authorization number from the conflicting claim, override using 0201 and disposition O. (Updated 4/4/08)

3. If the pended claim has the same authorization number as the conflicting claim and no justification is attached, deny 0201 using disposition D. (Updated 4/4/08)

Hospital:

Check Provider Type field. If Provider Type is in range 90-98 (out-of-state), pend to DMAS LOC 333.

Outpatient:

Check conflicting and pending payment requests for revenue codes.

1. If revenue codes are different, override using the ESC that pended and disposition indicator O.
2. If revenue codes are the same, check for attachment or remarks for justification of the second outpatient visit.
3. If justification is found, override using the ESC that pended and disposition indicator O.
4. If justification is not found, deny using the ESC that pended and disposition indicator D.

Outpatient/Inpatient:

Check conflicting and pending payment requests for revenue codes

1. If revenue codes are different, override using the ESC that pended and disposition indicator O.
2. If revenue codes are the same, check for attachment or remarks for justification of the duplicate.
3. If justification is found, override using the ESC that pended and disposition indicator O.
4. If justification is not found, deny using the ESC that pended and disposition indicator D.

Practitioner:

1. If procedure code S5161(Personal Emergency Response System Monthly Monitoring Fee) is billed twice, deny using the ESC that pended and disposition indicator D. Only one code should be paid per month. (updated 5/5/09)

Other procedure codes

Review the payment request, attachment or remarks for justification of the duplicate.

Example:

The diagnosis code is different.

The patient was seen both in the office and hospital on the same day.

Provider Specialty is different.

Look for any other justifiable reason to pay the duplicate.

1. If justification is found, override using the ESC that pended and disposition indicator O.
2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Independent Lab:

Review the lab invoice for remarks that give justification for the duplication, such as two tests on the same day.

1. If justification is found, override using the ESC that pended and disposition indicator O.
2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Title XVIII:

N/A

Dental:

If IC requested, check for remarks/documentation for justification of duplicate (same tooth X-rayed, Same tooth filled on same day).

1. If justification is found, override using the ESC that pended and disposition indicator O.
2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Transportation:

Review the documentation to determine if there was a valid reason for two trips on the same day.

Example:

Two one way trips with the destination and pickup points reversed.

Pickup and destination points are different on the two payment requests.

Two visits necessary on the same day.

Nature of the emergency.

Destination is different.

Destination is the same but remarks explain reason for two trips.

1. If justification is found, override using the ESC that pended and disposition indicator O.

2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Edit/Audit Inquiry Results Edit-202 ESC-202

Edit Information

Edit Number	202	esc Number	202	NCPDP Code	
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Short Desc	Duplicate of History File Record - Different Provider, Same DOS
Long Desc	Duplicate of History File Record, Different Provider, Same Dates of Service
Edit Criteria	This edit is set when the payment request being processed is a duplicate of a payment request from a previous check write cycle. See Edit 201/201 for edit criteria.

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	Y
Type	H	Priority	1	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy		Inpatient	v
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A		Xover B	
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	100	PEND	
		DENY	
EMC	100	PEND	
		DENY	
Adjustment	100	PEND	
		DENY	
POS			
Encounter		6	
Special Batch	217	PEND	
PA		PEND	

Programs

(None)

Exceptions

All TDO UB claim types that pend will pend to LOC 320 and HCFA claim types will pend to LOC 319. All SLH UB claim types that pend will pend to LOC 308 and HCFA claim types will pend to LOC 310. Pend for Capitation, Management, Admin Fees, and Assessments. Pend for CT 03. As of July 1st, 2005, dental encounter severity is changed to 8.

Resolution

All Claim Types:

1. Check for keying/scanning errors.

If errors are found in unprotected fields, correct the field entry.

If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.

2. If the pended claim has a different authorization number from the conflicting claim, override using 0202 and disposition O.

3. If the pended claim has the same authorization number as the conflicting claim and no justification is attached, deny 0202 using disposition D. (Updated 4/4/08)

Inpatient/Outpatient/Nursing Home: Updated 6/28/11

1. Check Provider Type field. If Provider Type is in range 90-98 (out-of- state), re-pend to DMAS LOC 333.

2. Check conflicting and pending payment requests for Revenue Codes.

If Revenue Codes are different, override using the ESC that pended and disposition indicator O.

If Revenue Codes are the same, check for attachment or remarks for justification of the second out-patient visit.

If justification is found, override using the ESC that pended and disposition indicator O.

If justification is not found, deny using the ESC that pended and disposition indicator D.

Practitioner: (Updated 10/26/10)

Review the payment request, attachment or remarks for justification of the duplicate.

Example:

1. The diagnosis code is different.
2. The place of service is different (Le., patient was seen both in the office and hospital on the same day.)
3. Two different servicing provider numbers billed for the same service.
4. The claim has modifier 76 and or 77.
5. The service was rendered twice on the same day at different times. (x-rays, lab services etc)
6. If modifier SG conflicts with a blank or any other modifier override the edit with disposition indicator O.

Look for any other justifiable reason to pay the duplicate.

1. If justification is found, override the edit with disposition indicator O.
2. If justification is not found, deny using the edit with disposition indicator D.

Independent Lab:

Review the lab invoice for remarks that give justification for the duplication, such as two tests on the same day.

1. If justification is found, override using the ESC that pended and disposition indicator O.
2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Title XVIII:

N/A

Dental:

If IC requested, check for remarks/documentation for justification of duplicate (same tooth X-rayed, Same tooth filled on same day).

1. If justification is found, override using the ESC that pended and disposition indicator O.
2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Transportation:

Review the documentation to determine if there was a valid reason for two trips on the same day.

Example:

Two one-way trips with the destination and pickup points reversed.

Pickup and destination points are different on the two payment requests.

Two visits necessary on the same day.

Destination is different.

Destination is the same but remarks explain reason for two trips.

1. If justification is found, override using the ESC that pended and disposition indicator O.

2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Edit/Audit Inquiry Results Edit-203 ESC-203

Edit Information

Edit Number	203	esc Number	203	NCPDP Code	
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Short Desc	Review of Service Frequency				
Long Desc	Review of Service Frequency				
Edit Criteria	<p>This edit is being deleted.</p> <p>For Personal Care (claim type 04), if the service limitation is exceeded, that is, the total hours are greater than the authorized hours for the same provider for the same month and year, set the edit.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

This edit is being deleted. See Edit 0203/1180 for resolution procedures.

Edit/Audit Inquiry Results Edit-205 ESC-205

Edit Information

Edit Number	205	esc Number	205	NCPDP Code	
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Short Desc	Review of Emergency Condition				
Long Desc					
Edit Criteria	This edit was not found in current MMIS and is deleted.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-206 ESC-206

Edit Information

Edit Number	206	esc Number	206	NCPDP Code	84
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Short Desc	Provider Suspend Payment Flag				
Long Desc	Provider Suspend Payment Flag				
Edit Criteria	<p>Restrictions on providers are stored on the Provider table, PS_PROV_PGM_RSTRCT. If the type of restriction = 02 (On Review) or 04 (Exception) for the payment request's dates of service, then the provider is on review or has an exception and this edit should set.</p> <p>The Provider restriction action type sets the error's disposition and overrides what is on the Error Text Database if the action type is not spaces. If the action type = P, then the pend location is set to 200.</p>				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind		PA Override Ind		Compound Ind	
Type	P	Priority	4	Recycle Days	999
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy	Y	Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
	200	PEND	
EMC	200	PEND	
	200	PEND	
Adjustment	200	PEND	
	200	PEND	
POS	200	PEND	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

All TDO UB claim types that pend will pend to LOC 320 and HCFA claim types will pend to LOC 319. All SLH UB claim types that pend will pend to LOC 308 and HCFA claim types will pend to LOC 310. Pend for Capitation, Management, Admin Fees, and Assessments. New dental encounter disposition as of July 1st, 2005 is 6.

Resolution

1. As long as the exception flag is set on the provider file, the payment request will remain suspended and cannot be resolved by resolutions staff.
 2. Edit should be set to recycle indefinitely (999 recycle days). Pend location 600. Note: after 999 days, the edit will pend to 200. If there is still no information from DMAS as to the disposition, transfer the claim back to location 600 to resume recycle status.
 3. Once the review is completed, DMAS will inform VMAP resolution staff to either pay or deny the claims that are pending for the provider, or DMAS may resolve themselves. (Example, provider restriction was set due to fraud investigation. Provider cancelled due to fraud. Pending claims for provider need to be denied.)
- If instruction from DMAS is to deny all pending claims, access the claims using pend location 600 and the provider ID number. Deny using the ESC code indicated on the denial notice from DMAS. If instruction from DMAS is to pay all pending claims, access the claims using pend location 600 and the provider ID number. Override with code 0206.

Edit/Audit Inquiry Results Edit-207 ESC-207

Edit Information

Edit Number	207	esc Number	207	NCPDP Code	
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Short Desc	deleted - Enrollee Aged 21 or Older				
Long Desc	Enrollee Aged 21 or Older				
Edit Criteria	<p>This edit is no longer valid and is not included in the new MMIS. This Edit is combined with Edit 211 and can be deleted</p> <p>For Dental (claim type 11), if the enrollee is greater than or equal to age 21, and the provider requested Individual Consideration (IC) with an attachment, set the edit.</p> <p>The edit is bypassed if an active PA exists on the PA File and the pre-authorization code = 52 (bypass age 21 edit).</p> <p>See edit 307 for action if there is no PA and no attachment.</p> <p>For Practitioner (claim type 05), if the procedure's Medical and Administrative Codes Database flag indicator = S or I (indicating EPSDT) and the provider class type = 20, 51, 52, 53, or 95 (Physician, Health Department Clinic, FQHC, Rural Health Clinic, Non-enrolled Physician), and the enrollee's age is >= 21, set the edit.</p> <p>For Practitioner (claim type 05), if the procedure's Medical and Administrative Codes Database pend for review of service indicator = S and the enrollee's age is >= 21, set the edit.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-208 ESC-208

Edit Information

Edit Number	208	esc Number	208	NCPDP Code	81
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Short Desc	Date of Service Over 1 Year Old
Long Desc	The payment request is past the filing limit of one year.
Edit Criteria	<p>Bypass the edit if the payment request is an adjustment or void or reprocess of denied claims or Title 18 (claim type 09).</p> <p>If the claim type is older than 1 year (determined by subtracting the Julian thru date of service of the payment request from the Julian date of the reference number):</p> <p>1) If a Dental payment request (claim type 11) and there is an attachment (C_ATTACHMNT_CVAL = Y on table CP_PYMT_REQT_DOC), set the edit.</p> <p>2) If a Practitioner payment request (claim type 05) and the provider class type is = 083-086 or 090-098 (out of state providers) OR if the premium indicator (C_PREMIUM_IND from the RS_ENROL_BENDEX using person id) = 8 or 9 OR if there is an attachment (C_ATTACHMNT_CVAL = Y on table CP_PYMT_REQT_DOC) OR if any procedure modifier = 22 or 99 (individual consideration), set the edit. See value set, ATTACH DISP PROC MODS</p> <p>3) For all other claim types, if there is an attachment (C_ATTACHMNT_CVAL = Y on table CP_PYMT_REQT_DOC), set the edit.</p> <p>NOTE: For Encounters (ICN media = 9), edit is set if older than 180 days instead of 1 year.</p> <p>See value set, OUT OF STATE PROV TYPES - E0208. See value set, CORF AND REHAB PROV TYPES 0208.</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority	2	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy		Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A		Xover B	
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	1/1/1960	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
		DENY	
EMC	200	PEND	
		DENY	
Adjustment	200	PEND	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA100	Adjudication Controller

Exceptions

Except CT01 pends to LOC 200. All TDO UB claim types that pend will pend to LOC 320 and HCFA claim types will pend to LOC 319. All SLH UB claim types that pend will pend to LOC 308 and HCFA claim types will pend to LOC 310. Pend for Capitation, Management, Admin Fees, and Assessments. EMC was changed to deny for both attachments and no attachment, effective 7/1/2000. New dental encounter disposition as of July 1st, 2005 is 6.

Resolution

All Claim Types: Updated 6/2014

1. Check for keying/scanning errors. If errors are found in unprotected fields, correct the field entry. If errors are found in protected fields, deny the pending the claim using code 0098 and disposition indicator D.
2. For inpatient services, check Provider Type field. If Provider Type is 85 or 91 (out-of-state hospital), transfer to DMAS LOC 300.
3. Resolve edit 208 if edit 0703 has been overridden. If the claim is pending for both 0703 and 0208, continue to transfer to location 300. DMAS will resolve 0703 and return to Xerox for the resolution of edit 0208. (Updated 6/2014)
4. Any claim submitted with a date of service older than 12 months (365 days) will pend with an attachment. Claims must be submitted to Medicaid within 12 months (365 days) from the date of service or the claim will be denied unless there is acceptable documentation (see 'Examples' below) attached to the claims.

The billing chapter in the provider manual states the following: Denied claims - Denied claims must be submitted and processed on or before thirteen months from date of the initial denied claim where the initial claim was filed within the 12 months limit to be considered for payment by Medicaid.

The procedures for resubmission are:

Complete invoice as explained in this billing chapter.

Attach written documentation to justify/verify the explanation. This documentation may be continuous denials by Medicaid or any dated follow-up correspondence from Medicaid showing that the provider has actively been submitting or contacting Medicaid on getting the claim processed for payment. Actively pursuing claim payment is defined as documentation of contacting DMAS at least every six months. Where the provider has failed to contact DMAS for six months or more, DMAS shall consider the resubmission to be untimely and no further action shall be taken.

Acceptable documentation is evidence that the provider has submitted a claim to VA Medicaid and was received within thirteen months from the date of the initial denied claim and documentation or continuous billing and/or contacting DMAS at least every six months after the timely submission denial.

The following documentation is considered acceptable: Override using code 0208 and disposition indicator O.

- The claim must be filed timely initially within 12 months.
- Claims must be re-filed on or before 13 months from the date of the initial submission.
- After the 13 months in the bullet above, provider must document continuous billing and or contacting DMAS at least every six months.

Examples of acceptable documentation: (Updated 6/2014).

1. VA Medicaid remittance dated less than twelve months from the date of service or
2. A provider returned letter dated less than twelve months from the date of service or
3. A CHIRP screen print attached documenting previous timely submission or

4. Provider documentation showing that the claim was returned or denied when it was submitted to VA Medicaid within twelve months from the date of service or
5. For dates of service less than 2 years, the attachment is stamped by DMAS to waive timely filing. Authorized DMAS personnel are Cyndie Bosley, Eileen Miller, Karen Thomas, Darryl Hellams and Peter Lubinskas. If dates of service are over 2 years, timely filing can only be waived by Cyndie Bosley or Karen Thomas. Requests from all other DMAS personnel should be transferred to location 219 or
6. Documented case of delayed eligibility with a dated letter/document attached from the Department of Social Services (DSS). The social worker's signature date or the date of issue of the letter/document is within 12 months of the claim's pend date (Julian Date) and the date of service is within the retroactive eligibility date span or
7. Documented case of delayed provider enrollment by PEU or DMAS. The claim must be filed within twelve months (365 days) from the date on the letter/document or
8. If a dated letter/document attached indicates that the payment was retracted by HMO, Private Insurance companies (Anthem, Aetna, Cigna etc) or DMAS, the claim must be filed within twelve months (365 days) from the date on the EOB or date on the letter/document or
9. If a dated letter/document attached indicates that the recipient was dis-enrolled from an HMO, the claim must be filed within twelve months (365 days) from the date on the letter/document or
10. If a screen print of the claim status information from the provider web inquiry or the VA Medicaid Web Portal is attached, the status information effective date is the RA date and should be handled just like a remittance advice. See #1. If any questions, add to remark screen and transfer to location 219 or
11. If an Emergency Medical Certificate is attached to the claim, the date of service cannot be greater than twelve months (365 days) from the date signed in the Referral Section of the form. (Section I) This should be signed by the social worker. (Per email dated 4/15/10 - C Olson)
12. A documented account of OmniTrack ticket numbers and or call documentation of contact at least every 6 months.
13. DDE (Direct Data Entry) claim submission forms.
14. Medicare EOB attached showing payment was made NO more than 6 months from the current claim pend date.

Documentation that is Not Acceptable: Deny using code 0208 and disposition indicator D.

Examples:

1. VA Medicaid remittance documenting initial timely submission is dated greater than twelve months from the date of service or
2. A provider returned letter undated or dated greater than twelve months from the date of service or
3. A CHIRP screen print attached not documenting previous timely submission or
4. Provider documentation showing that the claim was returned or denied when it was submitted to VA Medicaid greater than twelve months from the date of service or
5. Documented case of delayed recipient eligibility with a letter/document from the Department of Social Services (DSS) attached without a date or the claim's date of service is greater than twelve months (365 days) than the date on the letter/document or
6. The provider states recipient eligibility is retroactive, but there is no dated letter/document, deny using code 0457 add disposition indicator D or
7. Documented case of delayed provider enrollment by PEU or DMAS and the claim's date of service is greater than twelve months from the date on the letter/document or
8. A dated letter/document attached indicates that the payment was retracted by HMO or DMAS,

and the claim's date of service is greater than twelve months (365 days) from the date on the letter/document or

9. A dated letter/document attached indicates that the recipient was dis-enrolled from an HMO, and the claim's date of service is greater than twelve months (365 days) the date on the letter/document or the letter/document has no date or

10. A screen print of the claim status information from the provider web inquiry is attached; the status information effective date is the RA date and should be handled just like a remittance advice. See #1 or

11. An Emergency Medical Certificate is attached to the claim; the date of service cannot be greater than twelve months (365 days) from the date signed in the Referral Section of the form. (Section I) This should be signed by the social worker. (Per email dated 4/15/10 C Olson) or

12. Proof of timely filing to another insurance company, except Medicare (see #14 above), is not acceptable documentation to waive timely filing.

13. The provider did not know the patient had Medicaid coverage or

14. Documentation does not prove timely submission to Medicaid or

15. Attached copies of claims showing dates the claims were submitted or generated. No remittances or dated provider returned check off letter attached.

16. Provider states submitted several times but no dates are included in the documentation.

17. Documentation does not support continuous contact or billing every 6 months. If you are not sure if the documentation is justification to override, transfer to loc 219 with your remark.

If justification is not listed to pay and you are not sure of the resolution, transfer to loc 219 with your specific remark. If a reason to deny is not listed, transfer to loc 219 with your remark.

Edit/Audit Inquiry Results Edit-209 ESC-209

Edit Information

Edit Number	209	esc Number	209	NCPDP Code	
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Short Desc	Individual Consideration Requested (IC)
Long Desc	Individual Consideration Requested (IC)
Edit Criteria	<p>1) For HCFA 1500s except Transportation (claim type 13) and Personal Care (claim type 04):</p> <ul style="list-style-type: none"> - If the procedure requires a PA and there is a PA on file, bypass the edit. - If the billed amount is greater than or equal to 125% of the Medicaid allowed amount: <p>a) For claims whose procedure code does not have an 'I' or 'S' flag:</p> <ul style="list-style-type: none"> - If the claim meets the criteria for Edit 0266, bypass this edit. - If the billed amount is less than or equal to \$ 25.00, bypass the edit except when F_SPECIAL_BATCH = 'Y' - If procedure modifier is 22 or 99 (individual consideration) AND there is an attachment, set the edit <p>b) For claims whose procedure code has an 'I' or 'S' flag:</p> <ul style="list-style-type: none"> - If the procedure code is not 90707, bypass the edit - If procedure modifier is 22 or 99 (individual consideration) AND there is an attachment, set the edit. <p>2) For Dental (claim type 11), if a payment request is submitted with an attachment (a remark in block 38 of the dental form) and is not electronically submitted:</p> <p>a) If the procedure does not require a PA, set the edit.</p> <p>b) If the procedure requires a PA, but there is no PA number on the payment request, set the edit.</p> <p>c) If the billed charges are greater than the Medicaid allowed amount, set the edit.</p> <p>3) For Transportation (claim type 13):</p> <p>If procedure modifier is 22 or 99 and the claim has an attachment, set the edit.</p>

	See value set, ATTACH DISP PROC MODS
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General Indicators

Reject Ind		Deny Ind		Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	Y
Transportation	Y	Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
		PAY	
EMC	200	PEND	
		PAY	
Adjustment	200	PEND	
		PAY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA044	ADA Pricing
CPA350	ADA Service/PA Edit

Exceptions

All SLH Pends are assigned to LOC 310. Turned off for Dental with EWO 2003-225-001-M

Resolution

All Invoice Types:

1. Check for keying/scanning errors.

If errors are found in unprotected fields, correct the field entry.

If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.

Note: To obtain TPI information, click the "Member" button to retrieve TPL details. (Updated 07/22/11)

2. If no TPL amount is entered on the claim (blank or \$0.00) and the attached EOB shows a payment amount, deny claim using 0015 and the deny indicator D. If the TPL payment amount on the claim is different than the amount on the EOB, enter remark "TPL amts different", deny claim using 0015 and the deny indicator D. If no EOB is attached continue your review and resolve per attachment or procedures below. (Updated 5/13/08)

3. The system automatically calculates the TPL in the Allowed Charges field unless there is manual pricing. If there is manual pricing and the TPL is less than the allowed amount, manually subtract the TPL from the Allowed Charges field and enter the difference in the Manual Price field. If the calculated Manual Price is \$0.00, deny the pend request. Enter 0364 D. (Updated 3/21/08)

All Claim Types:

If an EOB is attached and a payment is noted on the EOB for the service billed, enter the amount paid in the TPL field and change COB code to 3 on the pend resolution screen. Override – 0209 O. (added to reso procedures 7/19/07) If the TPL amount is not keyed correctly as billed on the claim or the attached EOB, enter the correct amount in the TPL field and override – 0209 O. (updated 1/17/08)

Inpatient:

For inpatient services, check Provider Type field. If Provider Type is 85 or 91 (out-of-state hospital), repond to DMAS LOC 333.

ER:

1. Transfer ER claims pended with 0209 and 0223 to DMAS if the ER notes are attached, Physician ER to LOC 314.

UB-92 claims to LOC 312.

2. If ER notes are not attached and the TPL indicator is "N", change the Attachment indicator to N and override 209. Do not transfer and do not work the 223.

3. If ER notes are not attached and the TPL indicator is "Y", transfer to 219 with remarks "ER doc not attached"

(2-3 updated 3/21/08)

Dental:

1. If IC is requested and there is no price available, repond to DMAS location 400.

2. For anesthesia procedure codes (no calculated amount), look at remarks for minutes, look at anesthesia time sheet and calculate the allowance. Enter allowed amount in the manual price field.

3. Check PA.

If PA has no fee, repond to DMAS location 400.

If PA has a fee, override with code 0209 and disposition indicator 0, which will pay the calculated amount.

Practitioner

1. If modifier is 22 (attachment), review the attachment or remarks.

2. If procedure is surgery and is pending with a fee on file and the claim has an attachment or ACN (with or without a DMAS-3 attachment), override with code 0209 and disposition O. (updated 9/22/09)

3. If attachment indicates the provider is requesting a review, transfer to DMAS location 321. (Updated 2/19/09)

4. If no operative report, procedure notes, the procedure code is not surgery or #2 under All Invoice Types does not apply, override with code 0209 and disposition indicator O. (Updated 9/5/08)

5. If 209 set with other pricing edits, work the other edits and release to adjudication.

Edit/Audit Inquiry Results Edit-210 ESC-210

Edit Information

Edit Number	210	esc Number	210	NCPDP Code	
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Short Desc	No Fees Found on File
Long Desc	No pricing segment is on file.
Edit Criteria	<p>If any of the procedure codes are in the ICD-9 value set 328 (TRANSPLANT PROCEDURE CODE) or the ICD-10 value set 20328 (ICD-10 TRANSPLANT PROCEDURES) and (there is no PA or the authorization amount is zero), set the edit.</p> <p>If the rate on the Medical and Administrative Codes Database contains 'IC' or if no rate is found on the Provider Fee File or on the Medical and Administrative Codes Database, AND if the procedure requires a PA (PA type = 01 or 03), then the PA file is read for the rate. If no rate is found there, set the edit.</p> <p>If no rate is found on the Provider Fee File or if the rate on the Medical and Administrative Codes Database does not contain 'IC' or any other value AND if the procedure does not require a PA or if the rate is not on the System Parameter Table, set the edit.</p>

General Indicators

Reject Ind		Deny Ind		Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy		Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y

Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
	200	PEND	
EMC	200	PEND	
	200	PEND	
Adjustment	200	PEND	
	200	PEND	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA040	CMS-1500 Pricing
CPA042	UB92 Pricing

Exceptions

All TDO UB claim types that pend will pend to LOC 320 and HCFA claim types will pend to LOC 319. All SLH UB claim types that pend will pend to LOC 308 and HCFA claim types will pend to LOC 310. Pend for Capitation, Management, Admin Fees, and Assessments. New dental encounter disposition as of July 1st, 2005 is 4. CT 09 is set to "test". For CT 09 transportation with DOS on or after 10/1/09, the Error Text disposition is overridden with "pend".

Resolution

(Updated 6/1/12)

All Claim Types:

1. Check for keying/scanning errors.
- If errors are found in unprotected fields, correct the field entry.

- If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.

2. There are rare instances where a rate has been placed on file with begin and end date being the same. When a payment request encounters such a rate, edit 210 will set.

Verify that the date of service was entered correctly on the payment request.

Verify that the date of service matches the rate begin/end date.

- If dates match, enter the rate that is on file for that date in the manual price field and release the pend.

- If dates do not match, deny with code 0216 and disposition indicator D.

CMS 1500

3. If there is no rate on file, check the PA Type for the procedure code. Click on the 'Procedure' button. The medical procedure inquiry screen should appear. Click on the "next page" button. The 'Srv Auth Type' header appears in the right side of the screen.

If PA Type equals 01 or 03, there must be a rate on the PA file to price the service. If no price on the PA file, transfer to DMAS location 321.

If PA Type does not equal 01 or 03, and there is no rate on file for the procedure, transfer to DMAS location 321.

4. Hearing aid services, Procedure codes V5060, V5140, V5257, V5261, V5014, V5264 and V5266. Manually price these V services according to the prices listed on the matrix provided on 1/22/04. See Claims Resolution Procedures Manual, Appendix B.

5. Procedure Code S1040 (Cranial Remolding Orthosis): Transfer claims for this procedure code to LOC 321 for medical review. (Updated 7/1/08)

Personal Care Claims (CT04):

1. Check the enrollee eligibility screen to see if there is a 09 aged waiver segment. Verify dates.

If date of service is outside of waiver dates, deny with 0318.

If no 09 segment is listed, deny with 0318.

If a 09 segment is listed that covers the dates of service, go to step #2.

2. Verify that there is a PA segment for the date of service. Click PA button on pend screen to verify the PA covers the DOS on the claim.

If not authorized for the dates of service, or if no PA number on the claim, deny with 0318.

If there is authorization for the date of service, go to step #3.

3. If date of service falls within the 09 waiver dates and authorized PA dates, transfer to Location 219.

UB04

1. Transfer to location 219 with remark Edit 210.

Edit/Audit Inquiry Results Edit-211 ESC-211

Edit Information

Edit Number	211	esc Number	211	NCPDP Code	66
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Short Desc	Enrollee Less Than Minimum Age
Long Desc	Enrollee Less Than Minimum Age
Edit Criteria	<p>If the enrollee's age is less than the minimum age for the procedure (checked against the Medical and Administrative Codes Database), set the edit.</p> <p>For Pharmacy, if the enrollee's age is less than the minimum age for the drug (checked against the Benefit Master database), set the edit.</p> <p>(Formally Edit 246) If the enrollee's age is not within the minimum and/or maximum age limits on the Medical and Administrative Codes Database, set the edit. This edit number currently resides on the Medical and Administrative Codes Database.</p> <p>(formally Edit 309 A1) For Practitioner (claim type 05) or Laboratory (claim type 08): 1) If there is an age restriction on the Medical and Administrative Codes Database for the procedure and the enrollee age is not within procedure age range, set the edit.</p> <p>(From Edit 311) If the enrollee's age is less than the minimum age for the procedure (checked against the Medical and Administrative Codes Database), and there is no attachment, set the edit.</p> <p>(From Edit 389) If the enrollee's age is not within the Medical and Administrative Codes Database minimum and/or maximum age restrictions for the procedure, set the edit. The edit to be set is carried on the Medical and Administrative Codes Database.</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind	Y	Compound Ind	
Type	O	Priority	3	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	V	Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
		DENY	
EMC	200	PEND	
		DENY	
Adjustment	200	PEND	
		DENY	
POS			
Encounter		6	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
VPTM1DRG	POS Pharmacy Claims Drug Edits Process

Exceptions

All TDO UB claim types that pend will pend to LOC 320 and HCFA claim types will pend to LOC 319. All SLH UB claim types that pend will pend to LOC 308 and HCFA claim types will pend to LOC 310. Pend for Capitation, Management, Admin Fees, and Assessments. Disposition for Invoice Type 06 should DENY for paper claims. As of July 1st, 2005, dental encounter severity is changed to 8.

Resolution

All Claim Types:

Check for keying/scanning errors.

If errors are found in unprotected fields, correct the field entry.

If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.

Review attachment/remarks.

If remarks justify (i.e., recipient is a few days from the acceptable age), override with code 0211 and disposition indicator O.

If remarks do not justify, deny with code 0211 and disposition indicator D.

If physician notes or medical records are attached, transfer to location 321 and enter remarks explaining the reason for the referral.

If you are not able to determine whether the justification is valid, transfer to location 219 and enter remarks explaining the reason for the referral.

Edit/Audit Inquiry Results Edit-212 ESC-212

Edit Information

Edit Number	212	esc Number	212	NCPDP Code	66
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Short Desc	Enrollee Greater Than Maximum Age
Long Desc	Enrollee Greater Than Maximum Age
Edit Criteria	<p>If the enrollee's age is greater than the maximum age for the procedure (checked against the Medical and Administrative Codes Database), set the edit.</p> <p>For the Dental payment requests (claim type 11), if the recipient aid category is = '919' and the procedure is not 'D8070', 'D8080', 'D8090' (Orthodontic procedure), bypass the edit.</p> <p>For Pharmacy, if the enrollee's age is greater than the maximum age for the drug (checked against the Benefit Master database), set the edit.</p> <p>For Dental payment requests (claim type 11), if the procedure requires Prior Authorization and a PA is found and the PA service type = 0850 (adult dental), bypass this edit.</p> <p>(Formally Edit 207) For Dental (claim type 11), if the enrollee is greater than or equal to age 21, and the provider requested Individual Consideration (IC) with an attachment, set the edit.</p> <p>(Formally Edit 307) For Dental (claim type 11), if the enrollee's age is >= 21, and the provider requested an IC, and there is an attachment and no PA, set edit. If there is no PA and no attachment, set this edit.</p> <p>For Practitioner (claim type 05), if one of the Medical and Administrative Codes Database flag indicators = VAC (indicating vaccine) and the enrollee's age are between 19 and 20, Bypass the edit.</p> <p>For Practitioner (claim type 05), if one of the Medical and Administrative Codes Database flag indicators = S or I (indicating EPSDT screening) and the enrollee's age is greater than 20, set the edit.</p> <p>For Practitioner (claim type 05) and servicing provider type 049, or Hospital Out-patient/Home Health (claim type 03) and SLH enrollee; if one of the Medical and Administrative Codes Database flag indicators = 'AP1' through 'AP9' (indicating</p>

	Ambulatory Service Facility Fee) and the enrollee's age is greater than 20, set the edit.
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General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority	3	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
		DENY	
EMC	200	PEND	
		DENY	
Adjustment	200	PEND	
		DENY	
POS			
Encounter		2	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
VPTM1DRG	POS Pharmacy Claims Drug Edits Process

Exceptions

All TDO UB claim types that pend will pend to LOC 320 and HCFA claim types will pend to LOC 319. All SLH UB claim types that pend will pend to LOC 308 and HCFA claim types will pend to LOC 310. Pend for Capitation, Management, Admin Fees, and Assessments. Disposition for Invoice Type 06 should DENY for paper claims. As of July 1st, 2005, dental encounter severity is changed to 8.

Resolution

All Claim Types:
Check for keying/scanning errors.
If errors are found in unprotected fields, correct the field entry.
If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.
Review attachment/remarks.
If remarks justify (i.e., recipient is a few days from the acceptable age), override with code 0212 and disposition indicator O.
If remarks do not justify, deny with code 0212 and disposition indicator D.
If you are not able to determine whether the justification is valid, re-pend to DMAS location 321 and enter remarks explaining the reason for the referral. Updated 07/22/11

Edit/Audit Inquiry Results Edit-213 ESC-213

Edit Information

Edit Number	213	esc Number	213	NCPDP Code	
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Short Desc	UVS Not Equal to Service Period				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-214 ESC-214

Edit Information

Edit Number	214	esc Number	214	NCPDP Code	
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Short Desc	Pending Determination of Allowance
Long Desc	Pending determination of allowance.
Edit Criteria	<p>If the rate on the Medical and Administrative Codes Database contains 'IC' and if no PA is required for the service, set the edit. The payment request is then manually priced.</p> <p>If the rate contains "IC" and a PA is required for the service, see edit 210.</p>

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
	200	PEND	
EMC	200	PEND	
	200	PEND	
Adjustment	200	PEND	
	200	PEND	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA044	ADA Pricing

Exceptions

Pend for Capitation, Management, Admin Fees, and Assessments. New dental encounter disposition as of July 1st, 2005 is 4.

Resolution

Edit 214

All Claim Types

1. Check for keying/scanning errors.

If errors are found in unprotected fields, correct the field entry.

If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.

2. If a fee is on file for the procedure code but the date of service is prior to the begin date or after the end date, deny using 0147 with indicator D. (updated 4/4/08)

Dental

1. If there is an attachment or remark that is related to the procedure code billed, transfer to DMAS location 407. The attachment or remark can be a description of the service rendered, an x-ray, a purchase invoice, office notes etc.

2. If the attachment or remark does not apply to the procedure code, deny with code 0409 and the disposition indicator D.

Practitioner

1. If the claim is billed with modifier "52", transfer to location 321 with remark 'Provider billing with

modifier 52'. (Updated 03/28/11)

2. If S9125 is billed with modifier 'TE', check to determine if the member is in a waiver. Click on the Member tab, then the Eligibility tab on the next screen. Select the aid category section with the begin and end dates that include the date of service billed. Click Enter. The date of service should fall within the Waiver eligibility begin and end dates. If not deny 0117D.

Note: If a fee has not previously been determined by DMAS, transfer the claim to location 321 with remark 'Fee Needed'. Reference the list below for procedures not identified in steps 1-12.

Nutritional Supplements (section updated 02/2013)

Price as follows:

Use the provider's cost amount on the providers purchase invoice and add 30%. This is a change from previous instructions to use the retail amount.

Use the cost amount listed on the invoice, per can/pkg even when a case is billed. The billing unit for pricing should be the actual can/pkg not the case. (DMAS DME unit, email 02/12/13).

Examples for Nutritional Supplement Claims:

Example 1: The providers invoice shows a cost (103.6 per case divided by 24 cans per case = 4.31 per can) \$4.31per can plus 30% is 5.61 per can x 248 cans is \$1391.28. Enter the calculated fee in the manual price field minus any TPL payment amounts. Press the adjudication button to update the claim.

Note: Often a provider will need to deliver a certain amount of cans that may mean breaking a case. The same principal will apply in these situations. If the recipient need 110 cans per month and a case have 24 cans, the recipient will receive 4 cases and 14 loose cans. The provider should submit and invoice that clearly shows the purchase cost. Pay based on the invoice using the example listed above.

Claims should be paid based on the purchase invoice and it should be clear which item on the invoice corresponds to the item billed and the number of items used for the billing timeframe.

If the invoice does not clearly show which item is being billed, the number of cans/pkgs billed or if the invoice does not clearly show the provider's cost, indicate what information is missing on the remark screen, update and return to pend resolution screen. Deny the claim with code 0140 and disposition indicator D. Press the adjudication button to update the claim. If questions, transfer to location 219 with remarks.

Supplies and Supplements:

1. If invoice is attached, calculate manual price and enter in the manual price field. If invoice is not attached, deny with code 0073 and disposition indicator D.

2. If invoice does not include enough information to price, deny with code 0315. Refer to the Claims Resolution Procedures Manual Appendix B for instructions on manual pricing of supplies and sup-

plements.

3. Procedure Code 90723 (Pediatrics): Check recipient eligibility screen. If Enrollee Aid Category (PD) = 006, 007, 008, or 009 ((Eligibility Segment shows FAMIS as plan description). pay the price PLUS \$11.00. If recipient has regular Medicaid (all other PDs) pay \$11.00 only. VFC age limits still apply.

4. Laboratory Procedures: If procedure notes are attached, transfer to DMAS location 321. If rate is available in OPPC field for the date of service billed and the claim has no 26 modifier, pay the OPPC rate on file for the date of service billed. Do not pay for more than the number of units allowed in the reference file. If the provider is billing for 2 units and the procedure code only allows 1 unit, pay 1 x area maximum in reference for the date of service billed. If no fee is on file and no notes are attached to the claim, deny with code 0409 and disposition indicator D. Updated 4/04/08

5. All Procedures: If the procedure code has a recent begin date (new code), transfer to Location 321 for pricing. (Updated 2/18/10)

6. Drug:/J/Q Codes:

Note change starting 9/2015 for all NDCs:

- If an NDC has been entered on the claim and claim is pending with edit 0214, transfer to location 321 with or without an attachment.
- Q2042 and J1725 will remain without a fee transfer to location 321 for pricing with remark "Makena".
- If the provider is billing for Makena with procedure code J3490, for 17P compounded or suppository or Hydroxyprogesterone Caproate, transfer to location 321.
- If the provider is billing for Alpha Hydroxyprogesterone Caproate 17P with code J3490, transfer to location 321.

Note calculation change starting 7/1/2011 for all NDCs

If the procedure code is a J code, pricing is done on the NDC code provided in the claim remarks or attachment. Look up the NDC on the Reference File and choose Pricing. Calculate the price using the Reference Cost time's quantity prior to 7/1/11. On or after 7/1/11 calculate the price using the AWP minus 13.1%. The reference cost should be updated to reflect this calculation (updated 3/28/11) Enter the price in the manual pricing field. If you can't find the NDC code on file, look for the drug by name, then match the dose, strength, etc. The NDC should then match except for an extra zero at end or even in the middle. If the name and dosage match, but the NDC number does not match, deny with 0140 and disposition indicator D. Enter Remark "NDC". If purchase invoice is attached, calculate manual price and enter in the manual price field. (Added 7/23/07)

** Q2042 and J1725 are for Makena. There is no code for the 17P that is compounded or for the suppository.

J1725 effective 01/01/2012 is the permanent code for Makena – Prior authorization is required. Both the Q2042 and J1725 will remain without a fee transfer to location 321 for pricing with remark "Makena".

If the provider is billing for Makena with procedure code J3490, for 17P compounded or suppository or Hydroxyprogesterone caproate an invoice is needed for pricing. If an invoice is attached, transfer to location 219 with remark 'Makena'. If an invoice is not attached, deny 0073D. (Updated 6/1/12)

If the provider is billing for Alpha Hydroxyprogesterone Caproate 17P with code J3490, see attached invoice for pricing. Pay the cost of the medication and shipping (if noted). This is the ONLY

item shipping is considered for payment. (Updated 03/02/10)

**If the provider is billing for Testopel (testosterone pellet) with procedure code J3490 with either NDC 43773100102, 43773100103 or 43773100104, Deny 0370 and disposition indicator D. The provider should be billing with S0189 which requires PA. (Added 4/21/09)

If question is related to pricing a NDC request a purchase invoice. Do not transfer to location 321. Deny using 0073 and disposition D.

•Always request an invoice for J0897 (Updated 2/2013).

7. Hearing aid services, Procedure codes V5257 and V5261: Manually price these V services according to the prices listed on the matrix provided in Claims Resolution Procedures Manual, Appendix B.

8. Procedure Code S1040 (Cranial Remolding Orthosis): Transfer claims for this procedure code to Location 321 for medial review.

9. DME: If the procedure code is a DME code and the rate eff date is after the date of service, Deny with 0370. \~ Example:\~ DOS billed 11/1/03 and rate effective date is 1/1/04 \endash deny with 0370.

IMPORTANT NOTE: Procedure codes A9500-A9700 are not DME codes. Pay if pricing information is attached to the claim. (updated 01/20/10)

10. Planned Parenthood services: \f1 Allow payment for planned parenthood providers who bill for services listed on the DMAS Spreadsheet for Planned Parenthood Providers. The provider attaches the spread sheet to the claim and indicates the correct service and reimbursement rate. Manually price at the Reimbursement rate listed on the spreadsheet, or the billed charge, whichever is less.

11. Q codes billed for cast supplies can be denied 0370 with deny indicator D. Providers should bill with 99070. (Updated 4/18/08)

12. Unlisted procedure codes that will never have a rate are listed below. If there is no attachment, deny the claim for these procedures using the ESC noted in the list. If there is an attachment, transfer to DMAS location 321.

Unlisted Need Medical Doc	Code	Eff Date	Deny ESC
37799	A4210	01/01/2004	147
43999	A4211		370
44799	A4212	01/01/2004	147
46999	A4216	01/01/2004	147
49999	A4217	09/20/2004	147
53899	A4220		370
59899	A4221		370
64999	A4222		370
68899	A4258		370
69399	A4280		370

76498	A4300		370
76999	A4301		370
90799	A4305		370
90899	A4311	01/01/2004	147
90999	A4312	01/01/2004	147
91299	A4324	01/01/2004	147
92499	A4325	01/01/2004	147
93799	A4331	03/16/2004	147
95199	A4332		370
95999	A4334		370
96999	A4360		370
97799	A4372	01/01/2004	147
99499	A4373	01/01/2004	147
A4641	A4379	01/01/2004	147
A9900	A4385	01/01/2004	147
J3490	A4388	01/01/2004	147
J9999	A4389	01/01/2004	147
L8499	A4390	01/01/2004	147
	A4392	01/01/2004	147
	A4393	01/01/2004	147
	A4394	01/01/2004	147
	A4405	01/01/2004	147
	A4406	01/01/2004	147
	A4407	01/01/2004	147
	A4408	01/01/2004	147
	A4413	01/01/2004	147
	A4421		Misc code
	A4462	01/01/2004	147
	A4465		370
	A4480		370
	A4481		370
	A4483	08/01/2005	147
	A4520		370
	A4537		370
	A4595	01/01/2004	147
	A4605		370
	A4606	01/01/2004	147
	A4609	01/01/2004	147

	A4611	01/01/2004	147
	A4614	01/01/2004	147
	A4629		370
	A4632		370
	A4634		370
	A4640		370
	A4649		370
	A4652		370
	A4656		370
	A4657		370
	A4670		370
	A4673		370
	A4755		370
	A4928		370
	A4930	01/01/2004	147
	A4931		370
	A6010	01/01/2004	147
	A6020		370
	A6021	01/01/2004	147
	A6022	01/01/2004	147
	A6023	01/01/2004	147
	A6154	01/01/2004	147
	A6196	01/01/2004	147
	A6197	01/01/2004	147
	A6198		370
	A6199	01/01/2004	147
	A6200	01/01/2004	147
	A6201	01/01/2004	147
	A6203	01/01/2004	147
	A6204	01/01/2004	147
	A6209	01/01/2004	147
	A6212	01/01/2004	147
	A6215		370
	A6216	01/01/2004	147
	A6217		370
	A6218		370
	A6219	01/01/2004	147
	A6220	01/01/2004	147

	A6222	01/01/2004	147
	A6228		370
	A6234	01/01/2004	147
	A6236	01/01/2004	147
	A6237	01/01/2004	147
	A6241	01/01/2004	147
	A6242	01/01/2004	147
	A6243	06/20/2003	147
	A6245	06/20/2003	147
	A6250	01/01/2004	147
	A6253	01/01/2004	147
	A6254	01/01/2004	147
	A6257	01/01/2004	147
	A6258	01/01/2004	147
	A6266	01/01/2004	147
	A6402	12/01/2003	147
	A6403	01/01/2004	147
	A6422		370
	A6424		370
	A6451		370
	A6452		370
	A6454		370
	A6455		370
	A6456		370
	A6504		370
	A6509		370
	A6512		370
	A6550	08/01/2005	147
	A6551	01/01/2004	147
	A7000	01/01/2004	147
	A7001		370
	A7002	01/01/2004	147
	A7006	01/01/2004	147
	A7007	03/06/2004	147
	A7009	01/01/2004	147
	A7010		370
	A7016		370
	A7018	01/01/2004	147

	A7020		370
	A7030		370
	A7031	01/01/2004	147
	A7036	01/01/2004	147
	A7039	01/01/2004	147
	A7045		370
	A7046		370
	A7501		370
	A7504		370
	A7505		370
	A7507	01/01/2004	147
	A7508		370
	A7526	04/01/2004	147
	A9502	01/01/2004	147
	A9510		370
	A9512		370
	A9513		370
	A9516		370
	A9520		370
	A9522		370
	A9552		Need invoice Deny 0073
	A9901	01/01/2004	147
	B4186		370
	B4189		370
	B4193		370
	B4197		370
	B4220		370
	B4224		370
	B9998		370
	C1751		370
	D8080	if 05	370
	E0144	01/01/2004	147
	E0148	01/01/2004	147
	E0149	01/01/2004	147
	E0159	01/01/2004	147
	E0162	01/01/2004	147
	E0176		370
	E0178		370

	E0179	01/01/2004	147
	E0199	01/01/2004	147
	E0218		370
	E0230		370
	E0241		370
	E0242		370
	E0277		370
	E0290		370
	E0352		370
	E0431		370
	E0434		370
	E0435		370
	E0441		370
	E0442	01/01/2004	147
	E0444		370
	E0454		370
	E0463		370
	E0571		370
	E0574		370
	E0590		370
	E0602		370
	E0619	01/01/2004	147
	E0628		370
	E0667	01/01/2004	147
	E0668		147
	E0671		370
	E0673		370
	E0700		370
	E0791		370
	E1025		370
	E1031		370
	E1100		370
	E1238		370
	E1310		370
	E1340		147
	E1370		370
	E1390		370
	E1810		370

	E2101		370
	E2324		370
	E2340		370
	E2341		370
	E2342		370
	E2601		370
	E2603		370
	E2605		370
	E2607		370
	E2619		370
	G0101	01/01/2005	147
	G0123	01/01/2004	147
	G0179	dos <6/20/03	
	G0181	dos <6/20/03	370
	G0186	dos <6/20/03	370
	G0191	dos <6/20/03	370
	G0219	dos <6/20/03	370
	J0692		147
	J1056		147
	J2020		147
	J2543		147
	J2940		147
	J3411		147
	J3490	misc code	
	J7506		147
	J7510		147
	J7608		147
	J7618		147
	J7619		147
	J7631		147
	J7644		147
	J7682		147
	J8499		If health dept billing- needs mod U2
	J8521		147
	J9001		147
	J9178		147
	J9999		MISC
	K0001		370

	K0005		370
	K0016		370
	K0019		370
	K0034		370
	K0038		147
	K0045		370
	K0046		370
	K0054		370
	K0066		370
	K0070		370
	K0078		370
	K0082		370
	K0085		370
	K0091		370
	K0092		370
	K0096		370
	K0099		370
	K0108		370
	K0195		147
	K0588		370
	K0594		370
	K0595		370
	K0601		147
	K0602		147
	K0620		370
	L8499		0410 (Unl)
	P9047		147
	P9612		147
	Q0170		147
	Q3025		147
	Q4010		370
	Q4012		370
	Q3005		Need Invoice
	Q3009		Need Invoice
	Q3010		Need Invoice
	Q4018		370
	Q4022		370
	Q4030		370

	Q4037		370
	Q4038		370
	Q4039		370
	Q4040		370
	Q4042		370
	Q4044		370
	Q4045		370
	Q4046		370
	Q4048		370
	Q4049		370
	Q4050		370
	Q4051		370
	Q4054		370
	Q9965		Need Invoice
	Q9967		Need Invoice
	S0020		Need Invoice
	S1015		147
	S4993		370
	S5105		370
	S5115		370
	S5120		370
	S5125		370
	S5151		370
	S5180		370
	S5190		370
	S5497		370
	S5498		370
	S5498		370
	S5502		370
	S5521		370
	S8095		370
	S8096		370
	S8100		370
	S8101		370
	S8105		370
	S8182		370
	S8186		370
	S8189		370

	S8210		370
	S8260		370
	S8401		370
	S8451		370
	S8999		370
	S9123		370
	S9124		370
	S9128		370
	S9212		370
	S9213		370
	S9336		370
	S9340		370
	S9341		370
	S9342		370
	S9343		370
	S9345		370
	S9346		370
	S9349		370
	S9351		370
	S9430		370
	S9434		Need Invoice
	S9500		147
	S9502		147
	S9542		370
	T1000		370
	T1004		370
	T1006		370
	T1010		370
	T1012		370
	T1013		370
	T1014		370
	T1015		370
	T1018		370
	T1023		370
	T1025		370
	T1026		370
	T1039		370
	T1049		370

T1502	370
T2002	370
T2017	370
T2019	370
T2021	370
T2028	370
T2032	370
T2033	370
T4534	370
T4535	370
T4536	370
T4541	370
V2020	147
V2035	370
V2626	Need Invoice
V2756	370
V5008	370
V5010	370
V5011	147
V5014	147
V5275	370
17999	0410 (Unl)
22899	0410 (Unl)
25259	147
27299	0410 (Unl)
27599	0410 (Unl)
27899	0410 (Unl)
29086	147
31299	0410 (Unl)
33215	147
36299	0410 (Unl)
36514	147
37183	147
37799	0410 (Unl)
43289	0410 (Unl)
43659	0410 (Unl)
43999	0410 (Unl)
44238	0410 (Unl)

44799	0410 (Unl)
44979	0410 (Unl)
45381	147
46020	147
46999	0410 (Unl)
47379	0410 (Unl)
49329	0410 (Unl)
49659	0410 (Unl)
49999	0410 (Unl)
50549	0410 (Unl)
53899	0410 (Unl)
58578	0410 (Unl)
58579	0410 (Unl)
59899	0410 (Unl)
60659	0410 (Unl)
62264	147
63304	147
64999	0410 (Unl)
66999	0410 (Unl)
68899	0410 (Unl)
69399	0410 (Unl)
76498	0410 (Unl)
76499	0410 (needs desc)
77261	041
77263	041
77417	041
78812	Needs 26 Mod
78812	Needs 26 Mod
78814	Needs 26 Mod
78815	Needs 26 Mod
79005	Needs 26 Mod
80048	041
80053	041
80076	041
81001	041
81099	0410 (Unl)
82247	041
82248	041

	82553		041
	82787		041
	82805		041
	82945		041
	82962		041
	83520		041
	83906		041
	83912		Needs 26 Mod
	84154		041
	84165		Needs 26 Mod
	84379		041
	84999		0410 (Unl)
	85004		041
	85049		041
	85305		041
	85390		N
	85461		041
	85536		147
	85652		041
	86147		041
	86320		Needs 26 Mod
	86325		Needs 26 Mod
	86658		041
	86663		041
	86671		041
	86709		041
	86803		041
	86804		041
	87107		041
	87172		041
	87327		041
	87335		041
	87400		041
	87430		041
	87522		041
	87550		041
	87880		041
	87999		0410 (Unl)

88365	041
89060	Needs 26 Mod
89240	0410 (Unl)
89320	147
90471	370
90632	Need Invoice
90646	147
90647	147
90657	147
90691	147
90717	147
90721	147
90740	147
90743	147
90749	147
90799	0410 (Unl)
90899	0410 (Unl)
90999	0410 (Unl)
92499	0410 (Unl)
92586	041
92603	147
92604	147
92700	0410 (Unl)
92961	147
92971	0410 (Unl)
92977	0410 (Unl)
93000	041
93005	041
93010	041
93014	041
93040	041
93225	041
93227	041
9323	041
93543	041
93660	Needs 26 Mod
93720	041
93799	0410 (Unl)

	94640		041
	94657		041
	94664		041
	94760		041
	94761		041
	94762		041
	94799		0410 (Unl)
	95027		041
	95070		041
	95199		0410 (Unl)
	95999		0410 (Unl)
	96999		0410 (Unl)
	97004		370
	97799		0410 (Unl)
	99499		0410 (Unl)

NOTE: If the procedure does not fit any of the above instructions, transfer the claim to LOC 321 (medical consultant) with remarks indicating the reason for the transfer.

NOTE: Do not override this edit as the claim will not be able to price.

Procedure	Per Diem Rate Not subject to quantity
S9373	\$8.00
S9374	\$8.00
S9375	\$8.00
S9376	\$8.00
S9377	\$8.00
S9329	\$25.00
S9330	\$25.00
S9331	\$25.00
S9325	\$12.00
S9326	\$12.00
S9327	\$12.00
S9328	\$12.00
S9338	\$27.00
S9348	\$27.00
S9490	\$27.00
S9494	\$27.00
S9497	\$27.00
S9500	\$27.00

S9501	\$27.00
S9502	\$27.00
S9503	\$27.00
S9504	\$27.00
S9364	\$150.00
S9365	\$150.00
S9366	\$150.00
S9367	\$150.00
S9368	\$150.00

Edit/Audit Inquiry Results Edit-215 ESC-215

Edit Information

Edit Number	215	esc Number	215	NCPDP Code	
-------------	-----	------------	-----	------------	--

Short Desc	Review of Mammography Certification Date
Long Desc	Review of Mammography Certification Date
Edit Criteria	<p>For Outpatient (claim type 03), if the from date of service is >= 10/01/94 and the principal procedure code = 8736 or 8737 and one of the provider's specialties is not = 100 for the claim's dates of service, set the edit.</p> <p>For Practitioner (claim type 05), if the from date of service is >= 10/01/94 and the procedure code = 76090, 76091, or 76092 and one of the provider's specialties is not = 100 for the claim's dates of service, set the edit. (procedure codes end dated 12/31/2006)</p> <p>See value set, MMOGPHY PROC CODES CT03 - E215. See value set, MMOGPHY PROC CODES CT05 - E215. See value sets for current codes.</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	P	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	

Asmt Fee				
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Date Information

Effective Date Code	DOS	Effective Date	10/1/1994	Revision Date	
---------------------	-----	----------------	-----------	---------------	--

Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-216 ESC-216

Edit Information

Edit Number	216	esc Number	216	NCPDP Code	
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Short Desc	Pending Review of Charges
Long Desc	Pending Review of Charges
Edit Criteria	<p>This edit is being deleted; TDR, D-TPCP-ST-0250. For Outpatient (claim type 03), if the calculated allowed amount is greater than the billed amount, set the edit.</p> <p>For shadow payment requests, pay as priced. Do not set the edit.</p>

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-217 ESC-217

Edit Information

Edit Number	217	esc Number	217	NCPDP Code	
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Short Desc	Review Medicare Coverage				
Long Desc	Review Medicare Coverage				
Edit Criteria	This edit has been combined with edit 230 and is no longer valid in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-218 ESC-218

Edit Information

Edit Number	218	esc Number	218	NCPDP Code	
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Short Desc	Review Length of Stay				
Long Desc	Length of stay not justified.				
Edit Criteria	<p>If a PA is found, bypass the edit. If the provider class type = 01, the bill type = 111 - 114, 117 and the admit date is > 06/30/1996, bypass the edit. If the provider class type = 91, the bill type = 111 - 114, 117 and the admit date is > 12/31/1999, bypass the edit.</p> <p>If provider class type = 001, 008, 009, 013 or 091 and if the from date of service is > 8/31/95 and the enrollee's hospital stay exceeds 3 days (the difference between the admission date and thru date of service; 1 is added to the difference if the discharge status = 30) and the principal diagnosis is not Tuberculosis (010-018) or not Psychiatric (299-319), set the edit.</p> <p>Electronically submitted payment requests and paper requests with no attachment with Edit 0218 generate a letter requesting documentation. These payment requests automatically deny with edit 0375 after 21 days if no letter is returned.</p>				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority	0	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
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Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	300	PEND	
	650	PEND	
EMC	300	PEND	
	650	PEND	
Adjustment	300	PEND	
	650	PEND	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

All SLH Pends are assigned to LOC 308 if media is paper or EMC with an attachment; if paper or EMC with no attachment , they will pend to 650.

Resolution

Electronically submitted payment requests with Edit 0218 generate a letter requesting documentation. These payment requests automatically deny with edit 0375 after 21 days if no letter is returned. Until then, they are held in Location 650.

1. When the documentation is returned with a copy of the letter, access the pend in Location 650 using the ICN and transfer the claim to DMAS Location 300.
2. Enter a comment stating that the documentation has been received and is being forwarded to DMAS.
3. Send the documentation to the appropriate DMAS unit.

Edit/Audit Inquiry Results Edit-219 ESC-219

Edit Information

Edit Number	219	esc Number	219	NCPDP Code	
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Short Desc	Review Inpatient Psych/EPSTD Pre-Auth				
Long Desc	Review Inpatient Psych/EPSTD Pre-Auth				
Edit Criteria	<p>If a PA is found, bypass the edit. If the provider class type = 01, the bill type = 111 - 114, 117 and the admit date is > 06/30/1996, bypass the edit. If the provider class type = 91, the bill type = 111 - 114, 117 and the admit date is > 12/31/1999, bypass the edit.</p> <p>If provider class type = 001, 008, 009, 013 or 091 and if the from date of service is > 8/31/95 and the enrollee's hospital stay exceeds 3 days (the number of days between the admission date and the thru date of service) and the principal diagnosis is Tuberculosis (010-018) or Psychiatric (299-319), set the edit.</p> <p>Electronically submitted payment requests and paper requests with no attachment with Edit 0219 generate a letter requesting documentation. These payment requests automatically deny with edit 0375 after 21 days if no letter is returned.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority	0	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
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Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	300	PEND	
	650	PEND	
EMC	300	PEND	
	650	PEND	
Adjustment	300	PEND	
	650	PEND	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

All SLH Pends are assigned to LOC 308 if media is paper or EMC with an attachment; if paper or EMC with no attachment , they will pend to 650.

Resolution

Electronically submitted payment requests with Edit 0219 generate a letter requesting documentation. These payment requests automatically deny with edit 0375 after 21 days if no letter is returned. Until then, they are held in Location 650.

1. When the documentation is returned with a copy of the letter, access the pend in Location 650 using the ICN and transfer the claim to DMAS Location 300.
2. Enter a comment stating that the documentation has been received and is being forwarded to DMAS.
3. Send the documentation to the appropriate DMAS unit.

Edit/Audit Inquiry Results Edit-220 ESC-220

Edit Information

Edit Number	220	esc Number	220	NCPDP Code	
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Short Desc	Pending Review of Services
Long Desc	Medical Medical Justification/Documentation Not Attached
Edit Criteria	<p>Set an indicator to not require a PA, which is used in this edit process, when either of the following (along with other criteria) is true:</p> <ul style="list-style-type: none"> • One of the procedure codes is in the ICD-9 value set 300 (ICD9 PROC PA CONDITION 1) or the ICD-10 value set 20300 (ICD-10 PROCS VAGINAL DELIVERY) and the there are less than 4 days between the TO date of service and the ADMIT date. • One of the procedure codes is in the ICD-9 value set 301 (ICD9 PROC PA CONDITION 2) or the ICD-10 value set 20301 (ICD-10 PROCS CAESAR DELIVERY) and the there are less than 6 days between the TO date of service and the ADMIT date. <p>For Inpatient (claim type 01), Outpatient and Home Health (claim type 03):</p> <p>1) If any ICD procedure code billed has a pend review indicator, C_PEND_REVIEW, = P on the RF_PROCEDURE table, set the edit. Bypass part 1 if the claim type = 01, the provider class type = 01, 14, 85, or 91, the bill type = 111, 112, 113, 114, or 117, and the admission date is after 12/31/1999 OR if prior to 12/31/1999, the bill type = 113 or 114, the enrollee's age is > 20, and the provider type = 01 or 91 OR a PA is required (PA is required for claim type 01, provider types 01, 03, and 07).</p> <p>2) If the provider class type is 01 (Hospital), 08 (State MH-Med-Surg), 09 (Med-Surg-MR), 13 (Long stay IP MR), or 91 (non-enrolled Hospital) and either the adult days of service (the sum of units for the revenue codes 100-169, 180-219) or the neonatal ICU days of service (sum of units for the revenue code 174 or 175) are > 21days:</p> <p>a) if the enrollee's age is < 21 on the thru date of service and a condition code is A1 (EPSDT) and the provider's restriction type is not = 06, set the edit. Bypass if the provider type = 01 or 91 and the admission date is greater than 12/31/1999 or if a PA is required.</p>

	<p>b) if the enrollee turns 21 during the hospital stay and the length of stay before the enrollee reaches 21 is > 21 days and a condition code is A1 (EPSDT) and the provider's restriction type does not = 06, set the edit. Bypass the edit if the provider type = 01 or 91 and the admission date is greater than 12/31/1999 or if a PA is required.</p> <p>3) If any of the ICD9 procedures is in the ICD-9 value set 21005 (ICD-9 ALCOHOL/DRUG REHAB/DETOX) and is not covered according to the Medical and Administrative Codes (any procedure flag = 999), and the payment request provider type is = 01, 03, 07, 77, or 91, set the edit. If the enrollee is a non-resident alien, benefit plan = 01-01-3000 or 01-01-3001 OR if the bill type = 113 or 114, the enrollee's age is > 20 and the provider type = 01 OR if a PA is required, bypass this check.</p> <p>For Practitioner (claim type 05) and Laboratory (claim type 08): If the procedure code has a pend review indicator = P and either no PA is required or if a PA is required, no PA is on file, set the edit.</p> <p>For Dental (claim type 11): If the procedure code has a pend review indicator of P, set the edit.</p> <p>Claim type 01 requests pended to location 650 will generate a letter for information. If no information is received within 21 days, the request will automatically deny with edit 0375.</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental	Y	Pharmacy		Inpatient	Y
Nursing		Home Health	Y	Outpatient	Y
Physician	Y	Personal Care		Laboratory	Y
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
		DENY	
EMC	200	PEND	
		DENY	
Adjustment	200	PEND	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

Except CT01 pends to LOC 300 if media is paper with an attachment; if paper with no attachment or EMC, they will pend to LOC 650.

Resolution

Edit 220
All Claim Types:
Check for keying/scanning errors.
1. If errors are found in unprotected fields, correct the field entry.
2. If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.

Inpatient Hospital
Edit 220 automatically sends letter CP-O-445 to the provider requesting additional information.
1. When the documentation is returned with a copy of the letter, access the pend in Location 650 using the ICN and transfer the claim to DMAS Location 300.
2. Enter a comment stating that the documentation has been received and is being forwarded to DMAS.
3. Send the documentation to the appropriate DMAS unit.

Outpatient Hospital

1. If the attachment is hospital notes, operative report or physician notes, transfer the pend to DMAS location 321.
2. If the attachment is not one of the above, deny with ESC code 0220.

Independent Lab

1. Procedure code 84153 needs explanation. Review attachment for justification, i.e., hypertension.
 2. For other procedure codes that set 0220, review attachment for medical necessity.
- If valid justification is not provided, deny with 0220, disposition indicator D.
If valid justification is provided, override 0220, disposition indicator O.

Anesthesia

1. If there is an attachment for anesthesia codes that pend for 0220, transfer the pend to DMAS location 321.
2. If there is no attachment that justifies the procedure, deny with ESC code 0220.

Orthotics

Procedure codes z9548-z9550 must have CMN DMAS 352 attached to authorize service.

1. If proper form is attached, override 0220, disposition indicator O.
2. If proper form is not attached, deny with code 0496, disposition indicator D.

Home IV Therapies

Home IV Therapies include: Hydration, Chemotherapy, Pain Management, Drug Therapy, Total Parental Nutrition, and Incompatible Drug Therapy, Procedure codes are Z codes, which will be converted to National codes effective October 16, 2003. For pricing and additional information, refer to the Medicaid Services Day Rate Allowances Home IV Therapy matrix on file in the Pend Resolution Unit.

Practitioner

1. Check procedure code. If proper documentation/justification is attached, override 0220, disposition indicator O.

Note: Procedure Code 90660 is a new flu vaccine mist. Documentation to justify payment of this code is:

A site reaction from injection

Skin atrophy or not enough muscle to give an injection. (too thin)

If documentation allows payment, transfer the claim to location 219 for pricing as the procedure code has the wrong price on file. If determination cannot be made, see step 2 below.

2. If documentation is attached and justification cannot be determined, transfer pend to DMAS location 321.
3. If there is no attachment that justifies the procedure, deny with ESC code 0220.

Digital Mammography

Procedure code 76085 (Digitalization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography) must be billed with procedure code 76092 in order to be paid by Medicaid. Check claims history for another line billing procedure code 76092.

1. If 76085 is billed with 76092, override 0220, disposition indicator O
2. If 76085 is not billed with 76092, deny with 0220, disposition indicator D.

Medical Nutrition codes 97802 and 97803

1. Transfer to location 321. (Updated 6/2014)

Edit/Audit Inquiry Results Edit-221 ESC-221

Edit Information

Edit Number	221	esc Number	221	NCPDP Code	
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Short Desc	Pending Review for Other Insurance Coverage
Long Desc	Pending Review for Other Insurance Coverage
Edit Criteria	<p>If the procedure flag is '91' (Pregnancy, Preventative Srv. & Court-Ordered Office Visit Paid (Bypass TPL)) and any of the diagnosis codes are in the ICD-9 value set 172 (BYPASS DIAGNOSIS CODES) or the ICD-10 value set 20288 (ICD-10 PREGNANCY DIAG CODES), bypass the edit.</p> <p>For Transportation (claim type 13), if the COB code = 5 and the procedure code = Y0110 and there is major medical coverage (TPL coverage code = M) or Medicare Part B coverage (TPL coverage codes B/Z), set the edit.</p>

General Indicators

Reject Ind		Deny Ind		Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	T	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation	Y	Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
	200	PEND	
EMC	200	PEND	
	200	PEND	
Adjustment	200	PEND	
	200	PEND	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA032	TPL Edits

Exceptions

All TDO Pends are assigned to LOC 319.
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Resolution

<p>All Claim Types: Check for keying/scanning errors.</p> <p>1.\tab If errors are found in unprotected fields, correct the field entry. \tab If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.</p> <p>Transportation\tab</p> <p>Check attachment for denial letter from insurance carrier. All information on the letter must match the payment request information (dates of service, procedure codes). Also check denial reason.</p> <p>1.\tab If the letter indicates the insurance carrier denied the claim for a valid reason (service not covered), override with code 0221 and disposition indicator O. \tab If the letter indicates the insurance carrier denied the claim because it is a duplicate of a previously paid claim or because the carrier has requested additional information, deny with code 0313.</p> <p>3.\tab If there is no attachment or the information does not match (different dates of service), deny</p>

with code 0313.

4. If payment went to the deductible leaving \$0.00 payment to the provider, override with code 0221 and disposition indicator O.

Edit/Audit Inquiry Results Edit-222 ESC-222

Edit Information

Edit Number	222	esc Number	222	NCPDP Code	85
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Short Desc	Suspended for Enrollee Review
Long Desc	Suspended for Enrollee Review
Edit Criteria	If an enrollee has an entry on the Enrollee Pend Database for the claim's dates of service, set the edit. If there is a pend location on that Database, the claim will pend to that location and not the location on the Error Text Database.

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	R	Priority	4	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy	Y	Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	800	PEND	
	800	PEND	
EMC	800	PEND	
	800	PEND	
Adjustment	800	PEND	
	800	PEND	
POS	800	PEND	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA030	Recipient Edits
VPTM1RCP	POS Pharmacy Claims Enrollee Edits Process

Exceptions

All TDO UB claim types that pend will pend to LOC 320 and HCFA claim types will pend to LOC 319. All SLH UB claim types that pend will pend to LOC 308 and HCFA claim types will pend to LOC 310. Pend for Capitation, Management, Admin Fees, and Assessments.

Resolution

All claim Types:

DMAS Managed Care Unit enters a notation on the Enrollee Demographics page to suspend claims in cases where there is an enrollment error and the claims should be managed care encounters. Claims will suspend to location 100 for denial. Click on the Enrollee button and look at the Demographics page Comments section. The comment should indicate the reason for suspension of the claims and give the denial reason as 0453.

1. Review comment section on the member elig file. Note the dates indicated in the comment. If dates are not within the HMO/MCO responsibility dates, override 0222. If dates are within the HMO/MCO responsibility dates and is not a carved out service, deny 0453 D.
2. If comments states to ignore pend, check pend begin and end dates on the member demographic screen. (Bottom of the screen) If dates are the same, override 0222 0. If you have a question, transfer to location 219. Enter your concern

in the remark section.

3. Carved out services can be found in reference. Click on value set under System Support, Select Function: Select 'Inquiry' and enter value sets. These are included in the edit criteria for edit 0453.

MCO CARVE-OUT SERVICES

CPT ABORTION CODES

DIAG ABORTION CODES

PROC SUBSTANCE ABUSE

SPECIFIC HEALTH DEP PROC CODES

NUTRITION SERVICES - E0453

EPSDT PROCS RELATED TO S5126

EPSDT PA REQUIRED PROCS 0098

ALTC SPECIFIC PROC CODES

EI CARVE OUT SERVICES

Or the procedure code T1016

If the billed procedure code is on the list and the dates of service fall within the begin and end date of the procedure, override 0222O. If

procedure code is not listed and falls within the HMO responsibility dates deny 0453D. (Updated 6/1/12)

4. Do not consider written comments on the claims submitted by the provider.

5. If there is no comment in the Comments section, transfer the claim to LOC 800.

6. If you are not sure of your resolution, transfer to location 219 and enter your concern in the remark section.

For Inpatient (claim type 01) or Outpatient (claim type 03):

1 - Any procedure code is for abortion: 6901, 6951, 7491, or 750 (See value set, ICD9 ABORTION CODES or DIAG ABORTION CODES),
override 0222 O.

2- If procedure code is not listed, deny 0453 D.

Edit/Audit Inquiry Results Edit-223 ESC-223

Edit Information

Edit Number	223	esc Number	223	NCPDP Code	
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Short Desc	Review of Emergency Medical Documentation
Long Desc	Emergency not documented
Edit Criteria	<p>Bypass the edit if the enrollee's benefit exception code is 4, 5, or 6 (that is, enrollee is locked in to a particular physician, pharmacy, or transportation) or the payment request is a reentry.</p> <p>For outpatient (claim type 03) with date of service on or after 5/1/04, the edit is bypassed if there is an approved practitioner claim with procedure 99284 or 99285, POS 23, PT 20, TOS not 2, 4, 5, 6, 7, 8, same recipient and same from date of service as the outpatient claim.</p> <p>For Practitioner (claim type 05), also bypass the edit if the provider class type is not 20 (physician) or the place of treatment is not 23 (ER Hospital) or type of service = 2, 4, 5, 6, 7, or 8). Procedure code reference: (Procedure anesthesia (CPT codes 00100-01999), surgery (CPT codes 10040-69979), radiology (CPT codes 70010-79999), pathology or laboratory (CPT codes 80049 - 89399) or medicine (CPT codes 90700 - 99199).</p> <p>For Outpatient (claim type 03): If the from date of service is > 9/30/94 and the revenue code is in the range 450-459 and the principal procedure code is in the range spaces - '0090' or '8900' - '8909' and the principal (use the admitting diagnosis if the from date of service is after 5/31/2001) diagnosis code is on the Pend Diagnosis Table III, and the payment amount > \$30.00, this edit is set. If the principal (use the admitting diagnosis if the from date of service is after 5/31/2001) diagnosis code is not on the Pay Diagnosis Table III and not on the Pend Diagnosis Table III and the from date of service is > 05/31/2001, this edit is set. If the principal (use the admitting diagnosis if the from date of service is after 5/31/2001) diagnosis code is not on the Pay Diagnosis Table III and not on the Pend Diagnosis Table III and the from date of service is < 06/01/2001 and the payment amount is > \$30.00, the payment amount is reduced to \$30.00 and EOB 645 is set. If the payment amount is <= \$30.00, the payment amount is paid and EOB 647 is set regardless of the from date of service.</p> <p>For Outpatient (claim type 03): For claims that have a Bill-types = '13X', '72X', and '85X' and prov types ('001', '014', '085', '091'), and FDOS >= 01/01/14 the edit is bypassed.</p>

	<p>For Practitioner (claim type 05):</p> <p>If the procedure code is an emergency procedure Included in the Emergency Procedures Value Set and the primary diagnosis code is on the Pend Diagnosis Table III, and the payment amount is greater than the system parameter "NONEMDEFPR" value that is associated with the DOS, this edit is set. If the primary diagnosis code is not on the Pend Diagnosis Table III and not on the Pay Diagnosis Table III and the from date of service is > 05/31/2001, this edit is set. If the principal diagnosis code is not on the Pay Diagnosis Table III and not on the Pend Diagnosis Table III and the from date of service is < 06/01/2001 and the payment amount is greater than the system parameter "NONEMDEFPR" value that is associated with the DOS, the payment amount is reduced to the system parameter "NONEMDEFPR" value that is associated with the DOS and EOB 645 is set. If the payment amount is less than or equal to the system parameter "NONEMDEFPR" value that is associated with the DOS, the payment amount is paid and EOB 647 is set regardless of the from date of service.</p> <p>Payment requests with Edit 0223 generate a letter requesting documentation. These payment requests will automatically be reentered if the appropriate documentation is not returned for review after 21 days and pay with a reduced payment of the system parameter "NONEMDEFPR" value for the associated DOS or \$30 for outpatient claims. EOB 649 is set to indicate this action.</p> <p>The 'reduced payment' amounts for practitioner claims are maintained in system parameter "NONEMDEFPR".</p> <p>See value set, EMERGENCY PROCEDURES See value set, PEND ER DIAG CODE TABLE III See value set, PAYABLE ER DIAG CODE TABLE III</p>
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General Indicators

Reject Ind		Deny Ind		Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	

Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	300	PEND	
	650	PEND	
EMC	300	PEND	
	650	PEND	
Adjustment	300	PEND	
	650	PEND	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA100	Adjudication Controller

Exceptions

Claim type 05 will pend to location 314 if media is paper or EMC with an attachment; if paper or EMC with no attachment, they will pend to 650. Claim type 03 will pend to location 312 if media is paper or EMC with an attachment; if paper or EMC with no attachment, they will pend to 650.

Resolution

1. When the documentation is returned with a copy of the letter, access the pend in Location 650 using the ICN and transfer the claim to DMAS Location 300.
2. Enter a comment stating that the documentation has been received and is being forwarded to DMAS.
3. Send the documentation to the appropriate DMAS unit.
4. If you receive a message "Claim pended to auto recycle location 600" or "ICN currently not in a pend status", the claim has already been flagged for auto-adjudication or already paid and the records are not needed. Double check the ICN to be sure it was entered correctly. If the ICN was

entered correctly and you still get the message indicated above, use the same procedure for the records that you use when records come in past the purge date. See note below for explanation.

Note: A change was made to criteria for edit 223 in June, 2004, which has the system automatically pay OP emergency claims for two emergency diagnosis codes when a physician emergency claim has been paid for these diagnosis codes. If the physician claim is paid after the OP claim was pending requesting records, the system will automatically transfer the pending OP claim to location 600 and process the claim to full (not reduced) payment. In such a case, the records are no longer needed.

Edit/Audit Inquiry Results Edit-224 ESC-224

Edit Information

Edit Number	224	esc Number	224	NCPDP Code	
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Short Desc	Review of NDC				
Long Desc	Review of NDC				
Edit Criteria	This edit is no longer active.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-225 ESC-225

Edit Information

Edit Number	225	esc Number	225	NCPDP Code	
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Short Desc	Units Billed Exceed Allowable Units for Procedure
Long Desc	Units billed exceeded max allowable units for this procedure. Payment based on allowable units.
Edit Criteria	<p>For Practitioner (claim type 05) claims with anesthesia type of service 4 (date of service on or before 01/31/1995) or 7 (date of service after 01/31/1995), bypass the edit.</p> <p>For Practitioner (claim type 05) except for anesthesia which has type of service 4 or 7, Dental (claim type 11) and Personal Care (claim type 04), bypass the edit if a PA is required (code 01 or 03) according to the Medical and Administrative Codes Database.</p> <p>Otherwise, for Practitioner (claim type 05), Laboratory (claim type 08), Dental (claim type 11) and Personal Care (claim type 04): If the units billed divided by (the difference between from and thru dates of service plus 1) exceeds the maximum allowed on the Medical and Administrative Codes Database, cutback the units allowed to the maximum allowed and set EOB 691. However, if there is an attachment, set this edit.</p> <p>For Outpatient (claim type 03, bill types 131 and 137): 1) If the principal procedure = 3995 or 5498 (renal dialysis) and the number of units (n_covrd_days on cp_fac_clm) exceeds the rate of 1 every other day for the dates of service (difference between from and thru dates of service divided by 2), set the edit. 2) If there is a revenue charge for renal dialysis (revenue codes 820-859) and the principal procedure does not = 3995 or 5498 and the number of visits (n_covrd_days on cp_fac_clm) exceeds the rate of 1 every other day for the dates of service (difference between from and thru dates of service divided by 2), set the edit. For 1) and 2), if the from date of service = the thru date of service, add 1 to the difference before dividing by 2.</p> <p>For SLH practitioner payment requests, if the units are greater than (thru date minus from date plus one) and the provider type = 51, set the edit. (See edit 0059)</p> <p>As of June 3rd, 2013, this edit is bypassed if the procedure code is found on the RF_MUE_EDIT_BYPASS table, and the claim type is found in the NCCI Claim</p>

Type value set.
See value set, REV - RENAL DIALYSIS. See Value Set "NCCI INTERNAL BYPASS CLM TYPES" for claim types.

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation		Xover A		Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				Y

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
		DENY	
EMC	200	PEND	
		DENY	
Adjustment	200	PEND	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA350	ADA Service/PA Edit

Exceptions

Pend for Capitation, Management, Admin Fees, and Assessments. All SLH UB claim types that pend will pend to LOC 308 and HCFA claim types will pend to LOC 310.

Resolution

All Invoice Types:

1. Check for keying/scanning errors.

If errors are found in unprotected fields, correct the field entry.

If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.

2. If TPL amount on the claim is different than the amount on the EOB, deny 0015D. (Update 03/28/11)

3. The system automatically calculates the TPL in the Allowed Charges field unless there is manual pricing. If there is manual pricing and the TPL is less than the allowed amount, manually subtract the TPL from the Allowed Charges field and enter the difference in the Manual Price field. If the calculated Manual Price is \$0.00, deny the pend request. Enter 0364 D. (updated 3/21/08)

4. Look in the cutback units field on the pend reso screen to determine how many units were actually billed. (updated 03/28/11)

5. Review attachment for justification

* If Modifier 50 (bilateral procedure), manually price as follows:

a.) Pay 1.5 x fee on file if surgery is the primary procedure

b.) Pay 1 x the fee on file if the surgery is considered secondary.

* If surgery and justification is provided, transfer to DMAS location 321

* If a procedure is billed with a PA number, check the number of available units. If the remaining number is equal or greater to the units billed, override the ESC code that pended and enter disposition indicator O. If the remaining units are less than the billed units, deny using the ESC code that pended and enter disposition code D.

* If claim is for DME item and no PA number is billed, deny using the ESC code that pended and disposition indicator D.

* If claim is not for surgery or DME, and justification is provided, override using the ESC code that pended and disposition indicator O. If justification is not clear, transfer to LOC 321.

* If no justification, or if attachment does not pertain to the edit, deny using the ESC code that pended and disposition indicator D.

6. Procedure Code T1016 - Type F

Claims for dates of service PRIOR to 3/1/07 will pend for a rate. This will only apply to T1016 type F. Claims will require a certification rate sheet just like the claims pending for edit 0705. If no rate sheet is attached, deny 0410 D. Providers can bill for one month only (up to 31 units). Do not deny for 0225. Techs need to calculate the payment by multiplying the lesser of the rate on the attachment or the \$82.00 by the number of payment days. This code will eventually be preauthorized with a rate

on file for dates of service on or after 3/1/07. If a claim is pending with dos on or after 3/01/07 transfer to 219 until further notice. If any questions, add to remark screen and transfer to location 219.

Edit/Audit Inquiry Results Edit-226 ESC-226

Edit Information

Edit Number	226	esc Number	226	NCPDP Code	
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Short Desc	Review of Documentation for Place of Treatment				
Long Desc	Payment reduced to 50% of reimbursement rate for service when performed outpatient				
Edit Criteria	<p>The edit is bypassed if there is a PA.</p> <p>For Practitioner (claim type 05) and Title 18 Practitioner Claims (claim type 09 XOVB), if the from date of service is on or after 07/01/95, and the provider class type = 20, 23, 30, 31, 33, 35, 38, 40, 43, or 44, and if any of the procedures listed below are billed with a place of treatment = 22 (outpatient), reduce the reimbursement rate to 50% of the reimbursement rate established for these procedures when performed in a physician's office. These procedure codes have a flag indicator of 'RD' in the Medical and Administrative Codes Database.</p> <p>If there is an attachment or if any procedure modifier = 22 or 99 (individual consideration), set this edit to pend. Otherwise, pay it and set this edit as an EOB.</p> <p>See value set, ATTACH DISP PROC MODS</p> <p>Procedure Codes for Physician Reduction 10040 15792 22900 29049 29120 41826 10060 15793 23065 29055 29730 41850 10080 15810 23075 29058 29740 41870 10120 15811 23330 29065 29750 41872 11050 17000 24065 29075 30000 41874 11051 17001 24075 29085 30100 42000 11052 17002 24200 29105 30110 42100 11100 17100 25065 29125 30120 42104 11101 17101 25075 29126 30124 42106 11200 17102 26010 29130 30300 42300</p>				

11300 17104 26020 29131 36415 42310				
11301 17106 26025 29200 36468 42325				
11302 17110 26115 29220 36469 42400				
11303 17200 26160 29240 38300 42405				
11305 17201 26320 29260 38500 42409				
11306 17250 27040 29280 38505 42800				
11307 17260 27047 29305 40490 42802				
11308 17261 27086 29325 40800 42804				
11310 17270 27323 29345 40804 42806				
11311 17271 27327 29355 40806 46030				
11312 17280 27340 29358 40808 46040				
11313 17281 27345 29365 40810 46200				
11700 17304 27613 29405 40812 46210				
11701 17305 27618 29425 40820 46211				
11710 17306 28001 29435 41000 46220				
11711 17307 28043 29440 41005 46221				
11900 17310 28080 29445 41010 46230				
11901 17340 28090 29450 41100 46320				
11920 17360 28092 29505 41105 46500				
11975 17380 28100 29515 41108 46900				
11976 20000 28108 29520 41110 46910				
11977 20200 29000 29530 41115 46916				
15780 20206 29010 29540 41116 46917				
15781 20500 29015 29550 41800 46937				
15782 20520 29020 29580 41805 46940				
15783 20550 29025 29590 41820 46942				
15786 21497 29035 29700 41821 51700				
15787 21550 29040 29705 41822 53010				
15788 21555 29044 29710 41823 53060				
15789 21920 29046 29715 41825 53670				
54055 64420 90784 92330 92567 95125				
54056 64430 90788 92335 92568 95130				
54057 67141 92002 92340 92569 95131				
54060 67145 92004 92341 92571 95132				
54100 67208 92012 92342 92572 95133				
54500 67210 92014 92352 92573 95134				
54800 67227 92015 92353 92574 95144				
55100 67228 92020 92355 92575 95145				
55250 67800 92060 92358 92576 95146				
55600 67801 92065 92370 92577 95147				
55700 67805 92070 92390 92578 95148				
56405 67810 92081 92391 92580 95149				
56420 67820 92082 92392 92582 95165				
56440 67825 92083 92393 92583 95170				
56501 67840 92100 92395 92589 96400				
56605 67850 92120 92396 92590 96408				

56606 68020 92130 92531 92591 96900				
56720 68400 92140 92532 92592 96910				
57000 68420 92225 92533 92593 96912				
57020 68440 92226 92534 92594 99271				
57061 68510 92230 92541 92595 99272				
57100 68525 92235 92542 92596 99273				
57150 68530 92250 92543 95004 99274				
57160 68700 92260 92544 95010 99275				
57170 68705 92265 92545 95015				
57452 68760 92270 92546 95024				
57454 68761 92275 92547 95027				
57460 68800 92280 92551 95028				
58300 68820 92283 92552 95044				
58301 68840 92284 92553 95052				
64400 69000 92310 92555 95056				
64402 69020 92311 92556 95060				
64405 69100 92312 92557 95065				
64408 69105 92313 92559 95070				
64410 69110 92314 92560 95071				
64412 69140 92315 92561 95075				
64413 69145 92316 92562 95078				
64415 69210 92317 92563 95115				
64417 90782 92325 92564 95117				
64418 90783 92326 92565 95120				
11055 11056 11057 17003 17004				
11720 11721 15793 29720 54050				
68801 68810				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	Y

Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	100	PEND	
		EOB	
EMC	100	PEND	
		EOB	
Adjustment	100	PEND	
		EOB	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

Practitioner

1. Check for keying/scanning errors.
If errors are found in unprotected fields, correct the field entry.
If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.
2. Review attachment for justification of outpatient place of service.
If justification is provided, transfer to DMAS location 321. Note: if DMAS determines that the full rate should be paid, a manual price must be entered.
If no justification, override 0226, disposition indicator O. This will cause the claim to pay at the 50% reduced rate.

Edit/Audit Inquiry Results Edit-227 ESC-227

Edit Information

Edit Number	227	esc Number	227	NCPDP Code	
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Short Desc	Review of Svcs at Non-contracted Hospital				
Long Desc					
Edit Criteria	This edit was not found in current MMIS and is deleted from new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-228 ESC-228

Edit Information

Edit Number	228	esc Number	228	NCPDP Code	
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Short Desc	Pend for Bilateral Procedure				
Long Desc					
Edit Criteria	<p>The current 228 edit, "Pend for Bilateral Procedure", is no longer valid since the system prices the payment request at 150%.</p> <p>This edit is deleted. See edit 117 where the procedure code/bilateral modifier edit is done.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-229 ESC-229

Edit Information

Edit Number	229	esc Number	229	NCPDP Code	
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Short Desc	Review of Medallion PCP Authorization				
Long Desc					
Edit Criteria	Since only UB92 forms are accepted in the new MMIS, this edit is deleted. Edit 485 is used instead.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-230 ESC-230

Edit Information

Edit Number	230	esc Number	230	NCPDP Code	
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Short Desc	Review Medicare Coverage				
Long Desc	This service is covered fully by Medicare				
Edit Criteria	<p>1) If the payment request is for Inpatient (claim type 01), a Nursing Home (claim type 02), Outpatient (claim type 03), Practitioner (claim type 05), or Laboratory (claim type 08) and there is a valid enrollee number, and the disposition is not = 2 or 4 (debit adjustment or void), and the request is not a reentry and the enrollee premium indicator (C_PREMIUM_IND from the RS_ENRL_BENDEX using person id) = 9 (dialysis, Medicare pending or applied for), set the edit.</p> <p>2) If the payment request is an Outpatient (claim type 03) and the principal procedure code = 3995 or 5498 (renal dialysis) and enrollee has Medicare Part A on DOS and the enrollee premium indicator (C_PREMIUM_IND from the RS_ENRL_BENDEX using person id) is not = 8 (dialysis patient, not eligible for Medicare), set the edit. See also edit 310</p> <p>3) If the payment request is an Outpatient (claim type 03) and the principal procedure code does not = 3995 or 5498 and there is an ancillary revenue code = 820-859 (outpatient dialysis) and the enrollee has Medicare Part A on DOS, and the enrollee premium indicator is not = 8 (found on the Enrollee table, RS_ENRL_BENDEX), set the edit. See also edit 310</p> <p>4) If the payment request is a Practitioner (claim type 05) and the procedure code is > 90940 and < 91000 (lower GI) and the enrollee premium indicator is = 0 or 1 (not eligible for Medicare or SSA or receiving SSA benefits, updated by Bendex, found on the Enrollee table, RS_ENRL_BENDEX), set the edit.</p> <p>5) If the payment request is SLH Outpatient (claim type 03) or SLH Practitioner (claim type 05) and provider type 51 and the enrollee has Medicare type B or Z coverage and there is no TPL amount and the COB code = 2 or 3 (no other coverage or billed and paid), set the edit. If the payment request is SLH Practitioner (claim type 05) and provider</p>				

	type is not 51 and the enrollee has Medicare type B or Z coverage and the procedure code has TPL coverage B or Z and there is no TPL amount and the COB code = 2 or 3 (no other coverage or billed and paid), set the edit.				
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General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	T	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing	Y	Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	Y
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		TEST	
		TEST	
EMC		TEST	
		TEST	
Adjustment		TEST	
		TEST	
POS		PAY	
Encounter		0	
Special Batch		TEST	
PA			

Programs

Program	Program Title
CPA032	TPL Edits
CPA330	UB04 Service/PA Edit

Exceptions

All SLH claim types will pend to LOC 217 after recycling for 21 days. This edit was set to test effective 01/01/2003. It was set to deny until 12/31/2002.

Resolution

(None)

Edit/Audit Inquiry Results Edit-231 ESC-231

Edit Information

Edit Number	231	esc Number	231	NCPDP Code	
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Short Desc	Verify Enrollee Eligibility in HMO				
Long Desc	Verify Enrollee Eligibility in HMO				
Edit Criteria	<p>Bypass the edit if the payment request is a reentry.</p> <p>If claim is NOT an Encounter:</p> <p>If the provider class type = 67 (HMO Medallion II) or 69 (HMO Options), and the enrollee is not in an HMO, and there is an attachment OR any procedure modifier = 22 or 99, set edit 0231. If there is no attachment and no procedure modifier is equal to one of the above, set edit 0482.</p> <p>If the provider class type = 67 or 69, and the enrollee is in Medallion, and there is an attachment OR any procedure modifier = 22 or 99, set edit 0231. If there is no attachment and no procedure modifier is equal to one of the above, set edit 0482.</p> <p>For Practitioner (claim type 05), if the provider class type = 67 or 69 and the enrollee is in an HMO (Medallion II or Options), verify that the servicing provider submitting the claim is the Immunization provider for the claim dates of service for the HMO the enrollee is in (the enrollee's HMO provider should have the same base id number as the servicing provider submitting the claim). If not and there is an attachment OR any procedure modifier = 22 or 99, set edit 0231. If not and there is no attachment and no modifier is equal to one of the above, set edit 0482. If the provider is the Immunization provider, but the procedure is not an immunization procedure (flag indicator not = OC), set edit 0453.</p> <p>For Encounters (ICN media code = 9), set the edit if the provider type = 67 or 69.</p> <p>See value set, HMO PROV TYPES - E0231. See value set, ATTACH DISP PROC MODS</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	R	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy		Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	100	PEND	
		PAY	
EMC	100	PEND	
		PAY	
Adjustment	100	PEND	
		PAY	
POS		PAY	
Encounter		2	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA030	Recipient Edits

Exceptions

All TDO Pends are assigned to LOC 320. All SLH Pends are assigned to LOC 310. Pend for Capitation, Management, Admin Fees, and Assessments.

Resolution

All Claim Types:

1. Check for keying/scanning errors.

If errors are found in unprotected fields, correct the field entry.

If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.

2. Check for attachment that shows the recipient was enrolled in the HMO on the date of service.

The attachment may be a monthly HMO enrollment list or HMO card.

If justification is provided, override with 0231 and disposition indicator O.

If no justification is provided, deny with 0482 and disposition indicator D

Edit/Audit Inquiry Results Edit-232 ESC-232

Edit Information

Edit Number	232	esc Number	232	NCPDP Code	
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Short Desc	Invalid Nineteenth Diagnosis
Long Desc	INVALID NINETEENTH DIAGNOSIS
Edit Criteria	<p>The edit is set if the Nineteenth Diagnosis is not in the valid format or is not on the Diagnosis Database.</p> <p>For ICD-9 claims, the valid diagnosis format is either xnn, xnxx, or xxxnn where x = 0 - 9, E, V and n = 0 — 9. For ICD-10 claims, the diagnosis length is 3 - 7 characters and the valid format is a9xxxxx where a is alpha, 9 is numeric, and x is alpha-numeric.</p> <p>For claim type 01 (Inpatient), the edit is only done if the provider class type = 001 (General Hospital) and the admission date is > 6/30/1996 and the type bill is 111, 112, 113, 114, or 117.</p> <p>For claim type 01 (Inpatient), the edit is only done if the provider class type = 091 (Out of State Hospital) and the admission date is > 12/31/1999 and the type bill is 111, 112, 113, 114, or 117 .</p> <p>For claim type 01, provider types 003, 007, and 077 are the only other provider types that set the edit.</p> <p>For outpatient claim type 03, the edit is only done for bill types 131 and 137.</p> <p>Excluded from DRG:</p> <p>All diagnosis codes, except the diagnosis codes specifically mentioned in (iii), will be excluded from DRG pricing process if they satisfy condition (i) and (ii). The diagnosis codes mentioned in (iii) will have to satisfy (i), (ii) and (iii) to be excluded from DRG pricing :</p> <p>i.. If Present on Admission indicator is 'N' or 'U', or if Present on Admission indicator is '1' or blank and the diagnosis code is not present in the ICD-9 value set 9968 ('VALUE SET FOR EDIT 1370') or ICD-10 value set 29968 (ICD-10 VALUE SET FOR EDIT 1370).</p> <p>ii.If diagnosis code is in the ICD-9 value set 870 ('HAC DRG EXCLUDE CODES) or the ICD-10 value set 20870 (ICD-10 HAC DRG Exclude Codes)</p> <p>iii. Check specific to diagnosis codes:</p> <p>1. If the diagnosis code is present in ICD-9 value set 871 (519.2 DIAGNOSIS CODE) or the ICD-10 value set 20871 (ICD-10 HAC Diag Mediastinum) and any of the procedure codes is present in ICD-9 value set 872 (519.2 X-REFERENCE PROC CODES) or the ICD-10 value set 20872 (ICD-10 HAC Byp Coronary Artery).</p> <p>2. If the diagnosis code is present in ICD-9 value set 873 (996.67 OR 998.59</p>

	<p>DIAGNOSIS CODE) or the ICD-10 value set 20873 (ICD-10 HAC Diag Orthopedic) and any of the procedure codes is present in ICD-9 value set 874 (996.97 OR 998.59 XREF PROC CODES) or the ICD-10 value set 20874 (ICD-10 HAC Proc Orthopedic).</p> <p>3. If the diagnosis code is present in ICD-9 value set 875 (998.59 DIAGNOSIS CODE) or the ICD-10 value set 20875 (ICD-10 HAC Diag Sec Bariatric), the primary diagnosis code is present in ICD-9 value set 876 (278.01 DIAGNOSIS CODE) or the ICD-10 value set 20876 (ICD-10 HAC Diag Pri Bariatric), and any of the procedure codes is present in ICD-9 value set 877 (998.59 AND 278.01 XREF PROC CODES) or the ICD-10 value set 20877 (ICD-10 HAC Proc Bariatric).</p> <p>4. If the diagnosis code is present in ICD-9 value set 878 (DVT AND PE DIAG CODES) or the ICD-10 value set 20878 (ICD-10 DVT AND PE DIAG CODES) and any of the procedure codes is present in ICD-9 value set 879 (DVT AND PE PROC CODES) or the ICD-10 value set 20879 (ICD-10 DVT AND PE PROC CODES).</p>
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General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	Y
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	

EMC			
Adjustment		DENY	
		DENY	
POS			
Encounter		6	
Special Batch		PEND	
PA			

Programs

Program	Program Title
CPA330	UB04 Service/PA Edit

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-233 ESC-233

Edit Information

Edit Number	233	esc Number	233	NCPDP Code	
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Short Desc	Invalid Twentieth Diagnosis
Long Desc	Invalid Twentieth Diagnosis
Edit Criteria	<p>The edit is set if the Twentieth Diagnosis is not in the valid format or is not on the Diagnosis Database.</p> <p>For ICD-9 claims, the valid diagnosis format is either xnn, xnxx, or xxxnn where x = 0 - 9, E, V and n = 0 -- 9. For ICD-10 claims, the diagnosis length is 3 - 7 characters and the valid format is a9xxxxx where a is alpha, 9 is numeric, and x is alpha-numeric.</p> <p>For claim type 01 (Inpatient), the edit is only done if the provider class type = 001 (General Hospital) and the admission date is > 6/30/1996 and the type bill is 111, 112, 113, 114, or 117.</p> <p>For claim type 01 (Inpatient), the edit is only done if the provider class type = 091 (Out of State Hospital) and the admission date is > 12/31/1999 and the type bill is 111, 112, 113, 114, or 117 .</p> <p>For claim type 01, provider types 003, 007, and 077 are the only other provider types that set the edit.</p> <p>For outpatient claim type 03, the edit is only done for bill types 131 and 137.</p> <p>Excluded from DRG: All diagnosis codes, except the diagnosis codes specifically mentioned in (iii), will be excluded from DRG pricing process if they satisfy condition (i) and (ii). The diagnosis codes mentioned in (iii) will have to satisfy (i), (ii) and (iii) to be excluded from DRG pricing :</p> <p>i. If Present on Admission indicator is 'N' or 'U', or if Present on Admission indicator is '1' or blank and the diagnosis code is not present in the ICD-9 value set 9968 (VALUE SET FOR EDIT 1370) or the ICD-10 value set 29968 (VALUE SET FOR EDIT 1370).</p> <p>ii. If diagnosis code is in the ICD-9 value set 870 (HAC DRG EXCLUDE CODES) or the ICD-10 value set 20870 (ICD-10 HAC DRG Exclude Codes).</p> <p>iii. Check specific to diagnosis codes: 1. If the diagnosis code is present in the ICD-9 value set 871 (519.2 DIAGNOSIS CODE) or the ICD-10 value set 20871 ((ICD-10 HAC Diag Mediastinum) and any of the procedure codes is present in the ICD-9 value set 872 (519.2 X-REFERENCE PROC CODES) or the ICD-10 value set 20872 (ICD-10 HAC Byp</p>

	<p>Coronary Artery).</p> <p>2. If the diagnosis code is present in the ICD-9 value set 873 (996.67 OR 998.59 DIAGNOSIS CODE) or the ICD-10 value set 20873 (ICD-10 HAC Diag Orthopedic) and any of the procedure codes is present in the ICD-9 value set 874 (996.97 OR 998.59 XREF PROC CODES) or the ICD-10 value set 20874 (ICD-10 HAC Proc Orthopedic).</p> <p>3. If the diagnosis code is present in the ICD-9 value set 875 (998.59 DIAGNOSIS CODE) or the ICD-10 value set 20875 (ICD-10 HAC Diag Sec Bariatric), the primary diagnosis code is present in the ICD-9 value set 876 (278.01 DIAGNOSIS CODE) or the ICD-10 value set 20876 (ICD-10 HAC Diag Pri Bariatric), and any of the procedure codes is present in the ICD-9 value set 877 (998.59 AND 278.01 XREF PROC CODES) or the ICD-10 value set 20877 (ICD-10 HAC Proc Bariatric).</p> <p>4. If the diagnosis code is present in the ICD-9 value set 878 (DVT AND PE DIAG CODES) or the ICD-10 value set 20878 (ICD-10 DVT AND PE DIAG CODES) and any of the procedure codes is present in the ICD-9 value set 879 (DVT AND PE PROC CODES) or the ICD-10 value set 20879 (ICD-10 DVT AND PE PROC CODES).</p>
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General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	Y
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC			
Adjustment		DENY	
		DENY	
POS			
Encounter		6	
Special Batch		PEND	
PA			

Programs

Program	Program Title
CPA330	UB04 Service/PA Edit

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-0234 ESC-0234

Edit Information

Edit Number	0234	esc Number	0234	NCPDP Code	
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Short Desc	Invalid Twenty-first Diagnosis
Long Desc	INVALID TWENTY-FIRST DIAGNOSIS
Edit Criteria	<p>The edit is set if the Twenty-first Diagnosis is not in the valid format or is not on the Diagnosis Database.</p> <p>For ICD-9 claims, the valid diagnosis format is either xnn, xnxx, or xnxxn where x = 0 - 9, E, V and n = 0 - 9.</p> <p>For ICD-10 claims, the diagnosis length is 3 - 7 characters and the valid format is a9xxxxx where a is alpha, 9 is numeric, and x is alpha-numeric.</p> <p>For claim type 01 (Inpatient), the edit is only done if the provider class type = 001 (General Hospital) and the admission date is > 6/30/1996 and the type bill is 111, 112, 113, 114, or 117.</p> <p>For claim type 01 (Inpatient), the edit is only done if the provider class type = 091 (Out of State Hospital) and the admission date is > 12/31/1999 and the type bill is 111, 112, 113, 114, or 117 .</p> <p>For claim type 01, provider types 003, 007, and 077 are the only other provider types that set the edit.</p> <p>For outpatient claim type 03, the edit is only done for bill types 131 and 137.</p> <p>Excluded from DRG:</p> <p>All diagnosis codes, except the diagnosis codes specifically mentioned in (iii), will be excluded from DRG pricing process if they satisfy condition (i) and (ii). The diagnosis codes mentioned in (iii) will have to satisfy (i), (ii) and (iii) to be excluded from DRG pricing :</p> <p>i. If Present on Admission indicator is 'N' or 'U', or if Present on Admission indicator is '1' or blank and the diagnosis code is not present in the ICD 9 value set 9968 (VALUE SET FOR EDIT 1370) or the ICD-10 value set 29968 (ICD-10 VALUE SET FOR EDIT 1370).</p> <p>ii. If diagnosis code is in the ICD-9 value set 870 (HAC DRG EXCLUDE CODES) or the ICD-10 value set 20870 (ICD-10 HAC DRG Exclude Codes).</p> <p>iii. Check specific to diagnosis codes:</p>

1. If the diagnosis code is present in the ICD-9 value set 871 (519.2 DIAGNOSIS CODE) or the ICD-10 value set 20871 (ICD-10 HAC Diag Mediastinum) and any of the procedure codes is present in the ICD-9 value set 872 (519.2 X-REFERENCE PROC CODES) or the ICD-10 value set 20872 (ICD-10 HAC Byp Coronary Artery).
2. If the diagnosis code is present in the ICD-9 value set 873 (996.67 OR 998.59 DIAGNOSIS CODE) or the ICD-10 value set 20873 (ICD-10 HAC Diag Orthopedic) and any of the procedure codes is present in the ICD-9 value set 874 (996.97 OR 998.59 XREF PROC CODES) or the ICD-10 value set 20874 (ICD-10 HAC Proc Orthopedic).
3. If the diagnosis code is present in the ICD-9 value set 875 (998.59 DIAGNOSIS CODE) or the ICD-10 value set 20875 (ICD-10 HAC Diag Sec Bariatric), the primary diagnosis code is present in the ICD-9 value set 876 (278.01 DIAGNOSIS CODE) or the ICD-10 value set 20876 (ICD-10 HAC Diag Pri Bariatric), and any of the procedure codes is present in the ICD-9 value set 877 (998.59 AND 278.01 XREF PROC CODES) or the ICD-10 value set 20877 (ICD-10 HAC Proc Bariatric).
4. If the diagnosis code is present in the ICD-9 value set 878 (DVT AND PE DIAG CODES) or the ICD-10 value set 20878 (ICD-10 DVT AND PE DIAG CODES) and any of the procedure codes is present in the ICD-9 value set 879 (DVT AND PE PROC CODES) or the ICD-10 value set 20879 (ICD-10 DVT AND PE PROC CODES).

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA EMC		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental	Pharmacy	Inpatient	Y
Nursing	Home Health	Outpatient	Y
Physician	Personal Care	Laboratory	
Transportation	Xover A	Y Xover B	
Cap Pay	Man Fee	Admin	
Asmt Fee			

Date Information

Effective Date Code	Effective Date	Revision Date		
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC			
Adjustment		DENY	
		DENY	
POS			
Encounter		6	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA330	UB04 Service/PA Edit

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-0235 ESC-0235

Edit Information

Edit Number	0235	esc Number	0235	NCPDP Code	
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Short Desc	Invalid Twenty-second Diagnosis
Long Desc	INVALID TWENTY-SECOND DIAGNOSIS
Edit Criteria	<p>The edit is set if the Twenty-second Diagnosis is not in the valid format or is not on the Diagnosis Database.</p> <p>For ICD-9 claims, the valid diagnosis format is either xnn, xnxx, or xnxxn where x = 0 - 9, E, V and n = 0 - 9.</p> <p>For ICD-10 claims, the diagnosis length is 3 - 7 characters and the valid format is a9xxxxx where a is alpha, 9 is numeric, and x is alpha-numeric.</p> <p>For claim type 01 (Inpatient), the edit is only done if the provider class type = 001 (General Hospital) and the admission date is > 6/30/1996 and the type bill is 111, 112, 113, 114, or 117.</p> <p>For claim type 01 (Inpatient), the edit is only done if the provider class type = 091 (Out of State Hospital) and the admission date is > 12/31/1999 and the type bill is 111, 112, 113, 114, or 117 .</p> <p>For claim type 01, provider types 003, 007, and 077 are the only other provider types that set the edit.</p> <p>For outpatient claim type 03, the edit is only done for bill types 131 and 137.</p> <p>Excluded from DRG:</p> <p>All diagnosis codes, except the diagnosis codes specifically mentioned in (iii), will be excluded from DRG pricing process if they satisfy condition (i) and (ii). The diagnosis codes mentioned in (iii) will have to satisfy (i), (ii) and (iii) to be excluded from DRG pricing :</p> <p>i. If Present on Admission indicator is 'N' or 'U', or if Present on Admission indicator is '1' or blank and the diagnosis code is not present in the ICD 9 value set 9968 (VALUE SET FOR EDIT 1370) or the ICD-10 value set 29968 (ICD-10 VALUE SET FOR EDIT 1370).</p> <p>ii. If diagnosis code is in the ICD-9 value set 870 (HAC DRG EXCLUDE CODES) or</p>

the ICD-10 value set 20870 (ICD-10 HAC DRG Exclude Codes).

iii. Check specific to diagnosis codes:

1. If the diagnosis code is present in the ICD-9 value set 871 (519.2 DIAGNOSIS CODE) or the ICD-10 value set 20871 (ICD-10 HAC Diag Mediastinum) and any of the procedure codes is present in the ICD-9 value set 872 (519.2 X-REFERENCE PROC CODES) or the ICD-10 value set 20872 (ICD-10 HAC Byp Coronary Artery).

2. If the diagnosis code is present in the ICD-9 value set 873 (996.67 OR 998.59 DIAGNOSIS CODE) or the ICD-10 value set 20873 (ICD-10 HAC Diag Orthopedic) and any of the procedure codes is present in the ICD-9 value set 874 (996.97 OR 998.59 XREF PROC CODES) or the ICD-10 value set 20874 (ICD-10 HAC Proc Orthopedic).

3. If the diagnosis code is present in the ICD-9 value set 875 (998.59 DIAGNOSIS CODE) or the ICD-10 value set 20875 (ICD-10 HAC Diag Sec Bariatric), the primary diagnosis code is present in the ICD-9 value set 876 (278.01 DIAGNOSIS CODE) or the ICD-10 value set 20876 (ICD-10 HAC Diag Pri Bariatric), and any of the procedure codes is present in the ICD-9 value set 877 (998.59 AND 278.01 XREF PROC CODES) or the ICD-10 value set 20877 (ICD-10 HAC Proc Bariatric).

4. If the diagnosis code is present in the ICD-9 value set 878 (DVT AND PE DIAG CODES) or the ICD-10 value set 20878 (ICD-10 DVT AND PE DIAG CODES) and any of the procedure codes is present in the ICD-9 value set 879 (DVT AND PE PROC CODES) or the ICD-10 value set 20879 (ICD-10 DVT AND PE PROC CODES).

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA EMC		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	Y
Physician		Personal Care		Laboratory	

Transportation		Xover A	Y	Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date		
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC			
Adjustment		DENY	
		DENY	
POS			
Encounter		6	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA330	UB04 Service/PA Edit

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-0236 ESC-0236

Edit Information

Edit Number	0236	esc Number	0236	NCPDP Code	
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Short Desc	Invalid Twenty-third Diagnosis
Long Desc	INVALID TWENTY-THIRD DIAGNOSIS
Edit Criteria	<p>The edit is set if the Twenty-third Diagnosis is not in the valid format or is not on the Diagnosis Database.</p> <p>For ICD-9 claims, the valid diagnosis format is either xnn, xnxx, or xxxxxx where x = 0 - 9, E, V and n = 0 - 9.</p> <p>For ICD-10 claims, the diagnosis length is 3 - 7 characters and the valid format is a9xxxxx where a is alpha, 9 is numeric, and x is alpha-numeric.</p> <p>For claim type 01 (Inpatient), the edit is only done if the provider class type = 001 (General Hospital) and the admission date is > 6/30/1996 and the type bill is 111, 112, 113, 114, or 117.</p> <p>For claim type 01 (Inpatient), the edit is only done if the provider class type = 091 (Out of State Hospital) and the admission date is > 12/31/1999 and the type bill is 111, 112, 113, 114, or 117 .</p> <p>For claim type 01, provider types 003, 007, and 077 are the only other provider types that set the edit.</p> <p>For outpatient claim type 03, the edit is only done for bill types 131 and 137.</p> <p>Excluded from DRG:</p> <p>All diagnosis codes, except the diagnosis codes specifically mentioned in (iii), will be excluded from DRG pricing process if they satisfy condition (i) and (ii). The diagnosis codes mentioned in (iii) will have to satisfy (i), (ii) and (iii) to be excluded from DRG pricing :</p> <p>i. If Present on Admission indicator is 'N' or 'U', or if Present on Admission indicator is '1' or blank and the diagnosis code is not present in the ICD-9 value set 9968 (VALUE SET FOR EDIT 1370) or the ICD-10 value set 29968 (ICD-10 VALUE SET FOR EDIT 1370)</p> <p>ii. If diagnosis code is in the ICD-9 value set 870 (HAC DRG EXCLUDE CODES) or the ICD-10 value set 20870 (ICD-10 HAC DRG Exclude Codes).</p> <p>iii. Check specific to diagnosis codes:</p> <p>1. If the diagnosis code is present in the ICD-9 value set 871 (519.2 DIAGNOSIS CODE) or the ICD-10 value set 20871 (ICD-10 HAC Diag Mediastinum) and any of</p>

the procedure codes is present in the ICD-9 value set 872 (519.2 X-REFERENCE PROC CODES) or the ICD-10 value set 20872 (ICD-10 HAC Byp Coronary Artery).

2. If the diagnosis code is present in the ICD-9 value set 873 (996.67 OR 998.59 DIAGNOSIS CODE) or the ICD-10 value set 20873 (ICD-10 HAC Diag Orthopedic) and any of the procedure codes is present in the ICD-9value set 874 (996.97 OR 998.59 XREF PROC CODES) or the ICD-10 value set 20874 (ICD-10 HAC Proc Orthopedic).

3. If the diagnosis code is present in the ICD-9 value set 875 (998.59 DIAGNOSIS CODE) or the ICD-10 value set 20875 (ICD-10 HAC Diag Sec Bariatric), the primary diagnosis code is present in the ICD-9 value set 876 (278.01 DIAGNOSIS CODE) or the ICD-10 value set 20876 (ICD-10 HAC Diag Pri Bariatric), and any of the procedure codes is present in the ICD-9 value set 877 (998.59 AND 278.01 XREF PROC CODES) or the ICD-10 value set 20877 (ICD-10 HAC Proc Bariatric).

4. If the diagnosis code is present in the ICD-9 value set 878 (DVT AND PE DIAG CODES) or the ICD-10 value set 20878 (ICD-10 DVT AND PE DIAG CODES)' and any of the procedure codes is present in the ICD-9 value set 879 (DVT AND PE PROC CODES) or the ICD-10 value set 20879 (ICD-10 DVT AND PE PROC CODES).

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA EMC		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	Y
Physician		Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date		
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC			
Adjustment		DENY	
		DENY	
POS			
Encounter		6	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA330	UB04 Service/PA Edit

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-0237 ESC-0237

Edit Information

Edit Number	0237	esc Number	0237	NCPDP Code	
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Short Desc	Invalid Twenty-fourth Diagnosis
Long Desc	INVALID TWENTY-FOURTH DIAGNOSIS
Edit Criteria	<p>The edit is set if the Twenty-fourth diagnosis or is not in the valid format or is not on the Diagnosis Database.</p> <p>For ICD-9 claims, the valid diagnosis format is either xnn, xnxx, or xxxxxx where x = 0 - 9, E, V and n = 0 – 9. For ICD-10 claims, the diagnosis length is 3 - 7 characters and the valid format is a9xxxxx where a is alpha, 9 is numeric, and x is alpha-numeric.</p> <p>For claim type 01 (Inpatient), the edit is only done if the provider class type = 001 (General Hospital) and the admission date is > 6/30/1996 and the type bill is 111, 112, 113, 114, or 117.</p> <p>For claim type 01 (Inpatient), the edit is only done if the provider class type = 091 (Out of State Hospital) and the admission date is > 12/31/1999 and the type bill is 111, 112, 113, 114, or 117 .</p> <p>For claim type 01, provider types 003, 007, and 077 are the only other provider types that set the edit.</p> <p>For outpatient claim type 03, the edit is only done for bill types 131 and 137.</p> <p>Excluded from DRG:</p> <p>All diagnosis codes, except the diagnosis codes specifically mentioned in (iii), will be excluded from DRG pricing process if they satisfy condition (i) and (ii). The diagnosis codes mentioned in (iii) will have to satisfy (i), (ii) and (iii) to be excluded from DRG pricing :</p> <p>i. If Present on Admission indicator is 'N' or 'U', or if Present on Admission indicator is '1' or blank and the diagnosis code is not present in the ICD 9 value set 9968 (VALUE SET FOR EDIT 1370) or the ICD-10 value set 29968 (ICD-10 VALUE SET FOR EDIT 1370).</p> <p>ii. If diagnosis code is in the ICD-9 value set 870 (HAC DRG EXCLUDE CODES) or the ICD-10 value set 20870 (ICD-10 HAC DRG Exclude Codes).</p> <p>iii. Check specific to diagnosis codes:</p>

	<p>1. If the diagnosis code is present in the ICD-9 value set 871 (519.2 DIAGNOSIS CODE) or the ICD-10 value set 20871 (ICD-10 HAC Diag Mediastinum) and any of the procedure codes is present in the ICD-9 value set 872 (519.2 X-REFERENCE PROC CODES) or the ICD-10 value set 20872 (ICD-10 HAC Byp Coronary Artery).</p> <p>2. If the diagnosis code is present in the ICD-9 value set 873 (996.67 OR 998.59 DIAGNOSIS CODE) or the ICD-10 value set 20873 (ICD-10 HAC Diag Orthopedic) and any of the procedure codes is present in the ICD-9 value set 874 (996.97 OR 998.59 XREF PROC CODES) or the ICD-10 value set 20874 (ICD-10 HAC Proc Orthopedic).</p> <p>3. If the diagnosis code is present in the ICD-9 value set 875 (998.59 DIAGNOSIS CODE) or the ICD-10 value set 20875 (ICD-10 HAC Diag Sec Bariatric), the primary diagnosis code is present in the ICD-9 value set 876 (278.01 DIAGNOSIS CODE) or the ICD-10 value set 20876 (ICD-10 HAC Diag Pri Bariatric), and any of the procedure codes is present in the ICD-9 value set 877 (998.59 AND 278.01 XREF PROC CODES) or the ICD-10 value set 20877 (ICD-10 HAC Proc Bariatric).</p>
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General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA EMC		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	Y
Physician		Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date		
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC			
Adjustment		DENY	
		DENY	
POS			
Encounter		6	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA330	UB04 Service/PA Edit

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-238 ESC-238

Edit Information

Edit Number	238	esc Number	238	NCPDP Code	
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Short Desc	Invalid Twenty-fifth Diagnosis
Long Desc	INVALID TWENTY-FIFTH DIAGNOSIS
Edit Criteria	<p>The edit is set if the Twenty-fifth Diagnosis is not in the valid format or is not on the Diagnosis Database.</p> <p>For ICD-9 claims, the valid diagnosis format is either xnn, xnxx, or xxxnn where x = 0 - 9, E, V and n = 0 – 9.</p> <p>For ICD-10 claims, the diagnosis length is 3 - 7 characters and the valid format is a9xxxxx where a is alpha, 9 is numeric, and x is alpha-numeric.</p> <p>For claim type 01 (Inpatient), the edit is only done if the provider class type = 001 (General Hospital) and the admission date is > 6/30/1996 and the type bill is 111, 112, 113, 114, or 117.</p> <p>For claim type 01 (Inpatient), the edit is only done if the provider class type = 091 (Out of State Hospital) and the admission date is > 12/31/1999 and the type bill is 111, 112, 113, 114, or 117 .</p> <p>For claim type 01, provider types 003, 007, and 077 are the only other provider types that set the edit.</p> <p>For outpatient claim type 03, the edit is only done for bill types 131 and 137.</p> <p>Excluded from DRG:</p> <p>All diagnosis codes, except the diagnosis codes specifically mentioned in (iii), will be excluded from DRG pricing process if they satisfy condition (i) and (ii). The diagnosis codes mentioned in (iii) will have to satisfy (i), (ii) and (iii) to be excluded from DRG pricing :</p> <p>i. If Present on Admission indicator is 'N' or 'U', or if Present on Admission indicator is '1' or blank and the diagnosis code is not present in the ICD 9 value set 9968 (VALUE SET FOR EDIT 1370) or the ICD-10 value set 29968 (ICD-10 VALUE SET FOR EDIT 1370).</p> <p>ii. If diagnosis code is in the ICD-9 value set 870 (HAC DRG EXCLUDE CODES) or the ICD-10 value set 20870 (ICD-10 HAC DRG Exclude Codes).</p> <p>iii. Check specific to diagnosis codes:</p>

	<p>1. If the diagnosis code is present in the ICD-9 value set 871 (519.2 DIAGNOSIS CODE) or the ICD-10 value set 20871 (ICD-10 HAC Diag Mediastinum) and any of the procedure codes is present in the ICD-9 value set 872 (519.2 X-REFERENCE PROC CODES) or the ICD-10 value set 20872 (ICD-10 HAC Byp Coronary Artery).</p> <p>2. If the diagnosis code is present in the ICD-9 value set 873 (996.67 OR 998.59 DIAGNOSIS CODE) or the ICD-10 value set 20873 (ICD-10 HAC Diag Orthopedic) and any of the procedure codes is present in the ICD-9 value set 874 (996.97 OR 998.59 XREF PROC CODES) or the ICD-10 value set 20874 (ICD-10 HAC Proc Orthopedic).</p> <p>3. If the diagnosis code is present in the ICD-9 value set 875 (998.59 DIAGNOSIS CODE) or the ICD-10 value set 20875 (ICD-10 HAC Diag Sec Bariatric), the primary diagnosis code is present in the ICD-9 value set 876 (278.01 DIAGNOSIS CODE) or the ICD-10 value set 20876 (ICD-10 HAC Diag Pri Bariatric), and any of the procedure codes is present in the ICD-9 value set 877 (998.59 AND 278.01 XREF PROC CODES) or the ICD-10 value set 20877 (ICD-10 HAC Proc Bariatric).</p>
--	--

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	Y
Physician		Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC			
Adjustment		DENY	
		DENY	
POS			
Encounter		6	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA330	UB04 Service/PA Edit

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-239 ESC-239

Edit Information

Edit Number	239	esc Number	239	NCPDP Code	
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Short Desc	Void Pended for Review of Original Payment Request				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-240 ESC-240

Edit Information

Edit Number	240	esc Number	240	NCPDP Code	
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Short Desc	Adjustment Rejected. Watch for Letter				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-241 ESC-241

Edit Information

Edit Number	241	esc Number	241	NCPDP Code	
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Short Desc	Review of Medicare Coverage Effective Date				
Long Desc					
Edit Criteria	This edit is not set in current MMIS and is deleted from new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-242 ESC-242

Edit Information

Edit Number	242	esc Number	242	NCPDP Code	
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Short Desc	Combination Edit Denial - Pended for IC				
Long Desc	Combination Edit Denial - Pended for IC				
Edit Criteria	<p>Delete edit - Claim will pend with Combination Edit error code instead of 242.</p> <p>For Practitioner (claim type 05) and Lab (claim type 08) , if the payment request should be denied according to the Combination Edit Table, but was submitted with a procedure modifier = 22, then set this edit instead of the combination edit.</p> <p>For Dental (claim type 11), if the payment request should be denied according to the Combination Edit Table, but was submitted with an attachment, then set this edit instead of the combination edit.</p> <p>See value sets "0242/0242 001 thru 0242/0242 nnn" for procedure codes.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	

Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-243 ESC-243

Edit Information

Edit Number	243	esc Number	243	NCPDP Code	
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Short Desc	IC Requested				
Long Desc	Individual Consideration Requested				
Edit Criteria	<p>1) For HCFA 1500s except Transportation (claim type 13) and Personal Care (claim type 04):</p> <ul style="list-style-type: none"> - If the procedure requires a PA and there is a PA on file, bypass the edit. - If the billed amount is greater than the Medicaid allowed amount and less than 125% of the Medicaid allowed amount: <p>a) For claims whose procedure code does not have an 'I' or 'S' flag:</p> <ul style="list-style-type: none"> - If the claim meets the criteria for Edit 0266, bypass this edit. - If the billed amount is less than or equal to \$ 25.00, bypass the edit except when F_SPECIAL_BATCH = 'Y' - If procedure modifier is 22 or 99 (individual consideration) AND there is an attachment, set the edit <p>b) For claims whose procedure code has an 'I' or 'S' flag:</p> <ul style="list-style-type: none"> - If the procedure code is not 90707, bypass the edit - If procedure modifier is 22 or 99 (individual consideration) AND there is an attachment, set the edit. <p>See value set, ATTACH DISP PROC MODS</p>				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
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FAMIS	Y	Assessments			
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Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	Y
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
	200	PEND	
EMC	200	PEND	
	200	PEND	
Adjustment	200	PEND	
	200	PEND	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

All SLH Pends are assigned to LOC 310.
--

Resolution

All Claim Types:
 Check for keying/scanning errors.
 If errors are found in unprotected fields, correct the field entry.
 If errors are found in protected fields, deny the pending payment request using code 0098 and dis-

position indicator D.

Practitioner/Lab

1. If modifier is 22 (attachment), review the attachment or remarks.
2. If procedure is surgery and attachment is operative report or procedure notes, repond to DMAS location 321.
3. If no operative report or procedure notes, or procedure is not surgery, override with code 0243 and disposition indicator O.
4. If 0243 set with other pricing edits, work the other edits and release to adjudication.

Edit/Audit Inquiry Results Edit-244 ESC-244

Edit Information

Edit Number	244	esc Number	244	NCPDP Code	
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Short Desc	Review of Medicare Remittance or EOMB
Long Desc	Medicare remittance (EOMB) not attached
Edit Criteria	<p>If the procedure flag is '91' (Pregnancy, Preventative Srv. & Court-Ordered Office Visit Paid (Bypass TPL)) and any of the diagnosis codes are in the ICD-9 value set 172 (BYPASS DIAGNOSIS CODES) or the ICD-10 value set 20288 (ICD-10 PREGNANCY DIAG CODES), bypass the edit.</p> <p>For Title 18 (claim type 09): Part A and Part B crossover claims are submitted on the UB92 form and are identified by form XOVA. In this edit, form XOVA only pertains to part A, not part B.</p> <p>1) If the provider class type = 27 (CS-SNF) and the from date of service year <= 89 and the payment request's Medicare coverage code = A (form XOVA) and the days stay > 45, set edit 0402.</p> <p>2) For provider class types 06 (SNF-MH), 10 (SNF-Non-MH), 11 (SNF-MR), 27 (CS-SNF), 28 (SNF-State), or 92 (SNF-NE): If the payment request's Medicare coverage code = A (form XOVA) and the from date of service is >= 01/01/89 and < 01/01/90 and the days stay > 8, set edit 0402.</p> <p>3) If the payment request's coverage code = A (form XOVA) and the from date of service is >=01/01/90 or < 01/01/89:</p> <p>a) if the provider class type = 10 (SNF-Non-MH) and the payment request was submitted by a provider either as paper or electronically as EDI (media = 7) with submitter ID = EDIX, i.e. not crossed over, and the days count from admission to thru date of service is greater than 100: If there is an attachment, set this edit. If there is no attachment, set edit 0402.</p> <p>b) if the provider class type = 10 (SNF-Non-MH) and the payment request was submitted by a provider either as paper or electronically as EDI (media = 7) with submitter ID = EDIX, i.e. not crossed over, the days count of admission date plus 20 overlaps the payment days within the dates of service, i.e. the payment days include any or all of the</p>

	<p>first 20 days of the stay, and there is an attachment, set this edit.</p> <p>c) If the provider class type = 10 and the payment request was submitted by a carrier/intermediary either as NSF (media = 8) or EDI (media = 7) with submitter ID = EDI, (carrier/intermediary), and the days count from admission to thru date of service is greater than 100: If there is an attachment, set edit 0444. If there is no attachment, set edit 0402.</p> <p>d) If the provider class type = 6, 11, 27, 28, or 92 and the days stay > 100, set edit 0402.</p> <p>For Transportation (claim type 13): If the TPL coverage code = B or Z, there's no payment from a primary carrier and the procedure code is not equal to Y0112 and the COB code is not equal to 2 or 3, set this edit.</p>
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General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	T	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation	Y	Xover A	Y	Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
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Paper	200	PEND	
		DENY	
EMC	200	PEND	
		DENY	
Adjustment	200	PEND	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA032	TPL Edits
CPA330	UB04 Service/PA Edit

Exceptions

None

Resolution

All Invoice Types:

1. Check for keying/scanning errors.

If errors are found in unprotected fields, correct the field entry.

If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.

2. If TPL amount on the claim is different than the amount on the EOB, enter remark "TPL amts different" then transfer to location 219.

3. The system automatically calculates the TPL in the Allowed Charges field unless there is manual pricing. If there is manual pricing and the TPL is less than the allowed amount, manually subtract the TPL from the Allowed Charges field and enter the difference in the Manual Price field. If the calculated Manual Price is \$0.00, deny the pend request. Enter 0364 D.

(updated 3/21/08)

Edit/Audit Inquiry Results Edit-245 ESC-245

Edit Information

Edit Number	245	esc Number	245	NCPDP Code	
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Short Desc	Pend Review of Assessment				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-246 ESC-246

Edit Information

Edit Number	246	esc Number	246	NCPDP Code	
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Short Desc	This Procedure/Enrollee Age Questioned				
Long Desc	This Procedure/Enrollee Age Questioned				
Edit Criteria	<p>This Edit has been combined with edit 211 If the enrollee's age is not within the minimum and/or maximum age limits on the Medical and Administrative Codes Database, set the edit. This edit resides on the Medical and Administrative Codes Database.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-247 ESC-247

Edit Information

Edit Number	247	esc Number	247	NCPDP Code	
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Short Desc	Preauth Hours Not Equal to Enrollee File Hours				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-248 ESC-248

Edit Information

Edit Number	248	esc Number	248	NCPDP Code	
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Short Desc	Service Begin Date Prior to Auth Begin Date				
Long Desc	Service Begin Date Prior to Auth Begin Date				
Edit Criteria	<p>This edit is being deleted and combined with 0161. If a PA is required for the service, and an approved PA is on file, and the from date of service of the payment request is less than the PA begin date of authorization, set the edit.</p> <p>If the claim type = 01 and the provider type = 01 and the admission date is > 12/31/1999 and the principal diagnosis code is not = 290 - 319 (psych), the PA begin date must fall within the payment request's admission date and thru date of service. Therefore, this edit is not done. See also edit 0161.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-249 ESC-249

Edit Information

Edit Number	249	esc Number	249	NCPDP Code	
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Short Desc	Duplicate Payment Request - Same Provider, Overlap DOS				
Long Desc	Duplicate Payment Request - Same Provider, Overlapping Dates of Service				
Edit Criteria	<p>This edit is set when the payment request being processed is a duplicate of another payment request being processed in the same check write cycle, based on the following parameters:</p> <p>INPATIENT (CLAIM TYPE 01): Same enrollee Same base provider ID Overlapping dates of service (except discharge and admit dates)</p> <p>NURSING HOME (CLAIM TYPES 02 and 10): Same enrollee Same base provider ID Overlapping dates of service (except discharge and admit dates)</p> <p>CORF (CLAIM TYPE 03 - PT 19): Same enrollee Same base provider ID Overlapping dates of service</p>				

HOME HEALTH (CLAIM TYPE 03 - PT 58, 59, 94): (Edit 0249/1342)

Same enrollee

Same base provider ID

Overlapping dates of service

Any revenue codes are the same

OUTPATIENT (CLAIM TYPE 03 - other than CORF and Home Health)
without therapy revenue codes: (Edit 0249/1343)

Same enrollee

Same base provider ID

Overlapping dates of service

Same Patient Account Number

Bypass edit if both claims have revenue code 450 - 459 (ER), both have
valid admit hour, and the admit hours are different.

Bypass edit for non-emergency claims if both claims have any of the rev-
enue codes in value set "REVENUE MRI CODES", 'REVENUE CAT
SCANS', or 'REVENUE PET SCANS'.

Bypass edit for a combination of non-emergency and emergency claims if
both claims have any of the revenue codes in value set "REVENUE MRI
CODES", 'REVENUE CAT SCANS', or 'REVENUE PET SCANS'.

OUTPATIENT (CLAIM TYPE 03 - other than CORF and Home Health)
with therapy revenue codes (42x, 43x, and 44x): (Edit 0249/1344)

Same enrollee

Same base provider ID

Overlapping dates of service

Same Patient Account Number

Any therapy revenue codes are the same

PERSONAL CARE (CLAIM TYPE 04):

Same enrollee

Same base provider ID

Overlapping dates of service

PRACTITIONER - HEALTH DEPT. DRUGS (CLAIM TYPE 05 - PROV
TYPE 51 - PROCEDURES J8499, 99070, B4000 - B9999): (Edit
0249/1351)

Same enrollee

	<p>Same base provider ID Overlapping dates of service Same procedure code Same procedure modifier (any of the modifiers are the same) Same billed charge</p> <p>PRACTITIONER - HEALTH DEPT. OTHER (CLAIM TYPE 05 - PROV TYPE 51 - PROCEDURES NOT J8499, 99070, B4000 - B9999): (Edit 0249/1355) Same enrollee Same base provider id Overlapping dates of service Same procedure code Same procedure modifier (any of the modifiers are the same)</p> <p>- Bypass dupe check for procedures in Value set "Primary Diag/Procedure Bypass" if primary diagnoses are different</p> <p>PRACTITIONER - ALL OTHER (CLAIM TYPE 05 - PROV TYPE NOT 51): Same enrollee Same base provider ID Overlapping dates of service Same procedure code Same procedure modifier (any of the modifiers are the same)</p> <p>- Bypass dupe check for procedure E1399 - Bypass dupe check for procedures in Value set "Primary Diag/Procedure Bypass" if primary diagnoses are different</p> <p>PHARMACY (CLAIM TYPE 06): N/A</p> <p>INDEPENDENT LAB (CLAIM TYPE 08): Same enrollee Same base provider ID Overlapping dates of service Same procedure code</p> <p>- Bypass dupe check for procedures in Value set "Primary Diag/Procedure</p>				
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Bypass" if primary diagnoses are different

TITLE XVIII (CLAIM TYPE 09), PART A:

Same enrollee

Same base provider ID

Overlapping dates of service (except if admit date of one claim = TDOS of the other claim)

(Edit 249/249)

TITLE XVIII (CLAIM TYPE 09), OUTPATIENT:

Same enrollee

Same base provider ID

Overlapping dates of service

Same Billed Charges

(Edit 249/1376)

- Bypass dupe check for bill type starting with '72' conflicting with bill type starting with '13'.

TITLE XVIII (CLAIM TYPE 09), PART B:

Same enrollee

Same base provider ID

Overlapping dates of service

Same procedure code (Edit 249/1372) OR either current and/or history procedure code is blank

and billed charges are equal (Edit 249/249)

- Bypass dupe check for procedure codes A0010, A0020, A0150, A0170, A0300 thru A0422

- Bypass dupe check for procedure codes A0425 - A0436 if FDOS is on or after 01/01/2001

- Bypass dupe check for procedures in Value set "Primary Diag/Procedure Bypass" if primary diagnoses are different

DENTAL (CLAIM TYPE 11):

N/A

TRANSPORTATION (CLAIM TYPE 13):

Same enrollee

Overlapping dates of service

Same base provider ID

	<p>Same procedure code</p> <p>CAPITATION PAYMENT (CLAIM TYPE 15): Same enrollee Same base provider ID Overlapping dates of service</p> <p>MANAGEMENT FEE (CLAIM TYPE 16): Same enrollee Same base provider ID Overlapping dates of service</p> <p>ADMINISTRATIVE FEE (CLAIM TYPE 17): Same enrollee Same base provider ID Overlapping dates of service</p> <p>ASSESSMENTS (CLAIM TYPE 96): Same enrollee Same base provider ID Overlapping dates of service Same procedure code Same procedure modifier</p> <p>Different from current system: Some of the dupe logic is different.</p>					
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General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	Y
Type	D	Priority	1	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental		Pharmacy		Inpatient	Y
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Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS			
Encounter		6	
Special Batch	217	PEND	
PA		PEND	

Programs

(None)

Exceptions

TDO was added for XOVA, XOVB on 7/25/2008.
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Resolution

All Claim Types:
Check for keying/scanning errors.
If errors are found in unprotected fields, correct the field entry.
If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.
Hospital:

Check Provider Type field. If Provider Type is in range 90-98 (out-of-state), pend to DMAS LOC 333.

Outpatient:

1. If the service dates are the same, check the patient account number in block 3 on both claims. If the patient account number is the same, deny using the ESC that pended and disposition code D. If the patient account number is different, override using the ESC that pended and disposition code O.

Outpatient/Inpatient:

2. Check conflicting claim and pending claim for type of service (i.e., procedure codes, ancillaries). If type of service is different, override using the ESC that pended and disposition code O. If type of service is the same, check for attachments or remarks for justification of the duplicate.

Example:

a) The provider is charging for two outpatient visits on the same day and states that the patient was seen at two different times.

b) The provider performed bilateral procedures.

c) Look for any other justifiable reason to pay the duplicate.

If justification is found, override using the ESC that pended and disposition indicator O.

If justification is not found, deny using the ESC that pended and disposition indicator D.

Practitioner:

Review the claim for attachments or remarks for justification of the duplicate.

Example:

The provider is charging for two office visits on the same day and states that the patient was seen at two different times.

The patient was seen both in the office and hospital on the same day.

The provider performed bilateral procedures (modifier 50 in block 24D)..

Look for any other justifiable reason to pay the duplicate.

1. If justification is found, override using the ESC that pended and disposition indicator O.

2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Independent Lab:

Review the lab invoice for remarks justifying the duplicate, such as two tests on the same day.

1. If justification is found, override using the ESC that pended and disposition indicator O.

2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Title XVIII:

1. Check provider number, recipient number, amount and service dates. If they are the same, deny using the ESC that pended and disposition indicator D.

2. If a paper claim conflicts with a paper claim and there are no attachments or remarks, deny using the ESC that pended and disposition indicator D.

3. If a paper claim conflicts with a crossover claim, deny using the ESC that pended and disposition indicator D.

4. If a crossover claim conflicts with a crossover claim, deny using the ESC that pended and disposition indicator D.

5. If an electronic claim pends against a paper claim:

If amounts are the same, deny using the ESC that pended and disposition indicator D.

Check place of treatment and/or diagnosis code. If different, override using the ESC that pended and disposition indicator O.

6. If a paper claim pends against an electronic claim (electronic claim has 7 or 8 as the 8th digit of

the reference number):

If amounts are the same, deny using the ESC that pended and disposition indicator D.

If remarks/attachment on the paper claim indicates two or more visits required on the same day, override using the ESC that pended and disposition indicator O.

Check place of treatment and/or diagnosis code. If different, override using the ESC that pended and disposition indicator O.

Dental:

If IC requested, check the remarks/attachment for justification of duplication of service (i.e., same teeth x-rayed, same tooth filled on same date of service).

1. If justification is found, override using the ESC that pended and disposition indicator O.

2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Transportation:

Transportation providers are required to bill each date on a separate line so should not incur this error. If a transportation provider bills a date range and the claim encounters this error, deny using the ESC that pended and disposition indicator D.

Edit/Audit Inquiry Results Edit-250 ESC-250

Edit Information

Edit Number	250	esc Number	250	NCPDP Code	
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Short Desc	Review Primary Carrier Payment
Long Desc	Review Primary Carrier Payment
Edit Criteria	<p>For Practitioner (claim type 05): If the provider class type = 31 (optometrist) or 32 (optician) OR the provider class type = 20 (physicians), 52 (FQHC), 53 (RHC), or 95 (out of state physician) and the provider specialty = 63 (ophthalmology), AND the primary carrier payment is greater than the billed charges, set the edit.</p> <p>For Medicaid Inpatient (claim type 01 and 09) and SNF (claim type 02 and 09): If the enrollee has TPL coverage A or B AND also has other insurance coverage, set the edit if</p> <ol style="list-style-type: none"> 1) the COB code = 82, the primary carrier payment is > 0, and the claim type = 02 OR 2) the COB code = 83, the primary carrier payment is > 0, the claim type = 01 or 02 OR 3) the COB code = 85 and the primary carrier payment is > 0. <p>For SLH Inpatient (claim type 01): If the enrollee has Medicare Part A coverage AND the COB code = 85 AND the primary carrier payment is > 0, AND the enrollee has other insurance coverage, that is, any of the TPL liability codes is not = A or space, set the edit. If the primary carrier payment > 0 and the enrollee has no other insurance coverage, set the edit.</p> <p>Bypass the edit if: The enrollee's TPL indicates uninsured absent parent (U), or One of the procedure code flags = 90, or One of the procedure code flags = 91 and the first diagnosis on the payment request is in the ICD-9 value set 172 (BYPASS DIAGNOSIS CODES) or the ICD-10 value set 20288 (ICD-10 PREGNANCY DIAG CODES), or The first diagnosis on the payment request is in the ICD-9 value set 21004 (ICD-9 DX ROUTINE CHILD HEALTH) or the ICD-10 value set 22004 (ICD-10 DX ROUTINE CHILD HEALTH)</p> <p>Payment Request will PAY at Zero Dollars \$0.00 when this edit is set.</p>

General Indicators

Reject Ind		Deny Ind		Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	T	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing	Y	Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
	200	PEND	
EMC	200	PEND	
	200	PEND	
Adjustment	200	PEND	
	200	PEND	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA032	TPL Edits

Exceptions

All TDO UB claim types that pend will pend to LOC 320 and HCFA claim types will pend to LOC 319. All SLH UB claim types that pend will pend to LOC 308 and HCFA claim types will pend to LOC 310.

Resolution

All Claim Types:

Check for keying/scanning errors.

1. If errors are found in unprotected fields, correct the field entry.

If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.

Inpatient Claim type 01 and Outpatient Claim type 03:

1. Check locator 30 on the paper claim. If the word CROSSOVER is listed deny 0098D. If CROSSOVER is listed in another place on the claim. Deny 0399 and add remark crossover.
Updated 2/28/2011

Inpatient and SNF:

1. If Medicare Exhausted, Medicare Part A Exhausted, Medicare Funds Exhausted or Medicare did not cover service" is stated in remark section - locator 80, override with code 0250 and disposition indicator O. Updated 03/28/11

2. If #1 is not true and EOBs from Medicare and other carrier are attached, transfer to DMAS location 219. (Updated 03/28/11)

If EOBs from Medicare and other carrier are not attached, deny with code 0495 and disposition indicator D.

Practitioner:

1. If the provider entered the provider ID or the patient account number in the "Amount Paid" field on the payment request (image), reset the "TPL Amount" on the pend screen to zeros and release the pend. If there is a dollar amount in the "Amount Paid" field on the payment request (image) that is greater than the billed charges, override the edit with code 0250 and disposition indicator O.

Edit/Audit Inquiry Results Edit-251 ESC-251

Edit Information

Edit Number	251	esc Number	251	NCPDP Code	
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Short Desc	Review Blood and Coinsurance Charges
Long Desc	Review Blood and Coinsurance Charges.
Edit Criteria	<p>Note: This edit is obsolete after 10/26/2008 (Release 42 implementation date).</p> <p>For Title 18 (claim type 09): If the deductible amount entered on the payment request is > than the corresponding amount in the annual Part A or Part B table by \$175 or less, set this edit if the payment request was submitted on paper and there is an attachment. If the payment request was submitted on paper and there is no attachment, set edit 0444.</p> <p>This \$175 limit is stored on the RF_SYS_PARAMETER table with value id XOVA-DEDTL for part A payment requests and with value id XOVB-DEDTL for part B payment requests. The Medicare table amounts for part A are stored on the RF_SYS_PARAMETER table with the value id XOVA-DEDT and for part B with the value id XOVB-FACT5.</p> <p>For Title 18 Part A payment requests, this edit only applies to Crossover claims received from a carrier/intermediary, either through EMC via NSF (media = 8) or EMC via EDI (media = 7) with submitter ID EDI (carrier/intermediary).</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
		DENY	
EMC	200	PEND	
		DENY	
Adjustment	200	PEND	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

Title XVIII:
Check for keying/scanning errors.
If errors are found in unprotected fields, correct the field entry.
If errors are found in protected fields, deny the pending payment request using code 098 and disposition indicator D.

Review attachment. If attachment is not an EOMB, deny with 0244 and disposition indicator D.
3. If attachment is an EOMB, review to see if it is for deductible and blood.
If EOMB does not show blood, deny with 0244 and disposition indicator D.
If EOMB does show blood, override with 0251 and disposition indicator O.

Edit/Audit Inquiry Results Edit-252 ESC-252

Edit Information

Edit Number	252	esc Number	252	NCPDP Code	
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Short Desc	Review of Revised Medicare Coverage				
Long Desc	Review of Revised Medicare Coverage				
Edit Criteria	For Medicare Part A or B, if the deductible or coinsurance amounts are not found in the annual tables, set the edit.				

General Indicators

Reject Ind		Deny Ind		Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
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Paper	200	PEND	
	200	PEND	
EMC	200	PEND	
	200	PEND	
Adjustment	200	PEND	
	200	PEND	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

Title XVIII:

1. Transfer to supervisor location 250.
2. Supervisor, contact systems unit to request addition of new annual amounts to table.
3. Supervisor, request that all claims pending for 0252/0252 be recycled once the amounts have been added to the table. If there are only a few pends, access each pend by ICN and release them to adjudicate.

Edit/Audit Inquiry Results Edit-253 ESC-253

Edit Information

Edit Number	253	esc Number	253	NCPDP Code	
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Short Desc	Review of Coinsurance Charges				
Long Desc	Coinsurance Charge In Review				
Edit Criteria	<p>(1) If the payment request is electronically submitted OR the premium indicator = Q (see note below) OR the aid category is = 23, 43, or 63 (not aged, blind, or disabled) OR the provider type is = 001 or 091 with an admission date > 12/31/2000, continue processing, else if the coinsurance entered on the payment request is not = 0, set the edit if there is an attachment. If there is no attachment, set edit 0444.</p> <p>Note: An enrollee is QMB dually eligible when his aid category is not equal to 023, 043, or 063 AND one of his TPL coverage codes = A or Y and the month and year of the enrollee's application date is less than the month and year of the from date of service OR one of his TPL coverage codes = A or Y and the enrollee was eligible any part of the month prior to the from date of service. If he is determined to be QMB dually eligible, his premium indicator is set to Q.</p> <p>(2) If the from date of service is >= 01/01/90 and the payment request's coverage code = A (form XOVA), and the provider class type = 06 (SHF-MH), 10 (SNF-non MH), 11 (SNF-MR), 27 (CS-SNF), 28 (SNF-state), or 92 (SNF-non-enrolled) and the number of days stay < 21 and the coinsurance entered is > 0, set the edit if there is an attachment. If there is no attachment, set edit 0444.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
		DENY	
EMC	200	PEND	
		DENY	
Adjustment	200	PEND	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

Edit 0253

Title XVIII

Check for keying/scanning errors.

1. If errors are found in unprotected fields, correct the field entry.
2. If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.
3. Review attachment to verify that it is a matching Medicare EOMB. If the EOMB does not match the claim, deny with 0444 Disposition D.
4. If the EOMB does match, verify the dates of service and the coinsurance on the EOMB. If the dates and amount are the same as the claim, override with 0253 and Disposition indicator O. If the dates and amount do not match the claim, deny with 0344 Disposition D.

Edit/Audit Inquiry Results Edit-254 ESC-254

Edit Information

Edit Number	254	esc Number	254	NCPDP Code	
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Short Desc	Review Pre-Op Day(s)				
Long Desc	Review Pre-Op Day(s)				
Edit Criteria	<p>For Inpatient (claim type 01) and for provider class type is 01 (Hospital), 08 (MH Med Surgical Units), 09 (Med Surgical Units MR), 13 (Med-Surg Mental Health Retardation) or 91 (Non-Enrolled Hospital):</p> <p>1) if the number of days between the admission date and the principal procedure date is > 1 and the from date of service is <= 8/31/95, set the edit.</p> <p>2) if the number of days between the admission date and the principal procedure date is > 0 and the from date of service is > 8/31/95, set the edit.</p> <p>For SLH Set the edit if the principal procedure date is greater than the admission date.</p> <p>Bypass the edit if a PA is required.</p> <p>Requests pended to location 650 will generate a letter for information. If no information is received within 21 days, the request will automatically deny with edit 0375.</p>				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	333	PEND	
	650	PEND	
EMC	333	PEND	
	650	PEND	
Adjustment	333	PEND	
	650	PEND	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA330	UB04 Service/PA Edit

Exceptions

All SLH Pends are assigned to LOC 308 if media is paper with an attachment; if paper with no attachment or EMC, they will pend to 650. Note: All active segments for SLH are end dated 6/30/2004

Resolution

Edit 254 automatically sends a letter to the provider requesting additional information. These payment requests automatically deny with edit 0375 after 21 days if no letter is returned. Until then, they are held in Location 650.

1. When the documentation is returned with a copy of the letter, access the pend in Location 650 using the ICN and transfer the claim to DMAS Location 333.
2. Enter a comment stating that the documentation has been received and is being forwarded to DMAS.
3. Send the documentation to the appropriate DMAS unit.

Edit/Audit Inquiry Results Edit-255 ESC-255

Edit Information

Edit Number	255	esc Number	255	NCPDP Code	
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Short Desc	Review Weekend Admission				
Long Desc	Admission not justified				
Edit Criteria	<p>For Inpatient (claim type 01) and for provider class type is 01 (Hospital), 08 (MH Med Surgical Units), 09 (Med Surgical Units MR), 13 (Med-Surg Mental Health Retardation) or 91 (Non-Enrolled Hospital), if the from date of service is > 08/31/95 and the admission occurred on a Saturday or Sunday, set the edit. If the from date of service is <= 08/31/95 and the admission occurred on a Friday or Saturday, set the edit.</p> <p>Bypass the edit if:</p> <ol style="list-style-type: none"> 1) there is an invalid admission date or 2) the first three positions of the principal diagnosis = V22, V23, V24, V27, V30-V39 or (See value set, EDIT 0255/0255 DIAG SET) 3) the principal diagnosis is an Exempt-utilization-diagnosis or (See value set, EXEMPT UTILIZATION DIAGNOSES which includes E-codes) 4) a PA is required or 5) provider class type = 91 and admission date on or after 01/01/2000. <p>For SLH</p> <p>Bypass the edit if:</p> <ol style="list-style-type: none"> 1. Admission date is invalid or 2. The first three positions of the principal diagnosis = V22, V23, V24, V27, V30-V39 or (See value set, EDIT 0255/0255 DIAG SET) 3. Principal diagnosis is in the Utilization Review Exempt Diagnosis Table or (See value set, EXEMPT UTILIZATION DIAGNOSES includes E-codes) 4. The admission date is on or after the system live date. <p>If the admission date is a Saturday or Sunday, set the edit.</p> <p>Requests pended to location 650 will generate a letter for information. If</p>				

	no information is received within 21 days, the request will automatically deny with edit 0375.				
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General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	333	PEND	
	650	PEND	
EMC	333	PEND	
	650	PEND	
Adjustment	333	PEND	
	650	PEND	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

All SLH Pends are assigned to LOC 308 if media is paper with an attachment; if paper with no attachment or EMC, they will pend to 650. Note: All active segments for SLH are end dated 6/30/2004

Resolution

Edit 255 automatically sends a letter to the provider requesting additional information. These payment requests automatically deny with edit 0375 after 21 days if no letter is returned. Until then, they are held in Location 650.

1. When the documentation is returned with a copy of the letter, access the pend in Location 650 using the ICN and transfer the claim to DMAS Location 300.
2. Enter a comment stating that the documentation has been received and is being forwarded to DMAS.
3. Send the documentation to the appropriate DMAS unit.

Edit/Audit Inquiry Results Edit-256 ESC-256

Edit Information

Edit Number	256	esc Number	256	NCPDP Code	
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Short Desc	Review of Accident/Emergency Condition				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-257 ESC-257

Edit Information

Edit Number	257	esc Number	257	NCPDP Code	
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Short Desc	Length of Stay Exceeds Percentile Limit				
Long Desc	Length of Stay Exceeds Percentile Limit				
Edit Criteria	<p>Bypass the edit for any of the following:</p> <ol style="list-style-type: none"> 1. If the from or thru date is invalid. 2. If the provider number is invalid. 3. If the provider class type is not = 01 (Hospital), 08 (MH-Med-Surg), 09 (Med-Surg-MR), 13 (Long Stay IP-MR), or 91 (Non-enrolled Hospital). 4. If the admission date is invalid. 5. If the principal diagnosis = 999 or 9999. 6. If Medicaid or FAMIS, the bill type = 111 - 114 or 117, the provider class type = 01, the admission date > 06/30/96 and the principal diagnosis = spaces. 7. If the principal diagnosis is not found on the Diagnosis File. 8. If Medicaid or FAMIS, the from date of service is > 6/30/96 and a PA is required. 9. If Medicaid or FAMIS, the enrollee's age is > 20, the provider class type = 01, the bill type = 113 or 114, and the from date of service is > 6/30/96. 10. If Medicaid or FAMIS, the bill type = 111 - 114 or 117, the provider class type = 91, the admission date > 12/31/99. 11. If SLH, the bill type = 111 = 114 or 117, the provider class type = 01 or 91, and the admission date is >= the system live date. <p>If the payment request's principal diagnosis is on the Diagnosis File and is valid for the from and thru dates of service of the request, the percentile for the length of stay is the 90th for both Medicaid, FAMIS, and SLH.</p> <p>For requests with from date of service <= 6/30/94: The calculated length of stay = the number of days between the from date and the thru date. If the patient status = 30 (still a patient), add 1 to this number.</p> <p>For requests with from date of service > 6/30/94: The calculated length of stay = the number of days between the admis-</p>				

<p>sion date and the thru date. If the patient status = 30 (still a patient), add 1 to this number.</p> <p>If the calculated LOS is > the appropriate percentile amount found on the Diagnosis File, set the edit.</p> <p>Requests pended to location 650 will generate a letter for information. If no information is received within 21 days, the request will automatically deny with edit 0375.</p>				
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General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	333	PEND	
	650	PEND	
EMC	333	PEND	
	650	PEND	
Adjustment	333	PEND	
	650	PEND	

POS		PAY	
Encounter		2	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

All SLH Pends are assigned to LOC 308 if media is paper with an attachment; if paper with no attachment or EMC, they will pend to 650. Note: All active segments for SLH are end dated 6/30/2004

Resolution

Edit 257 automatically sends a letter to the provider requesting additional information. These payment requests automatically deny with edit 0375 after 21 days if no letter is returned. Until then, they are held in Location 650.

1. \tab When the documentation is returned with a copy of the letter, access the pend in Location 650 and transfer the claim to DMAS Location 300.

\tab Enter a comment stating that the documentation has been received and is being forwarded to DMAS.

3. \tab Send the documentation to the appropriate DMAS unit.

Edit/Audit Inquiry Results Edit-258 ESC-258

Edit Information

Edit Number	258	esc Number	258	NCPDP Code	
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Short Desc	Review 21 Day Hospital Care				
Long Desc	Review 21 Day Hospital Care				
Edit Criteria	<p>If more than 21 units of service are billed within 22 days by any provider for claims that meet the following conditions, set the edit:</p> <ul style="list-style-type: none"> - Procedure code is one of those listed below - Place of service is 21 (Inpatient) , 51 (Inpatient Psychiatric Facility), 56 (Psychiatric Residential Treatment Center), or 61 (Comp Inpat Rehab Facility) - Recipient's age on all claims is greater than 20 - Procedure modifier is not 'HF' <p>Edit is bypassed if there is an approved inpatient claim where the FDOS and TDOS of the current claim fall within the inpatient claim dates of service.</p> <p>Edit is bypassed if there is an approved inpatient PA (service type 0400 or 0401) where the FDOS and TDOS of the current claim fall within the PA authorized dates.</p> <p>Procedure codes: See Value Set "0258/0258 001" for procedure codes.</p> <p>See Value Set "POS Inclusions for 258/258" for POS. See Value Set "Age Inclusion for 258/258" for age. See Value Set "Proc Modifier HF" for modifiers</p>				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	L	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		TEST	
		TEST	
EMC		TEST	
		TEST	
Adjustment		TEST	
		TEST	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-259 ESC-259

Edit Information

Edit Number	259	esc Number	259	NCPDP Code	
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Short Desc	Hours Charged Exceed Pre-Authorized Hours				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-260 ESC-260

Edit Information

Edit Number	260	esc Number	260	NCPDP Code	
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Short Desc	Review for One Fee Per Month Limit				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-261 ESC-261

Edit Information

Edit Number	261	esc Number	261	NCPDP Code	
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Short Desc	Awaiting Type of Bill 112				
Long Desc	Awaiting Type of Bill 112				
Edit Criteria	Edit has been deleted - See Edit 407. For inpatient payment requests (claim type 01), if the provider class type = 01 (Hospital) or 91 (out of state Hospital) and the admission date is > 6/30/96 and a payment request with type of bill = 113 or 114 is entered, but a payment request for type of bill 112 has not been adjudicated, set the edit.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-262 ESC-262

Edit Information

Edit Number	262	esc Number	262	NCPDP Code	
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Short Desc	Break in Dates of Service for DRG Bill Type				
Long Desc	Break in Dates of Service for DRG Bill Type				
Edit Criteria	<p>Edit has been deleted - see Edit 416.</p> <p>For inpatient payment requests (claim type 01), if the provider class type = 01 (Hospital) or 91 (out of state Hospital) and the admission date is > 6/30/96 and a payment request with type of bill = 113 or 114 is entered, but the days of service are not contiguous, set the edit.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-263 ESC-263

Edit Information

Edit Number	263	esc Number	263	NCPDP Code	
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Short Desc	Emergency & Not Primary Provider ID				
Long Desc	Emergency & Not Primary Provider ID				
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-265 ESC-265

Edit Information

Edit Number	265	esc Number	265	NCPDP Code	85
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Short Desc	Drug Cost Not on File				
Long Desc	Drug Cost Not on File				
Edit Criteria	If the pharmacy claim is approved to pay and the drug cost (N_UNIT_PRICE) equals zero, set the edit.				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	Y
Type	\$	Priority	3	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy	Y	Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp
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Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment			
POS		DENY	
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-266 ESC-266

Edit Information

Edit Number	266	esc Number	266	NCPDP Code	
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Short Desc	Multiple Payment Requests Exceed 21 Days
Long Desc	Multiple Payment Requests Exceed 21 Days
Edit Criteria	<p>This edit ensures that for certain Hospital payment requests (claim type 01) the total days does not exceed 21 days within a 60-day period.</p> <p>This edit is performed for claims with the following conditions: 1) Enrollee's age is greater than 20 2) Provider type is 08 or 13 OR Provider type is 01 or 91 and type bill is 111 or 112 - For claims with admit dates prior to 1/1/2000 - all claims - For claims with admit dates on or after 1/1/2000 - only claims where principal diagnosis is psych (ICD-9 value set 218 (PSYCH DIAG CODE) or ICD-10 value set 20314 (ICD-10 DIAG CODE PSYCH CLAIM) 3) First three positions of principal diagnosis are not 999 (The ICD-9 diagnosis codes beginning with 999 are no longer valid and there are no ICD-10 diagnosis codes that begin with 999, so this statement can apply to both ICD-9 and ICD-10.)</p> <p>If the sum of the payment days of the current claim and history claims exceeds 21, set the edit. History claims must meet the following conditions: - Admit date within 60 days of the admit date of the current claim - First 3 positions of principal diagnosis must match the current claim - Provider type is 08 or 13 OR Provider type is 01 or 91 and type bill is 111 or 112</p> <p>Requests pended to location 650 will generate a letter for information. If no information is received within 21 days, the request will automatically deny with edit 0375.</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	

Type	H	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	300	PEND	
	650	PEND	
EMC	300	PEND	
	650	PEND	
Adjustment	300	PEND	
	650	PEND	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

All SLH Pends are assigned to LOC 308 if media is paper or EMC with an attachment; if paper or EMC with no attachment, they will pend to 650.

Resolution

Payment requests with Edit 0266 generate a letter requesting documentation. These payment requests automatically deny with edit 0375 after 21 days if no letter is returned. Until then, they are held in Location 650.

1. When the documentation is returned with a copy of the letter, access the pend in Location 650 using the ICN and transfer the claim to DMAS Location 300.
2. Enter a comment stating that the documentation has been received and is being forwarded to DMAS.
3. Send the documentation to the appropriate DMAS unit.

Edit/Audit Inquiry Results Edit-267 ESC-267

Edit Information

Edit Number	267	esc Number	267	NCPDP Code	
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Short Desc	Review Medicare Part A Coverage
Long Desc	This enrollee is covered by Medicare Part A, rebill on Title 18 invoice.
Edit Criteria	<p>For Hospice Inpatient (claim type 01): For a Hospice claim defined as Provider Type 046, enrollee exception 'D', and Bill Type 82X, set the edit if the Primary Carrier Payment Amount = 0, no Hospice Care Nursing Services revenue code is 0658, and there is any Medicare Part A coverage for the dates of service.</p> <p>For Medicaid Inpatient (claim type 01): If the enrollee has any of the TPL liability codes = A/Y and/or B/Z AND 1) the claim is for Hospice defined as Provider Type 046, Bill Type 81X, and with a Hospice Care Nursing Services revenue code 0658, bypass the edit. 2) the COB code = 82 (no other coverage) and the primary payment amount is >= 0, set the edit. 3) the COB code = 83 (billed and paid) and the primary payment amount = 0, set the edit. 4) the COB code = 85 (billed, no coverage) and the primary payment amount = 0 and the provider class type is not = 02, 04, 05, 12, 14 or 85 (state-mental hospital - A, long stay hospital, TB hospital, long stay IP MH, rehab hospital or rehab has NE), set the edit.</p> <p>For SLH (claim type 01): If the enrollee has TPL liability code = A/Y, AND 1) the COB code = 82 and the primary payment amount is >= 0, set the edit. 2) the COB code = 83 or 85 and the primary payment amount = 0, set the edit. 3) the COB code = 85 and the primary payment amount is > 0 and there is no other insurance, set the edit.</p> <p>Bypass the edit if: The enrollee's TPL indicates uninsured absent parent (U), or One of the procedure code flags = 90, or One of the procedure code flags = 91 and the first diagnosis on the payment request is in the ICD-9 value set 172 (BYPASS DIAGNOSIS CODES) or the ICD-10 value</p>

	<p>set 20288 (ICD-10 PREGNANCY DIAG CODES), or The first diagnosis on the payment request is in the ICD-9 value set 21004 (ICD-9 DX ROUTINE CHILD HEALTH) or the ICD-10 value set 22004 (ICD-10 DX ROUTINE CHILD HEALTH).</p> <p>Bypass the edit if: Claim Type = 01 (Hospital Inpatient) and Provider Class type = 046 and Bill Type (positions 1-2) = 81 and claim has a revenue code = 0658 (Hospice Care Nursing Services)</p> <p>For Medicaid SNF (claim type 02): 1) If the from date of service is < 01/01/90, and the COB code is not = 85 (billed, no coverage), and the aid category is not = 23, 43 or 63 (QMB enrollees, not dually-eligible - aged, blind or disable), and the TPL code = A/Y (Medicare Part A), and the provider class type = 6, 11, 28, or 92 (SNF-MH, SNF-MR, SNF-State, SNF-NE), and the dates of service are within the first 150 days, set the edit. 2) If the from date of service is >= 01/01/90, and the COB code not =85, and the aid category is not = 23, 43 or 63, and the TPL code = A/Y, and the provider class type = 6, 11, 28 or 92, and the days stay < 101, set the edit. 3) If the enrollee has Medicare coverage A/Y or B/Z, and the COB code = 82 or 83 (no other coverage or billed and paid), and the primary payment amount = 0, set the edit.</p> <p>Bypass the edit if: The enrollee's TPL indicates uninsured absent parent (U), or One of the procedure code flags = 90, or One of the procedure code flags = 91 and first diagnosis on the payment request is in the value set 172 (BYPASS DIAGNOSIS CODES) or the ICD-10 value set 20288 (ICD-10 PREGNANCY DIAG CODES), or The first diagnosis on the payment request is in the ICD-9 value set 21004 (ICD-9 DX ROUTINE CHILD HEALTH) or the ICD-10 value set 22004 (ICD-10 DX ROUTINE CHILD HEALTH).</p> <p>For Hospice Outpatient (claim type 03) For a Hospice claim defined as Provider Type 046, enrollee exception 'D', and Bill Type 83X, set the edit if the Primary Carrier Payment Amount = 0, no Hospice Care Nursing Services revenue code is 0658, and there is any Medicare Part A coverage for the dates of service.</p>
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General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	T	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing	Y	Home Health		Outpatient	Y
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
		DENY	
EMC	200	PEND	
		DENY	
Adjustment	200	PEND	
		DENY	
POS			
Encounter			
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA032	TPL Edits

Exceptions

All SLH Pends are assigned to LOC 308. This edit was turned off for nursing home (claim types 02 and 10) on 11/18/2003. This edit was turned off for inpatient (claim type 01) on 12/2/2003. This edit was turned back on for all claim types on 08/12/2004 with an effective date of 01/01/1990. On 1/4/05, ECS with attachment was changed from deny to pend to location 200 with an effective date of 07/01/2000.

Resolution

Hospital/Nursing Facility:

1. If attachment and/or comments state that Medicare coverage is exhausted and there is no payment by Medicare on the claim, override with code 0267 and disposition indicator O.
2. If there is no indication that Medicare coverage is exhausted and/or there is a Medicare payment on the claim, deny with code 0267 and disposition indicator D.
3. If there is no indication of Medicare on the claim in remarks, payer locator or attachment, check recipient TPL Summary screen for Medicare begin and end dates. If date of service is before the Medicare begin date or after the end date, override edit with ESC 267 and disposition indicator O. If dates of service are within the Medicare begin or end date range, deny the claim with ESC 267 and disposition indicator D.

Edit/Audit Inquiry Results Edit-268 ESC-268

Edit Information

Edit Number	268	esc Number	268	NCPDP Code	
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Short Desc	Review Laboratory Procedure Certification				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-269

ESC-269

Edit Information

Edit Number	269	esc Number	269	NCPDP Code	
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Short Desc	Review Inpatient Surgery
Long Desc	Not justified for inpatient surgery.
Edit Criteria	<p>Set an indicator to not require a PA when either of the following (along with other criteria) is true:</p> <ul style="list-style-type: none"> • One of the procedure codes is in the ICD-9 value set 300 (ICD9 PROC PA CONDITION 1) or the ICD-10 value set 20300 (ICD-10 PROCS VAGINAL DELIVERY) and the there are less than 4 days between the TO date of service and the ADMIT date. • One of the procedure codes is in the ICD-9 value set 301 (ICD9 PROC PA CONDITION 2) or the ICD-10 value set 20301 (ICD-10 PROCS CAESAR DELIVERY) and the there are less than 6 days between the TO date of service and the ADMIT date. <p>For Inpatient (claim type 01): If provider class type = 01, 14, 85, or 91, the bill type = 111, 112, 113, 114, or 117, and the admission date is > 12/31/1999 or if a PA is required, bypass the edit. If the ICD procedure code(s) pend for review indicator on the Medical and Administrative Codes Database = 0 (meaning outpatient services being billed by inpatient) and the from date of service is > 6/30/84, set the edit. Requests pended to location 650 will generate a letter for information. If no information is received within 21 days, the request will automatically deny with edit 0375.</p> <p>For Practitioner (claim type 05): If the date of service is > 6/30/84, and the treatment place = 21 (inpatient hospital), and the type of service is not = 7 (not anesthesia), and the Medical and Administrative Codes Database pend for review indicator = 0, set the edit.</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
		DENY	
EMC	200	PEND	
		DENY	
Adjustment	200	PEND	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

Except CT01 pends to LOC 300 if media is paper with an attachment; if paper with no attachment or EMC, they will pend to 650. All SLH UB claim types that pend will pend to LOC 308 if media is paper with attachment and HCFA claim types will pend to LOC 310; SLH UBs will pend to 650 if paper with no attachment or EMC.

Resolution

All Invoice Types:

If an EOB is attached and a payment is noted on the EOB for the service billed, enter the amount paid in the TPL field and change COB code to 3 on the pend resolution screen. If the TPL amount is not keyed correctly as billed on the claim or the attached EOB, enter the correct amount in the TPL field. Continue to resolve edit using procedures below. (updated 2/ 25 /08)

Hospital

Edit 269 automatically sends a letter to the provider requesting additional information for claim type 01 claims. These payment requests automatically deny with edit 0375 after 21 days if no letter is returned. Until then, they are held in Location 650.

When the documentation is returned with a copy of the letter:

1. Access the pend in Location 650 using the ICN and transfer the claim to DMAS Location 300.
2. Enter a comment stating that the documentation has been received and is being forwarded to DMAS.
3. Send the documentation to the appropriate DMAS unit.

Practitioner

If an inpatient stay was authorized for the dates of service billed, override 0269O. (updated 9/12/14)

To check for an authorization:

1. Exit the pend resolution screen.
2. Go to the main system menu.
3. Click on Prior Authorization.
4. Select PA Selection Menu.
5. Choose the Inquiry function.
6. Enter Enrollee ID then choose Enter.
7. Look for received dates close to the date of service on the claim.
8. Enter X next to the PA record, then submit request.
9. Click on the PA line button.
10. Look for the INPAT procedure code.
11. Note the date of service authorized.
 - a) If PA hospital stay has a date range, dates billed should be within the dates of service authorized. Override 0269O if dates are on or within dates authorized. Deny 0269 with disposition indicator D if dates billed are not within dates of service authorized.(updated 12/05/07)
 - b) If PA hospital stay has the same begin and end date (no date span is given) the date of service on the claim should be on or after the date on the PA file. Hospital stays can be from 1-120 days. Override 0269 with disposition indicator O if dates are on or after authorized dates. Deny 0269 with disposition indicator D if dates billed are before the authorized date of service.(update 12/05/07)
12. If no PA is on file for the date of service- Deny 0269 with disposition indicator D. (updated 7/2015)
13. If there is an attachment, and the attachment indicates the patient was already in the hospital when procedure was done, or the hospital stay was authorized. Override 0269 with disposition indicator O. (updated 12/05/07)
 - a. If the attachment is an authorization request, transfer to location 321.
 - b. If attachment is not clear, transfer to location 219 with remarks. (Updated 9/12/14)

Edit/Audit Inquiry Results Edit-270 ESC-270

Edit Information

Edit Number	270	esc Number	270	NCPDP Code	
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Short Desc	Review of Home Health Authorization				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-271 ESC-271

Edit Information

Edit Number	271	esc Number	271	NCPDP Code	
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Short Desc	Payment Temporarily Deferred				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-272 ESC-272

Edit Information

Edit Number	272	esc Number	272	NCPDP Code	
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Short Desc	Pend/Proc Code Conflicts with Enrollee Sex Code				
Long Desc	Pend/Proc Code Conflicts with Enrollee Sex Code				
Edit Criteria	This edit is no longer valid and is not included in the new MMIS. Procedure code 59012 will set edit 186 and ICD9 code 64000 will set edit 113.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-273 ESC-273

Edit Information

Edit Number	273	esc Number	273	NCPDP Code	
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Short Desc	Pend/Proc Code Conflicts with Enrollee Age				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-274 ESC-274

Edit Information

Edit Number	274	esc Number	274	NCPDP Code	
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Short Desc	Duplicate Rx Number/Different Drug Codes				
Long Desc					
Edit Criteria	This edit has been combined into edit 400 (Duplicate Rx Number/Different Drug Code), and so edit 274 is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-275 ESC-275

Edit Information

Edit Number	275	esc Number	275	NCPDP Code	
-------------	-----	------------	-----	------------	--

Short Desc	Pending Review of Pre-Authorization				
Long Desc	Procedure Not Authorized for This Patient				
Edit Criteria	For Practitioner (claim type 05): If the billing provider type = 72 (Department of Education), and the billing provider type 72 is found on the RF_PROC_PT_SPEC table for the claim's procedure code, and the enrollee's age is >= 23 on the from date of service, set the edit.				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

This edit was turned off effective 06/20/2003.

Resolution

Practitioner:

1. Check for keying/scanning errors.

If errors are found in unprotected fields, correct the field entry.

If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.

2. Check the payment request image for a PA number. If found, key the PA number in the PA # field on the pend screen.

3. If PA number is not found on the payment request image, check the attachment image. If the attachment is a copy of an approved authorization, key the authorization number in the PA # field on the pend screen.

4. If the attachment is not an authorization or authorization was not approved, deny using code 0275 and disposition indicator D.

Edit/Audit Inquiry Results Edit-276 ESC-276

Edit Information

Edit Number	276	esc Number	276	NCPDP Code	
-------------	-----	------------	-----	------------	--

Short Desc	Review of 175 NICU Code				
Long Desc	Review of 175 NICU Code				
Edit Criteria	This edit has been removed from the current MMIS. An action item said that this edit would be date sensitive based on when an individual hospital went on PA, and would only be used for "old" payment requests.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-277 ESC-277

Edit Information

Edit Number	277	esc Number	277	NCPDP Code	
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Short Desc	Pend Outpatient Surgery/Consent Form				
Long Desc	Consent Form Needed for This Surgical Procedure				
Edit Criteria	<p>This edit is deleted.</p> <p>For HCFA 1500 payment requests, set the edit if the procedure code billed has a suspense indicator of B or E (pend for professional service review), and the place of service is 21 (inpatient) or 22 (outpatient hospital).</p> <p>For inpatient payment requests, set the edit if one of the ICD9-CM procedures billed has a suspense indicator, C_PEND_REVIEW, on the RF_PROCEDURE table = E. Bypass if the enrollee's age is > 20, the bill type = 113 or 114, and the provider type = 01 or 91 OR if the PA-required-inv01 = Y.</p> <p>For outpatient payment requests, fail the edit if the ICD9-CM procedure billed has a suspense indicator of E.</p> <p>Requests pended to location 650 will generate a letter for information. If no information is received within 21 days, the request will automatically deny with edit 0375.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-278 ESC-278

Edit Information

Edit Number	278	esc Number	278	NCPDP Code	
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Short Desc	Review of Sterilization Consent Form
Long Desc	Review of Sterilization Consent Form
Edit Criteria	<p>If the payment request has an attachment, and the procedure or diagnosis indicates sterilization, and there is no active segment on the Consent File for the sterilization for the dates of service, set the edit. If there is no attachment, set edit 0349.</p> <p>For Outpatient Hospital Claims & Title-18 (XOVA) claims for Bill-types = '13X', '72X' and '85X', and prov types ('001', '014', '085', '091'), and FDOS >= 01/1/14 the Revenue line procedure code will be checked in CPT STERILIZATION CODES value set, and with an attachment set the edit.</p> <p>See value sets, CPT STERILIZATION CODES ICD9 STERILIZATION CODES (ICD-9 value set 117) and ICD-10 STERILIZATION PROCS (ICD-10 value set 20117) DIAG STERILIZATION CODES (ICD-9 value set 279) and ICD-10 STERILIZATION DIAGS (ICD-10 value set 20279)</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	Y

Transportation		Xover A	Y	Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
		PAY	
EMC	200	PEND	
		PAY	
Adjustment	200	PEND	
		PAY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

Except CT01 pends to LOC 300. All SLH UB claim types that pend will pend to LOC 308 and HCFA claim types will pend to LOC 310.

Resolution

All Claim Types:

Review the Attachment to verify that it is the Sterilization Consent Form.

1. If the attachment or procedure code indicates that the service rendered is not a sterilization or pathology procedure, override with code 0278 and disposition indicator O.

- Examples of sterilization procedure codes are: 00851, 00921, 54690, 55250, 55450, 56301, 56302, 56307, 56318, 58600, 58605, 58611, 58615, 58661, 58670, 58671, 58700, 58720 and 58940. Click on Procedure code button. If Pend Review indicator is "B", then the procedure billed is a sterilization procedure. (Updated 6/1/12).

- All procedures related to the sterilization, on the same day of the sterilization require a DMAS-3004 consent form. Examples include sedation and anesthesia. All procedures related to the ster-

ilization, may not have a "B" indicator since the procedures can be performed for other medical reasons. (Updated 1/29/13).

•Also ICD-9 pathology procedure codes beginning with '88' can be associated with the sterilization. Claims will also pend if the provider is billing a sterilization diagnosis. If the service is not a sterilization or pathology procedure and the date of service is different from the date of the sterilization, override with code 0278 and disposition indicator 'O'. (Updated 8/7/08).

2. If the attachment is not a Sterilization Consent Form but is operative notes, transfer to location 321 with remark 'notes attached'. If no attachment, deny with code 0140 and disposition indicator D.

3. If the Sterilization Consent Form is not legible, deny with code 0278, disposition indicator D. Enter EOB code 1002 and Disposition indicator E in the next available set of Reso Ind fields.

4. If the attachment is a Sterilization Consent Form, review the document to confirm that it meets all requirements for a valid consent form.

A valid form should have 'DMAS 3004' or 'DMAS 3004-S (Spanish version)' in the bottom left corner. Due to multiple copies distributed to providers, the DMAS 3004 or DMAS 3004-S may not appear, if copies are not aligned properly. If the:

a) If the consent file information has already been entered, review the form to make sure the consent form is acceptable using the resolution procedures for this edit. If the form is acceptable and information was entered correctly, override edit 0278 with disposition 'O'. If the consent file information was entered in error, transfer to location 219 with remark 'consent file error'. NOTE: If the consent file information has been added previously and the date of service is different and the type of sterilization is different from the pended claim, enter the information related to the current pended claim. If the type of sterilization is the same (S, A or H) do not enter any information. Transfer to location 219 for review with remark 'Consent file review' (updated 10/2012).

b) Form looks like the DMAS 3004 or DMAS 3004-S except for the missing 'DMAS 3004' or 'DMAS 3004-S' complete the information in the consent file and override edit 0278 with disposition "O" (Updated 7/15/11)

If there are any questions, note your question in the remark screen and transfer to location 219. (Updated 8/13/09) (Updated 3/21/08) Block numbers should be completed as follows

Item #3: the recipient must be 21 years old on the date the consent was given (month, day and year). If not, deny with code 0278, disposition indicator D. Enter EOB code 0377 and Disposition indicator E in the next available set of Reso Ind fields.

Items #7 and #8: The recipient must sign and date the consent form (minimum) 30 days and not more than (maximum) 180 days prior to the date of service on the claim. If not, deny with code 0278, disposition indicator D. Enter EOB code 0378 and Disposition indicator E in the next available set of Reso Ind fields.

Items #11 and #12: The person obtaining the consent must sign and date the form (date should be the same as block 8). If not, deny with code 0278, disposition indicator D. Also enter code 0341 and Disposition indicator D in the next available set of Reso Ind fields.

Items #13 and #14: Name of individual to be sterilized on date of sterilization (this date should agree with date of service on claim) must match recipient on claim. If not, deny with code 0278, disposition indicator D. Also enter code 0341 and Disposition indicator D in the next available set of Reso Ind fields.

Item #17: Physician date should be present. If not, deny with code 0278, disposition indicator D.

Also enter code 0341 and Disposition indicator D in the next available set of Reso Ind fields.

Items #18 and #19: If date of service is less than 30 days from date of recipient signature, deny with code 0278, disposition indicator D unless one of these items is checked: Also enter code 0341 and Disposition indicator D in the next available set of Reso Ind fields.

A. Premature delivery

B. Individual's expected date of delivery

C. Emergency abdominal surgery

5. If all information on the consent form meets the above requirements, enter the consent form data on the Consent Entry Screen (click on the Consent button). After entry is complete, return to the pend screen and release the claim to adjudicate (0278O). If information is already entered in the consent file and information has been verified (see 4a above) there is no need to enter the consent information twice for the same sterilization with the same date of service. (Updated 10/2012).

6. If claim is pending with ESC 0450 and 0278 is the only pend with 0450, deny with ESC 0450 D. (Update 03/28/11)

7. If claim is pending with another pend reason other than 0450 and 0278 transfer claim type 05 to location 317. If claim is claim type 01 or 03, transfer to location 300. (updated 3/28/11)

Edit/Audit Inquiry Results Edit-279 ESC-279

Edit Information

Edit Number	279	esc Number	279	NCPDP Code	
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Short Desc	Review New Procedure				
Long Desc	Review New Procedure				
Edit Criteria	This edit is being deleted. Edit 0214 should set for new procedure codes. If the procedure billed has a pend for review indicator = P on the Medical and Administrative Codes Database, set the edit.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-280 ESC-280

Edit Information

Edit Number	280	esc Number	280	NCPDP Code	
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Short Desc	Review EPSDT Service				
Long Desc	Review EPSDT Service				
Edit Criteria	<p>Note: Edit closed as of 7/1/2005.</p> <p>For Inpatient (claim type 01):</p> <p>1) If the provider class type is 01 (Hospital), 08 (State MH-Med-Surg), 09 (Med-Surg-MR), 13 (Long stay IP MR), or 91 (non-enrolled Hospital) and either the adult days of service (the sum of units for the revenue codes 100-169, 180-219) or the neonatal ICU days of service (sum of units for the revenue code 174 or 175) are > 21days:</p> <p>a) if the enrollee's age is < 21 on the thru date of service and a condition code is not = A1 (EPSDT) and the provider's restriction type is not = 06, set the edit.</p> <p>b) if the enrollee turns 21 during the hospital stay and the length of stay before the enrollee reaches 21 is > 21 days and a condition code is not = A1 (EPSDT) and the provider's restriction type does not = 06, set the edit.</p> <p>Bypass both parts of this edit if there is an approved PA or if the provider class type is 01 or 91 and the admission date is greater than 12/31/1999.</p> <p>Electronically submitted payment requests and paper requests without an attachment with Edit 0280 generate a letter requesting documentation. These payment requests automatically deny with edit 0375 after 21 days if no letter is returned.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	Y
PrtRA Ind		PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
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FAMIS	Y	Assessments			
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Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	300	PEND	
	650	PEND	
EMC	650	PEND	
	650	PEND	
Adjustment	300	PEND	
	650	PEND	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

All SLH Pends are assigned to LOC 308 if media is paper with an attachment; if paper with no attachment or EMC, they will pend to 650.

Resolution

Electronically submitted payment requests with Edit 0280 generate a letter requesting documentation. These payment requests automatically deny with edit 0375 after 21 days if no letter is returned. Until then, they are held in Location 650.

1. When the documentation is returned with a copy of the letter, access the pend in Location 650 using the ICN and transfer the claim to DMAS Location 300.
2. Enter a comment stating that the documentation has been received and is being forwarded to DMAS.
3. Send the documentation to the appropriate DMAS unit.

Edit/Audit Inquiry Results Edit-281 ESC-281

Edit Information

Edit Number	281	esc Number	281	NCPDP Code	
-------------	-----	------------	-----	------------	--

Short Desc	21/60/21 Hospital Medical Review				
Long Desc	21/60/21 Hospital Medical Review				
Edit Criteria	<p>This edit is deleted in the new MMIS. Edit 266/266 will cover all conditions for 21/60/21.</p> <p>This edit ensures that for certain Hospital payment requests (claim type 01) the total covered days does not exceed 21 days within a 60-day period.</p> <p>The edit is bypassed for any of the following:</p> <ol style="list-style-type: none"> 1) the admission date is after 12/31/1999 and the principal diagnosis is not psych (290 - 319) OR 2) the enrollee's age is > 20, the provider class type is 01 (Hospital) and the bill type = 113 or 114 OR 3) the first three positions of the principal diagnosis code = 999 OR 4) the activity and history payment requests' provider class types are not = 01 (Hospital), 08 (MH-Med-Surg), 09 (Med-Surg-MR), or 91 (non-enrolled Hospital) OR 5) the first 3 positions of the activity principal diagnosis code are not = the first 3 positions of the history principal diagnosis code OR 6) the admission date of the activity request is not within 60 days of the admission date of the history request. <p>If the activity principal diagnosis code equals the history principal diagnosis code or if not, if the first 3 positions of the activity principal diagnosis code equals the first 3 positions of the history principal diagnosis code AND the total covered days is > 21,</p> <ol style="list-style-type: none"> 1) if the admission date is after 12/31/1999 and the provider class type = 01 or 91 and the principal diagnosis code is within the ICD-9/10 range of 290 - 319.99 and the enrollee's age is >= 21, set edit 0266. 2) if the activity from date of service is > 9/30/86 and the enrollee's age on the activity thru date of service is < 21 and the provider's Utilization Review code is not = L or there is no PA on file, set this edit. If the activity from date of service is > 9/30/86 and the enrollee's age on the activity thru date is >= 21, set edit 0266. 				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-282 ESC-282

Edit Information

Edit Number	282	esc Number	282	NCPDP Code	
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Short Desc	Review of Medicare Coinsurance Coverage
Long Desc	Primary carrier payment needs explanation.
Edit Criteria	<p>If any of the diagnosis codes are in the ICD-9 value sets 169 (0282/0387 BYPASS) or 172 (BYPASS DIAGNOSIS CODES) or the ICD-10 value set 20288 (ICD-10 PREGNANCY DIAG CODES), bypass the edit.</p> <p>For Medicaid/FAMIS: If the claim type = 02 (Nursing Home), and the provider class type = 10 or 15 (nursing facility), and the COB code = 83 (billed and paid), and the enrollee exception indicator = 2 (SNF/Medicare certified), and the medical insurance code = A/Y (Medicare Part A), and there is < 101 days from the admission date to the thru date of service, and the payment from primary carrier does not = zero, and the payment request has attachments or remarks, set the edit.</p> <p>If the claim type = 02 (Nursing Home), and the provider class type = 10 or 15 (nursing facility), and the COB code = 85 (billed, no coverage), and the enrollee exception indicator = 2 (SNF/Medicare certified), and the medical insurance code = A/Y (Medicare Part A), and there is < 101 days from the admission date to the thru date of service, and the payment from the primary carrier does not = zero, and the payment request has attachments or remarks, set the edit.</p> <p>If the claim type = 09 (Title 18), part A and the enrollee does not have Medicare Part A coverage and the payment request is not submitted on magtape and there are attachments or remarks, set the edit.</p> <p>If the claim type = 09 (Title 18), part B and the enrollee does not have Medicare Part B coverage and the payment request is not submitted on magtape and there are attachments or remarks, set the edit.</p> <p>Bypass the edit if the primary diagnosis code is prenatal care (ICD-9 value set 169 (0282/0387 BYPASS) or ICD-10 value set 20288 (ICD-10 PREGNANCY DIAG CODES), pregnancy, or preventative pediatric care.</p> <p>For electronic crossover claims – Claim Type = 09 (DE 2002) and Media Type = 7</p>

	<p>(DE 2478) with a Submit ID (DE 0012) of 'EDIX', set edit 0282 when edit criteria is met. For electronic crossover claims – Claim Type = 09 (DE 2002) and Service Center = '1060' (DE 4082)', bypass the edit.</p> <p>SLH: If the payment request is SLH Outpatient (claim type 03) and the enrollee has TPL coverage other than Medicare type B coverage and there is no TPL amount and the COB code = 2 (no other coverage), set the edit. If the payment request is SLH Practitioner (claim type 05) and provider type is not 51 and the enrollee has TPL coverage and the procedure code does not have TPL coverage B or Z and there is no TPL amount and the COB code = 2 (no other coverage), set the edit.</p>
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General Indicators

Reject Ind		Deny Ind		Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	T	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing	Y	Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
		DENY	

EMC	200	PEND	
		DENY	
Adjustment	200	PEND	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA032	TPL Edits

Exceptions

This edit is for practitioner and outpatient only for SLH. All SLH UB claim types that pend will pend to LOC 308 and HCFA claim types will pend to LOC 310.

Resolution

All Claim Types

Check the attached EOB. The name on the EOB should match the recipient's name on the claim and on the pend screen. If the recipient's name on the pend screen does not match what is on the EOB and/or claim, indicate on the remark screen "name and ID do not match" then deny 0399 with disposition indicator D. If the information matches, proceed to the resolution procedures below. (added 5/13/09)

Nursing Home:

1. Review attachment. If remark "Medicare Benefits Exhausted" is in comments or attachment, override with code 0282 and disposition indicator O.
2. If attachment shows a payment by Medicare, deny with code 0385 and disposition indicator D.

Title XVIII:

1. Click Enrollee button to access Enrollee Demographics Inquiry screen.

Look in Comments area for this note: "No Medicare per Buy In Unit at DMAS". If the note is on the screen, deny the claim with edit 0371.

If the comment is not on the screen, go to step 2.

2. Click TPL Summary button to access the Enrollee TPL Summary Inquiry screen.

If date of service falls within the Medicare Part A begin and end dates, pay if Part A claim (override 0282, disposition indicator O).

If date of service falls within the Medicare Part B begin and end dates, pay if Part B claim (override

0282, disposition indicator O).

3. If Medicare EOB and/or Medicare card are attached, transfer to DMAS location 219.

4. If Medicare EOB and/or Medicare card are not attached, deny with code 0244 and disposition indicator D.

Note: Recipients have a choice of Medicare Advantage Plans (PPO or HMO) in lieu of the traditional Medicare A/B coverage. Providers may not list "Medicare" as the primary payor on the crossover claim. If one of the Medicare Advantage Plans listed below is shown as the primary payer and an EOB is attached, transfer to location 219. Medicare coverage type

(A or B) should be listed in the recipient file even if the recipient does not have regular Medicare.

(updated 3/21/08)

Some of the Medicare Advantage Plans

Aetna

Assurant/Fortis

Blue Cross Blue Shield Plans

Celtic Insurance Company

CIGNA

Fairmont Specialty/TIG

Golden Rule

Group Health Cooperative

Group Health Incorporated

Health Net

HealthPartners

Humana

Intermountain Health Care

Kaiser Permanente

LifeWise Health Plans

Medica

Medical Mutual of Ohio

Midwest Security

Oxford Health Plans

PacifiCare

Security Life Insurance

UNICARE

United Wisconsin Life/American Medical Security

Vista Health Plan

Edit/Audit Inquiry Results Edit-283 ESC-283

Edit Information

Edit Number	283	esc Number	283	NCPDP Code	
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Short Desc	Medical Consultant Review
Long Desc	Medical Consultant Review
Edit Criteria	<p>Set an indicator to not require a PA, which is used in this edit process, when either of the following (along with other criteria) is true:</p> <ul style="list-style-type: none"> • One of the procedure codes is in the ICD-9 value set 300 (ICD9 PROC PA CONDITION 1) or the ICD-10 value set 20300 (ICD-10 PROCS VAGINAL DELIVERY) and the there are less than 4 days between the TO date of service and the ADMIT date. • One of the procedure codes is in the ICD-9 value set 301 (ICD9 PROC PA CONDITION 2) or the ICD-10 value set 20301 (ICD-10 PROCS CAESAR DELIVERY) and the there are less than 6 days between the TO date of service and the ADMIT date. <p>For Home Health (claim type 03), Practitioner (claim type 05), Laboratory (claim type 08), and Dental (claim type 11): if the covered days (claim type 03) or units entered on the payment request is > the maximum days or units allowed for the following procedures on the Medical and Administrative Codes Database, then set the edit. By-pass codes if PA is found.</p> <p>Procedures with edit 283 on the Medical and Administrative Codes Database for maximum U/V/S: E0747 E0749 L5020 L5510 L5634 L5710 L6300 L6310 L6500 L6672 L6682 L6870 L6895 L7500 L7510 L8435 10061 11971 15940 15958 21246 22327 22612 22842 22395 24310 26415 26585 27295 27303 27487 27615 27686 27692 27703 27808 30400 30410 30420 30430 30435 30450 33426 33500 33530 33542 33788 33877 35102 35311 57291 63086 63088 63091 67825 67835 85102 92065 93312 93622 96425 99239 99373</p> <p>As of June 3rd, 2013, this edit is bypassed if the procedure code is found on the RF_MUE_EDIT_BYPASS table, and the claim type is found in the NCCI Claim Type</p>

	<p>value set.</p> <p>See value set, CPT MAX UVS E0283. See Value Set "NCCI INTERNAL BYPASS CLM TYPES" for claim types. See Value Sets 300 (ICD9 PROC PA CONDITION 1) for ICD-9 or 20300 (ICD-10 PROCS VAGINAL DELIVERY) for ICD-10 See Value Sets 301 (ICD9 PROC PA CONDITION 2) for ICD-9 or 20301 (ICD-10 PROCS CAESAR DELIVERY) for ICD-10</p>
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General Indicators

Reject Ind		Deny Ind		Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental	Y	Pharmacy		Inpatient	
Nursing		Home Health	Y	Outpatient	Y
Physician	Y	Personal Care		Laboratory	Y
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
	200	PEND	
EMC	200	PEND	
	200	PEND	
Adjustment	200	PEND	
	200	PEND	
POS		PAY	

Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

All SLH UB claim types that pend will pend to LOC 308 and HCFA claim types will pend to LOC 310.

Resolution

All Claim Types:

1. Transfer all procedure codes that begin with L to DMAS location 400.
2. For all other codes, if operative report is not attached, deny with code 0409 and disposition indicator D.
3. If procedure code does not begin with L and an operative report is attached, repond to DMAS location 321.

Edit/Audit Inquiry Results Edit-284 ESC-284

Edit Information

Edit Number	284	esc Number	284	NCPDP Code	
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Short Desc	Possible Duplicate - 2 Providers/Same Service				
Long Desc	Possible Duplicate - 2 Providers/Same Service				
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-285 ESC-285

Edit Information

Edit Number	285	esc Number	285	NCPDP Code	
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Short Desc	Review Payment Request for Possible Duplicate				
Long Desc	Review Payment Request for Possible Duplicate				
Edit Criteria	<p>This edit is deleted for the new MMIS.</p> <p>For Practitioner (claim type 05), if two payment requests have different types of service, but the base provider ID numbers, the from and thru dates of service, the enrollee numbers and the procedures are the same, set the edit.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-286 ESC-286

Edit Information

Edit Number	286	esc Number	286	NCPDP Code	
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Short Desc	Review of CMM Restriction
Long Desc	Review of CMM Restriction
Edit Criteria	<p>For Transportation (claim type 13):</p> <p>If the enrollee benefit exception indicator is 6, and the billing or servicing provider is not equal to the lock-in provider nor affiliated with the lock-in provider, but the referring provider is the lock-in provider or is affiliated with the lock-in provider, then set the edit if there is an attachment and the claim was submitted on paper or if the claim was submitted electronically.</p> <p>Bypass the edit if:</p> <ol style="list-style-type: none"> 1) the billing/servicing provider is the lock-in provider or affiliated with the lock-in provider 2) the provider/specialty types are <ul style="list-style-type: none"> 80/09 Neo-natal ambulance 80/21 Air ambulance 82 Emergency air ambulance 84 Out-of-state emergency air ambulance 3) the procedure codes are one of these: <ul style="list-style-type: none"> Y0110 Emergency Ambulance Y0121 Special code for authorized providers <p>For Practitioner (claim type 05):</p> <p>If the enrollee benefit exception indicator is 4, and the billing provider or the servicing provider is not the lock-in physician or affiliated with the lock-in physician, but the referring physician is the lock-in physician or is affiliated with the lock-in physician and the procedure code is not equal to 90500-90580, 99062, 99064, 99065, or 99281-99285 (See value set 166, EMERGENCY PROCEDURE CODES), then set the edit if there is an attachment and the claim was submitted on paper or if the claim is ECS (electronically submitted).</p> <p>Bypass the edit if any of the following apply:</p>

	<p>1) the provider class type is in value set 164 (CMM EXEMPT PROVIDER TYPES)</p> <p>2) the Medical and Administrative Codes Database flag indicator = S, I, or FP</p> <p>3) the place of treatment = 21 (inpatient hospital) or 51 (inpatient psychiatric)</p> <p>4) the type of service is anesthesia (7)</p> <p>5) the procedure code is in the range 70000 - 89999 and has a professional component modifier (26)</p> <p>6) the procedure code's first position is A or V</p> <p>7) the procedure code is in value set 165 (CMM EXEMPT PROCEDURES)</p> <p>8) the diagnosis code is one of these sterilization codes in the ICD-9 value set 279 (DIAG STERILIZATION CODES) or the ICD-10 value set 20279 (ICD-10 STERILIZATION DIAGS)</p> <p>9) the diagnosis code is one of these family planning codes in ICD-9 value set 280 (DIAG FAMILY PLAN CODES) or the ICD-10 value set 20280 (ICD-10 FAM PLN EDT BYPASS DIAG)</p> <p>Requests pended to location 650 will generate a letter for information. If no information is received within 21 days, the request will automatically deny with edit 0488 .</p> <p>Note: If a claim is submitted with an NPI, the match for servicing, referring or attending provider is done at the NPI level rather than the Provider Type/Location level.</p>
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General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation	Y	Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	100	PEND	
		N/A	
EMC	650	PEND	
	650	PEND	
Adjustment	100	PEND	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

Paper claims with attachments can be paid if the CMM form is attached and completed correctly. Electronic payment requests with Edit 0286 generate a letter requesting documentation. Transportation claims generate letter CP-O-044-7 and all other claim types generate letter CP-O-444-4. These payment requests automatically deny with edit 0488 after 21 days if no letter is returned. Until then, they are held in Location 650. When the documentation is returned with a copy of the letter:

1. Access pend in Location 650 using the ICN.
2. Pay the claim if the CMM form is attached, completed and the date of the referral is less than 90 days from the date of service.

Deny with ESC 0489 if:

- All fields on the form are not completed.
- A 12 digit Member ID number is missing/incomplete.
- Referral date on line two is not prior to the date of service.
- Purpose of Referral is not checked.
- Provider ID# is missing/incomplete.
- Signature of the primary care provider is missing.
- If referral date is greater than 90 days from the date of service.

- If unsure of the information on the CMM form, transfer to Location 321.
- If the attachment is not the CMM referral form (DMAS-70, 5/06 revised), deny with ESC 0488 and disposition indicator D. (Updated 6/2014)

Edit/Audit Inquiry Results Edit-287 ESC-287

Edit Information

Edit Number	287	esc Number	287	NCPDP Code	
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Short Desc	Prior Auth Conflict or Not on File				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-288

ESC-288

Edit Information

Edit Number	288	esc Number	288	NCPDP Code	
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Short Desc	Review Deductible Charges				
Long Desc	Review Deductible Charges				
Edit Criteria	<p>Note: This edit is obsolete after 10/26/2008 (Release 42 implementation date).</p> <p>If the payment request's Medicare coverage code = A and the deductible amount entered on the payment request is greater than the amount defined in the Medicare table by \$175, set the edit. This \$175 limit is stored on the RF_SYS_PARAMETER table with value id XOVA-DEDTL. The Medicare table amounts for part A are stored on the RF_SYS_PARAMETER table with the value id XOVA-DEDT.</p> <p>If the payment request's coverage code = A and the from date of service is earlier than the first date in the table, and the deductible amount entered on the payment request is greater than the first amount defined in the Medicare table by \$175, set the edit.</p> <p>If the payment request's coverage code = B and the deductible amount entered on the payment request is greater than the amount defined in the Medicare table by \$175, set the edit. This \$175 limit is stored on the RF_SYS_PARAMETER table with value id XOVB-DEDTL. The Medicare table amounts for part B are stored on the RF_SYS_PARAMETER table with the value id XOVB-FACT5.</p> <p>If the payment request's coverage code = B and the from date of service is earlier than the first date in the table, and the deductible amount entered on the payment request is greater than the first amount defined in the Medicare table by \$175, set the edit.</p>				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
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PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
		DENY	
EMC	200	PEND	
		DENY	
Adjustment	200	PEND	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

Title XVIII:

Verify the charges submitted against the Medicare EOB.

1. If the attachment is not a Medicare EOB, deny with code 0244 and disposition indicator D.
2. If the charges are correct according to the EOB, override with 0288 and disposition indicator O.
3. If charges do not match the EOB, deny with code 0244 and disposition indicator D

Edit/Audit Inquiry Results Edit-289

ESC-289

Edit Information

Edit Number	289	esc Number	289	NCPDP Code	
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Short Desc	Review of Units/Quantity Billed				
Long Desc					
Edit Criteria	This edit is combined with edit 0225 (Units billed exceed allowable units for procedure; edit 289 is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-290 ESC-290

Edit Information

Edit Number	290	esc Number	290	NCPDP Code	
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Short Desc	Review of CMM Accident/Emergency Condition
Long Desc	Review of CMM Accident/Emergency Condition
Edit Criteria	<p>For Practitioner (claim type 05):</p> <p>If the enrollee is a lock-in enrollee (enrollee benefit exception indicator = 4), and the from date of service is > 09/30/94, and the servicing provider class type = 20 (physician), and the treatment place = 23 (ER), and the type of service is not = 2, 4, 7, 8, or 6 (surgery, anesthesia, radiology), and the procedure code = 90500-90580, 99062, 99064, 99065, or 99281- 99285 (See value set EMERGENCY PROCEDURE CODES):</p> <p>1) and the principal diagnosis code is on the ICD-9 value set 319 (Payable ER Diagnosis Code Table) or ICD-10 value set 20319 (ICD-10 DX Emergency Pay Codes), pay the request at full coverage with EOB 0698.</p> <p>2) and the principal diagnosis is not on the ICD-9 value set 319 (Payable ER Diagnosis Code Table) or ICD-10 value set 20319 (ICD-10 DX Emergency Pay Codes), but is on the ICD-9 value set 320 (Pend ER Diagnosis Code Table) or ICD-10 value set 20320 (ICD-10 DX Emergency Pend Codes), pend the payment request for edit 0290.</p> <p>3) and the billing or servicing provider is the CMM lock-in provider or is affiliated with the CMM lock-in provider and the principal diagnosis code is not on the ICD-9 value set 319 (Payable ER Diagnosis Code Table) or ICD-10 value set 20319 (ICD-10 DX Emergency Pay Codes), nor on the ICD-9 value set 320 (Pend ER Diagnosis Code Table) or ICD-10 value set 20320 (ICD-10 DX Emergency Pend Codes) (meaning non-emergency ER), and the payment amount > \$20, pay the reduced non-emergency rate of \$20 with EOB 644 if the from date of service is < 06/01/2001. If the from date of service is > 05/31/2001, no reduction is taken and edit 0290 is set. If the payment amount is <= \$ 20, pay the payment amount and set the EOB 698.</p> <p>4) and the billing or servicing provider is not the CMM lock-in provider or affiliated with the CMM lock-in provider and the referring provider is the CMM lock-in provider or is affiliated with the CMM lock-in provider and the principal diagnosis code is not on the ICD-9 value set 319 (Payable ER Diagnosis Code Table) or ICD-10 value set 20319 (ICD-10 DX Emergency Pay Codes) nor on the ICD-9 value set 320 (Pend ER Diagnosis Code Table) or ICD-10 value set 20320 (ICD-10 DX Emergency Pend Codes) and:</p>

a) if there is an attachment and the claim was submitted on paper, set edit 0290.
b) if there is no attachment and the claim was submitted on paper, set edit 0488 if the from date of service is < 06/01/2001. If the from date of service is > 05/31/2001, edit 0497 is set.

c) if the claims was ECS (electronically submitted), set edit 0290.

5) and the billing or servicing or referring provider is not the CMM lock-in provider or affiliated with the CMM lock-in provider and the principal diagnosis is not on the ICD-9 value set 319 (Payable ER Diagnosis Code Table) or ICD-10 value set 20319 (ICD-10 DX Emergency Pay Codes) nor on the ICD-9 value set 320 (Pend ER Diagnosis Code Table) or ICD-10 value set 20320 (ICD-10 DX Emergency Pend Codes), and:

a) if the emergency indicator = Y, the attachment indicator = Y, and the claim was submitted on paper, set edit 0290.

b) if the emergency indicator = Y, the attachment indicator = N, and the claim was submitted on paper, set edit 0421.

c) if the emergency indicator = N and the claim was submitted on paper, set edit 0421.

d) if the claim is ECS (electronically submitted), set edit 0421.

Electronically submitted payment requests with Edit 0290 generate a letter requesting documentation. These payment requests automatically deny with edit 498 after 21 days if no letter is returned.

For Outpatient (claim type 03):

If the enrollee is a CMM locking enrollee (enrollee exception indicator = 4) and the from date of service is > 09/30/94 and the revenue code = emergency room (450 - 459) and the principal procedure code is not surgical (procedure code in ICD-9 value set 21002 (ICD-9 SURG PROC EXCL CODES) or ICD-10 value set 22002 (ICD-10 SURG PROC EXCL CODES)) :

1) and the principal diagnosis code (use the admitting diagnosis if the from date of service is after 5/31/2001) is on the ICD-9 value set 319 (Payable ER Diagnosis Code Table) or ICD-10 value set 20319 (ICD-10 DX Emergency Pay Codes), pay the request at full coverage with EOB 0698.

2) and the principal diagnosis (use the admitting diagnosis if the from date of service is after 5/31/2001) is not on the ICD-9 value set 319 (Payable ER Diagnosis Code Table) or ICD-10 value set 20319 (ICD-10 DX Emergency Pay Codes), but is on the ICD-9 value set 320 (Pend ER Diagnosis Code Table) or ICD-10 value set 20320 (ICD-10 DX Emergency Pend Codes), pend the payment request for edit 0290.

3) and the attending physician is the CMM lock-in provider or is affiliated with the CMM lock-in provider and the principal diagnosis code (use the admitting diagnosis if the from date of service is after 5/31/2001) is not on the ICD-9 value set 319 (Payable ER Diagnosis Code Table) or ICD-10 value set 20319 (ICD-10 DX Emergency Pay Codes) nor on the ICD-9 value set 320 (Pend ER Diagnosis Code Table) or ICD-10 value set 20320 (ICD-10 DX Emergency Pend Codes), and the payment amount > \$30, pay the reduced non-emergency rate of \$30 with EOB 644 if the from date of service is < 06/01/2001. If the from date of service is > 05/31/2001, no reduction is taken and edit 0290 is set. If the payment amount is <=

\$ 30, pay the payment amount and set the EOB 698.

4) and the attending provider is not the CMM lock-in provider or affiliated with the CMM lock-in provider and the Other1 provider (referring provider) is the CMM lock-in provider or is affiliated with the CMM lock-in provider and the principal diagnosis code (use the admitting diagnosis if the from date of service is after 5/31/2001) is not on the ICD-9 value set 319 (Payable ER Diagnosis Code Table) or ICD-10 value set 20319 (ICD-10 DX Emergency Pay Codes) nor on the ICD-10 value set 320 (Pend ER Diagnosis Code Table) or ICD-10 value set 20320 (ICD-10 DX Emergency Pend Codes), and:

a) the attachment indicator = Y and the claim was submitted on paper, set edit 0290.

b) the attachment indicator = N and the claim was submitted on paper, set edit 0488 if the from date of service < 06/01/2001. If the from date of service > 05/31/2001, edit 0497 is set.

c) the claim is ECS (electronically submitted), set edit 0290.

5) and the attending or referring provider is not the CMM lock-in provider or affiliated with the CMM lock-in provider and the principal diagnosis (use the admitting diagnosis if the from date of service is after 5/31/2001) is not on the ICD-9 value set 319 (Payable ER Diagnosis Code Table) or ICD-10 value set 20319 (ICD-10 DX Emergency Pay Codes) nor on the ICD-9 value set 320 (Pend ER Diagnosis Code Table) or ICD-10 value set 20320 (ICD-10 DX Emergency Pend Codes), and:

a) the attachment indicator = Y and the claim was submitted on paper, set edit 0290.

b) the attachment indicator = N and the claim was submitted on paper, set edit 0421.

c) the claim is ECS (electronically submitted), set edit 0421.

Bypass the edit if the principal procedure code is a surgical procedure (procedure NOT found in ICD-9 value set 21002 (ICD-9 SURG PROC EXCL CODES) or ICD-10 value set 22002 (ICD-10 SURG PROC EXCL CODES)).

Electronically submitted payment requests with Edit 0290 generate a letter requesting documentation. These payment requests automatically deny with edit 498 after 21 days if no letter is returned.

Note: If a claim is submitted with an NPI, the match for servicing, referring or attending provider is done at the NPI level rather than the Provider Type/Location level.

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy	Inpatient	
Nursing		Home Health	Outpatient	Y
Physician	Y	Personal Care	Laboratory	
Transportation		Xover A	Xover B	
Cap Pay		Man Fee	Admin	
Asmt Fee				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	313	PEND	
		DENY	
EMC	650	PEND	
	650	PEND	
Adjustment	313	PEND	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA100	Adjudication Controller

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-291 ESC-291

Edit Information

Edit Number	291	esc Number	291	NCPDP Code	
-------------	-----	------------	-----	------------	--

Short Desc	Suspended for Budget Relief				
Long Desc	Temporarily suspended due to insufficient funds				
Edit Criteria	<p>If there are not enough funds to cover a payment request, set the edit.</p> <p>The following part of this edit has been put into a new edit 801: For Inpatient: If provider class type does not = 85 or 91, and payment amount = rate x days, bypass the edit. Else, if the rate = 0 and it is not a reentry, set the edit. If provider class type = 85 or 91, set the edit.</p> <p>For Outpatient: If provider class type = 85 or 91, and the rate = 0, set the edit.</p> <p>If the provider rate is zero, a check is made for a PA and a rate on the PA; if there is no rate on the PA, set the edit.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy	Y	Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y

Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOR	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	001	PEND	
	001	PEND	
EMC	001	PEND	
	001	PEND	
Adjustment	001	PEND	
	001	PEND	
POS		PEND	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

Pend for Capitation, Management, Admin Fees, and Assessments. All TDO UB claim types that pend will pend to LOC 320 and HCFA claim types will pend to LOC 319. All SLH UB claim types that pend will pend to LOC 308 and HCFA claim types will pend to LOC 310.

Resolution

(None)

Edit/Audit Inquiry Results Edit-292 ESC-292

Edit Information

Edit Number	292	esc Number	292	NCPDP Code	
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Short Desc	Pend for Risk Screen				
Long Desc					
Edit Criteria	This edit is deleted from the new MMIS because it is now combined with edit 459.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-293 ESC-293

Edit Information

Edit Number	293	esc Number	293	NCPDP Code	
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Short Desc	Pend for Letter of Authorization				
Long Desc	Pend for Letter of Authorization				
Edit Criteria	This edit is being deleted. If the from DOS < 10/1/90 and the claim was submitted on magtape and the pend for review of services indicator = M and the procedure code = Z9105 or Z9106, set the edit.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-294 ESC-294

Edit Information

Edit Number	294	esc Number	294	NCPDP Code	
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Short Desc	Pend for Outcome Report				
Long Desc					
Edit Criteria	<p>This edit is deleted per Jack Andrews and TDR D-TPCP-ST-0138. Scott Cannady said the outcome report letter (DP-50) was still needed; the 2 Z-codes in this edit (Z9109 and Z9110) have end dates of 1/31/93. Do you need the letter or this edit? Edit was set if from DOS < 10/1/90.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-295 ESC-295

Edit Information

Edit Number	295	esc Number	295	NCPDP Code	
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Short Desc	Review of Risk Screen
Long Desc	Risk Screen Not Attached
Edit Criteria	<p>For Practitioner (claim type 05), if the Medical and Administrative Codes Database pend for review indicator = 'R' and there is an attachment indicator, set the edit.</p> <p>Requests pended to location 650 will generate a letter for information. If no information is received within 21 days, the request will automatically deny with edit 0375.</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	100	PEND	
	650	PEND	
EMC	650	PEND	
	650	PEND	
Adjustment	100	PEND	
	650	PEND	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

Payment requests with Edit 0295 generate a letter requesting a copy of the Risk Screen. These payment requests automatically deny with edit 0375 after 21 days if no letter is returned. Until then, they are held in Location 650.

1. When the documentation is returned with a copy of the letter, access the pend in Location 650 using the claim ICN.
2. Work the pend using the instructions detailed below.

Practitioner:

Review the attachment to verify that it is a "Maternity Risk Screen" for high risk pregnancy prenatal care or an "Infant Risk Screen" for high risk infant care.

1. If the attachment is not a Maternity Risk Screen or an Infant Risk Screen, deny with code 0459, disposition indicator D.
2. If the attachment is illegible, deny with code 0342, disposition indicator D.
3. If the attachment is a Maternity Risk Screen, check for the following requirements:
 - a.) Patient's name must be (reasonably) same as the name on the claim.
 - b.) Recipient # must be the same as on the claim.
 - c.) Expected delivery date (EDC) must be completed.
 - d.) Referral section must be completed/item checked. (rev 03/28/11)
4. If the attachment is an Infant Risk Screen, check for the following requirements:
 - a.) Patient's name must be (reasonably) same as the name on the claim.
 - b.) Recipient # must be the same as on the claim.

c.) Referral must be completed/item checked. (rev 03/28/11)

5. If all items in step 3 or 4 are true, override with code 0295, disposition indicator O.

6. If all items in step 3 or 4 are not true, deny with code 0459, disposition indicator D.

(revised 04/21/09 per A Barton)

Edit/Audit Inquiry Results Edit-296 ESC-296

Edit Information

Edit Number	296	esc Number	296	NCPDP Code	
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Short Desc	Pend for Review of Care Coord Documents				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-297 ESC-297

Edit Information

Edit Number	297	esc Number	297	NCPDP Code	
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Short Desc	Medicare Procedure Code Not on File				
Long Desc					
Edit Criteria	<p>This edit is no longer valid and is not included in the new MMIS.</p> <p>Procedures not on file were no longer pended for edit 297 as of 9/3/91 for Title 18 claims.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-298 ESC-298

Edit Information

Edit Number	298	esc Number	298	NCPDP Code	
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Short Desc	Review for EMG Service for Alien
Long Desc	Non-resident alien eligible for medical emergency only.
Edit Criteria	<p>For payment requests with thru dates of service prior to the new system live date, this edit is set. For payment requests with thru dates of service after the new system live date, edit 0450 is set.</p> <p>Only emergency medical services are paid for a non-resident alien (benefit plan 01-01-3000). The edit is set if any of the following is true:</p> <ol style="list-style-type: none"> 1) the payment request is not for inpatient hospital services OR 2) the payment request is for outpatient services (claim type 03) and the revenue code 450-459 is not billed OR 3) the payment request is for medical services (claim type 05) and the place of treatment is not 21 (inpatient hospital) or 23 (emergency room) OR 4) the payment request is for sterilization (see attached list of diagnosis and procedure codes); this includes inpatient payment requests. <p>Sterilization Codes: ICD9 Procedure Codes for claim type 01 and 03:</p> <p>624 6241 6242 637 6370 6371 6372 6373 655 6551 6552 6553 6554 656 6561 6562</p>

6563

6564

662

6621

6622

6629

663

6631

6632

6639

665

6651

6652

See value set, ICD9 STERILIZATION CODES

ICD9-CM Diagnosis Codes for claim types 01, 03, 05, and 09, part B:

V252

See value set, DIAG STERILIZATION CODES

CPT Procedure Codes for claim type 05 and 09, part B:

54690

55250

55450

56301

56302

56307

56318

58600

58605

58611

58615

58661

58670

58671

58700

58720

See value set, CPT STERILIZATION CODES

OUTPATIENT PRICING:

For Outpatient Hospital Claims & Title-18 (XOVA) claims for Bill-types = '13X', '72X' and '85X' and prov types ('001', '014', '085', '091'), and FDOS >= 01/01/14 the Revenue line procedure code will be checked in the respective value sets and if found set the edit.

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	317	PEND	
	317	PEND	
EMC	317	PEND	
		DENY	
Adjustment	317	PEND	
	317	PEND	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-299 ESC-299

Edit Information

Edit Number	299	esc Number	299	NCPDP Code	
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Short Desc	Multiple Errors				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-300 ESC-300

Edit Information

Edit Number	300	esc Number	300	NCPDP Code	
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Short Desc	Other Payment Sources Exceed VMAP Payment				
Long Desc	Other payment sources exceed DMAS allowable amount.				
Edit Criteria	This edit is done for payment requests with coverage code entered = A, AND provider class type 10 (nursing home), AND from date of service > 6/30/98 OR from date of service > 07/01/93 and thru date of service < 07/01/96, AND the calculated coinsurance greater than zeros. The LESSER of (1) the coinsurance specified by the Provider, (2) the calculated coinsurance, and (3) the difference between the PIRS coinsurance and the amount Medicare paid MINUS the primary carrier amount is the payment amount. If the payment amount minus the patient pay amount is less than or equal to zero, set the edit.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		EOB	
		EOB	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA100	Adjudication Controller

Exceptions

Adjustments for all media except special batch were changed from DENY to EOB on 1/31/2005. Crossover B was also added.

Resolution

(None)

Edit/Audit Inquiry Results Edit-301 ESC-301

Edit Information

Edit Number	301	esc Number	301	NCPDP Code	83
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Short Desc	Duplicate Payment Request - Same Provider, Same DOS
Long Desc	Duplicate Payment Request - Same Provider, Same Dates of Service
Edit Criteria	<p>This edit is set when the payment request being processed is a duplicate of another payment request being processed in the same check write cycle, based on the following parameters:</p> <p>INPATIENT (CLAIM TYPE 01): Same enrollee Same base provider ID Same from date of service Same thru date of service</p> <p>NURSING HOME (CLAIM TYPES 02 and 10): Same enrollee Same base provider ID Same from date of service Same thru date of service</p> <p>CORF (CLAIM TYPE 03 - PT 19): Same enrollee Same base provider ID Same from date of service Same thru date of service</p> <p>HOME HEALTH (CLAIM TYPE 03 - PT 58, 59, 94): (Edit 0301/1335) Same enrollee Same base provider ID</p>

Same from date of service
 Same thru date of service
 Any revenue codes that are the same are set to nopay

OUTPATIENT (CLAIM TYPE 03 - other than CORF and Home Health) without therapy revenue codes: (Edit 0301/1336)
 Same enrollee
 Same base provider ID
 Same from date of service
 Same thru date of service
 Same Patient Account Number
 Bypass edit if both claims have revenue code 450 - 459 (ER), both have valid admit hour, and the admit hours are different.
 Bypass edit for non-emergency claims if both claims have any of the revenue codes in value set "REVENUE MRI CODES", 'REVENUE CAT SCANS', or 'REVENUE PET SCANS'.
 Bypass edit for a combination of non-emergency and emergency claims if both claims have any of the revenue codes in value set "REVENUE MRI CODES", 'REVENUE CAT SCANS', or 'REVENUE PET SCANS'.

OUTPATIENT (CLAIM TYPE 03 - other than CORF and Home Health) with therapy revenue codes (42x, 43x, and 44x): (Edit 0301/1337)
 Same enrollee
 Same base provider ID
 Same from date of service
 Same thru date of service
 Same Patient Account Number
 Any therapy revenue codes that are the same are set to nopay

PERSONAL CARE (CLAIM TYPE 04):
 Same enrollee
 Same base provider ID
 Same from date of service
 Same thru date of service

PRACTITIONER - HEALTH DEPT. DRUGS (CLAIM TYPE 05 - PROV TYPE 51 - PROCEDURES J8499, 99070, B4000 - B9999): (Edit 0301/1349)
 Same enrollee
 Same base provider ID
 Same from date of service
 Same thru date of service
 Same procedure code
 Same procedure modifier (any of the modifiers are the same)
 Same billed charge

PRACTITIONER - HEALTH DEPT. OTHER (CLAIM TYPE 05 - PROV TYPE 51 - PROCEDURES NOT J8499, 99070, B4000 - B9999): (Edit 0301/1353)

Same enrollee

Same base provider ID

Same from date of service

Same thru date of service

Same procedure code

Same procedure modifier (any of the modifiers are the same)

- Bypass dupe check for procedures in Value set "Primary Diag/Procedure Bypass" if primary diagnoses are different

PRACTITIONER - ALL OTHER (CLAIM TYPE 05 - PROV TYPE NOT 51):

Same enrollee

Same base provider ID

Same from date of service

Same thru date of service

Same procedure code

Same procedure modifier (any of the modifiers are the same)

- Bypass dupe check for procedure E1399

- Bypass dupe check for procedures in Value set "Primary Diag/Procedure Bypass" if primary diagnoses are different

- Bypass dupe check for modifiers in Value set "MODIFIERS/PROCEDURE BYPASS" if any exist on the CIP or the PAC claim

PRACTITIONER - (CLAIM TYPE 05 -Procedure is Jcode): (Edit 0301)

Same enrollee

Different base provider id

Same from date of service

Same thru date of service

Same procedure code (same Jcode)

Same NDC

PHARMACY (CLAIM TYPE 06):

Same enrollee

Same base provider ID

Same NDC (1st 9 pos)

Same dispensed date

INDEPENDENT LAB (CLAIM TYPE 08):

Same enrollee

Same base provider ID

Same from date of service
Same thru date of service
Same procedure code
Same NDC (if procedure code is Jcode)

- Bypass dupe check for procedures in Value set "Primary Diag/Procedure Bypass" if primary diagnoses are different
- Bypass dupe check for modifiers in Value set "MODIFIERS/PROCEDURE BYPASS" if any exist on the CIP or the PAC claim

TITLE XVIII (CLAIM TYPE 09), XOVA (Institutional)
Same enrollee
Same base provider ID
Same from date of service
Same thru date of service
(Edit 301/301)

TITLE XVIII (CLAIM TYPE 09), OUTPATIENT (Bill Types are 12x, 13x, 14x, 19x, 22x, 23x, 30x, 31x, 32x, 33x, 34x, 37x, 43x, 54x, 57x, 62x, 64x, 71x, 72x, 73x, 74x, 75x, 76x, 77x, 79x, 82x, 83x, 84x, 85x, 86x, 89x, 90x)
XOVA (Institutional) VS XOVB (Professional)
Same enrollee
Same base provider ID
Same from date of service
Same thru date of service
Same Billed Charges (for XOVA, this is the revenue line billed charged)
This edit applies to both ways 1) current claim XOVA and history claim XOVB and 2) current claim XOVB and history claim XOVA
(Edit 301/1374)

TITLE XVIII (CLAIM TYPE 09), XOVB (Professional)
Same enrollee
Same base provider ID
Same from date of service
Same thru date of service
Same procedure code (Edit 301/1371) OR either current and/or history procedure code is blank and billed charges are equal (Edit 301/301)

- Bypass dupe check for procedure codes A0010, A0020, A0150, A0170, A0300 thru A0422
- Bypass dupe check for procedure codes A0425 - A0436 if FDOS is on or after 01/01/2001
- Bypass dupe check for procedures in Value set "Primary Diag/Procedure Bypass" if primary diagnoses are different

Same NDC (If procedure code is Jcode)

- Bypass dupe check for modifiers in Value set "MODIFIERS/PROCEDURE BYPASS" if any exist on the CIP or the PAC claim

DENTAL (CLAIM TYPE 11):

Same enrollee
Same base provider ID
Same from date of service
Same thru date of service
Same procedure code
Same tooth number
Same surfaces

- Bypass dupe check for tooth code 33
- Bypass dupe check for quadrant related procedure codes. These procedure codes are identified as those on the current Geofee File with a value in the quadrant field. See Value Set "Dental Quadrant Proc Code".
- Bypass dupe check for procedures in value set "Dental procs - Bypass edit 301" provided the ICN date is the same.

TRANSPORTATION (CLAIM TYPE 13):

Same enrollee
Same from date of service
Same thru date of service
Same base provider ID
Same procedure code

- Bypass dupe check for modifiers in Value set "MODIFIERS/PROCEDURE BYPASSCT13" if any exist on the CIP or the PAC claim

FEE CLAIMS (CAPITATION PAYMENT (CLAIM TYPE 15),
MANAGEMENT FEE (CLAIM TYPE 16),
ADMINISTRATIVE FEE (CLAIM TYPE 17)) :

Edit 301 will be set for a duplicate claim as they are system generated claims.
Same enrollee
Same base provider ID
From date of service in same month and year.

ASSESSMENTS (CLAIM TYPE 96):

Same enrollee
Same base provider ID
Same from date of service
Same thru date of service
Same procedure code

	<p>Same procedure modifier</p> <p>See Value Set "DENTAL QUADRANT PROC CODE", "PROC CODE - XOVB", "PROV. TYPE", "PROC CODE - CLAIM TYPE 05", "DENTAL PROCS - BYPASS EDIT 301" and "PRIMARY DIAG/PROCEDURE BYPASS".</p> <p>Different from current system: Some of the dupe logic is different.</p>
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General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	Y
Type	D	Priority	1	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy	Y	Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	v	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	

POS		DENY	
Encounter		6	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA420	Duplicate Check

Exceptions

All media types except dental for special batch and adjustments deny. Pend locations for CT 15 (for programs -01 and 07) have been changed to 225 for individual and mass adjustments as of 11/4/2004. For CT 16 (both programs), locations have been changed to 230 for individual and mass adjustments as of 11/4/2004.

Resolution

All Invoice Types:

Check for keying/scanning errors.

If errors are found in unprotected fields, correct the field entry.

If errors are found in protected fields, deny the pending payment request using code 098 and disposition indicator D.

Outpatient:

1. If the Julian dates are different and the diagnosis code is the same, deny using the ESC that pended and disposition indicator D.

2. If the Julian dates are the same, check the patient account number in block 3 of both payment requests.

If patient account numbers are the same, deny using the ESC that pended and disposition indicator D.

If patient account numbers are different, override using the ESC that pended and disposition indicator O.

Outpatient/Inpatient:

Check conflicting and pending payment requests for type of service (procedure codes, ancillaries)

1. If type of service is different, override using the ESC that pended and disposition indicator O.

2. If type of service is the same, check for attachment or remarks for justification of the duplicate.

Example:

The provider is charging for two outpatient visits on the same day and states that the patient was seen at two different times.

Look for any other justifiable reason to pay the duplicate.

If justification is found, override using the ESC that pended and disposition indicator O.

If justification is not found, deny using the ESC that pended and disposition indicator D.

Practitioner:

Check for attachment/remarks for justification of the duplicate.

Example:

The provider is charging for two office visits on the same day and states that the patient was seen at two different times.

Look for any other justifiable reason to pay the duplicate.

1. If justification is found, override using the ESC that pended and disposition indicator O.
2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Independent Lab:

Review the lab invoice for remarks that give justification for the duplication, such as two tests on the same day.

1. If justification is found, override using the ESC that pended and disposition indicator O.
2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Title XVIII:

Look for documentation to justify billing.

1. If justification is found, override using the ESC that pended and disposition indicator O.
2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Dental:

If IC requested, check for remarks/documentation for justification of duplicate (same tooth X-rayed, Same tooth filled on same day).

1. If justification is found, override using the ESC that pended and disposition indicator O.
2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Transportation:

Review the documentation to determine if there was a valid reason for two trips on the same day.

Example:

Two one-way trips with the destination and pickup points reversed.

Pickup and destination points are different on the two payment requests.

Two visits necessary on the same day.

Destination is different.

Destination is the same but remarks explain reason for two trips.

1. If justification is found, override using the ESC that pended and disposition indicator O.
2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Edit/Audit Inquiry Results Edit-302 ESC-302

Edit Information

Edit Number	302	esc Number	302	NCPDP Code	83
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Short Desc	Duplicate of History File Record - Same Provider, Same DOS				
Long Desc	Duplicate of History File Record, Same Provider, Same Dates of Service				
Edit Criteria	<p>This edit is set when the payment request being processed is a duplicate of a payment request from a previous check write cycle.</p> <p>See Edit 301/301 for edit criteria.</p> <p>PA Criteria does exist for Pharmacy, which allows for a PA to be entered for this edit for pharmacy</p>				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	Y
Type	H	Priority	1	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy	Y	Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		DENY	
Encounter		6	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

All media types except dental for special batch and adjustments deny.

Resolution

All Invoice Types:
 Check for keying/scanning errors.
 If errors are found in unprotected fields, correct the field entry.
 If errors are found in protected fields, deny the pending payment request using code 098 and disposition indicator D.

Outpatient:
 1. If the Julian dates are different and the diagnosis code is the same, deny using code 0302 and disposition indicator D.
 2. If the Julian dates are the same, check the patient account number in block 3 of both payment requests.
 If patient account numbers are the same, deny using the ESC that pended and disposition indicator D.
 If patient account numbers are different, override using the ESC that pended and disposition indicator O.

Outpatient/Inpatient/Nursing Home:
 Check conflicting and pending payment requests for type of service (procedure codes, ancillaries)
 1. If type of service is different, override using the ESC that pended and disposition indicator O.
 2. If type of service is the same, check for attachment or remarks for justification of the duplicate.

Example:

The provider is charging for two outpatient visits on the same day and states that the patient was seen at two different times.

Look for any other justifiable reason to pay the duplicate.

3. If justification is found, override using the ESC that pended and disposition indicator O.
4. If justification is not found, deny using the ESC that pended and disposition indicator D.

Practitioner:

Check for attachment/remarks for justification of the duplicate.

Example:

The provider is charging for two office visits on the same day and states that the patient was seen at two different times.

Look for any other justifiable reason to pay the duplicate.

1. If justification is found, override using the ESC that pended and disposition indicator O.
2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Independent Lab:

Review the lab invoice for remarks that give justification for the duplication, such as two tests on the same day.

1. If justification is found, override using the ESC that pended and disposition indicator O.
2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Title XVIII:

Look for documentation to justify billing.

1. If justification is found, override using the ESC that pended and disposition indicator O.
2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Dental:

If IC requested, check for remarks/documentation for justification of duplicate (same tooth X-rayed, Same tooth filled on same day).

1. If justification is found, override using the ESC that pended and disposition indicator O.
2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Transportation:

Review the documentation to determine if there was a valid reason for two trips on the same day.

Example:

Two one-way trips with the destination and pickup points reversed.

Pickup and destination points are different on the two payment requests.

Two visits necessary on the same day.

Nature of the emergency.

Destination is different.

Destination is the same but remarks explain reason for two trips.

1. If justification is found, override using the ESC that pended and disposition indicator O.
2. If justification is not found, deny using the ESC that pended and disposition indicator D.

Edit/Audit Inquiry Results Edit-303 ESC-303

Edit Information

Edit Number	303	esc Number	303	NCPDP Code	
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Short Desc	Limitation - Once in a Lifetime
Long Desc	Frequency Limitation Exceeded
Edit Criteria	<p>This edit is deleted - criteria included in edit 825.</p> <p>For Dental (claim type 11): This limitation audit sets when a once-in-a-lifetime procedure code is billed a second time for the same tooth code.</p> <p>Once-in-a-lifetime procedures are: 01330 Patient Education 01340 Patient Education 01351 Sealant, per tooth 07110 Initial Extraction 07120 Additional Extractions 07130 Root Removal 07250 Surgical Removal of Roots</p>

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	

Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-304 ESC-304

Edit Information

Edit Number	304	esc Number	304	NCPDP Code	
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Short Desc	Procedure Related to Approved Major Procedure
Long Desc	Procedure Related to Approved Major Procedure
Edit Criteria	<p>This edit is used by Pend Resolution to deny a physician claim that is covered under the facility reimbursement and should be billed to the facility.</p> <p>Search for an existing claim when the current claim has a procedure of 90785. The existing claim will have to have the same enrollee, service provider, date of service, and one of the CPT codes associated with 90785. The existing claim must be in a paid or to be to be paid status. If a claim is not found, set an error 0304.</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch		DENY	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-305 ESC-305

Edit Information

Edit Number	305	esc Number	305	NCPDP Code	
Short Desc	Services Not Authorized				
Long Desc	Services Not Authorized				
Edit Criteria	<p>This edit has been deleted, see edit 415. For Inpatient (claim type 01), if a payment request for provider class type = 04 (long stay hospital not MH) and from date of service > 12/31/92 has no coverage on the Enrollee File (level of care = 4) for the date of service, set the edit.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health	Y	Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA100	Adjudication Controller

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-306 ESC-306

Edit Information

Edit Number	306	esc Number	306	NCPDP Code	
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Short Desc	Services Not Justified				
Long Desc					
Edit Criteria	This edit is combined with 409 (Medical justification not indicated on claim type), and is deleted from the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-307 ESC-307

Edit Information

Edit Number	307	esc Number	307	NCPDP Code	66
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Short Desc	Enrollee Age 21 or Older				
Long Desc	Drug Not Covered for Enrollee's Age 21 or Older				
Edit Criteria	For Pharmacy (claim type 06), if the NDC's drug service limit on the Medical and Administrative Codes Database = 5, and the enrollee's age is >= 21, set the edit.				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	G	Priority	2	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy	Y	Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		DENY	
Encounter		2	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
VPTM1DRG	POS Pharmacy Claims Drug Edits Process

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-308 ESC-308

Edit Information

Edit Number	308	esc Number	308	NCPDP Code	81
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Short Desc	Payment Request Filed After 1 Yr Limit Not Justified
Long Desc	Your payment request was filed past the filing time limit without acceptable documentation.
Edit Criteria	<p>Bypass the edit if the payment request is an adjustment or void or reprocess of denied claims.</p> <p>If the claim type is older than 1 year (determined by subtracting the Julian thru date of service of the payment request from the Julian date of the reference number. For Pharmacy POS claims, the current date is used to compare to the Julian thru date of service (Fill Date) since the claim's reference number is not yet assigned for this edit process):</p> <p>1) If a Dental payment request (claim type 11) and the provider requested no Individual Consideration (attachment indicator not = Y), set the edit.</p> <p>2) If a Practitioner payment request (claim type 05) and any procedure modifier not = 22 or 99 (individual consideration) and there is no attachment, set the edit. See value set, ATTACH DISP PROC MODS</p> <p>3) For all other claim types, if there is no attachment, set the edit.</p> <p>NOTE: For Encounters (ICN media = 9), edit is set if older than 180 days instead of 1 year.</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	Z	Priority	1	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
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FAMIS	Y	Assessments	Y		
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Claim Type

Dental	Y	Pharmacy	Y	Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	100	PEND	
		DENY	
EMC	100	PEND	
		DENY	
Adjustment	100	PEND	
		DENY	
POS		DENY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
VPTM1DRG	POS Pharmacy Claims Drug Edits Process
CPA012	UB92 Edits

Exceptions

All TDO UB claim types that pend will pend to LOC 320 and HCFA claim types will pend to LOC 319. All SLH UB claim types that pend will pend to LOC 308 and HCFA claim types will pend to LOC 310. Pend for Capitation, Management, Admin Fees, and Assessments. Pharmacy paper will pend to location 100 if there is an attachment. New dental encounter disposition as of July 1st, 2005 is 6.

Resolution

All Invoice Types:

All Claim Types:

1. Check for keying/scanning errors.

If errors are found in unprotected fields, correct the field entry.

If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.

2. For inpatient services, check Provider Type field. If Provider Type is 85 or 91 (out-of-state hospital), repond to DMAS LOC 333.

3. Check attachment for reasons listed below:

Example:

Acceptable documented evidence that the provider has submitted a payment request within the last twelve months from the date of service.

Payment request is stamped by DMAS to waive timely filing.

Provider has had payment requests rejected during the first twelve months.

Documented case of delayed recipient eligibility (dated letter from social services.) Payment request must be filed within one year of the date on the letter. If payment request is more than one year beyond the date of the letter, deny using code 0308 and disposition indicator D. If letter is not dated, deny using code 0308 and disposition indicator D.

If provider states recipient eligibility is retroactive, but there is no dated letter, deny using code 0457 and disposition indicator D.

Documented case of delayed provider enrollment.

If justification is found, override using code 0308 and disposition indicator O.

If justification is not found, deny using code 0308 and disposition indicator D.

4. If attachment does not meet the requirements listed above, choose CHIRP. Enter the provider number, procedure code and date of service. Check the results to determine whether the claim has been submitted previously.

If the claim was submitted within 12 months from the date of service, override the edit with 0308 and disposition indicator O.

If the claim was not submitted within 12 months from the date of service, deny using code 0308 and disposition indicator D.

Edit/Audit Inquiry Results Edit-309 ESC-309

Edit Information

Edit Number	309	esc Number	309	NCPDP Code	
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Short Desc	Services Not Covered
Long Desc	Services Not Covered
Edit Criteria	<p>For Medicaid/FAMIS: For Inpatient (claim type 01), if any of the Medical and Administrative Codes flags = 999 and the procedure code is in the ICD-9 value set 21005 (ALCOHOL/DRUG REHAB/DETOX) for ICD-9 claims, and the payment request provider type does not = 001, 003, 007, 077, or 091, set the edit. Bypass this part of the edit if a PA is required OR the enrollee is a non-resident alien, benefit package = 01-01-3000 or 01-01-3001 OR the bill type is 113 or 114 and the enrollee's age is > 20 and the provider type is 001. If the procedure code does not = '94600' thru '94699' and if any of the Medical and Administrative Codes flags = 999, set the edit.</p> <p>For FAMIS MCO with service date > 12/01/01: If enrollee is in an HMO (sub-program 03 or 04), the benefit program code is 07 (FAMIS) and the procedure code is flagged FS, set the edit. The following procedure codes are currently flagged FS on the RF_PROC_FLAG_CODES table: Z8503 (S4353), Z8505 (S4333), Z8507 (S4332), Z8510 (S4334), Z8512 (S4330), Z8516 (S4368), Z8998 (S4340), Z9986 (S4357), Z9987 (S4338), Z8997 (H0015), Z8994 (H0018), H0039, H0046, H2017, and H2019.</p> <p>For Outpatient and Home Health (claim type 03), Personal Care (claim type 04), Practitioner (claim type 05), Nursing Home (claim types 02, 10), Dental (claim type 11), or Laboratory (claim type 08): If the any of the Medical and Administrative Codes Database flags = 999, set the edit. . Bypass this part of the edit if CT = 01, 02, 03, 04, 05, 08, 10 and aid category is in value set "Aid Categories – Finance Pgm 10" and pgm is Medicaid and enrollee is not in an HMO and procedure has flag "999" and flag "EEE". This is bypass for Medicaid Expansion.</p> <p>For Transportation (claim type 13): 1) If the procedure code does not = Y0121 and the from date of service is >= 4/01/98, and if the enrollee is a nursing home enrollee and the nursing home provider is in one of the locality codes = 027, 051, 105, 167, 169, 185, 195 or 720, set the edit. If the enrollee is not a nursing home enrollee, but the enrollee is in one of the locality codes</p>

= 027, 051, 105, 167, 169, 185, 195 or 720, set the edit.

2) If the payment request is from a registered driver (procedure code Y0115 or Y0116), and the from date of service is > 09/30/91, the mileage rate is obtained from the Medical and Administrative Codes Database using the procedure code A0080. If any of the flags = 999, set the edit.

3) If from date of service is >= 10/01/2009 and any of the medical and administrative codes flag = 999.

- If the enrollee is GAP (Aid Category 087 – see Value Set GAP AID CATGS (#1036) and claim form is “UB92”, the following is covered; for any other “UB92”, set the edit:

- CT 03 with Bill Type 131 (See Value Set GAP OUTPAT BILL TYPES (#1034), Provider Type 001 or 091 (See Value Set GAP OUTPAT PROV TYPES(#1033)), and all revenue line procedure codes in Value Set GAP OUTPAT PROC CODES (#1031).

- If the enrollee is GAP (Aid Category 087 – see Value Set GAP AID CATGS (#1036) and claim form is “UB92”, set the edit the condition below:

- CT 03 with Bill Type 131 (See Value Set GAP OUTPAT BILL TYPES (#1034) and Provider Type 001 or 091 (See Value Set GAP OUTPAT PROV TYPES (#1033)) and any of the facility line Revenue Code is ‘0450’ (See Value Set GAP NON COVERED REV CODES (#1037).

- If the enrollee is GAP (Aid Category 087 – see Value Set GAP AID CATGS (#1036)) and claim form is “HCFA”, the following are covered; for any other “HCFA”, set the edit:

- CT 08
- CT 05, PT 062 or 090 (See Value Set GAP DME PROVIDER TYPES (#1026)), and Procedure Code in Value Set GAP DME PROC CODES (#1027)
- CT 05
 - PT 020, 023, 030, 031, 051, 052, 053, 078, 093, 095, 097, or PT/Spec 040/080 (See Value Set GAP PRACTITIONER PROV TYPES (#1028))
- and
- POS 11, 12, 50, 53, 71, 72 (See Value Set GAP PRACTITIONER POS (#1029))
- and
- Procedure Code is not in Value Set GAP RESTRICTED PROC CODES (#1030)
- CT 05
 - PT 020, 023, 030, 031, 051, 052, 053, 078, 093, 095, 097, or

PT/Spec
 040/080 (See Value Set GAP PRACTITIONER PROV TYPES
 (#1028))
 and
 - POS 19, 22 (See Value Set GAP OUTPAT POS (#1038))
 and
 - Procedure Code is in Value Set GAP OUTPAT PROC CODES
 (#1031)

For SLH/TDO for revenue codes and ICD procedures:
 If the enrollee's aid category is 001, 002, 003, or 004 (the enrollee is SLH) and the revenue or ICD procedure Procedure Table flag is not = SLH, set the edit. Also, for SLH enrollees, if the claim type is 02, 04, 08, 09, 10, 11, or 13, set the edit.
 If the enrollee's aid category is 203, 213, 215, 217, or 225 (the enrollee is TDO) and the revenue or ICD procedure Procedure Table flag is not = TDO, set the edit. Also, for TDO enrollees, if the claim type is 02, 04, 10, or 11, set the edit.
 If provider class type = '046' (Hospice) and enrollee's LOC not equal to 'D' (Hospice), set the edit.
 *** With implementation of EWO 2008-100-001-M the following statement no longer applies.
 If the enrollee's exception indicator is T, but the servicing provider's type is not 079 and the servicing provider's speciality is not 105, then set the edit.

 *** With implementation of EWO 2010-270-001-M, the following applies for the claims with Claim Types 05 (HCFA Practitioner) or 09 (XOV Title 18 – Part B) and dates of service of 10/01/2010 or greater
 The edit is set to Deny if the procedure code is 99406 or 99407 and diagnosis code is not in either of the following
 • ICD-9 value set 892 (PREGNANCY DIAGNOSIS) or ICD-10 value set 20288 (ICD-10 Pregnancy Diag Codes)
 The edit is bypassed if the claim contains
 • Procedure code 99406 or 99407 and diagnosis codes is in ICD-9 value set 892 (PREGNANCY DIAGNOSIS) or ICD-10 value set 20288 (ICD-10 Pregnancy Diag Codes)
 Only Immunization Procedures (see value set FAMIS SELECT IMMUNIZATION) are covered for FAMIS SELECT enrollees. FAMIS SELECT enrollees are in benefit program 07- 01- 0500. If an enrollee is in this benefit program and a procedure other than immunization is submitted for DOS > 7/31/2005, set the edit.
 The edit is bypassed for ESHI enrollees (see value set ESHI) for the period of 08/01/2005 thru 01/31/2006.

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy		Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A		Xover B	
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

Pend for Capitation, Management, Admin Fees, and Assessments. New dental encounter disposition as of July 1st, 2005 is 8.

Resolution

(None)

Edit/Audit Inquiry Results Edit-310 ESC-310

Edit Information

Edit Number	310	esc Number	310	NCPDP Code	
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Short Desc	This Service Covered by Medicare				
Long Desc	This service is covered fully by Medicare.				
Edit Criteria	<p>Bypass the edit if the payment request's COB code = 85.</p> <p>For Outpatient (claim type 03):</p> <p>1) If the principal procedure code = 3995 or 5498 (renal dialysis) and the enrollee's premium indicator (C_PREMIUM_IND from the RS_ENROL_BENDEX using person id) = 2 (receiving Medicare, eligible for state buyer) and the TPL liability code = A or Y (Medicare part A), set the edit. See also edit 230 (2)</p> <p>2) If the principal procedure code is not = 3995 or 5498 and the enrollee's premium indicator (C_PREMIUM_IND from the RS_ENROL_BENDEX using person id) = 2 (receiving Medicare - eligible for state buyer) and the TPL liability code = A or Y (Medicare part A) and one of the revenue codes = 820 - 859 (charge for dialysis), set the edit. See also edit 230 (3)</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	T	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	Y

Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		TEST	
		TEST	
EMC		TEST	
		TEST	
Adjustment		TEST	
		TEST	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA330	UB04 Service/PA Edit

Exceptions

On 5/7/2000, the disposition was changed from deny to test with an effective date of 07/01/2000 except for special batch.

Resolution

(None)

Edit/Audit Inquiry Results Edit-311 ESC-311

Edit Information

Edit Number	311	esc Number	311	NCPDP Code	
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Short Desc	Enrollee Less Than Minimum Age				
Long Desc	Procedure code billed not compatible with enrollee's age.				
Edit Criteria	<p>This edit is no longer valid and is not included in the new MMIS. Consolidated with Edit 211</p> <p>If the enrollee's age is less than the minimum age for the procedure (checked against the Medical and Administrative Codes Database), and there is no attachment, set the edit.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-312 ESC-312

Edit Information

Edit Number	312	esc Number	312	NCPDP Code	
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Short Desc	Enrollee Greater Than Maximum Age				
Long Desc	Procedure code billed not compatible with enrollee's age				
Edit Criteria	<p>This edit is no longer valid and is not included in the new MMIS. Consolidated with Edit 212.</p> <p>If the enrollee's age is greater than the maximum age for the procedure (checked against the Medical and Administrative Codes Database), and there is no attachment, set the edit.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-313 ESC-313

Edit Information

Edit Number	313	esc Number	313	NCPDP Code	41
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Short Desc	Bill Any Other Available Insurance
Long Desc	Enrollee is covered by private insurance, refer to third party information of this R/A.
Edit Criteria	<p>The edit is bypassed if</p> <ol style="list-style-type: none"> 1) the enrollee's TPL type of coverage = U (absent parent) OR 2) one of the procedure code flag indicators is = 90 OR 3) one of the procedure code flag indicators is = 91 and the first diagnosis on the payment request is in the ICD-9 value set 172 (BYPASS DIAGNOSIS CODES) or ICD-10 value set 20288 (ICD-10 Pregnancy Diag Codes) OR 4) the first diagnosis on the payment request is in the ICD-9 value set 21004 (ICD-9 DX ROUTINE CHILD HEALTH) or ICD-10 value set 22004 (ICD-10 DX ROUTINE CHILD HEALTH) and one of the procedure modifiers is an EPSDT modifier (H, K, T, U, W, Y or Z) 5) the procedure code's first position is Z or Y (except Y0110, Y0111, or Y0112). 6) the claim type is 05, the provider type is 072, and the procedure is in Value Set entry School Rehab Services. 7) the Procedure Code is found in the "State Plan Options Services" Value Set. 8) For Hospital Inpatient, Hospital Outpatient and Crossover A (claim type 01, 03, 09A) if the other coverage is only Pharmacy or Dental (TPL type coverage is 'R' or 'D'). <p>For Transportation (claim type 13): If there is no payment from the primary carrier and the COB code = 2 and the procedure code = Y0110 and the TPL type of coverage code = M, set the edit.</p> <p>For Title 18 (claim type 09): If the TPL type of coverage = A, B, Y, or Z and there is also coverage type H, K, L, M, N, P, or S and there is no payment from the primary carrier and the COB code = 2, set the edit.</p> <p>For Outpatient (claim type 03): For a Hospice claim defined as Provider Type 046, enrollee exception of 'D', and Bill Type 83X, set the edit if the Primary Carrier Payment Amount = 0, there is any</p>

coverage other than Medicare Part A or B for the dates of service, and the COB code is 82.

For claims other than Hospice defined as Provider Type 046, enrollee exception of 'D', and Bill Type 83X, if there is coverage other than Medicare (TPL not = B/Z) and there is no payment from the primary carrier, set the edit.

For Practitioner and Laboratory (claim types 05 and 08):

If there is coverage other than Medicare (TPL not = B/Z) and any of the TPL coverage's match the procedure code's TPL coverage codes and there is no payment from the primary carrier, set the edit.

For Inpatient (claim type 01):

For a Hospice claim defined as Provider Type 046, enrollee exception 'D', and Bill Type of 82X, set the edit if the Primary Carrier Payment Amount = 0, there is any coverage other than Medicare Part A and B for the dates of service, and the COB code is 82.

For a claim that is not Hospice claim defined as Provider Type 046, enrollee exception 'D', and Bill Type of 82X, if the TPL type of coverage is not = A/Y or B/Z, but there are other TPL types of coverage and the COB = 82 and there is no payment from the primary carrier, set the edit.

For SNF (claim type 02):

If there is TPL coverage other than A/Y, the COB = 82, there is no payment from the primary carrier, the provider type is 10 or 15, and the enrollee exception indicator = 2, set the edit.

For Pharmacy (claim type 06):

If the enrollee has other pharmacy coverage (TPL type = R) and the payment request other coverage code = 0 (Not Specified) and the payment request TPL amount is > 0, set the edit.

If the enrollee has other pharmacy coverage (TPL type = R) and the payment request other coverage code = 1 (No Other Coverage Identified) and the payment request TPL amount = 0, set the edit.

If the payment request other coverage code = 4 (Other Coverage Exists, Payment Not Collected) and the payment request TPL amount = 0, set the edit.

If the enrollee is Medicare Part D eligible (TPL type = RD), with the NDC excluded on benefit master (INCL/EXCL = X), and payment request other coverage code = 1 (No Other Coverage Identified), set the edit.

For Dental (claim type 11):

If the payment request other coverage code = 'Y' and the payment request TPL

amount = 0, set the edit.

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	T	Priority	4	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental	Y	Pharmacy	Y	Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp
Paper		DENY
		DENY
EMC		DENY
		DENY
Adjustment		DENY
		DENY
POS		DENY
Encounter		0
Special Batch	217	PEND
PA		

Programs

Program	Program Title
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CPA032	TPL Edits
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Exceptions

Dental (Claim Type 11) will pend to LOC 200 with attachments. New dental encounter disposition as of July 1st, 2005 is 8.

Resolution

Edit 0313

Dental:

Dental claims setting edit 0313 pend because there is no place for the provider to enter TPL on one of the new dental forms. An EOB from the insurance carrier should be attached. Review the attachment:

1. If attachment is not an EOB deny the claim with 0313 and disposition D.
2. If attachment is an EOB, enter the TPL payment amount manually on the pend screen and release the claim by choosing Adjudication. Do not override the edit.

Edit/Audit Inquiry Results Edit-314 ESC-314

Edit Information

Edit Number	314	esc Number	314	NCPDP Code	
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Short Desc	Benefits Exceeded; Resubmit for 14 Days				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-315 ESC-315

Edit Information

Edit Number	315	esc Number	315	NCPDP Code	
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Short Desc	Unlisted Procedure; Not Explained				
Long Desc	Unlisted Procedure; Not Explained				
Edit Criteria	<p>For Practitioner (claim type 05), Dental (claim type 11), and Independent Lab (claim type 08):</p> <p>In pricing procedures, if there is no area fee (either from the Medical and Administrative Codes Database or from the PA File), the Medical and Administrative Codes Database fee indicates Individual Consideration, the procedure code ends in '99' (except for procedure code '28299'), and there is no attachment, set the edit.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	Y
Transportation		Xover A		Xover B	
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		N/A	
		DENY	
EMC		N/A	
		DENY	
Adjustment		N/A	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA044	ADA Pricing

Exceptions

Pend for Capitation, Management, Admin Fees, and Assessments.

Resolution

(None)

Edit/Audit Inquiry Results Edit-1123 ESC-316

Edit Information

Edit Number	1123	esc Number	316	NCPDP Code	
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Short Desc	Maximum Payment Previously Made				
Long Desc	Maximum Payment Previously Made				
Edit Criteria	<p>This edit can be used by Pend Resolution to deny a payment request that pended for 201 or 202 if tech does not want to use 201 or 202 .</p> <p>The following criteria is deleted for edit 0316/0316. The situation is covered by dupe checks and edits 0740/0740, 0740/3253, 0740/3254, and 0740/3255.</p> <p>Also, for Practitioner (claim type 05):</p> <p>1 - If the current activity payment request is for an X-ray service (procedure codes 70000-79999) and has the same procedure code and the same from and thru dates of service as a history payment request and full payment of the history procedure has previously been made (that is, no history procedure code modifier is equal to 26 (professional component) or TC (technical component)), then set the edit on the activity payment request.</p> <p>2 - If the procedure code modifiers of the activity payment request indicate that the payment request is for full payment of the procedure (that is, no activity procedure code modifier is equal to 26 or TC), and both components have been paid previously, set the edit on the activity payment request.</p>				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	Y
Transportation		Xover A		Xover B	
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch		DENY	
PA			

Programs

(None)

Exceptions

Pend for Capitation, Management, Admin Fees, and Assessments.

Resolution

(None)

Edit/Audit Inquiry Results Edit-317 ESC-317

Edit Information

Edit Number	317	esc Number	317	NCPDP Code	
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Short Desc	Pre-authorization Required/ MD to Justify				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-318 ESC-318

Edit Information

Edit Number	318	esc Number	318	NCPDP Code	65
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Short Desc	Enrollee Not Eligible on DOS
Long Desc	Enrollee Not Eligible on DOS
Edit Criteria	<p>For all claim types except Medicaid, FAMIS claim type 01 and provider class types 01 (Hospital), 03 (Private Mental Hospital), 07 (State MH under 21), 77 (Residential Treatment Center), or 91 (Out of State Hospital) and admission date > 6/30/96, SLH claim type 01, provider type 01 or 91 with admission date after the system live date and Medicare inpatient, if the payment request is an original payment request and the enrollee is not eligible during the from and thru dates of service, set the edit.</p> <p>For Medicaid, FAMIS claim type 01(Inpatient), provider class types 01 (Hospital), 03 (Private Mental Hospital), 07 (State MH under 21), 77 (Residential Treatment Center), or 91 (Out of State Hospital) and admission date > 6/30/96 and Medicare inpatient, if the enrollee is eligible for only part of the from and thru dates of service, then the number of payment days is cutback to the days eligible and EOB 638 is set. If there are no eligible days, including the last day, set edit 0318; if the enrollee is eligible on the last day and the bill type = 111 or 116, set EOB 640 and pay for zero days.</p> <p>If the admission date > 6/30/96 and the enrollee's age is > 20 and the type of bill = 113 or 114 and the provider type = 01 or 91, pay for zero days regardless of full or partial eligibility.</p> <p>If the admission date > 12/31/99 and the type of bill = 113 or 114 and the provider type = 01 or 91, pay for zero days regardless of full or partial eligibility.</p> <p>If the admission date > 12/31/99 and the primary diagnosis = rehab (ICD-9 value set 147 (REHAB CLAIM) or ICD-10 value set 20147 (ICD-10 REHAB DIAG)) and the provider type = 14 or 85 and there is a valid PA and the type of bill = 113 or 114, pay the calculated amount; else pay zero.</p> <p>If the admission date > 12/31/99 and the primary diagnosis = psych (ICD-9 value set 314 (DIAG CODE PSYCH CLAIM) or ICD-10 value set 20314 (ICD-10 DIAG CODE PSYCH CLAIM)) and the enrollee's age < 21 and the type of bill = 113 or 114, pay the calculated amount; else pay zero.</p> <p>For SLH payment requests: For claim type 01(Inpatient), provider class types 01 (Hospital) or 91 (Out of State Hospital) and admission date > the system live date, processing is same as for Medi-</p>

caid and FAMIS claim type 01, provider types 01 and 91.
 Otherwise, If the payment request is an original and has recycled for more than 60 days (determined by comparing the current cycle date to the payment request's activity date which holds the first pend date) and the enrollee is still not eligible on the dates of service, set the edit. If the enrollee eligibility segment is not found on the Enrollee Datastore, set the edit.

When edit 0318 is set, move the coverage expiration date (set from the Last Cancel Date) to the AWR file.

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	R	Priority	2	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy	Y	Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	

Adjustment		DENY	
		DENY	
POS		DENY	
Encounter		8	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
VPTM1RCP	POS Pharmacy Claims Enrollee Edits Process
CPA100	Adjudication Controller

Exceptions

SLH has recycle days = 60 and will pend to location 600 the first time this edit is done. After recycling for 21 days, if the edit is set, it will set one of the above dispositions. Pend for Capitation, Management Fees, and Assessments. Deny for Administrative Fees (claim type 17). As of July 1st, 2005, dental encounter severity is changed to 8.

Resolution

Claim Type 17
 Claims that pend for CT 17 (CMM) or (Pharmacy Admin Fees) are to be denied.
 Deny 0318 D for Claim Type 96 (updated 10/25/07).

Edit/Audit Inquiry Results Edit-319 ESC-319

Edit Information

Edit Number	319	esc Number	319	NCPDP Code	
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Short Desc	Enrollee Cancelled				
Long Desc	Enrollee Cancelled				
Edit Criteria	<p>This edit is deleted since it is covered by edit 0318.</p> <p>For all claim types except claim type 01, provider class types 01 (Hospital), 03 (Private Mental Hospital), 07 (State MH under 21), or 91 (Out of State Hospital) and admission date > 6/30/96, if the payment request is an original payment request and the enrollee was cancelled during the from and thru dates of service, set the edit.</p> <p>For claim type 01, provider class types 01 (Hospital), 03 (Private Mental Hospital), 07 (State MH under 21), or 91 (Out of State Hospital) and admission date > 6/30/96, if the payment request is an original payment request and the enrollee was cancelled prior to the from and thru dates of service, set the edit.</p> <p>For claim type 01(Inpatient), provider class types 01 (Hospital), 03 (Private Mental Hospital), 07 (State MH under 21), or 91 (Out of State Hospital) and admission date > 6/30/96, if the enrollee is eligible for only part of the from and thru dates of service, then the number of payment days is cutback to the days eligible and EOB 638 is set. If the type of bill is 111,112,113, & 114 and there are no eligible days, including the last day, set edit 0318; if the enrollee is eligible on the last day, set EOB 640 and pay for zero days.</p> <p>For SLH payment requests: If the payment request is an original and has recycled for more than 60 days (determined by comparing the current cycle date to the payment request's activity date which holds the first pend date) and the enrollee is still cancelled on the dates of service, set the edit.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	

Type	Priority	Recycle Days	0
HIPAA esc	CutBack Ind		

Program Indicators

Medicaid	SLH	TDO
FAMIS	Assessments	

Claim Type

Dental	Pharmacy	Inpatient
Nursing	Home Health	Outpatient
Physician	Personal Care	Laboratory
Transportation	Xover A	Xover B
Cap Pay	Man Fee	Admin
Asmt Fee		

Date Information

Effective Date Code	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp
Paper		
EMC		
Adjustment		
POS		
Encounter		
Special Batch		
PA		

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-320 ESC-320

Edit Information

Edit Number	320	esc Number	320	NCPDP Code	40
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Short Desc	EAPG NCCI PTP EDIT
Long Desc	EAPG NCCI PTP EDIT
Edit Criteria	<p>This is a Medicaid NCCI Procedure Edit (PTP) executed by the EAPG software. The edit will set on the current claim if the procedure code on the history claim and the procedure code on the current claim exist as an active edit code pair on the CMS NCCI file stored in the EAPG software.</p> <p>The column 1 claim will pay and the column 2 claim will deny. If the column 2 claim was previously paid, it will be voided and flagged with an adjustment reason code of 1197.</p> <p>Claim Adjudication Algorithm</p> <p>(1) Apply edits to services by same provider to same member on same date of service.</p> <p>(2) Determine whether type of claim and site of service are subject to NCCI PTP edits.</p> <p>(a) For practitioner claims regardless of site of service, use Practitioner NCCI PTP edit file.</p> <p>(b) For ambulatory surgical center claims with Provider Type 049, use Practitioner NCCI PTP edit file.</p> <p>(c) For outpatient hospital claims, use Outpatient Hospital Services NCCI PTP edit file.</p> <p>(d) For facility (hospital) emergency department, observation, and hospital laboratory services claims, use Outpatient Hospital Services NCCI PTP edit file.</p> <p>(3) For each HCPCS/CPT code submitted on a claim identify all other HCPCS/CPT codes submitted on current claim or earlier claims in history with the same date of service for the same provider and same member. This is subset of HCPCS/CPT codes for each code that needs to be tested against the NCCI procedure-to-procedure edit files.</p> <p>(a) For each code in the subset, use it as a column one code and pair it with every other code in the subset as a column two code. Each code is paired with every other code as both column one and column two codes. (Note that this method identifies code pairs such that each code as a column one code is paired with every other code as a column two code AND each code as a column two code is paired with every other code as a column one code.) Determine whether any of these code pairs match any of the code pair edits in the appropriate NCCI PTP edit file for the relevant site of service.</p>

	<p>(b) After code pairs that match NCCI PTP edits in the edit file are identified, test date of service against the effective date and deletion date (if relevant) for each edit. Apply NCCI PTP edit to claim only if the date of service is “on or after” the effective date and “on or before” the deletion date of the edit. Most edits do not have deletion dates.</p> <p>(c) After code pairs that match NCCI PTP edits in the edit file with dates of service within the effective period of the corresponding edit are identified, determine whether an NCCI-associated modifier is appended to either or both of the codes of the code pair. Proceed as follows:</p> <p>(i) If modifier indicator of edit is “1”, the column two code is eligible for payment only if an NCCI-associated modifier is appended to either code of the edit pair. That is, the edit is bypassed and both the column one and column two codes are eligible for payment.</p>
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General Indicators

Reject Ind		Deny Ind	Y	Override Ind	N
PrtRA Ind	Y	PA Override Ind	N	Compound Ind	
Type	S	Priority	0	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments	Y		

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	Y
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	

EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS			
Encounter			
Special Batch		DENY	
PA			

Programs

CPA416VA	CPA416CI	CPA417VA
CPA417CI		

Exceptions

DENY is changed to EOB for Outpatient claims by program CPA417CI and CPA417VA

Resolution

(None)

Edit/Audit Inquiry Results Edit-321 ESC-321

Edit Information

Edit Number	321	esc Number	321	NCPDP Code	
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Short Desc	DELETED Enrollee Under 65 Not Covered for NM/TB				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS. It is included in edit 118.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-322 ESC-322

Edit Information

Edit Number	322	esc Number	322	NCPDP Code	
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Short Desc	DELETED-HIB Number on EOMB Does Not Match Payment Request				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-323 ESC-323

Edit Information

Edit Number	323	esc Number	323	NCPDP Code	40
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Short Desc	EAPG NCCI MUE EDIT
Long Desc	EAPG NCCI MUE EDIT
Edit Criteria	<p>This is a Medicaid NCCI Medically Unlikely Edit (MUE) executed by the EAPG software. The edit will set on the current claim if the units for the procedure code are greater than the allowed units found on the CMS NCCI file stored in the EAPG software.</p> <p>Claim Adjudication Algorithm</p> <ol style="list-style-type: none"> (1) Apply edits to services by same provider/supplier for same member on same date of service. (2) Determine whether type of claim and site of service are subject to MUE edits. <ol style="list-style-type: none"> (a) For practitioner claims regardless of site of service including DME billed by practitioner, use Practitioner MUE File. (b) For ambulatory surgical center claims with provider type 049, use Practitioner MUE File. (c) For outpatient hospital (including critical access hospitals) claims including DME billed by hospital, use Outpatient Hospital MUE File. (d) For hospital facility (including critical access hospitals) emergency department claims, use Outpatient Hospital MUE File. (e) For hospital facility (including critical access hospitals) observation care claims, use Outpatient Hospital MUE File. (f) For DME billed by suppliers, not practitioners or hospitals, use Durable Medical Equipment (DME) MUE File. (3) MUE is a claim line edit that compares UOS (unit of service) reported for the HCPCS/CPT code on the claim line to the MUE value for that code. (4) If MUE value for HCPCS/CPT code on claim line is greater than or equal to reported UOS on the claim line, the UOS pass the MUE. (5) If MUE value for HCPCS/CPT code is less than the reported UOS on the claim line, the UOS fail the MUE, and the entire claim line is denied. That is, no UOS are paid for the code reported on that claim line. (6) Statements (3)-(5) apply to claim lines where the “from date” to the “to date” is the same. However, if a code subject to an MUE is reported with a different “from date” and “to date” on the claim line, the claims processor should divide the reported units of service by the number of days in the date span and round to the nearest whole number. This number is compared to the MUE value for the code on the claim line, and the rules stated in (4) and (5) above are applied substituting this calculated number for the UOS.

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	N
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	S	Priority	0	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments	Y		

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	Y
Transportation		Xover A		Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS			
Encounter			
Special Batch		DENY	
PA			

Programs

CPA416VA	CPA416CI	CPA417VA
CPA417CI		

Exceptions

DENY is changed to EOB for Outpatient claims by program CPA417CI and CPA417VA

This edit is effective from 01/01/2014 for CPA417CI and CPA417VA

Resolution

(None)

Edit/Audit Inquiry Results Edit-324 ESC-324

Edit Information

Edit Number	324	esc Number	324	NCPDP Code	
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Short Desc	Place of Treatment Not Justified				
Long Desc					
Edit Criteria	This edit is not longer valid and is not included in the new MMIS. Refer to edit 226.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-325 ESC-325

Edit Information

Edit Number	325	esc Number	325	NCPDP Code	
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Short Desc	Maximum Units/Visits/Studies Exceeded
Long Desc	Maximum Units/Visits/Studies Exceeded
Edit Criteria	<p>For Practitioner (claim type 05) except for anesthesia which has type of service 4 or 7, and Dental (claim type 11), bypass the edit if a PA is required (code 01 or 03) according to the Medical and Administrative Codes Database.</p> <p>If the units billed exceeds the maximum allowed on the Medical and Administrative Codes Database, cutback the units allowed to the maximum allowed and set EOB 691.</p> <p>This edit is no longer set because of the EOB and cutback.</p>

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-326 ESC-326

Edit Information

Edit Number	326	esc Number	326	NCPDP Code	70
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Short Desc	Non-Legend Drug				
Long Desc	Non-Legend Drug				
Edit Criteria	<p>For non-nursing home enrollees, if the Medical and Administrative Codes Database drug class = 'O', and any of the following conditions are true, set the edit:</p> <p>1) the Medical and Administrative Codes Database drug DEA indicator = 5 OR</p> <p>2) the therapeutic class is NOT one of the following over-the-counter pay classes: 0241, 1142, 1714, 2094, 2337, 2394, 3988, 4736, 4763, 5987, 5988, 6501, 6503, 6506, 7158, 7400, 8631, 8651, 9580, 9581, 9582, 9583, 9584, 9585, 9587, 9588, 5339 OR</p> <p>3) if the therapeutic class = 0241(oral analgesic) and the GCN is one of the following: 17690, 42773, 70220, 70221, 71350, 71360, 71361, 71660, 71710, 71730, 71800, 71920, 72120, 72470, 72481, 72780, 72790, 72820, 72830, 94060, 96076, 96356, 96413, 96820 OR</p> <p>4) the therapeutic class is 8631 (scabicide) and the GCN is 43230 OR</p> <p>5) the therapeutic class is 5987 (electrolyte) and the GCN is one of the following: 04280, 04281, 04390, 04770, 05370, 05760, 05830, 06140, 06150, 06270, 06280, 06290, 06300, 06310, 06390, 06400, 06440, 06460, 06462, 06470, 06480, 06490, 06540, 06541, 06550, 06580, 27842, 37380, 46870, 49232, 56600, 57010, 57590, 58400, 61660, 61690, 61720, 61760, 62790, 62810, 63300, 63301, 63302, 63770, 63960, 94140, 99999 OR</p> <p>6) the therapeutic class is 5339 (diabetic test) and the GCN is one of the following: 00190, 00191, 07330, 07333, 07349, 09290, 09570, 21910, 21911, 21912, 21913, 25160, 25170, 26680, 33700, 34250, 34330, 35440, 35460, 35470, 35480, 35520, 35540, 35541, 35550, 35560, 35570, 35580, 35590, 46440, 46820, 46830, 48270, 48280, 71000, 94200 OR</p> <p>7) the therapeutic class is 5988 (hematinic) and the GCN is one of the following: 57040, 58030, 58260, 58300, 58320, 58340, 58360, 58500, 58510, 58580, 58600, 58610, 59030, 59170, 59310, 59660, 60130, 60360, 60371, 60380, 60390, 60410, 60640, 60730, 60802, 60820, 60860, 60880, 95540, 95542, 95551, 95592.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	G	Priority	5	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy	Y	Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		DENY	
Encounter		0	
Special Batch			
PA			

Programs

Program	Program Title
VPTM1DRG	POS Pharmacy Claims Drug Edits Process

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-327 ESC-327

Edit Information

Edit Number	327	esc Number	327	NCPDP Code	
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Short Desc	Drug Not Identified, Identify and Rebill				
Long Desc					
Edit Criteria	This edit is not in current system, is not mapped to an EDS edit, and is deleted from new MMIS. For SLH edit 327, see new edit 0917.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-328 ESC-328

Edit Information

Edit Number	328	esc Number	328	NCPDP Code	
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Short Desc	Incorrect Drug Code, Legend Drug				
Long Desc					
Edit Criteria	This edit is not in current system, is not mapped to an EDS edit, and is deleted from new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-329

ESC-329

Edit Information

Edit Number	329	esc Number	329	NCPDP Code	
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Short Desc	This Edit is turned off and end dated on 10/31/2013. Instead the similar edit 1269 is being used. EAPG Multiple Significant Procedure Discounting
Long Desc	EAPG Multiple Significant Procedure Discounting
Edit Criteria	This Edit is turned off and end dated on 10/31/2013. Instead the similar edit 1269 is being used. This edit is set as an EOB on claims as a result of EAPG Multiple Significant Procedure Discounting.

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	S	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	4/5/2010	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		EOB	
		EOB	
EMC		EOB	
		EOB	
Adjustment		EOB	
		EOB	
POS			
Encounter			
Special Batch		EOB	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-330 ESC-330

Edit Information

Edit Number	330	esc Number	330	NCPDP Code	
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Short Desc	Duplicate of History File Record - Same Provider, Overlap DOS				
Long Desc	Duplicate of History File Record, Same Provider, Overlapping Dates of Service				
Edit Criteria	This edit is set when the payment request being processed is a duplicate of a payment request from a previous check write cycle. See Edit 249/249 for edit criteria.				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	Y
Type	H	Priority	1	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy		Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS			
Encounter		6	
Special Batch	217	PEND	
PA		PEND	

Programs

(None)

Exceptions

Pend for Capitation Fees.

Resolution

All Invoice Types:
Check for keying/scanning errors.
If errors are found in unprotected fields, correct the field entry.
If errors are found in protected fields, deny the pending payment request using code 0098 and disposition indicator D.

Outpatient:
1. If the service dates are the same, check the patient account number in block 3 on both claims.
If the patient account number is the same, deny with 0330 and disposition code D.
If the patient account number is different, override with 0330 and disposition code O.

Outpatient/Inpatient/Nursing Home:
2. Check conflicting claim and pending claim for type of service (i.e., revenue codes).
If revenue code is different, override with 0330 and disposition code O.
If revenue code is the same, check for attachments or remarks for justification of the duplicate.

Example:
a) The provider is charging for two outpatient visits on the same day and states that the patient was seen at two different times.
b) Look for any other justifiable reason to pay the duplicate.
If justification is found, override using code 0330 and disposition indicator O.

If justification is not found, deny using code 0330 and disposition indicator D.

Practitioner:

Review the claim for attachments or remarks for justification of the duplicate.

Example:

The provider is charging for two office visits on the same day and states that the patient was seen at two different times.

The patient was seen both in the office and hospital on the same day.

Look for any other justifiable reason to pay the duplicate.

1. If justification is found, override using code 0330 and disposition indicator O.

2. If justification is not found, deny using code 0330 and disposition indicator D.

Independent Lab:

Review the lab invoice for remarks justifying the duplicate, such as two tests on the same day.

1. If justification is found, override using code 0330 and disposition indicator O.

2. If justification is not found, deny using code 0330 and disposition indicator D.

Title XVIII:

1. Check provider number, recipient number, amount and service dates. If they are the same, deny using code 0330 and disposition indicator D.

2. If a paper claim conflicts with a paper claim and there are no attachments or remarks, deny using code 0330 and disposition indicator D.

3. If a paper claim conflicts with a crossover claim, deny using code 0330 and disposition indicator D.

4. If a crossover claim conflicts with a crossover claim, deny using code 0330 and disposition indicator D.

5. If an electronic claim pends against a paper claim:

If amounts are the same, deny using code 0330 and disposition indicator D.

Check place of treatment and/or diagnosis code. If different, override using code 0330 and disposition indicator O.

6. If a paper claim pends against an electronic claim (electronic claim has 7 or 8 as the 8th digit of the reference number):

If amounts are the same, deny using code 0330 and disposition indicator D.

If remarks/attachment on the paper claim indicates two or more visits required on the same day, override using code 0330 and disposition indicator O.

Check place of treatment and/or diagnosis code. If different, override using code 0330 and disposition indicator O.

Dental:

If IC requested, check the remarks/attachment for justification of duplication of service (i.e., same teeth x-rayed, same tooth filled on same date of service).

1. If justification is found, override using code 0330 and disposition indicator O.

2. If justification is not found, deny using code 0330 and disposition indicator D.

Transportation:

Transportation providers are required to bill each date on a separate line so should not incur this error. If a transportation provider bills a date range and the claim encounters this error, deny using code 0330 and disposition indicator D.

Edit/Audit Inquiry Results Edit-331 ESC-331

Edit Information

Edit Number	331	esc Number	331	NCPDP Code	
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Short Desc	This Edit is turned off and end dated on 10/31/2013. Instead the similar edit 1315 is being used. EAPG Repeat Ancillary Procedure discounting
Long Desc	EAPG Repeat Ancillary Procedure discounting
Edit Criteria	This Edit is turned off and end dated on 10/31/2013. Instead the similar edit 1315 is being used. This edit is set as an EOB on generated claims as a result of an EAPG Repeat Ancillary Procedure discounting.

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	S	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	4/5/2010	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		EOB	
		EOB	
EMC		EOB	
		EOB	
Adjustment		EOB	
		EOB	
POS			
Encounter			
Special Batch		EOB	
PA			

Programs

Program	Program Title
CPA416CI	EAPG Integration Program - CICS
CPA416VA	EAPG Integration Program - Batch

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-332

ESC-332

Edit Information

Edit Number	332	esc Number	332	NCPDP Code	
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Short Desc	This Edit is turned off and end dated on 10/31/2013. Instead the similar edits 1334,1041,1042,1043,1044,1098,1104,1106,1141,1199 are being used. EAPG Bilateral Discounting
Long Desc	EAPG Bilateral Discounting
Edit Criteria	This Edit is turned off and end dated on 10/31/2013. Instead the similar edits 1334,1041,1042,1043,1044,1098,1104,1106,1141,1199 are being used. This edit is set as an EOB on claims as a result of EAPG Bilateral Discounting.

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	S	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	4/5/2010	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		EOB	
		EOB	
EMC		EOB	
		EOB	
Adjustment			
		EOB	
POS			
Encounter			
Special Batch		EOB	
PA			

Programs

Program	Program Title
CPA416CI	EAPG Integration Program - CICS
CPA416VA	EAPG Integration Program - Batch

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-333 ESC-333

Edit Information

Edit Number	333	esc Number	333	NCPDP Code	
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Short Desc	This Edit is turned off and end dated on 10/31/2013. Instead the similar edit 1451 is being used. EAPG Terminated Procedure Discounting
Long Desc	EAPG Terminated Procedure Discounting
Edit Criteria	This Edit is turned off and end dated on 10/31/2013. Instead the similar edit 1451 is being used. This edit is set as an EOB on claims as a result of an EAPG payment discounting.

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	S	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	4/5/2010	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		EOB	
		EOB	
EMC		EOB	
		EOB	
Adjustment			
		EOB	
POS			
Encounter			
Special Batch		EOB	
PA			

Programs

Program	Program Title
CPA416CI	EAPG Integration Program - CICS
CPA416VA	EAPG Integration Program - Batch

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-334 ESC-334

Edit Information

Edit Number	334	esc Number	334	NCPDP Code	
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Short Desc	EAPGCLAIM SELECTION - SAME DAY				
Long Desc	EAPGCLAIM SELECTION - SAME DAY				
Edit Criteria	Same date of service selection criteria. If the claims meet this criteria, they are passed to the EAPG integration program. This edit is not set on a claim Criteria: Same recipient Same provider Same DOS Procedure code in value set "EAPG CHECK Same Day Procs"				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type	E	Priority	0	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	4/5/2010	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

Program	Program Title
CPA410	History Utilization Review (U/R) Edits

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-335 ESC-335

Edit Information

Edit Number	335	esc Number	335	NCPDP Code	
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Short Desc	EAPG Full Payment
Long Desc	EAPG Full Payment
Edit Criteria	This edit is set as an EOB on claims as a result of an EAPG full payment.

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	S	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments	Y		

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	4/5/2010	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
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Paper		EOB	
		EOB	
EMC		EOB	
		EOB	
Adjustment		EOB	
		EOB	
POS			
Encounter			
Special Batch		EOB	
PA			

Programs

Program	Program Title
CPA416CI	EAPG Integration Program - CICS
CPA416VA	EAPG Integration Program - Batch

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-336 ESC-336

Edit Information

Edit Number	336	esc Number	336	NCPDP Code	
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Short Desc	EAPG Consolidation/Packaged
Long Desc	EAPG Consolidation/Packaged
Edit Criteria	<p>This edit is set on claims as a result of Consolidation.</p> <p>This Edit set is when :</p> <ul style="list-style-type: none"> • GO2-Y-LI-PAYMENT-ACTION-OPCT(Index) = '02' <p>This edit is effective from 01/01/2014 for Outpatient or Medicare Outpatient claims being set up by programs CPA417CI and CPA417VA .</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	S	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments	Y		

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	POS	Effective Date	4/5/2010	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS			
Encounter			
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA416CI	EAPG Integration Program - CICS
CPA416VA	EAPG Integration Program - Batch
CPA417CI	EAPG Outpatient Pricing Program - CICS
CPA417VA	EAPG Outpatient Pricing Program - Batch

Exceptions

Disposition EOB is set by the program CPA417CI and CPA417VA for Outpatient or Medicare Outpatient claims.

Resolution

(None)

Edit/Audit Inquiry Results Edit-337 ESC-337

Edit Information

Edit Number	337	esc Number	337	NCPDP Code	
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Short Desc	Unable to Resolve This Pended Payment Request				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-338 ESC-338

Edit Information

Edit Number	338	esc Number	338	NCPDP Code	
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Short Desc	Bill Type 112/113 for Adults Must = 21 Days				
Long Desc	Bill Type 112/113 for Adults Must = 21 Days				
Edit Criteria	<p>For Inpatient (claim type 01) and provider type 01 and type of bill 112 or 113 and date of admission > 6/30/96 and <= 12/31/1999, if the enrollee's age is greater than 20 on the date of service and the total adult days billed (revenue codes 100-169, 180-219) is less than 21, set the edit.</p> <p>Since providers are instructed to split bill if an enrollee changes benefit programs during a hospital stay, bypass the edit if the enrollee or any linked enrollee is eligible in a different benefit program on the date following the thru date of service of the claim.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-339 ESC-339

Edit Information

Edit Number	339	esc Number	339	NCPDP Code	
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Short Desc	Hysterectomy Certificate Not Acceptable				
Long Desc	Hysterectomy Certificate Not Acceptable				
Edit Criteria	<p>If a payment request that has a hysterectomy procedure code and/or diagnosis code is submitted with a consent form that contains an uncorrectable error, set the edit.</p> <p>See value sets, CPT HYSTERECTOMY CODES ICD9 HYSTERECTOMY CODES</p>				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	Y
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-340 ESC-340

Edit Information

Edit Number	340	esc Number	340	NCPDP Code	
-------------	-----	------------	-----	------------	--

Short Desc	Abortion Certificate Not Acceptable				
Long Desc	Abortion Certificate Not Acceptable				
Edit Criteria	<p>If a payment request that has an abortion procedure code and/or diagnosis code is submitted with a consent form that contains an uncorrectable error, set the edit.</p> <p>See value sets, CPT ABORTION CODES ICD9 ABORTION CODES DIAG ABORTION CODES</p>				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	Y
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-341 ESC-341

Edit Information

Edit Number	341	esc Number	341	NCPDP Code	
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Short Desc	Sterilization Consent Form Not Acceptable				
Long Desc	Sterilization Consent Form Not Acceptable				
Edit Criteria	<p>If a payment request that has a sterilization procedure code and/or diagnosis code is submitted with a consent form that contains an uncorrectable error, set the edit.</p> <p>See value sets, CPT STERILIZATION CODES ICD9 STERILIZATION CODES DIAG STERILIZATION CODES</p>				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	Y
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-342 ESC-342

Edit Information

Edit Number	342	esc Number	342	NCPDP Code	
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Short Desc	Insufficient Data Available/Illegible				
Long Desc	Insufficient Data Available/Illegible				
Edit Criteria	This edit is used by Pend Resolution when they are unable to resolve a payment request because of insufficient data or illegible data.				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy	Y	Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		N/A	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

Pend for Capitation, Management, Admin Fees, and Assessments.

Resolution

(None)

Edit/Audit Inquiry Results Edit-343 ESC-343

Edit Information

Edit Number	343	esc Number	343	NCPDP Code	
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Short Desc	EAPG PACKAGED
Long Desc	EAPG PACKAGED
Edit Criteria	<p>This edit is set on the claim or claim revenue line as the result of packaging.</p> <p>This Edit set is when :</p> <ul style="list-style-type: none"> • GO2-Y-LI-PAYMENT-ACTION-OPCT(Index) = '04' <p>This edit is effective from 01/01/2014 for Outpatient or Medicare Outpatient claims being set up by programs CPA417CI and CPA417VA .</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	S	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments	Y		

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS			
Encounter			
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA416CI	EAPG Integration Program - CICS
CPA416VA	EAPG Integration Program - Batch
CPA417CI	EAPG Outpatient Pricing Program - CICS
CPA417VA	EAPG Outpatient Pricing Program - Batch

Exceptions

Disposition EOB is set by the program CPA417CI and CPA417VA for Outpatient or Medicare Outpatient claims.

Resolution

(None)

Edit/Audit Inquiry Results Edit-344 ESC-344

Edit Information

Edit Number	344	esc Number	344	NCPDP Code	
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Short Desc	Bill Medicare Part B for Coverage; Rebill on Title 18 Invoice
Long Desc	Bill Medicare Part B for Coverage; Rebill on Title 18 Invoice
Edit Criteria	<p>For Practitioner (claim type 05), if the procedure code is > 90940 and < 91000, and the enrollee's premium indicator (C_PREMIUM_IND from the RS_ENROL_BENDEX using person id) = 2 (receiving Medicare, eligible for state buy-in), and the thru date of service is not less than the enrollee's eligibility date for Medicare Part B, set the edit.</p> <p>For Transportation (claim type 13), if the enrollee has coverage type B or Z and there is no payment from the primary carrier and the COB code = 2 or 3, set the edit.</p> <p>Bypass the edit if: The enrollee's TPL indicates uninsured absent parent (U), or One of the procedure code flags = 90, or One of the procedure code flags = 91 and the first diagnosis on the payment request is in the ICD-9 value set 172 (BYPASS DIAGNOSIS CODES) or ICD-10 value set 20288 (ICD-10 Pregnancy Diag Codes), or The first diagnosis on the payment request is in the ICD-9 value set 21004 (ICD-9 DX ROUTINE CHILD HEALTH) or ICD-10 value set 22004 (ICD-10 DX ROUTINE CHILD HEALTH).</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	T	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy	Inpatient	
Nursing		Home Health	Outpatient	
Physician	Y	Personal Care	Laboratory	
Transportation	Y	Xover A	Xover B	
Cap Pay		Man Fee	Admin	
Asmt Fee				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	200	PEND	
		DENY	
EMC	200	PEND	
		DENY	
Adjustment	200	PEND	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA032	TPL Edits

Exceptions

All SLH Pends are assigned to LOC 310.

Resolution

All Claim Types:

Review attachment for statement that Medicare benefits have been exhausted or did not cover the service.

1. If documentation or EOB from Medicare shows Medicare benefits exhausted or did not cover service, override with code 0344 and disposition indicator O. (Updated 2/18/10)

2. Check the procedure codes on the EOB. If codes are different from the billed code Deny 0370D

3. If no such statement, deny with code 0344 and disposition indicator D

Edit/Audit Inquiry Results Edit-345 ESC-345

Edit Information

Edit Number	345	esc Number	345	NCPDP Code	
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Short Desc	EAPG NO PAYMENT
Long Desc	EAPG NO PAYMENT
Edit Criteria	<p>This edit is set on the claim or claim revenue line as the result of no payment.</p> <p>This Edit set is when :</p> <ul style="list-style-type: none"> • GO2-Y-LI-PAYMENT-ACTION-OPCT(Index) = '05' <p>This edit is effective from 01/01/2014 for Outpatient or Medicare Outpatient claims being set up by programs CPA417CI and CPA417VA .</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	S	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments	Y		

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date	4/5/2010	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS			
Encounter			
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA416CI	EAPG Integration Program - CICS
CPA416VA	EAPG Integration Program - Batch
CPA417CI	EAPG Outpatient Pricing Program - CICS
CPA417VA	EAPG Outpatient Pricing Program - Batch

Exceptions

Disposition EOB is set by the program CPA417CI and CPA417VA for Outpatient or Medicare Outpatient claims.

Resolution

(None)

Edit/Audit Inquiry Results Edit-346 ESC-346

Edit Information

Edit Number	346	esc Number	346	NCPDP Code	
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Short Desc	Check NDC, Resubmit, Identify Drug/MFTR				
Long Desc	Check NDC, Resubmit, Identify Drug/MFTR				
Edit Criteria	This edit is used by Pend Resolution to resolve Pharmacy payment requests that pended for edit 224. Since edit 224 is no longer used, this error is irrelevant.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-347 ESC-347

Edit Information

Edit Number	347	esc Number	347	NCPDP Code	
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Short Desc	Abortion Certificate Not Attached				
Long Desc					
Edit Criteria	This edit is deleted from the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-348 ESC-348

Edit Information

Edit Number	348	esc Number	348	NCPDP Code	
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Short Desc	Referring Provider Invalid for IMD Member
Long Desc	Referring Provider Invalid for IMD Member
Edit Criteria	If the member has exception indicator "IM" for the claim dates of service, regardless of whether the claim was processed under the "IM", and the referring provider is missing or is not the provider associated with the "IM" on the benefit plan, set the edit. For Institutional Claims (UB92 and XOVA), the input referring provider is mapped to other provider 1 so use the other provider 1 for this edit.

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	R	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental	Y	Pharmacy		Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	7/1/2014	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS			
Encounter		6	
BHSA Encounter		6	
Special Batch	217	PEND	
PA			

Programs

CPA028VA	Provider Edits
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Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-349 ESC-349

Edit Information

Edit Number	349	esc Number	349	NCPDP Code	
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Short Desc	Sterilization Consent Form Needed
Long Desc	Sterilization Consent Form Needed
Edit Criteria	<p>If the procedure and/or diagnosis indicates sterilization, and there is no matching active segment on the Consent File for this enrollee and there is no attachment, set the edit. If there is an attachment, set edit 0278.</p> <p>For Outpatient Hospital Claims & Title-18 (XOVA) claims for Bill-types = '13X', '72X' and '85X', and prov types ('001', '014', '085', '091'), and FDOS >= 01/1/14 the Revenue line procedure code will be checked in the CPT STERILIZATION CODES value set, and without an attachment set the edit.</p> <p>See value sets, CPT STERILIZATION CODES 117 - ICD9 STERILIZATION CODES (ICD-9) and 20117 - ICD-10 STERILIZATION PROCS (ICD-10) 279 - DIAG STERILIZATION CODES (ICD-9) and 20279 - ICD-10 STERILIZATION DIAGS (ICD-10)</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	Y

Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-350 ESC-350

Edit Information

Edit Number	350	esc Number	350	NCPDP Code	
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Short Desc	Info Rec Not Signed in Advance				
Long Desc	Info Rec Not Signed in Advance				
Edit Criteria	If the payment request was submitted on paper and has a hysterectomy, abortion, or sterilization procedure code and/or diagnosis code, but the attachment was not signed and/or dated by the enrollee prior to the surgery, set this EOB.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	Y
Physician`	Y	Personal Care		Laboratory	Y
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		EOB	
		EOB	
EMC		DENY	
		DENY	
Adjustment		EOB	
		EOB	
POS		PAY	
Encounter		0	
Special Batch		EOB	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-351 ESC-351

Edit Information

Edit Number	351	esc Number	351	NCPDP Code	
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Short Desc	EAPG NOT PROCESSED
Long Desc	EAPG NOT PROCESSED
Edit Criteria	<p>This edit is set when the 3M software did not process the claim or the claim revenue line.</p> <p>This Edit set is when :</p> <ul style="list-style-type: none"> GO2-Y-LI-PAYMENT-ACTION-OPCT(Index) = '00' <p>This edit is effective from 01/01/2014 for Outpatient or Medicare Outpatient claims being set up by programs CPA417CI and CPA417VA .</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	S	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments	Y		

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	POS	Effective Date	4/5/2010	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS			
Encounter			
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA416CI	EAPG Integration Program - CICS
CPA416VA	EAPG Integration Program - Batch
CPA417CI	EAPG Outpatient Pricing Program - CICS
CPA417VA	EAPG Outpatient Pricing Program - Batch

Exceptions

Disposition EOB is set by the program CPA417CI and CPA417VA for Outpatient or Medicare Outpatient claims.

Resolution

(None)

Edit/Audit Inquiry Results Edit-352 ESC-352

Edit Information

Edit Number	352	esc Number	352	NCPDP Code	
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Short Desc	Only Paid Payment Requests Can be Adjusted/Voided				
Long Desc	Only Paid Payment Requests Can be Adjusted/Voided				
Edit Criteria	If an adjustment or void is submitted for a previously denied or pending payment request, set the edit. Only paid payment requests can be adjusted or voided.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	J	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy		Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment		DENY	
		DENY	
POS		DENY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA020	Adjustment Edits

Exceptions

Pend for Capitation, Management, Admin Fees, and Assessments. As of November 2, 2005, the date type has been changed from S to R for CT modifier 4, media paper - all programs.

Resolution

(None)

Edit/Audit Inquiry Results Edit-353 ESC-353

Edit Information

Edit Number	353	esc Number	353	NCPDP Code	
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Short Desc	Incorrect Provider Number
Long Desc	Incorrect Provider Number
Edit Criteria	If the provider class type = 01 or 91 and the principal diagnosis code is in the ICD-9 value set 147 (REHAB CLAIM) or the ICD-10 value set 20147 (ICD-10 REHAB DIAG)(rehab diagnoses), set the edit. See value sets, REHAB CLAIM (ICD-9) and ICD-10 REHAB DIAG (ICD-10) .

General Indicators

Reject Ind		Deny Ind		Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		4	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-354 ESC-354

Edit Information

Edit Number	354	esc Number	354	NCPDP Code	
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Short Desc	EAPG BILATERAL
Long Desc	EAPG BILATERAL
Edit Criteria	<p>This edit is set on the claim or claim revenue line as the result of Bilateral. This Edit set is when :</p> <ul style="list-style-type: none"> GO2-Y-LI-PAYMENT-ACTION-OPCT(Index) = '06' <p>This edit is effective from 01/01/2014 for Outpatient or Medicare Outpatient claims being set up by programs CPA417CI and CPA417VA .</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	S	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments	Y		

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	POS	Effective Date	4/5/2010	Revision Date		
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS			
Encounter			
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA416CI	EAPG Integration Program - CICS
CPA416VA	EAPG Integration Program - Batch
CPA417CI	EAPG Outpatient Pricing Program - CICS
CPA417VA	EAPG Outpatient Pricing Program - Batch

Exceptions

Disposition EOB is set by the program CPA417CI and CPA417VA for Outpatient or Medicare Outpatient claims.

Resolution

(None)

Edit/Audit Inquiry Results Edit-355 ESC-355

Edit Information

Edit Number	355	esc Number	355	NCPDP Code	81
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Short Desc	Payment Request Too Old to Adjust or Void				
Long Desc	Payment Request Too Old to Adjust or Void				
Edit Criteria	If the payment date of the payment request to be adjusted or voided is greater than 36 months old (or 5 years in special cases), then set the edit.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	J	Priority	3	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy	Y	Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp
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Paper			
EMC			
Adjustment		DENY	
		DENY	
POS		DENY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
VPT99VOD	Reversal Process for Voided and Rebilled Transactions

Exceptions

Pend for Capitation, Management, Admin Fees, and Assessments.

Resolution

(None)

Edit/Audit Inquiry Results Edit-356 ESC-356

Edit Information

Edit Number	356	esc Number	356	NCPDP Code	
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Short Desc	To Adjust Payment, Submit Adjustment Request				
Long Desc	To Adjust Payment, Submit Adjustment Request				
Edit Criteria	Pend Resolution uses this edit to deny claims submitted in error as originals.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	Y
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy	Y	Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp
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Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		DENY	
Encounter		0	
Special Batch		DENY	
PA			

Programs

(None)

Exceptions

Pend for Capitation, Management, Admin Fees, and Assessments.

Resolution

(None)

Edit/Audit Inquiry Results Edit-357 ESC-357

Edit Information

Edit Number	357	esc Number	357	NCPDP Code	
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Short Desc	EAPG DISCOUNTED BILATERAL
Long Desc	EAPG DISCOUNTED BILATERAL
Edit Criteria	<p>This edit is set on the claim or claim revenue line as the result of Discounted Bilateral. This Edit set is when :</p> <ul style="list-style-type: none"> GO2-Y-LI-PAYMENT-ACTION-OPCT(Index) = '07' <p>This edit is effective from 01/01/2014 for Outpatient or Medicare Outpatient claims being set up by programs CPA417CI and CPA417VA .</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	S	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments	Y		

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	POS	Effective Date	4/5/2010	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS			
Encounter			
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA416CI	EAPG Integration Program - CICS
CPA416VA	EAPG Integration Program - Batch
CPA417CI	EAPG Outpatient Pricing Program - CICS
CPA417VA	EAPG Outpatient Pricing Program - Batch

Exceptions

Disposition EOB is set by the program CPA417CI and CPA417VA for Outpatient or Medicare Outpatient claims.

Resolution

(None)

Edit/Audit Inquiry Results Edit-358 ESC-358

Edit Information

Edit Number	358	esc Number	358	NCPDP Code	
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Short Desc	EAPG DISCOUNTED
Long Desc	EAPG DISCOUNTED
Edit Criteria	<p>This edit is set on the claim or claim revenue line as the result of discounting. This Edit set is when :</p> <ul style="list-style-type: none"> GO2-Y-LI-PAYMENT-ACTION-OPCT(Index) = '03' <p>This edit is effective from 01/01/2014 for Outpatient or Medicare Outpatient claims being set up by programs CPA417CI and CPA417VA .</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	S	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments	Y		

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	POS	Effective Date	4/5/2010	Revision Date		
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS			
Encounter			
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA416CI	EAPG Integration Program - CICS
CPA416VA	EAPG Integration Program - Batch
CPA417CI	EAPG Outpatient Pricing Program - CICS
CPA417VA	EAPG Outpatient Pricing Program - Batch

Exceptions

Disposition EOB is set by the program CPA417CI and CPA417VA for Outpatient or Medicare Outpatient claims.

Resolution

(None)

Edit/Audit Inquiry Results Edit-359 ESC-359

Edit Information

Edit Number	0359	esc Number	0359	NCPDP Code	
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Short Desc	3M EAPG SOFTWARE FLAG INVALID
Long Desc	3M EAPG SOFTWARE FLAG INVALID
Edit Criteria	<p>This edit is set on a claim or a claim revenue line when the 3M software doesn't return the expected values on any of the flags. Edit is set when the flags return anything other than Below values for the respective flags:</p> <p>MULT-SP-DISC-FLAG=1,0,space REPEAT-ANC-DISC-FLAG=1, 0,space BILATERAL-DISC-FLAG=2 ,3, 0,space TERM-PROC-DISC-FLAG=1, 0,space SAME-SP-CONS-FLAG=1, 0,space CLIN-SP-CONS-FLAG=1, 0,space PACKAGING-FLAG=1, 0,space PCKGD-PER-DIEM-FLAG=1, 0,space LINE-ITEM-ACT-FLAG=31,32,33, 00,space</p> <p>This edit is effective from 01/01/2014 for Outpatient or Medicare Outpatient claims being set up by programs CPA417CI and CPA417VA .</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	S	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments	Y		

Claim Type

Dental		Pharmacy		Inpatient	
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Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	4/5/2010	Revision Date		
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS			
Encounter			
Special Batch	217	DENY	
PA			

Programs

Program	Program Title
CPA416CI	EAPG Integration Program - CICS
CPA416VA	EAPG Integration Program – Batch
CPA417CI	EAPG Outpatient Pricing Program - CICS
CPA417VA	EAPG Outpatient Pricing Program - Batch

Exceptions

DENY may be changed to EOB by program CPA416CI or CPA416VA.
DENY is changed to EOB by program CPA417CI and CPA417VA

Resolution

(None)

Edit/Audit Inquiry Results Edit-360 ESC-360

Edit Information

Edit Number	360	esc Number	360	NCPDP Code	
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Short Desc	Procedure is already included in a related procedure				
Long Desc	Procedure is already included in a related procedure				
Edit Criteria	This edit moved to edit 370.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-361 ESC-361

Edit Information

Edit Number	361	esc Number	361	NCPDP Code	BE
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Short Desc	M/I Prof. Service Fee Submitted
Long Desc	M/I Professional Service Fee Submitted
Edit Criteria	For service transactions only, set 361 when the Professional Service Fee is not numeric or is equal to zeros

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
11/21/2011					

Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-362 ESC-362

Edit Information

Edit Number	362	esc Number	362	NCPDP Code	
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Short Desc	Service Limit Exception Not Substantiated				
Long Desc	Service Limit Exception Not Substantiated				
Edit Criteria	This edit is used by Pend Resolution to deny a payment request that pended for a service limit edit.				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental	Y	Pharmacy		Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
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Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-363 ESC-363

Edit Information

Edit Number	363	esc Number	363	NCPDP Code	
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Short Desc	Primary Practitioner Not Identified				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-364 ESC-364

Edit Information

Edit Number	364	esc Number	364	NCPDP Code	74
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Short Desc	Primary Carrier Pay't Equals/Exceeds DMAS'				
Long Desc	Primary carrier payment equals or exceeds DMAS' allowed amount.				
Edit Criteria	<p>For payment requests with Medicare coverage code entered = A, AND provider class type = 10 (nursing facility), AND from date of service > 6/30/98 OR from date of service > 07/31/93 and thru date of service < 07/01/96, AND the calculated coinsurance greater than zeros.</p> <p>For all Title 18 payment requests, if the Medicare paid amount is greater than the Medicaid allowed amount, pay zero, and set the edit.</p> <p>For pharmacy claims (invoice type = 06), if the other carrier amount (DE 2222) submitted on the incoming claim is greater than or equal to the calculated allowed amount, set this edit.</p>				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	\$	Priority	4	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy	Y	Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	Y

Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		EOB	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
VPTM1PRC	POS Pharmacy Claims Pricing Process
CPA100	Adjudication Controller

Exceptions

For claim type 09, crossover A and B, the disposition is EOB for adjustments except for special batch which is pend. For Medicare Transportation claims, the disposition is EOB.

Resolution

(None)

Edit/Audit Inquiry Results Edit-365 ESC-365

Edit Information

Edit Number	365	esc Number	365	NCPDP Code	76
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Short Desc	DELETED-Disp Unit Outside Program Min-Max Allowance				
Long Desc	Disp Unit Outside Program Min-Max Allowance				
Edit Criteria	This edit is no longer valid.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-366 ESC-366

Edit Information

Edit Number	366	esc Number	366	NCPDP Code	76
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Short Desc	Authorized Number of Refills Exceeded				
Long Desc	Maximum number of refills has been reached				
Edit Criteria	Refills are not allowed for drugs with a '1' or '2' in the fourth position of therapeutic class (which is the DEA code). A 'refill' is defined by the same prescription number and NDC.				
	There is a limit of six refills for drugs with a DEA code of '3', '4'.				

General Indicators

Reject Ind		Deny Ind		Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	H	Priority	3	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy	Y	Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		DENY	
Encounter		0	
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-367 ESC-367

Edit Information

Edit Number	367	esc Number	367	NCPDP Code	
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Short Desc	Bill Medicare
Long Desc	This enrollee is covered by Medicare Part B, Rebill on Title 18 invoice.
Edit Criteria	<p>For Outpatient (claim type 03, not Home Health), Practitioner (claim type 05), and Independent Lab (claim type 08): If Medicare Part B is in effect (the enrollee's TPL type = B or Z), COB code = 2 (82) or 3 (83) (no other charge or billed and paid), and there is no payment from the primary carrier, set the edit.</p> <p>Bypass the edit if: The enrollee's TPL indicates uninsured absent parent (U), or One of the procedure code flags = 90, or One of the procedure code flags = 91 and the first diagnosis on the payment request is in the ICD-9 value set 172 (BYPASS DIAGNOSIS CODES) or ICD-10 value set 20288 (ICD-10 Pregnancy Diag Codes), or The first diagnosis on the payment request is in the ICD-9 value set 21004 (ICD-9 DX ROUTINE CHILD HEALTH) or ICD-10 value set 22004 (ICD-10 DX ROUTINE CHILD HEALTH), or The procedure code's first position is Z or Y (except Y0110, Y0111, or Y0112), or The Procedure Code is found in the "State Plan Options Services" Value Set.</p>

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	T	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy	Inpatient	
Nursing		Home Health	Outpatient	Y
Physician	Y	Personal Care	Laboratory	Y
Transportation		Xover A	Xover B	
Cap Pay		Man Fee	Admin	
Asmt Fee				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper	100	PEND	
		DENY	
EMC	100	PEND	
		DENY	
Adjustment	100	PEND	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA032	TPL Edits

Exceptions

All SLH UB claim types that pend will pend to LOC 308 and HCFA claim types will pend to LOC 310.

Resolution

All Claim Types: (Updated 06/2014)
Review attachment for statement that Medicare benefits have been exhausted or did not cover the service. Most Medicare EOBs have "Medicare" typed in the left and/or the right upper corners of the EOB. Read all before decision is made.

1. If documentation shows Medicare benefits exhausted or did not cover service, override with code 0367 and disposition indicator O.
2. If the provider states that he/she does not participate in Medicare, override 0367O.
3. If no such statement and attached EOB shows a payment, deny with code 0385 and disposition indicator D.
4. If provider states "No Medicare on date of service" with no additional documentation such as a denial from Medicare or card with effective dates to prove the recipient does not have Medicare, deny with code 0367 and disposition indicator D.
5. If #2 and #3 do not apply and no Medicare EOB is attached, deny with code 0385 and disposition indicator D.
6. If the payment, coinsurance and deductible amounts are all \$0.00 on the Medicare EOB due to a billing error (duplicate, name and number do not match etc.) Deny 0367D unless the provider explains the Medicare denial (Updated 6/2014).
7. If the payment, coinsurance and deductible amounts are all \$0.00 on the EOB, change the COB code to 5 and override code 0367. Use disposition indicator O (updated 6/2014).
8. If a payment amount is listed in the paid, coinsurance and or deductible field on the EOB, deny with code 0385 and disposition indicator D.
9. If a payment is made to the provider by Medicare, deny with 0385. Use disposition indicator D.
10. If a payment is made to the provider by another insurance that is not Medicare and the recipient has Medicare coverage, deny 0385. Use disposition indicator D. Recipient will have Medicare coverage on file even when a Medicare Advantage Plan (Medicare HMO) has made a payment. The provider should bill as a cross-over claim.
11. If a claim is billed with procedure code E 1399 on an electronic claim, an EOB should be attached to determine what procedures were billed to Medicare or provider should indicate that the procedure is not covered.
12. If any other situation is not listed above and you are not sure of the resolution, transfer to location 219 and indicate your question in the remark section.

Edit/Audit Inquiry Results Edit-368 ESC-368

Edit Information

Edit Number	368	esc Number	368	NCPDP Code	
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Short Desc	Services in Non-Contracted Hosp Not Authorized				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-369 ESC-369

Edit Information

Edit Number	369	esc Number	369	NCPDP Code	
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Short Desc	Use 80 81 82 in Block 24D to Indicate Asst.				
Long Desc	Use 80 81 82 in Block 24D to Indicate Asst.				
Edit Criteria	This edit is used by Pend Resolution when a claim pends and the medical records show that the payment request was submitted by the assistant and not the surgeon.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-370 ESC-370

Edit Information

Edit Number	370	esc Number	370	NCPDP Code	
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Short Desc	Wrong Procedure Code Billed				
Long Desc	Wrong Procedure Code Billed				
Edit Criteria	<p>For Practitioner (claim type 05): If there is a 'Q' flag for the payment request's procedure code on the RF_PROC_FLAG_CODES table and the enrollee's exception indicator is not = 'Q', set the edit.</p> <p>For Practitioner (claim type 05), if the payment request is for a clinic visit (indicated by provider class type = 52 or 53 and the from date of service > 5/31/94), the procedure code is not in the range of 70000 thru 89999, and the procedure code does not have a Medical and Administrative Codes Database flag indicator = S, I (enrollee's age < 21), CF, or CV, set the edit.</p> <p>If the from date of service is > 12/31/89 and the provider class type = 51 (H-D clinic) and the procedure code = 59420, set the edit.</p> <p>If the provider class type = 14, 19, 57, 60, or 62 (Rehab Hosp, CORF, Rehab Agency, Pharmacy, and DME), and the first digit of the procedure code is numeric, set the edit.</p> <p>The following criteria for claim type 05 was removed from the edit on 5/28/2004: If there is no 'R' flag for the payment request's procedure code on the RF_PROC_FLAG_CODES table and the enrollee's exception indicator is = 'R', set the edit.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental	Y	Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-371 ESC-371

Edit Information

Edit Number	371	esc Number	371	NCPDP Code	
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Short Desc	Wrong Procedure/Wrong Claim Type				
Long Desc	Wrong Procedure/Wrong Claim Type				
Edit Criteria	<p>For payment requests entered as claim type 04:</p> <p>(1) Prior to 7/1/91, Home Health payment requests were entered as claim type 04; after that date they are entered as claim type 03. If provider class type = 58 (State Home Health), 59 (Private Home Health), or 94 (Out of State Home Health) submits a request as claim type 04, and the from date of service is >= 7/01/91, set the edit.</p> <p>(2) After checking eligibility waivers, if the enrollee exception indicator = X (being deleted) or Y , and the provider class type is not = 55 (Personal Care), set the edit.</p> <p>For payment requests entered as claim type 03:</p> <p>a. Prior to 7/01/91, Home Health payment requests were entered as claim type 04; after that date they are entered as claim type 03. If provider class type = 58 (State Home Health), 59 (Private Home Health), or 94 (Out of State Home Health) submits a request on claim type 03, and the from date of service is < 7/01/91, set the edit.</p> <p>b. If provider class type = 70(Independent Lab) or 98(Out of State Lab), set the edit.</p> <p>For payment requests entered as claim type 08 (Lab): If the provider class type is not = 01 (Hospital), 08 (State MH-Med-Surg), 09 (Med-Surg-MR), 70 (Independent Lab), 91 (Out of State Hospital), or 98 (Out of State Lab), set the edit.</p> <p>For payment requests entered as claim type 09 (Title 18): If the enrollee exception indicator = 1 (Nursing ICF) and the provider class type = 10 (SNF, non-MH) and the from date of service is > 9/30/90 and the Medicare coverage code entered on the request = A, set the edit.</p> <p>See value set, HOME HLH PROV TYPES - E0371.</p>				

	See value set, IDNPT AND OUT OF ST LAB -E0371. See value set, LAB PROVIDER TYPES - E0371.				
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General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	P	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health	Y	Outpatient	Y
Physician		Personal Care	Y	Laboratory	Y
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-372 ESC-372

Edit Information

Edit Number	372	esc Number	372	NCPDP Code	62
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Short Desc	Enrollee Name and ID Number Do Not Match				
Long Desc	Enrollee name/number mismatch. Resubmit with correct name/number or contact local DSS.				
Edit Criteria	If the first digit of the enrollee's first name and first four digits of the enrollee's last name which are entered on a payment request do not match the first digit of the first name and the first four digits of the last name on the Enrollee Datastore, set the edit.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	R	Priority	4	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy	Y	Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC			
Adjustment			
POS		DENY	
Encounter		0	
Special Batch			
PA			

Programs

Program	Program Title
CPA030	Recipient Edits
VPTM1RCP	POS Pharmacy Claims Enrollee Edits Process

Exceptions

Disposition/Location rows with Disposition = 'E' and Begin Effective Date = 06/26/2003 were changed to have the Begin Effective Date moved back to 07/01/2000.

Resolution

(None)

Edit/Audit Inquiry Results Edit-373 ESC-373

Edit Information

Edit Number	373	esc Number	373	NCPDP Code	
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Short Desc	Provider Not Authorized to Bill These Services				
Long Desc	Provider not authorized to bill these services.				
Edit Criteria	<p>If the provider class type = 16, 17, 18, or 86 (ICF-MH, ICF-MR - state owned, ICF-MR - community owned, ICF-non enrolled), set the edit.</p> <p>See edit 901 for criteria that was moved from this edit.</p> <p>See value set, PROV TYPES FOR E0373.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	P	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-374 ESC-374

Edit Information

Edit Number	374	esc Number	374	NCPDP Code	83
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Short Desc	HMO Copay Duplicate Edit				
Long Desc	HMO Copay Duplicate Edit				
Edit Criteria	<p>For Physician (claim type 05):</p> <p>If the 0997 edit is set, identifying an HMO Copay condition, a duplicate check process is started by invoking History Edits program CPA430VA. This program attempts to identify existing non-denied claims, original or debit adjustments, based on matching provider, enrollee, and the same dates of service. If a duplicate condition is identified, then a 0374 error is assigned to the claim and it is denied.</p>				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type		Priority	0	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	1/1/1990	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		N/A	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA430	History Edits - Other

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-375 ESC-375

Edit Information

Edit Number	375	esc Number	375	NCPDP Code	
-------------	-----	------------	-----	------------	--

Short Desc	Requested Information Not Received				
Long Desc	Requested Information Not Received				
Edit Criteria	<p>This edit is used by Pend Resolution to deny a payment request if information requested is not received within 20 days.</p> <p>This edit is also used for payment reduction for such as emergency room claims for hospitals and physicians.</p> <p>See edits 218-220, 254, 255, 257, 266, 269, 275, 277, 278, 280, 823, 824.</p>				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		EOB	
		EOB	
EMC		EOB	
		EOB	
Adjustment		EOB	
		EOB	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA100	Adjudication Controller

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-376 ESC-376

Edit Information

Edit Number	376	esc Number	376	NCPDP Code	
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Short Desc	Procedure Performed Not Clearly Identified				
Long Desc	Procedure Performed Not Clearly Identified				
Edit Criteria	Used by Pend Resolution to Deny Claims for Practitioner (claim type 05), Lab (claim type 08) and Dental (claim type 11).				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy		Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
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Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS			
Encounter		0	
Special Batch		DENY	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-377 ESC-377

Edit Information

Edit Number	377	esc Number	377	NCPDP Code	
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Short Desc	Enrollee Below Min Age for Consent Signature				
Long Desc	Enrollee Below Min Age for Consent Signature				
Edit Criteria	<p>If a payment request, submitted on paper, is for sterilization (identified by sterilization procedure or diagnosis):</p> <p>1) If SLH, the enrollee's age is less than 18 on the date of signature, set the edit.</p> <p>2) Otherwise, If the enrollee's age is less than 21 on the date of signature, set the edit.</p> <p>See value sets, CPT STERILIZATION CODES ICD9 STERILIZATION CODES DIAG STERILIZATION CODES</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	Y
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-378 ESC-378

Edit Information

Edit Number	378	esc Number	378	NCPDP Code	
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Short Desc	Sterilization Done Outside Consent Time Limits				
Long Desc	Sterilization Done Outside Consent Time Limits				
Edit Criteria	<p>For sterilization payment requests, set the edit if either of the following is true:</p> <p>1) there has not been a 3 day (72 hours) waiting period between the signature date on the consent form and the emergency abdominal surgery date, OR</p> <p>2) there has not been a 30 day waiting period between the signature date on the consent form and the date of service , OR</p> <p>3) there has been more than 180 days between the signature date on the consent form and the date of service.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	Y
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		EOB	
		EOB	
EMC		DENY	
		DENY	
Adjustment		EOB	
		EOB	
POS		PAY	
Encounter		0	
Special Batch		EOB	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-379 ESC-379

Edit Information

Edit Number	379	esc Number	379	NCPDP Code	
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Short Desc	Date of Service Does Not Match Orig Payment Request				
Long Desc	Date of Service Does Not Match Orig Payment Request				
Edit Criteria	<p>For Inpatient (claim type 01): For provider class type 01, 14, 85, and 91: If the adjustment/void from and thru dates of service do not match the original payment request's from and thru dates of service, set the edit.</p> <p>For Title 18 (claim type 09): If the provider class type = 01, 14, 85, or 91 and the adjustment/void from and thru dates of service do not match the original payment request's from and thru dates of service, set the edit.</p> <p>For Dental (claim type 11): If the provider class types = 40, 41 and 42 and the adjustment or void dates of service are different from the original dates of service, set the edit.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	J	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental	Y	Pharmacy		Inpatient	Y
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	

Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment		DENY	
		DENY	
POS		N/A	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA020	Adjustment Edits

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-380 ESC-380

Edit Information

Edit Number	380	esc Number	380	NCPDP Code	
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Short Desc	Bill Nursing Home for This Service
Long Desc	Bill Nursing Home for this Service.
Edit Criteria	<p>Outpatient (claim type 03) rehab payment requests are now paid for nursing home enrollees and so this edit is no longer set for claim type 03 requests.</p> <p>For Physician (claim type 05), the edit is set if the following is true: The procedure code billed is greater than '96999' and less than '97800' (physical therapy) or equal to '92507', '92508' or 'H5300' (speech or occupational therapy), and the enrollee's exception indicator = '1' (ICF/Nursing Facility) or '2' (SNF/Medicare certified), and the provider class type = 20 (physicians), 51 (health department clinics), 52 (FQHC), 53 (rural health clinics), or 95 (non-enrolled physicians), and the enrollee is in a nursing home (the enrollee's lock-in provider has provider class type = 10 or 15 which is a nursing facility) or enrollee is VALTC-REGULAR-LTD or VALTC-PLUS-LTD or VALTC-XTRA-LTD.</p> <p>For Physician (claim type 05), the edit WILL NOT SET if the procedure code is in values set 'CPT CARVE OUT FOR EDIT 380' and the date of receipt is on or after 8/1/2015.</p> <p>For Title 18 (claim type 09), the edit is bypassed if</p> <ol style="list-style-type: none"> 1- the aid category = 23, 43, or 63 OR 2- the from date of service is greater than 6/30/96 OR 3- the provider class type = 57 (Rehab Agency) and the from date of service is greater than 10/23/95 OR 4- the provider number = 4978111, 4978463, 4978579, 4978129, 4978510, 4978200, 4978218, 4978455, 4978617, 4978668, or 4978609 OR 5- the enrollee's exception indicator is not = 1 or 2 indicating the enrollee is in a nursing home OR 6- the Medicare coverage code entered on the payment request is not = B OR 7- the provider class type = 01 (Hospital), 14 (Rehab Hospital), 85 (non-enrolled Rehab Hospital), or 91 (non-enrolled Hospital) and the place of treatment = 21 (inpatient hospital). <p>Otherwise, if the enrollee's nursing home provider's class type = 10 or 15, set the</p>

	<p>edit if one of the following is true:</p> <p>1- the payment request provider class type = 20, 51, 52, 53, or 95 AND the thru date of service is > 6/30/88 and the procedure code is > 96999 and < 97800 OR</p> <p>2- the payment request provider class type = 20, 51, 52, 53, or 95 AND the thru date of service is > 8/31/90 and the procedure code = 92507, 92508, or H5300 OR</p> <p>3- the payment request provider class type = 01, 14, 19, 57, 85, or 91 AND the thru date of service is > 8/31/90 and the procedure code = 92507, 92508, or H5300 AND the service center is 987, 988, 992, or 993 OR</p> <p>4- the payment request provider class type = 01, 14, 19, 57, 85, or 91 AND the thru date of service is > 6/30/88 and the procedure code is > 96999 and < 97800 AND the service center is 987, 988, 992, or 993 OR</p> <p>5- the payment request provider class type = 01, 14, 19, 57, 85, or 91 AND the thru date of service is > 6/30/88 and the procedure code is > 92999 and < 93400 AND the service center is not 987, 988, 992, or 993 OR</p> <p>6- the payment request provider class type = 01, 14, 19, 57, 85, or 91 AND the thru date of service is > 8/31/90 and the procedure code is = 93830, 93730, 93740, or 93750 AND the service center is not 987, 988, 992, or 993.</p> <p>See value set, PROV SET 7. See value set, PROV SET 8. See value set, EDIT 0380/0380 EXCP PROVS. See value set, EXCLUDE SERVICE CENTER - E0380.</p>
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General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-381 ESC-381

Edit Information

Edit Number	381	esc Number	381	NCPDP Code	
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Short Desc	Error Begin/From Date of Service/Coverage				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-382 ESC-382

Edit Information

Edit Number	382	esc Number	382	NCPDP Code	85
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Short Desc	Maint Dose/Duration Exceeded - Give Diagnosis				
Long Desc	Maint Dose/Duration Exceeded - Give Diagnosis				
Edit Criteria	This edit is used for maintenance type drug such as the anti-ulcer initiative. This edit was turned off 1/19/2004.				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind	Y	Compound Ind	
Type	H	Priority	3	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy	Y	Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		EOB	
		EOB	
EMC		EOB	
		EOB	
Adjustment		PAY	
		PAY	
POS		DENY	
Encounter		0	
Special Batch			
PA			

Programs

(None)

Exceptions

This edit was turned off 1/19/2004.

Resolution

(None)

Edit/Audit Inquiry Results Edit-384 ESC-384

Edit Information

Edit Number	384	esc Number	384	NCPDP Code	
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Short Desc	Single Source NSAID - Justify Use				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-385 ESC-385

Edit Information

Edit Number	385	esc Number	385	NCPDP Code	
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Short Desc	Re-bill on Title XVIII Invoice
Long Desc	Re-bill on Title XVIII Invoice
Edit Criteria	<p>For Medicaid Inpatient (claim type 01) and SNF (claim type 02): If the enrollee has Medicare Part A (the TPL type codes = A or Y) AND the COB code = 83 AND the primary carrier payment is > 0 AND the enrollee has no other insurance coverage other than A, set the edit. For claim type 01, the admission date must be less than or equal to 6/30/96, or if the admission date is > 6/30/96, the provider type is not equal 01, 14, 85, or 91.</p> <p>For Medicaid Inpatient (claim type 01) and SNF (claim type 02): If the enrollee has Medicare Part A and/or Part B coverage (TPL type codes = A/Y and/or B/Z) AND the COB code = 85 AND the primary carrier payment is > 0 AND the enrollee has no other insurance coverage other than A and/or B, set the edit. For claim type 01, the admission date must be less than or equal to 6/30/96, or if the admission date is > 6/30/96, the provider type is not equal 01, 14, 85, or 91.</p> <p>For SNF (claim type 02): If the enrollee has Medicare Part A and/or Part B coverage (any of the TPL type codes = A/Y and/or B/Z) AND the COB code = 82 AND the primary carrier payment is > 0 AND the enrollee has no other insurance coverage other than A and/or B, set the edit.</p> <p>For Outpatient (claim type 03, not Home Health), Practitioner (claim type 05), and Independent Lab (claim type 08): If Medicare Part B is in effect (the enrollee's TPL type = B or Z) and the primary carrier payment is > 0, set the edit.</p> <p>For Transportation (claim type 13): If Medicare Part B is in effect (the enrollee's TPL type = B or Z), the procedure code = Y0110, Y0111, or Y0112, and the primary carrier payment is > 0, set the edit.</p> <p>Bypass the edit if: The enrollee's TPL indicates uninsured absent parent (U), or</p>

	<p>One of the procedure code flags = 90, or</p> <p>One of the procedure code flags = 91 and the first diagnosis on the payment request is in the ICD-9 value set 172 (BYPASS DIAGNOSIS CODES) or ICD-10 value set 20288 (ICD-10 PREGNANCY DIAG CODES), or</p> <p>The first diagnosis on the payment request is in the ICD-9 value set 21004 (ICD-9 DX ROUTINE CHILD HEALTH) or ICD-10 value set 22004 (ICD-10 DX ROUTINE CHILD HEALTH), or</p> <p>The procedure code's first position is Z or Y (except Y0110, Y0111, or Y0112), or</p> <p>The Procedure Code is found in the "State Plan Options Services" Value Set.</p>
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General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	T	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	Y
Nursing	Y	Home Health		Outpatient	Y
Physician	Y	Personal Care		Laboratory	Y
Transportation	Y	Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	

POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA032	TPL Edits

Exceptions

All HCFAs as of 1/1/2007 PEND to loc 200 for individual adjustment and all paper with attachments. Individual adjustments and paper without attachments continue to DENY.

Resolution

Physician/Lab/Transportation:

1. If attachment and/or comments state that Medicare coverage is exhausted or service is not covered or the provider does not participate with Medicare and there is no payment by Medicare, override with code 0385 with disposition indicator O. The provider must comment or justify that Medicare did not pay. The TPL payment on the claim should be for other insurance, NOT Medicare.
2. If there is no indication that Medicare coverage is exhausted or service is not covered or the provider does not participate with Medicare and/or there is a Medicare payment on the claim, deny with code 0385 with disposition indicator D.
3. If there are questions, note your concern in the remark screen, transfer to location 219.

Edit/Audit Inquiry Results Edit-386 ESC-386

Edit Information

Edit Number	386	esc Number	386	NCPDP Code	
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Short Desc	Requested Primary Carrier Remittance Not Attached				
Long Desc	Requested Primary Carrier Remittance Not Attached				
Edit Criteria	This edit is used by Pend Resolution to deny payment requests.				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental	Y	Pharmacy	Y	Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
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Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS			
Encounter		0	
Special Batch		DENY	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-387 ESC-387

Edit Information

Edit Number	387	esc Number	387	NCPDP Code	13
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Short Desc	Primary Carrier Payment Needs Explanation
Long Desc	Primary Carrier Payment Needs Explanation
Edit Criteria	<p>If the claim type = 02 (Nursing Home), and the provider class type = 10 or 15 (nursing facility), and the COB code = 83 (billed and paid), and the enrollee exception indicator = 2 (SNF/Medicare certified), and the medical insurance code = A/Y (Medicare Part A), and there is < 101 days from the admission date to the thru date of service, and the payment from primary carrier does not = zero, and the payment request does not have attachments or remarks, set the edit.</p> <p>If the claim type = 02 (Nursing Home), and the provider class type = 10 or 15 (nursing facility), and the COB code = 85 (billed, no coverage), and the enrollee exception indicator = 2 (SNF/Medicare certified), and the medical insurance code = A/Y (Medicare Part A), and there is < 101 days from the admission date to the thru date of service, and the payment from the primary carrier does not = zero, and the payment request does not have attachments or remarks, set the edit.</p> <p>If the claim type = 09 (Title 18) and the enrollee does not have Medicare Part A or B coverage (TPL types not = A/Y or B/Z) and the payment request is not submitted on magtape and there are no attachments or remarks, set the edit.</p> <p>Bypass the edit if the primary diagnosis code is in value set 169 '0282/0387 BYPASS' (ICD-9) or 20288 'ICD-10 PREGNANCY DIAG CODES' (ICD-10). pregnancy, or preventative pediatric care.</p> <p>See value sets, 169-'0282/0387 BYPASS' (ICD-9) and 20288 – 'ICD-10 Pregnancy Diag Codes' (ICD-10).</p> <p>If claim type = 06 (Pharmacy), and the enrollee does not have other pharmacy coverage (TPL type not = R) and the payment request other coverage code = 0 (Not specified) and the payment request TPL amount is > 0, set the edit.</p> <p>If claim type = 06 (Pharmacy), and the enrollee does not have other pharmacy coverage (TPL type not = R) and the payment request other coverage code = 1 (No Other Coverage Identified) and the payment request TPL amount is > 0, set the</p>

<p>edit.</p> <p>If claim type = 06 (Pharmacy), and the enrollee has other pharmacy coverage (TPL type = R) and the payment request other coverage code = 2 Other coverage exists, payment collected) and the payment request TPL amount = 0, set the edit.</p> <p>If claim type = 06 (Pharmacy), and the payment request other coverage code = 3 (Other coverage exists, this claim not covered) and the payment request TPL amount is > 0, set the edit.</p> <p>If claim type = 06 (Pharmacy), and the payment request other coverage code = 4 (Other coverage exists, payment not collected) and the payment request TPL amount is > 0, set the edit.</p> <p>For electronic crossover claims – Claim Type = 09 (DE 2002) and Media Type = 7 (DE 2478) with a Submit ID (DE 0012) of 'EDIX', set edit 0282 when edit criteria is met.</p> <p>For electronic crossover claims – Claim Type = 09 (DE 2002) and Service Center = '1060' (DE 4082)', bypass the edit.</p>
--

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	T	Priority	4	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy	Y	Inpatient	
Nursing	Y	Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A	Y	Xover B	Y
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		DENY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
CPA032	TPL Edits
VPTM1RCP	POS Pharmacy Claims Enrollee Edits Process

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-388 ESC-388

Edit Information

Edit Number	388	esc Number	388	NCPDP Code	
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Short Desc	Coins/Deduct Amounts Need Explanation				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-389

ESC-389

Edit Information

Edit Number	389	esc Number	389	NCPDP Code	
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Short Desc	This Procedure/Enrollee Age Incompatible				
Long Desc	This Procedure/Enrollee Age Incompatible				
Edit Criteria	<p>This edit is no longer valid and is not included in the new MMIS. Consolidated with Edit 211.</p> <p>If the enrollee's age is not within the Medical and Administrative Codes Database minimum and/or maximum age restrictions for the procedure, set the edit. The edit to be set is carried on the Medical and Administrative Codes Database.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-390 ESC-390

Edit Information

Edit Number	390	esc Number	390	NCPDP Code	
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Short Desc	More Than Three Sessions in Seven Days				
Long Desc	More Than Three Sessions in Seven Days				
Edit Criteria	<p>This audit sets if more than three (3) psychiatric visits occur in seven (7) days. Payment requests with place of service = 21 (Inpatient), 51 (Inpatient Psychiatric Facility), 56 (Psychiatric Residential Treatment Center), or 61 (Comp Inpat Rehab Facility) are excluded from the audit.</p> <p>See Value Set "POS EXCLUSIONS 0390/0390". See Value Sets "0390/0390 001" thru "0390/0390 nnn" for procedure codes.</p>				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	L	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		PAY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-391 ESC-391

Edit Information

Edit Number	391	esc Number	391	NCPDP Code	
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Short Desc	Procedure Expired on Service Date				
Long Desc	Procedure Expired on Service Date				
Edit Criteria	This procedure code is invalid for the service date on the claim. This edit applies to recipients whose locality code (county) resides in VALTC regions. Valtc regions are located on the RF_REGION_LOC table where Region Type = 'CAP2' and Region = '0001' (Tidewater) and Region = '0002' (Richmond).				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician	Y	Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	s	Effective Date	7/1/2009	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		DENY	
Encounter		DENY	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-0392 ESC-0392

Edit Information

Edit Number	0392	esc Number	0392	NCPDP Code	
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Short Desc	Nurse/Soc Work Svc Alwd Last 7 Days
Long Desc	Nurse and Social Worker Services Allowed Only for Last 7 Days of Life
Edit Criteria	<p>This edit is performed on each line of a Hospice (PT 046) CT 03 that has revenue code 0551 (Registered Nurse Service) or 0561 (Social Worker Service).</p> <ol style="list-style-type: none"> If there is not a revenue code 0651 with the same line DOS on the claim, set the edit. If there is no indication that the recipient is deceased or the line DOS is more than 6 days before the date of death, set the edit. The date of death is determined as follows: <ul style="list-style-type: none"> If the current claim has patient status 20 or 40, the header TDOS is the date of death. or If there is a history claim that meets the following criteria that has patient status 20 or 40, the header TDOS is the date of death. <ul style="list-style-type: none"> Same enrollee as current claim Status - any Claim type modifier = 1 or 2 CT = 03 PT = 046 History claim header TDOS is greater than current claim header TDOS

General Indicators

Reject Ind		Deny Ind		Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	H	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental	Pharmacy	Inpatient	
Nursing	Home Health	Outpatient	Y
Physician	Personal Care	Laboratory	
Transportation	Xover A	Xover B	
Cap Pay	Man Fee	Admin	
Asmt Fee			

Date Information

Effective Date Code	DOS	Effective Date	01/01/2016	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		NON-COV	
		NON-COV	
EMC		NON-COV	
		NON-COV	
Adjustment		NON-COV	
		NON-COV	
POS		NA	
Encounter		0	
BH Encounter		0	
Special Batch	217	PEND	
PA			

Edit/Audit Inquiry Results Edit-0393 ESC-0393

Edit Information

Edit Number	0393	esc Number	0393	NCPDP Code	
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Short Desc	Nurse/Soc Work Svc Limitation
Long Desc	Nurse and Social Worker Services – 16 Units Allowed Per Day
Edit Criteria	This edit is performed on each line of a Hospice (PT 046) CT 03 that has revenue code 0551 (Registered Nurse Service) or 0561 (Social Worker Service). If the total units for revenue codes 0551 and 0561 with the same line DOS exceed 16, set the edit. This count includes paid history claims and previously approved lines on current claim as well as current line on current claim. If some units can be paid without exceeding the limit but not all, cutback to payable units with EOB 0392.

General Indicators

Reject Ind		Deny Ind		Override Ind	Y
PrtRA Ind	Y	PA Override Ind		Compound Ind	
Type	H	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental	Pharmacy	Inpatient	
Nursing	Home Health	Outpatient	Y
Physician	Personal Care	Laboratory	
Transportation	Xover A	Xover B	
Cap Pay	Man Fee	Admin	
Asmt Fee			

Date Information

Effective Date Code	DOS	Effective Date	01/01/2016	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper		NON-COV	
		NON-COV	
EMC		NON-COV	
		NON-COV	
Adjustment		NON-COV	
		NON-COV	
POS		NA	
Encounter		0	
BH Encounter		0	
Special Batch	217	PEND	
PA			

Edit/Audit Inquiry Results Edit-394 ESC-394

Edit Information

Edit Number	394	esc Number	394	NCPDP Code	70
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Short Desc	Drug Not Covered				
Long Desc	Drug Not Covered				
Edit Criteria	This edit is determined by the Include/Exclude Indicator on the Benefit Master file. Desi drugs and OTC drugs are excluded from this edit.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind	Y	Compound Ind	Y
Type	G	Priority	2	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy	Y	Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp
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Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		DENY	
Encounter		6	
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-395 ESC-395

Edit Information

Edit Number	395	esc Number	395	NCPDP Code	
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Short Desc	DELETED -Duplicate NDC				
Long Desc					
Edit Criteria	This edit is no longer valid and is not included in the new MMIS.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind		PA Override Ind		Compound Ind	
Type		Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid		SLH		TDO	
FAMIS		Assessments			

Claim Type

Dental		Pharmacy		Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code		Effective Date		Revision Date	
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Media/Disposition/Pend Location Codes

Media		LOC		Disp	
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Paper			
EMC			
Adjustment			
POS			
Encounter			
Special Batch			
PA			

Programs

(None)

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-396 ESC-396

Edit Information

Edit Number	396	esc Number	396	NCPDP Code	87
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Short Desc	Adjust. Denied - Orig Payment Request Not on File				
Long Desc	Unable to locate paid payment request to be adjusted. Please verify reference number.				
Edit Criteria	<p>If the original payment request cannot be found on the paid history file, set the edit.</p> <p>For pharmacy POS rebill transaction and batch adjustments, the history claim is found using provider, date of service and Rx number. For batch claims where a match was not found, the history claim will then try to be found using the reference number and provider number.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	Y
Type	Z	Priority	1	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy	Y	Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment		DENY	
		DENY	
POS		DENY	
Encounter		8	
Special Batch	217	PEND	
PA			

Programs

Program	Program Title
VPT99VOD	Reversal Process for Voided and Rebilled Transactions

Exceptions

Pend for Capitation, Management, Admin Fees, and Assessments. For Pharmacy, this edit applies to paper claims only.

Resolution

(None)

Edit/Audit Inquiry Results Edit-397 ESC-397

Edit Information

Edit Number	397	esc Number	397	NCPDP Code	87
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Short Desc	Void Denied - Orig Payment Request Not on File				
Long Desc	Unable to locate original paid payment request. Please resubmit with correct payment request number.				
Edit Criteria	<p>If the original payment request cannot be found on the paid history file, set the edit.</p> <p>For pharmacy POS and batch claims, the history claims is found using provider, date of service and Rx number. For batch claims where a match is not found, the history claim will then try to be found using the reference number and provider number.</p>				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	Y
Type	Z	Priority	1	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy	Y	Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date	
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
Paper			
EMC			
Adjustment		DENY	
		DENY	
POS		DENY	
Encounter		8	
Special Batch		DENY	
PA			

Programs

Program	Program Title
VPT99VOD	Reversal Process for Voided and Rebilled Transactions

Exceptions

Pend for Capitation, Management, Admin Fees, and Assessments.

Resolution

(None)

Edit/Audit Inquiry Results Edit-398 ESC-398

Edit Information

Edit Number	398	esc Number	398	NCPDP Code	70
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Short Desc	DESI Drug - Federal Funds Not Available				
Long Desc	Less than effective drug				
Edit Criteria	DESI drugs are not covered. If the DESI indicator is = 5 or 6, set the edit.				

General Indicators

Reject Ind		Deny Ind		Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	Y
Type	G	Priority	4	Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH		TDO	
FAMIS	Y	Assessments			

Claim Type

Dental		Pharmacy	Y	Inpatient	
Nursing		Home Health		Outpatient	
Physician		Personal Care		Laboratory	
Transportation		Xover A		Xover B	
Cap Pay		Man Fee		Admin	
Asmt Fee					

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
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Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		DENY	
Encounter		0	
Special Batch			
PA			

Programs

Program	Program Title
VPTM1DRG	POS Pharmacy Claims Drug Edits Process

Exceptions

None

Resolution

(None)

Edit/Audit Inquiry Results Edit-399 ESC-399

Edit Information

Edit Number	399	esc Number	399	NCPDP Code	
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Short Desc	Multiple Errors				
Long Desc	Multiple Errors				
Edit Criteria	This edit is used Pend Resolution to deny claims with errors.				

General Indicators

Reject Ind		Deny Ind	Y	Override Ind	
PrtRA Ind	Y	PA Override Ind		Compound Ind	Y
Type	O	Priority		Recycle Days	0
HIPAA esc		CutBack Ind			

Program Indicators

Medicaid	Y	SLH	Y	TDO	Y
FAMIS	Y	Assessments	Y		

Claim Type

Dental	Y	Pharmacy	Y	Inpatient	Y
Nursing	Y	Home Health	Y	Outpatient	Y
Physician	Y	Personal Care	Y	Laboratory	Y
Transportation	Y	Xover A	Y	Xover B	Y
Cap Pay	Y	Man Fee	Y	Admin	Y
Asmt Fee	Y				

Date Information

Effective Date Code	DOS	Effective Date	Revision Date
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Media/Disposition/Pend Location Codes

Media	LOC	Disp	
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Paper		DENY	
		DENY	
EMC		DENY	
		DENY	
Adjustment		DENY	
		DENY	
POS		DENY	
Encounter		0	
Special Batch	217	PEND	
PA			

Programs

(None)

Exceptions

Pend for Capitation, Management, Admin Fees, and Assessments.

Resolution

All Claim Types:

Use this code to deny when there is no other appropriate denial code. If you use code 0399, you must enter Remarks to indicate the true reason for denial. Remarks can then be viewed by the Help line if the provider asks for further explanation.