Smart Edits - HRSA COVID-19 Uninsured Program Reference Guide

As Returned on the 277CA Clearinghouse Rejection Report as CSCC A7:21 (Invalid - Rejected Information) or CSCC A3:33 (Membership Rejection)

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Informational Banner	**INFO**	Please visit CovidUninsuredClaim.linkhealth.com for additional information. Repaired claims should be sent with the original bill type ending in 1, not a replacement or voided bill type ending in 7 or 8.	The INFO Banner is exhibited on all claims receiving COVID-19 Uninsured reject Smart Edits. The intent of the INFO Banner is to provide resources for further information on Smart Edits and the associated policies. For professional claims, the claim frequency code is submitted in the 2300 loop, CLM05-3 segment per X12 guidelines. For institutional claims, the claim frequency code is the last digit of the bill type, and is submitted in the 2300 loop, CLM05-3 segment per X12 guidelines. A claim being submitted for the first time or is being resubmitted due to a rejection should have a frequency code of 1. A claim being resubmitted as a response to an electronic remittance advice as a replacement with corrections should be sent with a frequency code 7. A claim being resubmitted as a response to electronic remittance advice unchanged from the original intended to be avoided claim should be sent with a frequency code 8.	4/30/20	Professional and Institutional
Reject Edit	**uELIG**	REJECT (uELIG) The temporary member ID for the HRSA COVID Uninsured Program is inactive for the date of service. Review information related to this temporary member ID by visiting the program portal at coviduninsuredclaim.linkhealth.com/registration.	The temporary member ID for the HRSA COVID-19 Uninsured Program is inactive for the date of service. You can review information related to this temporary member ID by visiting the COVID Uninsured Portal at: COVIDUninsuredClaim.linkhealth.com/registration.	4/30/20	Professional and Institutional

Reimbursement applies to eligible claims, as determined by HRSA (subject to adjustment as may be necessary), for dates of service or admittance delivered on or after February 4, 2020, subject to available funding; see details at COVIDUninsuredClaim.HRSA.gov. Terms and conditions will apply. Content subject to change.

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**002IAG**	The other diagnosis code <1> is for adolescents and is not typical for the patient's age <2> years.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual, Chapter 4, Section 40.3, Outpatient Code Editor Manual V17.1.	4/30/20	Institutional
Reject Edit	**002IAG**	The other diagnosis code <1> is for newborns and is not typical for the patient's age <2> years.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual, Chapter 4, Section 40.3, Outpatient Code Editor Manual V17.1.	4/30/20	Institutional
Reject Edit	**002IAG**	The other diagnosis code <1> is for maternity and is not typical for the patient's age <2> years.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual, Chapter 4, Section 40.3, Outpatient Code Editor Manual V17.1.	4/30/20	Institutional
Reject Edit	**002IAG**	The other diagnosis code <1> is for adults and is not typical for the patient's age <2> years.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual, Chapter 4, Section 40.3, Outpatient Code Editor Manual V17.1.	4/30/20	Institutional
Reject Edit	**006IPC**	Invalid HCPCS code, <1> based on the date of service on the claim.	Please refer to CMS website at CMS.gov for CMS Integrated OCE (IOCE) Specifications Version 15.2.	4/30/20	Institutional
Reject Edit	**009NCS**	Per Medicare, the item, service, or code is a non-covered service.	Please refer to CMS website at CMS.gov for CMS Claims Processing Manual Chapter 4 Section 10.1.1, CMS Integrated Outpatient Code Editor (IOCE) Specifications V16.0.	4/30/20	Institutional
Reject Edit	**009NCS**	Per Medicare, the item, service, or code is a non-covered service.	Please refer to CMS website at CMS.gov for CMS Claims Processing Manual Chapter 4 Section 10.1.1, CMS Integrated Outpatient Code Editor (IOCE) Specifications V16.0, CMS Transmittal R3728CP.	4/30/20	Institutional
Reject Edit	**010DNY**	Non-Covered Service submitted for verification of denial (Condition Code 21).	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual, Chapter 4, Section 180.5, CMS Integrated OCE (IOCE) Specifications V17.0.	4/30/20	Institutional
Reject Edit	**018INP**	Per CMS, procedure code <1> is designated as an inpatient only procedure performed in an outpatient hospital setting.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 4 Section 180.7, IOCE Specification Version.	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**018INP**	Per CMS, procedure code <1> is designated as an inpatient only procedure performed in an outpatient hospital setting.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 4 Section 180.7, IOCE Specification Version 15.3.	4/30/20	Institutional
Reject Edit	**018INP**	Per CMS, procedure code <1> is designated as an inpatient only procedure performed in an outpatient hospital setting.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 4 Section 180.7, IOCE Specification Version 17.0.	4/30/20	Institutional
Reject Edit	**018INP**	Per CMS, procedure code <1> is designated as an inpatient only procedure performed in an outpatient hospital setting.	Please refer to CMS website at CMS.gov for CMS IOCE Specification Version 20.0, CMS Claim Processing Manual Chapter 4 Section 180.7.	4/30/20	Institutional
Reject Edit	**01ADID**	The admission diagnosis code <1> is invalid because it has an incomplete number of digits.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual, Chapter 25, Section 75.6 and Chapter 3 Section 170, Official UB-04 Data Specifications Manual 2017.	4/30/20	Institutional
Reject Edit	**01AMD**	The admitting diagnosis code is missing.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual, Chapter 25, Section 75.6 and Chapter 3 Section 170, Official UB-04 Data Specifications Manual 2017.	4/30/20	Institutional
Reject Edit	**01ODID**	The other diagnoses codes <1> are invalid due to having an incomplete number of digits.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 3, Section 20.2.1, Chapter 32, Section 240.1, CMS Definitions of Medicare Code Edits Version 34.0.	4/30/20	Institutional
Reject Edit	**01ODIP**	The other procedure code <1> has an incomplete number of digits.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 3, Section 20.2.1, Chapter 32, Section 240.1, CMS Definitions of Medicare Code Edits Version 34.0.	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**020CCP**	Procedure code <1> is considered to be a component of comprehensive code <2> and is rejected. A modifier will not override this edit.	Please refer to CMS website at CMS.gov for CMS National Correct Coding Initiative (NCCI) Policy Manual, CMS Integrated Outpatient Code Editor (IOCE) Specifications V19.3.	5/14/20	Institutional
Reject Edit	**022IMO**	The modifier code <1> is either not a valid code or not valid for the from date of service on the claim.	Please refer to CMS website at CMS.gov for CMS Integrated OCE (IOCE) Specifications Version 19.2.	4/30/20	Institutional
Reject Edit	**023BDS**	The service date <1> on line <2>, is not within the From and Through dates of service on the claim.	Please refer to CMS website at CMS.gov for CMS Integrated Outpatient Code Editor - Version 15.2.	4/30/20	Institutional
Reject Edit	**027OIS**	Only incidental services are billed on this claim.	Please refer to CMS website at CMS.gov for CMS Integrated Outpatient Code Editor, Version 19.0, CMS Transmittal R3425CP.	4/30/20	Institutional
Reject Edit	**028NRM**	The HCPCS code <1> on this line is not recognized by Medicare. The following alternate code may be appropriate, <2>.	Please refer to CMS website at CMS.gov for CMS Integrated Outpatient Code Editor - Version 15.2.	4/30/20	Institutional
Reject Edit	**028NRM**	The HCPCS code <1> on this line is not recognized by Medicare.	Please refer to CMS website at CMS.gov for CMS Integrated Outpatient Code Editor, Version 17.0, Addendum D1.	4/30/20	Institutional
Reject Edit	**037TBP**	Terminated procedures should not be billed with multiple units of service.	Please refer to CMS website at CMS.gov for Integrated OCE Specifications; Medicare Claims Processing Manual - Chapter 4, "Part B Hospital Including Inpatient Hospital Part B and OPPS" Section 231.2.	4/30/20	Institutional
Reject Edit	**038IIP**	Inconsistency between implanted device and implantation procedure.	Please refer to CMS website at CMS.gov for CMS Integrated OCE (IOCE) Specifications Version 16.2.	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**040CCO**	Procedure code <1> is considered to be a component of the comprehensive code <2> and is rejected. Review to determine if a modifier is appropriate.	Please refer to CMS website at CMS.gov for CMS National Correct Coding Initiative (NCCI) Policy Manual, CMS Integrated Outpatient Code Editor (IOCE) Specifications V19.3	4/30/20	Institutional
Reject Edit	**043TBP**	The Blood Administration code <1> requires that a HCPCS Blood Product code be present on the claim.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual, Chapter 4, Section 231.8, CMS Integrated Outpatient Code Editor - Version 15.2.	4/30/20	Institutional
Reject Edit	**044ORC**	Observation room revenue code without specification of appropriate observation room service.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual, Chapter 4, Section 290.2.1, CMS Integrated Outpatient Code Editor - Version 15.2.	4/30/20	Institutional
Reject Edit	**045SNA**	Per CMS, procedure code <1> is designated as an inpatient separate procedure performed in an outpatient hospital setting.	Please refer to CMS website at CMS.gov for IOCE Specification Version 17.1.	4/30/20	Institutional
Reject Edit	**046PHC**	Partial hospitalization Condition Code 41 is not appropriate for this Type of Bill.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 4, section 260, CMS Integrated Outpatient Code Editor, Version 17.0.	4/30/20	Institutional
Reject Edit	**048RRH**	Claim line revenue code <1> requires submission of a HCPCS code.	Please refer to CMS website at CMS.gov for Integrated Outpatient Code Editor V18.0, CMS Claim Processing Manual Chapter 4 Section 20.1.	4/30/20	Institutional
Reject Edit	**04AAGE**	Age conflict; the Admission diagnosis <1> is not permissible for the patient's age.	Please refer to CMS website at CMS.gov for Medicare Code Editor V37.	4/30/20	Institutional
Reject Edit	**04OAGE**	Age conflict; the Other diagnosis <1> is not permissible for the patient's age.	Please refer to CMS website at CMS.gov for Medicare Code Editor V37.	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**050NCE**	Non-covered based on statutory exclusion.	Please refer to CMS website at CMS.gov for CMS Claims Processing Manual Chapter 15 Section 50.2, CMS Integrated Outpatient Code Editor (IOCE) Manual V17.1.	4/30/20	Institutional
Reject Edit	**053OTB**	Observation HCPCS codes can only be billed with a bill type of 013X or 085X.	Please refer to CMS website at CMS.gov for CMS Integrated Outpatient Code Editor (IOCE) Specifications.	4/30/20	Institutional
Reject Edit	**058OAP**	Observation HCPCS code G0378 is missing on the claim.	Please refer to CMS website at CMS.gov for CMS Integrated Outpatient Code Editor, Version 17.0, Integrated Outpatient Code Editor Specifications Manual, v17.0, Medicare Claims Processing Manual Chapter 4 Section 290.4.1 and 290.5.1.	4/30/20	Institutional
Reject Edit	**060MCA**	Use of modifier CA with more than one procedure or units greater than one is not allowed.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 4, Section 20.6.7 and Section 180.7, Integrated Outpatient Code Editor Specifications Manual, v17.0, Integrated Outpatient Code Editor Software, v17.0,	5/14/20	Institutional
Reject Edit	**062CNR**	HCPCS code <1> is not recognized by OPPS. An alternate code <2> may be appropriate.	Please refer to CMS website at CMS.gov for CMS Claims Processing Manual, Chapter 4, Section 10.1.1, Integrated OCE (IOCE) CMS Specifications.	4/30/20	Institutional
Reject Edit	**062CNR**	HCPCS code <1> is not recognized by OPPS.	Please refer to CMS website at CMS.gov for CMS Claims Processing Manual, Chapter 4, Section 10.1.1, Integrated OCE (IOCE) CMS Specifications.	4/30/20	Institutional
Reject Edit	**065RNM**	Revenue code <1> is not recognized by Medicare.	Please refer to CMS website at CMS.gov for the Integrated Outpatient Code Editor Software Manual V17.1.	4/30/20	Institutional
Reject Edit	**067SPA**	The HCPCS code <1> on this line is billed on a line item service date that is prior to the FDA approval date.	Please refer to CMS website at CMS.gov for CMS Integrated Outpatient Code Editor, Version 17.0.	4/30/20	Institutional
Reject Edit	**068PCD**	The HCPCS code <1> on this line is billed on a line item service date that is prior to the date of National Coverage Determination (NCD).	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 4, Section 20.6.7 and Section 180.7, Integrated Outpatient Code Editor Specifications Manual, v17.0, Integrated Outpatient Code Editor Software, v17.0.	5/14/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**070CA**	CA modifier requires patient discharge status indicating expired or transferred.	Please refer to CMS website at CMS.gov for Integrated Outpatient Code Editor Specifications Manual, v17.0.	4/30/20	Institutional
Reject Edit	**073IBP**	Incorrect billing of blood and blood products.	Please refer to CMS website at CMS.gov for Integrated OCE Specifications; Medicare Claims Processing Manual - Chapter 4, "Part B Hospital Including Inpatient Hospital Part B and OPPS" Section 231.2.	4/30/20	Institutional
Reject Edit	**074UBP**	Units greater than one for bilateral procedure billed with modifier 50.	Please refer to CMS website at CMS.gov for Integrated OCE (IOCE) CMS Specifications.	4/30/20	Institutional
Reject Edit	**076TRC**	A trauma response critical care code has been submitted without revenue code 068x and CPT code 99291.	Please refer to CMS website at CMS.gov for Claims Processing Manual Chapter 4 Section 160.1, CMS Integrated Outpatient Code Editor, Version 17.0.	4/30/20	Institutional
Reject Edit	**079IRC**	Revenue codes 381 and 382 can only be used when billing for packed red blood cells (381) and whole blood (382).	Please refer to CMS website at CMS.gov for Integrated OCE (IOCE), Medicare Claims Processing Manual, Chapter 4, Section 231.	4/30/20	Institutional
Reject Edit	**080MHA**	HCPCS code <1> is not approved for a partial hospitalization claim.	Please refer to CMS website at CMS.gov for Integrated OCE (IOCE) CMS Specifications.	4/30/20	Institutional
Reject Edit	**081MHP**	Approved partial hospitalization mental health services submitted with bill type 12X or 13X must have condition code 41 on the claim.	Please refer to CMS website at CMS.gov for Integrated OCE (IOCE) CMS specifications.	4/30/20	Institutional
Reject Edit	**082CET**	The charged amount for HCPCS code C9898 cannot exceed $1.01.	Please refer to CMS website at CMS.gov for Integrated Outpatient Code Editor V15.2, CMS Claim Processing Manual Chapter 4 Section 200.8 and 90.2.	4/30/20	Institutional
Reject Edit	**084LPC**	The HCPCS add-on code <1> is lacking a required primary code on the claim.	Please refer to CMS.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits and download the current zip file for Complete File of Add-on Code Edits for Implementation for Medicare.	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**087SSR**	Skin substitute application procedure code <1> must be submitted with the appropriate skin substitute product procedure code on the same date of service.	Please refer to CMS website at CMS.gov for CMS Transmittal R2838CP, Integrated OCE (IOCE) CMS Specifications V15. 0.	4/30/20	Institutional
Reject Edit	**087SSR**	Skin substitute application procedure code <1> must be submitted with the appropriate skin substitute product procedure code on the same date of service.	Please refer to CMS website at CMS.gov for CMS Transmittal R2838CP, Integrated OCE (IOCE) CMS Specifications V15.	4/30/20	Institutional
Reject Edit	**08QOA**	Procedure code <1> indicates a questionable obstetric admission.	Please refer to CMS website at CMS.gov for Medicare Code Editor V. 36 October 2018, Medicare Claims Processing Manual Chapter 100-04, Chapter 3 Section 20.2.1.	4/30/20	Institutional
Reject Edit	**093CTP**	The corneal tissue processing HCPCS code <1> requires a corneal transplant procedure submitted on the same date of service.	Please refer to CMS website at CMS.gov for CMS Integrated Outpatient Code Editor, Version 17.0, CMS Transmittal R3425CP.	4/30/20	Institutional
Reject Edit	**094BMM**	The Biosimilar HCPCS code <1> requires a modifier that identifies the manufacturer of the specific product.	Please refer to CMS website at CMS.gov for CMS Integrated Outpatient Code Editor, Version 17.0, CMS Transmittal R1542OTN, CMS Transmittal R3683CP.	4/30/20	Institutional
Reject Edit	**094BMM**	The Biosimilar HCPCS code <1> requires a modifier that identifies the manufacturer of the specific product.	Please refer to CMS website at CMS.gov for CMS Integrated Outpatient Code Editor, Version 17.2, CMS Transmittal R3683CP.	4/30/20	Institutional
Reject Edit	**098LRP**	This claim contains a pass-through device code <1>, but lacks the required associated procedure.	Please refer to CMS website at CMS.gov for Integrated Outpatient Code Editor Specifications v17.2.	5/14/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**099LPP**	This claim contains a pass-through or non-pass-through drug or biological HCPCS code <1>, but lacks the associated payable procedure that must be submitted on the same claim.	Please refer to CMS website at CMS.gov for Integrated OCE (IOCE) CMS Specifications V17.3, CMS Transmittal R3591CP, Integrated Outpatient Code Editor Software Manual V17.3.	5/14/20	Institutional
Reject Edit	**100AEC**	An External Cause code cannot be used as the Admit diagnosis code.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 3 Section 20.2.1, CMS Definitions of Medicare Code Edits Version 33.0.	4/30/20	Institutional
Reject Edit	**100TLR**	HSCT allogeneic transplantation, procedure code <1>, lacks required revenue code line 815 for donor acquisition.	Please refer to CMS website at CMS.gov for Integrated Outpatient Code Editor Specifications, V18.0, CMS Transmittal R3685CP.	4/30/20	Institutional
Reject Edit	**101PNM**	Item or service <1> with modifier PN is not allowed.	Please refer to CMS website at CMS.gov for CMS Integrated OCE (IOCE) Specifications V18.1, CMS Transmittal R3685CP.	4/30/20	Institutional
Reject Edit	**102IMP**	The modifier pairing on the claim line is not allowed.	Please refer to CMS website at CMS.gov for Integrated Outpatient Code Editor, V20.0, Centers for Medicare and Medicaid Services Transmittal R4185CP.	4/30/20	Institutional
Reject Edit	**103MPA**	The modifier code <1> is billed prior to the FDA approval date.	Please refer to CMS website at CMS.gov for CMS Integrated Outpatient Code Editor, Version 19.0.	4/30/20	Institutional
Reject Edit	**104AIR**	Rural Health Clinic (RHC) claim, bill type 071x contains procedure code <1> reported with modifier CG that is not eligible for the RHC all-inclusive rate.	Please refer to CMS website at CMS.gov for CMS Integrated Outpatient Code Editor, Version 19.1.	4/30/20	Institutional
Reject Edit	**105DPA**	The pass-through device code <1> is billed prior to the FDA approval date.	Please refer to CMS website at CMS.gov for CMS Integrated Outpatient Code Editor, Version 19.1.	5/14/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**110SPM**	The HCPCS code <1> on this line is billed prior to the initial marketing date.	Please refer to CMS website at CMS.gov for Integrated Outpatient Code Editor Specifications Version 20.0.	4/30/20	Institutional
Reject Edit	**11ANCP**	Procedure code <1> is non-covered since this patient's age is <2> years.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Medicare Code Edits Version 34.0.	4/30/20	Institutional
Reject Edit	**11DNCP**	Procedure code <1> is non-covered when a designated diagnosis code(s) <2> is present.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Medicare Code Edits Version 34.0.	4/30/20	Institutional
Reject Edit	**11NCP**	ICD procedure code(s) <1>, is non-covered.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 32.0, Version 31R.	4/30/20	Institutional
Reject Edit	**11NCP**	ICD procedure code <1> is non-covered unless exempted by a qualifying diagnosis code or procedure code.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 3, Section 20.2.1, CMS Definitions of Medicare Code Edits Version 32.0, Version 31R.	4/30/20	Institutional
Reject Edit	**18OWPP**	The Other diagnosis code <1> indicates that a wrong procedure was performed.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 32, Section 230, CMS Definitions of Medicare Code Edits Version 31.0, Version 31R.	4/30/20	Institutional
Reject Edit	**18PWPP**	The Principal diagnosis code <1> indicates that a wrong procedure was performed.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 32, Section 230, CMS Definitions of Medicare Code Edits Version 31.0, Version 31R.	4/30/20	Institutional
Reject Edit	**19LOS**	Procedure code 5A1955Z should not be reported when the patient's length of stay is less than or equal to four days.	Please refer to CMS website at CMS.gov for CMS Transmittal R3504CP, CMS Policy, Pub 100-4, Chapter 3, Section 20.2.1.	4/30/20	Institutional
Reject Edit	**37TBP**	Terminated procedures should not be billed as bilateral.	Please refer to CMS website at CMS.gov for Integrated OCE Specifications; Medicare Claims Processing Manual - Chapter 4, "Part B Hospital Including Inpatient Hospital Part B and OPPS" Section 231.2.	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**AHCf**	Ambulance service HCPCS code requires an ambulance mileage HCPCS code.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual, Chapter 15 - Ambulance, Section 30.2.1 - A/MAC Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation.	4/30/20	Institutional
Reject Edit	**AKIAXf**	Per Medicare guidelines, Modifier code <1> is not allowed on an Acute Kidney Injury (AKI) claim.	Please refer to CMS website at CMS.gov for CMS Transmittal R1941OTN.	4/30/20	Institutional
Reject Edit	**AKIDBf**	Per Medicare guidelines, HCPCS code <1> is not allowed on an Acute Kidney Injury (AKI) claim.	Please refer to CMS website at CMS.gov for CMS Transmittal R1941OTN.	4/30/20	Institutional
Reject Edit	**AKIDf**	Per Medicare guidelines, HCPCS code <1> is not allowed on an Acute Kidney Injury (AKI) claim.	Please refer to CMS website at CMS.gov for CMS Transmittal R2192OTN.	4/30/20	Institutional
Reject Edit	**AKIDXf**	The Acute Kidney Injury (AKI) claim is missing one of the required ICD-10-CM diagnosis codes.	Please refer to CMS website at CMS.gov for IOCE Specification Version 15.3.	4/30/20	Institutional
Reject Edit	**AKIf**	Acute Kidney Injury (AKI) code G0491 and End Stage Renal Disease (ESRD) hemodialysis code 90999 are not allowed on the same claim.	Please refer to CMS website at CMS.gov for CMS Transmittal R1725OTN.	4/30/20	Institutional
Reject Edit	**AKIHf**	Acute Kidney Injury (AKI) code <1> should not be reported on the same day as hemodialysis code <2> on history claim ID <3> Line ID <4>.	Please refer to CMS website at CMS.gov for CMS Transmittal R1725OTN.	4/30/20	Institutional
Reject Edit	**AKIICf**	Revenue code <1> is not valid for Acute Kidney Injury Claims.	Please refer to CMS website at CMS.gov for Centers for Medicare and Medicaid Services Transmittal R2062OTN.	4/30/20	Institutional
Reject Edit	**AKIPXf**	The Acute Kidney Injury (AKI) claim is missing the required procedure code.	Please refer to CMS website at CMS.gov for CMS Transmittal R1725OTN, R2062OTN.	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**AKIRCf**	The Acute Kidney Injury (AKI) claim is missing the required revenue code.	Please refer to CMS website at CMS.gov for Centers for Medicare and Medicaid Services Transmittal R2062OTN.	4/30/20	Institutional
Reject Edit	**ANRf**	Code J0882 must be submitted with revenue code 0636.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 8 Sections 60.4.2, 60.4.6.4, 60.4.6.5.	4/30/20	Institutional
Reject Edit	**ARCf**	Ambulance HCPCS codes require an appropriate revenue code.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual, Chapter 15 - Ambulance, Section 30.2.1 - A/MAC Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation.	4/30/20	Institutional
Reject Edit	**ARMf**	Invalid or missing required ambulance modifier(s).	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual, Chapter 15 - Ambulance, Section 30.2.1 - A/MAC Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation.	4/30/20	Institutional
Reject Edit	**ASRf**	Assistant at surgery modifiers are only payable by Medicare in Method II Critical Access Hospitals (CAHs).	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual 100-04, Chapter 4, Section 250.9.	4/30/20	Institutional
Reject Edit	**ATSf**	Hospitals MUST ALWAYS report a therapy modifier for "Always Therapy" procedure codes.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 5, Section 10.4 & 20.2, CMS Transmittal R2596CP.	5/14/20	Institutional
Reject Edit	**BAG**	Per LCD or NCD guidelines, procedure code <1> has not met the associated Age relationship criteria for CMS ID(s) <2>.	National Coverage Determination guidelines are developed by CMS for specific services. Smart Edits based on NCD requirements evaluate claim data for age, gender, code-to-code relationships, and allowable units. NCD policies are specific to the service that was performed. The alphabetical index for all Medicare NCDs can be found here: CMS.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx.	5/14/20	Professional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**BCC**	Per LCD or NCD guidelines, procedure code <1> has not met the associated Code-to-Code relationship criteria for CMS ID(s) <2>.	National Coverage Determination guidelines are developed by CMS for specific services. Smart Edits based on NCD requirements evaluate claim data for age, gender, code-to-code relationships, and allowable units. NCD policies are specific to the service that was performed. The alphabetical index for all Medicare NCDs can be found here: CMS.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx.	5/14/20	Professional
Reject Edit	**BPO**	Per LCD or NCD guidelines, procedure code <1> has not met the associated Place of Service relationship criteria for CMS ID(s) <2>.	National Coverage Determination guidelines are developed by CMS for specific services. Smart Edits based on NCD requirements evaluate claim data for age, gender, code-to-code relationships, and allowable units. NCD policies are specific to the service that was performed. The alphabetical index for all Medicare NCDs can be found here: CMS.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx.	5/14/20	Professional
Reject Edit	**BSX**	Per LCD or NCD guidelines, procedure code <1> has not met the associated Gender relationship criteria for CMS ID(s) <2>.	National Coverage Determination guidelines are developed by CMS for specific services. Smart Edits based on NCD requirements evaluate claim data for age, gender, code-to-code relationships, and allowable units. NCD policies are specific to the service that was performed. The alphabetical index for all Medicare NCDs can be found here: CMS.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx.	5/14/20	Professional
Reject Edit	**CAHTf**	Modifier GT can only be billed on Critical Access Hospital (TOB 085X) claims.	Please refer to CMS website at CMS.gov for CMS Transmittal R2095OTN.	4/30/20	Institutional
Reject Edit	**CCCf**	Type of Bill 0328 or 0338 must be submitted with condition code D5 or D6.	Please refer to CMS website at CMS.gov for The Medicare Claims Processing Manual, Chapter 10 Section 40.1; Section 40.2, CMS Transmittal R2833CP.	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**CCNAf**	Condition code 54 is not allowed on this Type of Bill.	Please refer to CMS website at CMS.gov for CMS Transmittal 3553.	4/30/20	Institutional
Reject Edit	**CCQf**	Type of Bills with frequency code Q must have condition code W2.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual, Chapter 1, Section 70.5, Transmittal R3219CP.	4/30/20	Institutional
Reject Edit	**CCQf**	Type of Bills with frequency code Q must have condition code D0, D1, D2, D4, D9 or E0.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual, Chapter 1, Section 70.5, Transmittal R3219CP.	4/30/20	Institutional
Reject Edit	**CCQf**	Type of Bills with frequency code Q must have a condition code from the R1-R9 range.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual, Chapter 1, Section 70.5, Transmittal R3219CP.	4/30/20	Institutional
Reject Edit	**DCCf**	Per CMS guidelines, one condition code 59, 71, 72, 73, 74, 76, 80 or 87 must be present on End Stage Renal Disease (ESRD) type of bill 072x claims.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 8 Section 50.3 and 80.2.1, CMS Transmittal R1715OTN.	4/30/20	Institutional
Reject Edit	**DCC1f**	Only one of the following condition codes 71, 72, 73, 74, 75, 76 or 87 can be submitted on an ESRD claim.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 8 Section 50.3, CMS Transmittal R1715OTN.	5/14/20	Institutional
Reject Edit	**DCP**	This claim appears to be a duplicate of a previously submitted claim. It has been rejected and will not be processed.	This claim appears to be a duplicate of a previously submitted claim. It has been rejected and will not be processed.	4/30/20	Professional
Reject Edit	**DSOf**	Occurrence code 55 is required on the claim when the patient discharge status is <1>.	Please refer to CMS website at CMS.gov for CMS Transmittal R1079OTN.	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**DTU**	Discrepancy detected between the number of units <1> on this claim line and the difference between the Beginning DOS <2> and the Ending DOS <3> which is <4> days.	Please refer to CMS website at CMS.gov for National Coverage Determination guidelines are developed by CMS for specific services. Smart Edits based on NCD requirements evaluate claim data for age, gender, code-to-code relationships and allowable units. NCD policies are specific to the service that was performed. The alphabetical index for all Medicare NCDs can be found here: CMS.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx.	5/14/2020	Professional
Reject Edit	**ECTf**	Inpatient psychiatric facility requires ICD procedure for electroconvulsive therapy (ECT).	Please refer to CMS website at CMS.gov for CMS Integrated OCE (IOCE) Specifications V15.3, CMS Transmittal R1395OTN.	4/30/20	Institutional
Reject Edit	**EPOBf**	Injection Epoetin Beta (Non-ESRD use), HCPCS Q9973, cannot be reported on type of bill 072x (ESRD).	Please refer to CMS website at CMS.gov for CMS Transmittal R2995CP.	5/14/20	Institutional
Reject Edit	**EPRf**	Code Q4081 must be submitted with revenue code 0634 or 0635.	Please refer to CMS website at CMS.gov for CMS Transmittal R231BP.	4/30/20	Institutional
Reject Edit	**ESDEf**	Non-ESRD HCPCS code <1> is not permitted on ESRD claims.	Please refer to CMS website at CMS.gov for CMS Transmittal R250BP.	5/14/20	Institutional
Reject Edit	**ESRDf**	Per Medicare guidelines, the statement date range cannot be greater than 1 month.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual, Chapter 1 - General Billing Requirements, 50.2.2.	4/30/20	Institutional
Reject Edit	**FCRP**	Procedure code <1> found on claim ID <2> is a facility service code. This service is not to be reported on a professional claim.	Please refer to CMS website at CMS.gov for policy information.	4/30/20	Professional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**FTDf**	Missing admission date or invalid Statement Covers Period "From" or "Through" dates.	Please refer to CMS website at CMS.gov for UB04 Data Specifications Manual 2015, Medicare Claims Processing Manual Chapter 25, Section 75.1 p. 17, CMS MLN Special Edition SE1117.	4/30/20	Institutional
Reject Edit	**HCCf**	Per Medicare guidelines, condition code 85 is not allowed on Type of Bill (TOB) code <1>.	Please refer to CMS website at CMS.gov for CMS Transmittal R3577CP.	4/30/20	Institutional
Reject Edit	**HDCf**	Revenue code 082X requires HCPCS code 90999.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 8 Section 50.3.	4/30/20	Institutional
Reject Edit	**HRVCf**	Revenue Code must be submitted with appropriate value code.	Please refer to CMS website at CMS.gov for Medlearn Matter 5745 Medicare Claims Processing Manual, Chapter 11 Section 30.3.	4/30/20	Institutional
Reject Edit	**IACCf**	Per Medicare guidelines, condition code 44 is not allowed on Type of Bill (TOB) code <1>.	Please refer to CMS website at CMS.gov for CMS MLN Matters SE0622, CMS Transmittal R299CP.	4/30/20	Institutional
Reject Edit	**IAG**	Diagnosis code(s) <1> is not typical for a patient whose age is <2> <3>.	Please refer to the CMS website at CMS ICD-10 CM guidelines: CMS.gov/medicare/coding/icd10.	4/30/20	Professional
Reject Edit	**IBDCf**	Value code FD requires a condition code reported on the claim.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 4, Section 61.3.5, Transmittal R3181CP.	4/30/20	Institutional
Reject Edit	**IDDMf**	The discharge date is missing.	Please refer to CMS website at CMS.gov for The Medicare Claims Processing Manual, Chapter 10, Section 40.2; Transmittal #R2680CP.	4/30/20	Institutional
Reject Edit	**IDX**	Additional digits are required for nonspecific diagnosis code(s) <1>.	Please refer to the CMS website at CMS ICD-10 CM guidelines: CMS.gov/medicare/coding/icd10.	4/30/20	Professional
Reject Edit	**IM27f**	Modifier 27 is not appropriate as another line with an evaluation and management code is not found in history.	Please refer to CMS website at CMS.gov for CMS Evaluation and Management Services Guide, CMS Transmittal R2845CP, CMS PM Transmittal A-01-80.	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**IMC**	Modifier <1> and cannot be submitted on the same claim line.	Please refer to CMS website at CMS.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4188CP.pdf.	4/30/20	Professional
Reject Edit	**INPT**	This claim appears to be a duplicate of a previously submitted claim. It has been rejected and will not be processed.	This claim appears to be a duplicate of a previously submitted claim. It has been rejected and will not be processed.	4/30/20	Institutional
Reject Edit	**IPRf**	A principal procedure code is required when a procedure code is found in the other procedure code field.	Please refer to CMS website at CMS.gov for CMS Transmittal R3329CP, CMS Transmittal R2438CP, CMS Medicare Preventive Services - Quick Reference Information: Medicare Immunization Billing, Seasonal Influenza Virus, Pneumococcal, and Hepatitis B.	4/30/20	Institutional
Reject Edit	**ISX**	Diagnosis code(s) <1> typically would not be reported for a patient whose gender is <2>.	Please refer to CMS.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1877CP.pdf for policy information.	4/30/20	Professional
Reject Edit	**JEMDf**	Modifier JE is required on HCPCS code J1444 when submitted on an ESRD claim (Type of Bill 072X).	Please refer to CMS website at CMS.gov for CMS Transmittal R4285CP.	5/14/20	Institutional
Reject Edit	**LBM**	Per LCD or NCD guidelines, procedure code <1> has not met the associated Modifier Code relationship criteria for CMS ID(s) <2>.	National Coverage Determination guidelines are developed by CMS for specific services. Smart Edits based on NCD requirements evaluate claim data for age, gender, code-to-code relationships, and allowable units. NCD policies are specific to the service that was performed. The alphabetical index for all Medicare NCDs can be found here: CMS.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx.	5/14/20	Professional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**LBS**	Per LCD or NCD guidelines, procedure code <1> has not met the associated Secondary Diagnosis Code relationship criteria for CMS ID(s) <2>.	National Coverage Determination guidelines are developed by CMS for specific services. Smart Edits based on NCD requirements evaluate claim data for age, gender, code-to-code relationships, and allowable units. NCD policies are specific to the service that was performed. The alphabetical index for all Medicare NCDs can be found here: CMS.gov/medicare-coverage-database/indexes/ ncd-alphabetical-index.aspx.	5/14/20	Professional
Reject Edit	**LBT**	Per LCD or NCD guidelines, procedure code <1> has not met the associated Tertiary Diagnosis Code relationship criteria for CMS ID(s) <2>.	National Coverage Determination guidelines are developed by CMS for specific services. Smart Edits based on NCD requirements evaluate claim data for age, gender, code-to-code relationships, and allowable units. NCD policies are specific to the service that was performed. The alphabetical index for all Medicare NCDs can be found here: CMS.gov/medicare-coverage-database/indexes/ ncd-alphabetical-index.aspx.	5/14/20	Professional
Reject Edit	**LCAG**	Per LCD or NCD guidelines, procedure code <1> has not met the associated Age relationship criteria for CMS ID(s) <2>.	National Coverage Determination guidelines are developed by CMS for specific services. Smart Edits based on NCD requirements evaluate claim data for age, gender, code-to-code relationships, and allowable units. NCD policies are specific to the service that was performed. The alphabetical index for all Medicare NCDs can be found here: https://www.cms.gov/medicare-coverage-database/ indexes/ncd-alphabetical-index.aspx	5/14/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**LCDY**	Per LCD or NCD guidelines, procedure code <1> has met the associated Deny relationship criteria for CMS ID(s) <2>.	National Coverage Determination guidelines are developed by CMS for specific services. Smart Edits based on NCD requirements evaluate claim data for age, gender, code-to-code relationships, and allowable units. NCD policies are specific to the service that was performed. The alphabetical index for all Medicare NCDs can be found here: CMS.gov/medicare-coverage-database/indexes/ ncd-alphabetical-index.aspx.	5/14/20	Institutional
Reject Edit	**LCI**	Per LCD or NCD guidelines, procedure code <1> has not met the associated Diagnosis Code relationship criteria for CMS ID(s) <2>.	National Coverage Determination guidelines are developed by CMS for specific services. Smart Edits based on NCD requirements evaluate claim data for age, gender, code-to-code relationships, and allowable units. NCD policies are specific to the service that was performed. The alphabetical index for all Medicare NCDs can be found here: CMS.gov/medicare-coverage-database/indexes/ ncd-alphabetical-index.aspx.	5/14/20	Institutional
Reject Edit	**LCM**	Per LCD or NCD guidelines, procedure code <1> has not met the associated Modifier Code relationship criteria for CMS ID(s) <2>.	National Coverage Determination guidelines are developed by CMS for specific services. Smart Edits based on NCD requirements evaluate claim data for age, gender, code-to-code relationships, and allowable units. NCD policies are specific to the service that was performed. The alphabetical index for all Medicare NCDs can be found here: CMS.gov/medicare-coverage-database/indexes/ ncd-alphabetical-index.aspx.	5/14/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**LCON**	Per LCD or NCD guidelines, procedure code <1> has not met the associated Condition Code relationship criteria for CMS ID(s) <2>.	National Coverage Determination guidelines are developed by CMS for specific services. Smart Edits based on NCD requirements evaluate claim data for age, gender, code-to-code relationships, and allowable units. NCD policies are specific to the service that was performed. The alphabetical index for all Medicare NCDs can be found here: CMS.gov/medicare-coverage-database/indexes/ ncd-alphabetical-index.aspx.	5/14/20	Institutional
Reject Edit	**LDY**	Per LCD or NCD guidelines, procedure code <1> has not met the associated Diagnosis Code relationship criteria for CMS ID(s) <2>.	National Coverage Determination guidelines are developed by CMS for specific services. Smart Edits based on NCD requirements evaluate claim data for age, gender, code-to-code relationships, and allowable units. NCD policies are specific to the service that was performed. The alphabetical index for all Medicare NCDs can be found here: CMS.gov/medicare-coverage-database/indexes/ ncd-alphabetical-index.aspx.	5/14/20	Professional
Reject Edit	**LVC**	Per LCD or NCD guidelines, procedure code <1> has not met the associated Value Code relationship criteria for CMS ID(s) <2>.	National Coverage Determination guidelines are developed by CMS for specific services. Smart Edits based on NCD requirements evaluate claim data for age, gender, code-to-code relationships, and allowable units. NCD policies are specific to the service that was performed. The alphabetical index for all Medicare NCDs can be found here: CMS.gov/medicare-coverage-database/indexes/ ncd-alphabetical-index.aspx.	5/14/20	Institutional
Reject Edit	**mAM**	Per CMS guidelines, HCPCS Code <1> is identified as an ambulance code and requires an ambulance modifier appended.	Please refer to CMS website at CMS.gov for Centers for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual, Chapter 15, 30 - General Billing Guidelines, Page 25.	4/30/20	Professional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**mANM**	Per Medicare guidelines, anesthesia code <1> on claim line ID <2> requires an appropriate modifier.	Please refer to CMS website at CMS.gov for CMS Claims Processing Manual, Chapter 12.	4/30/20	Professional
Reject Edit	**mAS**	Per Medicare guidelines, a statutory payment restriction for assistants at surgery applies to procedure code <1>.	Please refer to CMS website at CMS.gov for National Physician Fee Schedule Relative Value File.	4/30/20	Professional
Reject Edit	**MASf**	Modifier 80, 81 or 82 must also be billed in conjunction with modifier AS.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual 100-04, Chapter 4, Section 250.9.	4/30/20	Institutional
Reject Edit	**MAXRf**	When HCPCS code J0604 or J0606 is billed with modifier AX on an End Stage Renal Disease claim (TOB 072X), the revenue code must be 0636.	Please refer to CMS website at CMS.gov for Transmittal R1889OTN.	5/14/20	Institutional
Reject Edit	**MAYf**	Modifier AY is not allowed on an Acute Kidney Injury (AKI) claim.	Please refer to CMS website at CMS.gov for CMS Transmittal R1725OTN.	4/30/20	Institutional
Reject Edit	**mB50**	Per Medicare guidelines, bilateral procedure <1> submitted with modifier 50 should not be billed with more than one unit of service.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual chapter 23 section 20.9.3.2 Medicare Claims Processing Manual chapter 12 section 40.7.	5/14/20	Professional
Reject Edit	**mBC**	Per CMS guidelines, payment for procedure code <1> is always bundled into payment for other services not specified and no separate payment is made.	Please refer to CMS.gov/Medicare/Coding/NationalCorrectCodInitEd for additional information on NCCI billing guidelines. Scroll to the bottom of the page to access the NCCI policy manual effective Jan. 1, 2020 zip file. Once the file is open, locate the correct chapter for the code range in question. All files do not have to be unzipped to locate the chapter that is needed.	4/30/20	Professional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**mBIO**	Procedure code <1> needs to be reported with a modifier that identifies the manufacturer of the biosimilar biological product.	Please refer to CMS website at CMS.gov for policy information.	4/30/20	Professional
Reject Edit	**MCGf**	The presence of modifier CG indicates the dialysis treatment does not meet medical justification requirements and should not be paid separately.	Please refer to CMS website at CMS.gov for CMS Transmittal R1849OTN.	4/30/20	Institutional
Reject Edit	**mCO**	Per Medicare guidelines, billing for co-surgeons is not permitted for procedure code <1>.	Please refer to CMS website at CMS.gov for National Physician Fee Schedule Relative Value File.	4/30/20	Professional
Reject Edit	**mDT**	Per Medicare guidelines, procedure code <1> describes a diagnostic procedure that requires a professional component modifier in POS <2>.	Please refer to CMS website at CMS.gov for National Physician Fee Schedule Relative Value File.	4/30/20	Professional
Reject Edit	**MFLf**	A diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid.	Please refer to CMS website at CMS.gov for CMS Transmittal R3329CP, CMS Transmittal R2438CP, CMS Medicare Preventive Services - Quick Reference Information: Medicare Immunization Billing, Seasonal Influenza Virus, Pneumococcal, and Hepatitis B.	5/14/20	Institutional
Reject Edit	**mFOM**	Per Medicare guidelines, it is inappropriate to report modifier <1> for a procedure that is discontinued on a professional claim. This modifier is used by the facility to indicate that a procedure was terminated.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 4 Section - 20.6.4.	4/30/20	Professional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**mFR**	Per Medicare guidelines, the frequency does not meet policy requirements for the procedure code.	Please refer to CMS website at CMS.gov for Medicare Internet-Only Manuals Medicare Benefit Policy Manual Chapter 15 - Covered Medical and other Healthcare Services.	5/14/20	Professional
Reject Edit	**mGS**	Per Medicare guidelines, procedure code <1> has been reported without the appropriate ICD 10 CM screening diagnosis code Z13.5.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 18 Section 70.1.1.	4/30/20	Professional
Reject Edit	**mGT**	Per Medicare guidelines, modifier <1> is inappropriately appended to procedure code <2>.	Please refer to CMS website at CMS.gov for National Physician Fee Schedule Relative Value File.	4/30/20	Professional
Reject Edit	**MHBf**	A diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid.	Please refer to CMS website at CMS.gov for CMS Transmittal R3329CP, CMS Transmittal R2438CP, CMS Medicare Preventive Services - Quick Reference Information: Medicare Immunization Billing, Seasonal Influenza Virus, Pneumococcal, and Hepatitis B.	5/14/20	Institutional
Reject Edit	**MHSf**	Procedure code <1> is for mental health services and must be billed with revenue code 0900 for Rural Health Center (RHC) claims.	Please refer to CMS website at CMS.gov for CMS Transmittal R1637OTN.	5/14/20	Institutional
Reject Edit	**mIC**	Per Medicare guidelines, procedure code <1> is a service covered incident to a physician's service and modifier 26 or TC is not appropriate.	Please refer to CMS website at CMS.gov for Centers for Medicare and Medicaid National Physician Fee Schedule.	4/30/20	Professional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**mIM**	Per Medicare guidelines, modifier <1> is not appropriate for procedure code <2>.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual chapter 4 section 20.6 Medicare Claims Processing Manual chapter 12 sections 20.4.6, 20.4.6, 40.6, and 40.9 Medicare Claims Processing Manual chapter 23 section .20.9.1 Medicare Contractor Beneficiary and Provider Communication Manual chapter 5 section 20.4Medicare Phys.	4/30/20	Professional
Reject Edit	**mIN**	Per Medicare guidelines, the current procedure code <1> is considered a bundled service when procedure code <2> in history on claim ID <3> and line ID <4> is billed on the same day by the same provider.	Please refer to CMS website at CMS.gov for National Physician Fee Schedule Relative Value File.	4/30/20	Professional
Reject Edit	**mLIH**	Per Medicare guidelines, procedure code <1> describes a diagnostic procedure that requires a professional component modifier in POS <2>.	Please refer to CMS website at CMS.gov for Medicare Physician Fee Schedule Relative Value File.	4/30/20	Professional
Reject Edit	**mLP**	Per the Medicare Physician Fee Schedule, Procedure <1> is inappropriate with Modifier -TC. Performance of the test is paid under the lab fee schedule.	Please refer to CMS website at CMS.gov for National Physician Fee Schedule Relative Value File.	4/30/20	Professional
Reject Edit	**mLTH**	Per Medicare guidelines, procedure code <1> describes a laboratory procedure that is not eligible for separate reimbursement in place of service <2>.	Please refer to CMS website at CMS.gov for Medicare Physician Fee Schedule Relative Value File.	4/30/20	Professional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**mM33**	An Annual Wellness Visit and Advanced Care planning were reported together for the same date of service on claim <1>, and CPT code <2> was billed without a modifier 33.	Please refer to CMS website at CMS.gov for Medicare Benefits Policy Manual and TM 216.	4/30/20	Professional
Reject Edit	**mMAT**	Per Medicare guidelines, modifier AT is required when billing procedure code <1> for active treatment. Medicare does not pay for maintenance therapy.	Please refer to CMS website at CMS.gov for CMS MLN SE1602.	4/30/20	Professional
Reject Edit	**mMFL**	Per Medicare guidelines, the associated administration code for vaccine procedure code <1>, is missing or invalid.	Please refer to CMS website at CMS.gov for The Guide to Preventive Services; Medicare Claims Processing Manual, Chapter 18, Section 10.	4/30/20	Professional
Reject Edit	**mMHB**	Per Medicare guidelines, the associated administration code for vaccine procedure code <1>, is missing or invalid.	Please refer to CMS website at CMS.gov for The Guide to Preventive Services; Medicare Claims Processing Manual, Chapter 18, Section 10.	4/30/20	Professional
Reject Edit	**mMPN**	Per Medicare guidelines, the associated administration code for vaccine procedure code <1>, is missing or invalid.	Please refer to CMS website at CMS.gov for The Guide to Preventive Services; Medicare Claims Processing Manual, Chapter 18, Section 10.	4/30/20	Professional
Reject Edit	**mMSP**	Per Medicare guidelines the diagnosis code(s) billed does not support the medical necessity of G0101.	Please refer to CMS website at CMS.gov for Medicare Preventive Services ICN 006559 October 2016.	5/14/20	Professional
Reject Edit	**umMUE**	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2> <3>.	Please refer to CMS website at CMS.gov for National Correct coding Initiative Edits Medically Unlikely Edits Practitioner Services MUE table.	5/14/20	Professional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**umMUE**	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2>.	Please refer to CMS website at CMS.gov for National Correct coding Initiative Edits Medically Unlikely Edits Practitioner Services MUE table.	5/14/20	Professional
Reject Edit	**mMUR**	Per Medicare HCPCS code R0075 was billed without the required UN, UP, UQ, UR, or US modifier.	Please refer to CMS website at CMS.gov for CMS Claims Processing Manual, Chapter 13, Sections 90.3 and 90.5.	4/30/20	Professional
Reject Edit	**mNC**	Per Medicare guidelines, the HCPCS code or modifier billed is a non covered HCPCS code or modifier.	Please refer to CMS website at CMS.gov/Regulations-and-Guidance/Guidance/Transmittals/index to locate the appropriate transmittal document. This document will help determine the appropriate codes to use when billing for the services rendered.	4/30/20	Professional
Reject Edit	**mNP**	Procedure Code <1> does not typically require performance by a physician in Place of Service <2> per Medicare Guidelines.	Please refer to CMS website at CMS.gov for Centers for Medicare and Medicaid National Physician Fee Schedule, Attachment A of the National Physician Fee Schedule (NPFS).	4/30/20	Professional
Reject Edit	**mNS**	Procedure code <1> is not covered by Medicare.	Please refer to CMS website at CMS.gov for Centers for Medicare and Medicaid National Physician Fee Schedule.	4/30/20	Professional
Reject Edit	**mNV**	Procedure code <1> is not valid for Medicare purposes.	Please refer to CMS website at CMS.gov/Regulations-and-Guidance/Guidance/Transmittals/index to locate the appropriate transmittal document. This document will help determine the appropriate codes to use when billing for the services rendered.	4/30/20	Professional
Reject Edit	**MODEf**	Modifier EE or ED must be submitted on codes J0882 or Q4081 when value code 48 is greater than 13.0 or value code 49 is greater than 39.0.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 8 Sections 60.4 and 60.7.	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**MODEf**	Modifier EE or ED must be submitted on codes J0882 or Q4081 when value code 48 is greater than 13.0 or value code 49 is greater than 39.0.	Please refer to CMS website at CMS.gov for CMS Claims Processing Manual Chapter 8 Sections 60.4.	4/30/20	Institutional
Reject Edit	**MODEf**	Only one modifier EE or ED is appropiate for a claim line.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 8 Sections 60.4 and 60.7.	4/30/20	Institutional
Reject Edit	**MODEf**	Modifier EE or ED should only be used when value code 48 is greater than 13 or value code 49 is greater than 39.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 8 Sections 60.4 and 60.7.	4/30/20	Institutional
Reject Edit	**MODf**	Use of modifier(s) <1> is not typical for procedure code <2>.	Please refer to CMS website at CMS.gov for CMS NCCI Policy, Chapter 1.	4/30/20	Institutional
Reject Edit	**MODGf**	Code 90999 is missing appropriate URR modifier (G1-G6).	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 8 Section 50.3 Page 39; MM6782; Transmittal R1932CP; Renal Dialysis Facility Manual.	4/30/20	Institutional
Reject Edit	**MODJf**	Modifier JA or JB must be submitted with code Q4081 or J0882.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 8 60.4.2 Transmittal R2311CP.	4/30/20	Institutional
Reject Edit	**MODNEf**	HCPCS codes J0881 and J0885 must be submitted with modifier EA, EB or EC.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 17 Section 80.9; Transmittal 1412.	4/30/20	Institutional
Reject Edit	**MODV2f**	Modifier V5, V6 or V7 must be submitted with revenue code 0821.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 8 Section 50.3; MM6782; Transmittal R1932CP.	4/30/20	Institutional
Reject Edit	**mONP**	Per Medicare CPT/HCPCS code <1> on line <2> must have modifier GN.	Please refer to CMS website at CMS.gov for CMS Transmittal R3863.	4/30/20	Professional
Reject Edit	**mONP**	Per Medicare CPT/HCPCS code <1> on line <2> must have modifier GO.	Please refer to CMS website at CMS.gov for CMS Transmittal R3863.	4/30/20	Professional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**mONP**	Per Medicare CPT/HCPCS code <1> on line <2> must have modifier GP.	Please refer to CMS website at CMS.gov for CMS Transmittal R3863.	4/30/20	Professional
Reject Edit	**mPC**	Per Medicare guidelines, procedure code <1> describes the physician work portion of a diagnostic test. Modifier 26 or TC on current line ID <2> is not appropriate.	Please refer to CMS website at CMS.gov for National Physician Fee Schedule Relative Value File.	4/30/20	Professional
Reject Edit	**mPDP**	The PD modifier must be billed with the 26 modifier.	Please refer to CMS website at CMS.gov for Transmittal 2373.	4/30/20	Professional
Reject Edit	**mPDT**	The PD modifier may not be billed with the TC modifier.	Please refer to CMS website at CMS.gov for Transmittal 2373.	4/30/20	Professional
Reject Edit	**mPI**	Per Medicare guidelines, procedure code <1> describes a physician interpretation for this service and is inappropriate in place of service <2>.	Please refer to CMS website at CMS.gov for National Physician Fee Schedule Relative Value File.	4/30/20	Professional
Reject Edit	**MPMf**	The claim line contains a PA modifier which indicates that this surgical code was performed on the wrong body part and should be denied.	Please refer to CMS website at CMS.gov for CMS Claims Processing Manual, Chapter 32, section 230, CMS National Coverage Determination Manual, Chapter 1- Part 2, Section 140.6-140.8, CMS Transmittal R1819CP.	4/30/20	Institutional
Reject Edit	**MPMf**	The claim line contains a PB modifier which indicates that this surgical code was performed on the wrong patient and should be denied.	Please refer to CMS website at CMS.gov for CMS Claims Processing Manual, Chapter 32, section 230, CMS National Coverage Determination Manual, Chapter 1- Part 2, Section 140.6-140.8, CMS Transmittal R1819CP.	4/30/20	Institutional
Reject Edit	**MPMf**	The claim line contains a PC modifier which indicates that the wrong surgical code was performed on the patient and should be denied.	Please refer to CMS website at CMS.gov for CMS Claims Processing Manual, Chapter 32, section 230, CMS National Coverage Determination Manual, Chapter 1- Part 2, Section 140.6-140.8, CMS Transmittal R1819CP.	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**MPNf**	A diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid.	Please refer to CMS website at CMS.gov for CMS Transmittal R3329CP, CMS Transmittal R2438CP, CMS Medicare Preventive Services - Quick Reference Information: Medicare Immunization Billing, Seasonal Influenza Virus, Pneumococcal, and Hepatitis B.	5/14/20	Institutional
Reject Edit	**mPS**	Per Medicare guidelines, procedure code <1> describes the physician service. Use of modifier 26 or TC is not appropriate.	Please refer to CMS website at CMS.gov for National Physician Fee Schedule Relative Value File.	4/30/20	Professional
Reject Edit	**MRCf**	Per Medicare guidelines, the required revenue code is missing or inappropriate.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 18, Section 20.2.2, CMS Transmittal R4225CP.	4/30/20	Institutional
Reject Edit	**mSB**	Add-on procedure code <1> has been submitted without an appropriate primary procedure code.	Please refer to CMS.gov/Medicare/Coding/NationalCorrectCodInitEd/ Add-On-Code-Edits.	5/14/20	Professional
Reject Edit	**MSFf**	Per Medicare, only one service line per day with revenue code 052X with a qualifying visit medical services HCPCS code <1> is allowed on a RHC claim. HCPCS code <2> was billed on claim ID <3> on claim line <4> (excluding approved preventive services and modifier 59).	Please refer to CMS website at CMS.gov for CMS Transmittal R1637OTN.	5/14/20	Institutional
Reject Edit	**MSPf**	Per Medicare guidelines the diagnosis code(s) billed does not support the medical necessity of G0101.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 18, Section 40.6, Medicare Preventive Services ICN 006559 October 2016.	5/14/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**MSPHf**	Procedure code <1> is for either medical services or preventive health services and must be billed with revenue code 052X for Rural Health Clinic (RHC) claims.	Please refer to CMS website at CMS.gov for CMS Transmittal R1637OTN.	5/14/20	Institutional
Reject Edit	**mTC**	Per Medicare guidelines, procedure code <1> describes only the technical portion of a service or diagnostic test. Modifier 26 or TC is not appropriate.	Please refer to CMS website at CMS.gov for National Physician Fee Schedule Relative Value File.	4/30/20	Professional
Reject Edit	**mTCH**	Per Medicare guidelines, procedure code <1> describes a diagnostic procedure that is not eligible for separate reimbursement in place of service <2>.	Please refer to CMS website at CMS.gov for Medicare Physician Fee Schedule Relative Value File.	4/30/20	Professional
Reject Edit	**mTF**	The beginning date of service occurred more than 12 months from the entry date <1>, this exceeds Medicare's timely filing guidelines.	Please refer to CMS website at CMS.gov for Centers for Medicare and Medicaid Services Transmittal 2140.	5/14/20	Professional
Reject Edit	**mTHP**	Per Medicare guidelines telehealth procedure code <1> must be performed in POS 02.	Please refer to CMS website at CMS.gov for policy information.	4/30/20	Professional
Reject Edit	**mTS**	Per Medicare guidelines, team surgery is not permitted for procedure code <1>.	Please refer to CMS website at CMS.gov for National Physician Fee Schedule Relative Value File.	4/30/20	Professional
Reject Edit	**MUEf**	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2> <3>.	Please refer to CMS website at CMS.gov for National Correct coding Initiative Edits, Medically Unlikely Edits, Facility Outpatient Services MUE Table, Centers for Medicare and Medicaid Services Transmittal R1421OTN.	5/14/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**MUEf**	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code <1> exceed the allowed number of units of <2>.	Please refer to CMS website at CMS.gov for National Correct coding Initiative Edits, Medically Unlikely Edits, Facility Outpatient Services MUE Table, Centers for Medicare and Medicaid Services Transmittal R1421OTN.	5/14/20	Institutional
Reject Edit	**NERf**	HCPCS codes J0881 and J0885 must be reported with revenue code 0636.	Please refer to CMS website at CMS.gov for CMS Transmittal R1637OTN.	4/30/20	Institutional
Reject Edit	**OCD51f**	Occurrence code 51 must be submitted on all ESRD claims unless value code D5 with amount 9.99 or 8.88 is present.	Please refer to CMS website at CMS.gov for The Medicare Claims Processing Manual, Chapter 8, Section 50.9 MM6782 Transmittal R1932CP.	4/30/20	Institutional
Reject Edit	**ORSf**	Inappropriate type of bill or revenue code for outpatient rehabilitation service.	Please refer to CMS website at CMS.gov for The Medicare Claims Processing Manual, Chapter 5 Section 40.2.	4/30/20	Institutional
Reject Edit	**ORSf**	Inappropriate type of bill or revenue code for outpatient rehabilitation service.	Please refer to CMS website at CMS.gov for CMS Transmittal R2690CP.	4/30/20	Institutional
Reject Edit	**ORSf**	Inappropriate type of bill or revenue code for outpatient rehabilitation service.	Please refer to CMS website at CMS.gov for The Medicare Claims Processing Manual, Chapter 5 Section 40.2 and 40.3.	4/30/20	Institutional
Reject Edit	**ORSf**	Inappropriate type of bill for outpatient rehabilitation service.	Please refer to CMS website at CMS.gov for The Medicare Claims Processing Manual, Chapter 5 Section 40.2.	4/30/20	Institutional
Reject Edit	**ORSf**	Inappropriate revenue code for outpatient rehabilitation service.	Please refer to CMS website at CMS.gov for The Medicare Claims Processing Manual, Chapter 5 Section 40.2 and 40.3.	4/30/20	Institutional
Reject Edit	**OSCf**	The occurrence span code <1> on the claim is invalid.	Please refer to CMS website at CMS.gov for UB04 Data Specifications Manual 2017, CMS Claims Processing Manual, Chapter 25, section 75.3.	4/30/20	Institutional
Reject Edit	**OTFRMf**	This outpatient therapy functional reporting HCPCS code requires a severity/complexity modifier.	Please refer to CMS website at CMS.gov for CMS Transmittal R2622CP, R1196OTN, CMS Claim Processing Manual, Chapter 5, Section 10.6.	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**OUTPT**	This claim appears to be a duplicate of a previously submitted claim. It has been rejected and will not be processed.	This claim appears to be a duplicate of a previously submitted claim. It has been rejected and will not be processed.	4/30/20	Institutional
Reject Edit	**OTSf**	Only one therapy modifier can be reported on a line of service.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual, Chapter 5 Sections 20.1 and 40.2.	4/30/20	Institutional
Reject Edit	**PMODf**	Code J0890 must be reported with modifier JA or JB.	Please refer to CMS website at CMS.gov for Transmittal R2582CP.	4/30/20	Institutional
Reject Edit	**POABf**	Present on Admission (POA) indicator is not valid for this Type of Bill (TOB).	Please refer to CMS website at CMS.gov for CMS Transmittal R1844OTN, SE17015.	4/30/20	Institutional
Reject Edit	**PSCf**	The patient discharge status code is missing.	Please refer to CMS website at CMS.gov for National Uniform Billing Committee (NUBC), Official UB-04 Data Specifications Manual 2012.	4/30/20	Institutional
Reject Edit	**QSTf**	Per Medicare, qualified stay requirements have not been met.	Please refer to CMS website at CMS.gov for CMS Integrated OCE (IOCE) Specifications V18.0, CMS Transmittal R3685CP.	4/30/20	Institutional
Reject Edit	**RAPf**	Revenue code 0023 must be billed with a Home Health HIPPS code.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual, Chapter 10, Section 40.1.	5/14/20	Institutional
Reject Edit	**RCNAf**	Claim line revenue code <1> not allowed for RHC claims.	Please refer to CMS website at CMS.gov for CMS Transmittal R1637OTN.	5/14/20	Institutional
Reject Edit	**RCRHf**	Claim line revenue code <1> requires submission of a HCPCS code for RHC claims.	Please refer to CMS website at CMS.gov for CMS Transmittal R1637OTN.	5/14/20	Institutional
Reject Edit	**RCSf**	Must use revenue code that is to the highest specificity; 0880 is not specified.	Please refer to CMS website at CMS.gov for Transmittal R2134CP January 14, 2011 MM #7064 January 14, 2011.	4/30/20	Institutional
Reject Edit	**RFVRf**	A patient reason for visit diagnosis code is required.	Please refer to CMS website at CMS.gov for CMS Transmittal R3435CP.	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**RMEGf**	Revenue code 0860 or 0861 is submitted with inappropriate type of bill.	Please refer to CMS website at CMS.gov for Transmittal R783OTN MM7100 NUBC.	4/30/20	Institutional
Reject Edit	**RRCf**	Revenue code 0023 can only be billed one time on RAP (Request for Anticipated Payment) claims.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual, Chapter 10, Section 40.1.	4/30/20	Institutional
Reject Edit	**SBTBf**	The type of bill code <1> submitted on the claim is inappropriate for screening digital breast tomosynthesis.	Please refer to CMS website at CMS.gov for CMS Transmittal R3160CP.	5/14/20	Institutional
Reject Edit	**SBTDf**	Screening digital breast tomosynthesis HCPCS code <1> requires the appropriate diagnosis code.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 18, Section 20.2.2, CMS Transmittal R3232CP.	5/14/20	Institutional
Reject Edit	**SBTDf**	Screening digital breast tomosynthesis HCPCS code <1> requires the appropriate diagnosis code.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 18, Section 20.2.2, CMS Transmittal R3160CP.	5/14/20	Institutional
Reject Edit	**SBTDf**	Screening digital breast tomosynthesis HCPCS code <1> requires the appropriate diagnosis code.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 18, Section 20.2.2, CMS Transmittal R3844CP.	4/30/20	Institutional
Reject Edit	**SBTRf**	Screening digital breast tomosynthesis HCPCS code <1> requires the appropriate revenue code.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 18, Section 20.2.2, CMS Transmittal R3160CP.	4/30/20	Institutional
Reject Edit	**SDBTf**	Screening digital breast tomosynthesis HCPCS code <1> requires the appropriate primary mammogram code.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 18, Section 20.2.2, CMS Transmittal R3844CP.	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**SDBTf**	Screening digital breast tomosynthesis HCPCS code <1> requires the appropriate primary mammogram code.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual Chapter 18, Section 20.2.2, CMS Transmittal R3232CP.	5/14/20	Institutional
Reject Edit	**SNFH1f**	Revenue code 0022 is required on type of bill <1>.	Please refer to CMS website at CMS.gov for Medicare Claim Processing Manual, Chapter 6, Section 30.	4/30/20	Institutional
Reject Edit	**SOA2f**	Point of origin for admission is missing or invalid.	Please refer to CMS website at CMS.gov for Transmittal R2250 CP.	4/30/20	Institutional
Reject Edit	**TCRf**	A therapy code has been submitted with inappropriate therapy revenue code.	Please refer to CMS website at CMS.gov for Medicare Claims Processing Manual Chapter 5 Section 40.2, 40.3.	4/30/20	Institutional
Reject Edit	**THMOf**	For claim lines billing therapy assistant services, modifier CQ must be submitted with modifier GP and modifier CO must be submitted with modifier GO.	Please refer to CMS website at CMS.gov for CMS Transmittal R4440CP.	4/30/20	Institutional
Reject Edit	**THSf**	Procedure code <1> is a telehealth service and must be billed with revenue code 0780 for Rural Health Clinic (RHC) claims.	Please refer to CMS website at CMS.gov for CMS Transmittal R1637OTN.	5/14/20	Institutional
Reject Edit	**TMCEf**	Therapy evaluation and re-evaluation procedure code requires a therapy service modifier.	Please refer to CMS website at CMS.gov for CMS Transmittal R2868CP, Claim Processing Manual, Chapter 5, Section 20.1.	4/30/20	Institutional
Reject Edit	**TMCEf**	Therapy evaluation and re-evaluation procedure code requires a therapy service modifier.	Please refer to CMS website at CMS.gov for CMS Transmittal R2868CP, Claim Processing Manual, Chapter 5, Sections 20.1, & 20.2.	4/30/20	Institutional
Reject Edit	**TOAf**	This claim has a missing type of admission code.	Please refer to CMS website at CMS.gov for Official UB-04 Data Specifications Manual 2017, CMS Claims Processing Manual Ch.25 Section 75, Transmittal R2250CP.	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**TRCf**	A therapy service revenue code requires a therapy service modifier.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual, Chapter 5, Sections 20.1 and 40.2.	4/30/20	Institutional
Reject Edit	**TSMf**	Therapy service modifier requires therapy service revenue code.	Please refer to CMS website at CMS.gov for CMS Claim Processing Manual, Chapter 5 Sections 20.1 and 40.2.	4/30/20	Institutional
Reject Edit	**uCOVLAB**	Per HRSA COVID-19 Uninsured Program Guidelines, only the COVID-19 test procedure code should be submitted if a COVID-related diagnosis is not submitted on the claim.	Claims submitted for reimbursement must meet effective date of service, diagnosis, place of service, and procedure code guidelines. For more information on the independent lab billing guidelines, please refer to COVIDUninsuredClaim.linkhealth.com/billing-codes.html.	5/21/2020	Professional
Reject Edit	**uCOVP**	This claim does not meet diagnosis and/or procedure code requirements for testing or treatment per HRSA COVID-19 Uninsured Program Guidelines. It is rejected and will not be processed.	Claims submitted for reimbursement must meet effective date of service, diagnosis, place of service, and procedure code guidelines. For more information on the program guidelines, please refer to COVIDUninsuredClaim.linkhealth.com/billing-codes.html.	4/30/20	Professional
Reject Edit	**uCOVPf**	This claim does not meet diagnosis and/or procedure code requirements for testing or treatment per HRSA COVID-19 Uninsured Program Guidelines. It is rejected and will not be processed.	Claims submitted for reimbursement must meet effective date of service, diagnosis, place of service, and procedure code guidelines. For more information on the program guidelines, please refer to COVIDUninsuredClaim.linkhealth.com/billing-codes.html.	4/30/20	Institutional
Reject Edit	**uDCPT**	Procedure <1> is a Medicare Part D drug based on submitted claim information and is not eligible for reimbursement. This claim is rejected and will not be processed.	Please refer to CMS website for CMS Part D - CPT and HCPCS codes that are always classified as Part D CMS.gov/Medicare/Medicare-Contracting/ContractorLearningResources/Downloads/JA0652.pdf.	5/14/20	Professional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**uDCPTf**	Procedure <1> is a Medicare Part D drug based on submitted claim information and is not eligible for reimbursement. This claim is rejected and will not be processed.	Please refer to CMS website for CMS Part D - CPT and HCPCS codes that are always classified as Part D CMS.gov/Medicare/Medicare-Contracting/ContractorLearningResources/Downloads/JA0652.pdf.	5/14/20	Institutional
Reject Edit	**uDHBVf**	Procedure <1> is a Medicare Part D drug based on submitted claim information and is not eligible for reimbursement. This claim is rejected and will not be processed.	Please refer to CMS website for CMS Part D Hepatitis B Vaccine CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Vaccines-Part-D-Factsheet-ICN908764.pdf.	5/14/20	Institutional
Reject Edit	**uDHI**	Procedure <1> is a Medicare Part D drug based on submitted claim information and is not eligible for reimbursement. This claim is rejected and will not be processed.	Please refer to CMS website for CMS Part D - Home Infusion CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Overview.	5/14/20	Professional
Reject Edit	**uDHIC**	Procedure <1> is a Medicare Part D drug based on submitted claim information and is not eligible for reimbursement. This claim is rejected and will not be processed.	Please refer to CMS website for CMS Part D - Home Infusion without a cancer diagnosis code CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Overview.	5/14/20	Professional
Reject Edit	**uDHII**	Procedure <1> is a Medicare Part D drug based on submitted claim information and is not eligible for reimbursement. This claim is rejected and will not be processed.	Please refer to CMS website for CMS Part D - URL in research; Home Infusion without an immunodeficiency diagnosis code CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Overview.	5/14/20	Professional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**uDHIJ**	Procedure <1> is a Medicare Part D drug based on submitted claim information and is not eligible for reimbursement. This claim is rejected and will not be processed.	Please refer to CMS website for CMS Part D - Home Infusion with specific J-codes CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Overview.	5/14/20	Professional
Reject Edit	**uDHIKD**	Procedure <1> is a Medicare Part D drug based on submitted claim information and is not eligible for reimbursement. This claim is rejected and will not be processed.	Please refer to CMS website for CMS Part D - Home Infusion with KD modifier CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Overview.	5/14/20	Professional
Reject Edit	**uDHIT**	Procedure <1> is a Medicare Part D drug based on submitted claim information and is not eligible for reimbursement. This claim is rejected and will not be processed.	Please refer to CMS website for CMS Part D - Home Infusion without transplant diagnosis code CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Overview.	5/14/20	Professional
Reject Edit	**uDRTf**	Procedure <1> is a Medicare Part D drug based on submitted claim information and is not eligible for reimbursement. This claim is rejected and will not be processed.	Please refer to CMS website for CMS Part D Rabies and Tetanus CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0678.pdf.	5/14/20	Institutional
Reject Edit	**uDRTVf**	Procedure <1> is a Medicare Part D drug based on submitted claim information and is not eligible for reimbursement. This claim is rejected and will not be processed.	Please refer to CMS website for CMS Part D Rabies and Tetanus Vaccine CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Vaccines-Part-D-Factsheet-ICN908764.pdf.	5/14/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**uFREQf**	Per HRSA COVID-19 Uninsured Program guidelines, interim or late charges will not be accepted for payment. This claim is rejected and will not be processed.	Please refer to COVIDUninsuredClaim.linkhealth.com for Policy information.	4/30/20	Institutional
Reject Edit	**uHINDC**	NDC code <1> is not valid for procedure code <2>. Please update with an active NDC code that is valid for the procedure code and resubmit.	Please refer to CMS website at CMS.gov/medicare/medicare-part-b-drug-average-sales-price/2020-asp-drug-pricing-files for additional information, where you can select the most recent ASP NDC-HCPCS Crosswalk in the related links section.	9/3/2020	Professional
Reject Edit	**uHMNDC**	Procedure code <1> requires an NDC code. Please resubmit with updated NDC code. NDC code submission also requires quantity and units of measure	Please refer to CMS website at CMS.gov/medicare/medicare-part-b-drug-average-sales-price/2020-asp-drug-pricing-files for additional information, where you can select the most recent ASP NDC-HCPCS Crosswalk in the related links section.	9/3/2020	Professional
Reject Edit	**uIBC**	Invalid Billing CLIA ID	Please refer to CMS website at CMS.gov for CLIA Policy.	4/30/20	Professional
Reject Edit	**uISC**	Invalid Servicing CLIA ID	Please refer to CMS website at CMS.gov for CLIA Policy.	4/30/20	Professional
Reject Edit	**umAT**	Per Medicare guidelines procedure code <1> requires modifier GP, GO, or GN.	Please refer to CMS website at CMS.gov for CMS Transmittal R3863.	5/14/20	Professional
Reject Edit	**uMCID**	Missing CLIA ID	Please refer to CMS website at CMS.gov for CLIA Policy.	4/30/20	Professional
Reject Edit	**umONP**	Per Medicare, CPT/HCPCS code <1> must have modifier GN.	Please refer to CMS website at CMS.gov for CMS Transmittal R3863 - Speech Therapy.	5/14/20	Professional
Reject Edit	**umONP**	Per Medicare, CPT/HCPCS code <1> must have modifier GP.	Please refer to CMS website at CMS.gov for CMS Transmittal R3863 - Physical Therapy.	5/14/20	Professional
Reject Edit	**umONP**	Per Medicare, CPT/HCPCS code <1> must have modifier GO.	Please refer to CMS website at CMS.gov for CMS Transmittal R3863 - Occupational Therapy	5/14/20	Professional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
Reject Edit	**UNSL**	Diagnosis code <1> is unspecified and has an equivalent diagnosis code for laterality.	Please refer to the CMS website at CMS ICD-10 CM guidelines: CMS.gov/medicare/coding/icd10/.	5/14/20	Professional
Reject Edit	**uNVP**	Per Medicare guidelines, procedure code <1> is not valid for reimbursement.	Please refer to the CMS website at CMS ICD-10 CM guidelines: CMS.gov for Medicare and Medicaid National Physician Fee Schedule.	7/2/2020	Professional
Reject Edit	**uONELAB**	Per HRSA COVID-19 Uninsured Program Guidelines, only one COVID-related test can be billed per claim if a COVID-related diagnosis is not submitted on the claim.	Claims submitted for reimbursement must meet effective date of service, diagnosis, place of service, and procedure code guidelines. For more information on the independent lab billing guidelines, please refer to COVIDUninsuredClaim.linkhealth.com/billing-codes.html.	5/21/2020	Professional
Reject Edit	**uOPLABf**	Per HRSA COVID-19 Uninsured Program Guidelines, services that are not for COVID-19 testing should not be submitted for payment with COVID-19 lab tests.	Please refer to COVIDUninsuredClaim.linkhealth.com/billing-codes.html for policy information.	5/17/2020	Institutional
Reject Edit	**uSVC**	Per HRSA COVID-19 Uninsured Program guidelines, this service is excluded for reimbursement. This claim is rejected and will not be processed.	Please refer to COVIDUninsuredClaim.linkhealth.com for Policy information. The HRSA COVID-19 Uninsured Program does not apply to hospice, air ambulance, or Medicare Part D claims. This edit validates revenue codes and procedure codes for hospice, and revenue codes for self-administered drugs, that are always considered to be Part D per Medicare guidelines.	4/30/20	Professional
Reject Edit	**uSVCf**	Per HRSA COVID-19 Uninsured Program guidelines, this service is excluded for reimbursement. This	Please refer to COVIDUninsuredClaim.linkhealth.com for Policy information. The HRSA COVID-19 Uninsured Program does not apply to hospice, air ambulance, or Medicare Part D claims. This edit validates revenue codes	4/30/20	Institutional

Edit	Smart Edit	Smart Edits Message	Sourcing or Description for Smart Edit	Effective Date	Claim Type
		claim is rejected and will not be processed.	and procedure codes for hospice, and revenue codes for self-administered drugs, that are always considered to be Part D per Medicare guidelines.		
Reject Edit	**uUNLC**	Per Medicare guidelines, procedure code <1> is an unlisted code and does not qualify for reimbursement.	Please refer to CMS website at CMS.gov for the CMS 2020 Unlisted Codes files.	7/2/2020	Professional
Reject Edit	**VCCCf**	Value code 42 and condition code 26 must both be present on the claim.	Please refer to CMS website at CMS.gov for CMS Transmittal R3779CP.	4/30/20	Institutional
Reject Edit	**VCDf**	Value code default of 99.99 cannot be reported on code J0882 or Q4081.	Please refer to CMS website at CMS.gov for CMS Transmittal R2361CP.	4/30/20	Institutional
Reject Edit	**VCHf**	An appropriate value code is required for HCPCS codes Q4081 or J0882.	Please refer to CMS website at CMS.gov for CMS Claims Processing Manual Chapter 8 Sections 60.4 and 60.7 Transmittal R1307CP.	4/30/20	Institutional
Reject Edit	**VRCf**	Vaccine HCPCS codes require an appropriate revenue code.	Please refer to CMS website at CMS.gov for CMS Transmittal R2438CP, CMS Medicare Preventive Services - Quick Reference Information: Medicare Immunization Billing, Seasonal Influenza Virus, Pneumococcal, and Hepatitis B.	4/30/20	Institutional

Reject Edit - Sent when the claim in question was rejected for missing or invalid information. This edit is found at the line level of the claim.

Informational Banner - Exhibited on all claims receiving Smart Edits. The intent of the banner is to provide resources for further information on Smart Edits.