

EDIT 001 - INCORRECT CLAIM STATUS CODE

This edit is posted to any encounter claim if it has been assigned an invalid claim status code by the MMIS. This edit is for internal use and has no applicability to data provided by the HMO.

EDIT 002 - BILLING PROVIDER NUMBER MISSING/INVALID

This edit is posted to any encounter claim if the billing provider number is invalid (non-numeric or spaces) or contains the HMO Medicaid provider number (0155179, 5451302, 6228704, 6228607, 6700403, 6231004).

EDIT 004 - PRESCRIBING PROVIDER MISSING/INVALID

This edit is posted to a pharmacy (claim type 12) encounter claim if the thirteen position prescribing SSN or EIN is either invalid (non-numeric or spaces) or missing.

EDIT 005 - ATTENDING PROVIDER MISSING/INVALID

This edit is posted to a inpatient (claim type 01), outpatient (claim type 03), or home health (claim type 06), encounter claim if the thirteen position attending SSN or EIN is either invalid (non-numeric or spaces) or missing.

EDIT 006 - REFERRING PROVIDER MISSING/INVALID

This edit is posted to any encounter claim if the thirteen position referring SSN or EIN is either invalid (non-numeric or spaces) or missing. This referring provider number is required for all encounter claims submitted by an HMO, or

This edit is posted to any encounter claims if the thirteen position SSN or Tax ID, representing an "other" provider, is invalid.

EDIT 009 - SERVICING PROVIDER NAME MISSING

This edit is posted to any encounter claims if the name of the servicing provider is missing.

EDIT 010 - SERVICING PROVIDER MISSING/INVALID

This edit is posted to any encounter claim if the thirteen position servicing provider SSN or EIN is missing or invalid. The servicing provider number is required on all encounter claims submitted.

EDIT 011 - RECIPIENT NUMBER MISSING OR INVALID

This edit is posted to any encounter claim if the Recipient ID Number (E-CURRENT-RECIP-ID-NUM) is not numeric or is equal to zero.

Additionally, this edit is posted if the County (1st and 2nd digits), the Aid Category (3rd and 4th digits), and the Person Number (11th and 12th digits) in the Current Recipient ID are not compatible according to the rules below for the various recipient types:

Edit 011 will be posted if:

- County is 01 thru 21, (Categorically Needy) and Aid Cat NOT = 10,20,30,50,60,70,80.
- County is 01 thru 21, and Person Num is greater than 49.
- County is 23 (Medicaid Expansion) or 24 (Kid Care) and Aid Cat is not 20, 30 or 70.
- County is 23 or 24 and Person Num is greater than 49.
- County is 90 (Special) and Aid Cat is not = 10,20,30,50,60,70, or 80.
- County is 90 and Person Num is greater than 49.
- County is other than 01-24 or 90.

EDIT 013 - INVALID BIRTHDATE

This edit is posted to any encounter claim if the birth date is invalid. In other words, the birth date is non-numeric, equal to zeros, or failed standard date editing routines.

EDIT 015 - STATEMENT THRU DATE < STATEMENT FROM DATE

This edit is posted to a inpatient (claim type 01) or home health (claim type 06) encounter claim if the statement thru date is less than the statement from date.

EDIT 016 - SERVICE FROM DATE MISSING/INVALID

This edit is posted to any encounter claim if the service from date is either missing or invalid. In other words, the service from date is non-numeric, equal to zeros, or failed standard date editing routines.

EDIT 017 - SERVICE THRU DATE MISSING/INVALID

This edit is posted to any encounter claim if the service thru date is either missing or invalid. In other words, the service thru date is non-numeric, equal to zeros, or failed standard date editing routines.

EDIT 018 - SERVICE THRU DATE < SERVICE FROM DATE

This edit is posted to any encounter claim if the service thru date is less than the service from date.

EDIT 020 - SERVICE THRU DATE > DATE RECEIVED

This edit is posted to any encounter claim if the service thru date is greater than the Julian date in the first five positions of the ICN.

EDIT 022 - CAPITATION DETAIL SERVICE PERIOD INVALID

This edit is posted to a capitation detail encounter claim if the service period (i.e., the monthly capitation period) as indicated by the range of service FROM/THRU dates is less than July, 2009.

EDIT 023 - VOID MATCHED MULTIPLE ENCOUNTERS

This edit is posted to a pharmacy (claim type 12) encounter void claim if more than one match is found on the PHARMENC file based on NPI, Date of Service, Prescription number and NDC.

EDIT 024 - DUPLICATE PHARMACY/SERVICE DATE/PRESCRIPTION NUMBER

This edit is applicable to pharmacy claims only:

This edit is posted when an original claim is received where another paid claim is found in the Claims History file with the same Provider ID, Date of Service, Prescription Number and NDC.

Action: Assign Different RX number.

EDIT 025 - DISPENSED DATE INVALID

This edit is posted to a vision (claim type 08) encounter claim if the dispense date is invalid. In other words, the vision dispense date is non-numeric, other than spaces, or failed standard date editing routines.

EDIT 026 - CLAIM EXCEEDS TIMELY FILING LIMITS

This edit is posted to any encounter claim if the service date (or as of 7/1/2009 Service Date Thru for inpatient encounters) is 365 days less than the Julian date in the first five positions of the ICN.

NOTE: Effective 07/01/2009 when other payers are involved (TPL) the time limit is extended from 12 months to 18 months.

EDIT 042 - TYPE OF BILL CODE MISSING/INVALID

This edit posted to an inpatient (claim type 01), outpatient (claim type 03), or home health (claim type 06) encounter claim if the type of bill is either missing or not one of the following values:

Inpatient 111, 112-114, 117, 118, 121, 122-124, 127, 128
Outpatient 131-135, 141-144, 147, 148, 211-219, 221-229, 231-239, 281-289, 721-725, 727-729, 741-744,
831-834
Home Health 321-324, 327, 328, 331-334, 337, 338, 341-344, 347, 348

EDIT 044 - ADMISSION TYPE MISSING/INVALID

This edit is posted to an inpatient (claim type 01) or outpatient (claim type 03) encounter claim if the type of admission is either missing or not one of the following values:

- 1 - Emergency
- 2 - Urgent
- 3 - Elective
- 4 - Newborn
- 5 - Trauma Center
- 9 - Information Not Available

EDIT 045 - PATIENT STATUS CODE MISSING/INVALID

This edit is posted to an inpatient (claim type 01) encounter claim if the patient status is either missing or not one of the following values:

- 01 - Discharged to Home
- 02 - Discharged to LTC Facility
- 03 - Death
- 04 - Other

EDIT 048 - SURGICAL PROCEDURE CODE MISSING/INVALID

This edit is posted to an inpatient (claim type 01) or outpatient (claim type 03) encounter claim if the surgical procedure code is either missing or invalid (equal to spaces). This field is required when a surgical date is specified.

EDIT 049 - SURGICAL DATE MISSING/INVALID

This edit is posted to an inpatient (claim type 01) or outpatient (claim type 03) encounter claim if the surgical date is missing or invalid.

In other words, the surgical date is non-numeric, equal to zeros, or failed standard date editing routines. This field is required when a surgical procedure code is specified.

EDIT 056 - REVENUE UNITS MISSING/INVALID

This edit is posted to an inpatient (claim type 01) or home health (claim type 06) if the revenue code is greater than 001 and the revenue units are not greater than zero, or

This edit is posted to an outpatient (claim type 03) encounter claim if the revenue code is 300-319 (lab), 450-459 (emergency), 510, 511, 519 (clinic), 634, 635, 821, 829, 831, 841, 851, or 859 (ERSD), and the revenue units are not greater than zero.

EDIT 058 - REVENUE/CHARGE/CODE INVALID

This edit is posted to an inpatient (claim type 01), outpatient (claim type 03), and home health (claim type 06) claims if a revenue code is present and the revenue charge is non-numeric or the revenue code is non-numeric or less than 001.

EDIT 060 - OCCURRENCE CODE MISSING/INVALID

This edit is posted to an inpatient (claim type 01), outpatient (claim type 03), or home health (claim type 06) encounter claim if the occurrence date is greater than zeros and the occurrence code is spaces, or the not one of the following values:

- 01 - Auto Accident
- 02 - Auto Accident - No Fault Insurance
- 03 - Accident/Tort Liability
- 04 - Accident/Employment Related
- 05 - Other Accident
- 06 - Crime Victim
- 10 - Last Menstrual Period
- 11 - Onset of Symptoms/Illness
- 18 - Patient Date of Retirement
- 19 - Spouse Date of Retirement
- 20 - Guarantee of Payment Began
- 21 - UR/PSRO Notice Received
- 22 - Date Active Care Ended
- 24 - Date Insurance Denied
- 25 - Date Benefits Terminated/Primary Payer
- 26 - Date SNF Bed Available
- 31 - Date Patient Notified - Bill Accommodations
- 32 - Date Patient Notified - Bill Procedures
- 33 - First Day, First Month 12 Month ESRD Period
- 34 - Date Election Extended Care Facilities
- 35 - Date Treatment Started
- 36 - Date of Discharge - Transplant Procedure
- 42 - Date of Discharge
- 43 - Scheduled Date of Canceled Surgery
- 45 - Accident Hour
- 70 - SNF Billing
- 71 - Payer Code
- 74 - Non-Covered Level of Care
- 79 - Payer Code
- A1 - Birthdate - Insured A
- B1 - Birthdate - Insured B
- C1 - Birthdate - Insured C
- A2 - Effective Date - Insured A Policy
- B2 - Effective Date - Insured B Policy
- C2 - Effective Date - Insured C Policy
- A3 - Benefits Exhausted
- B3 - Benefits Exhausted
- C3 - Benefits Exhausted
- J3 - Charity Care Write-Off Date

EDIT 064 - SERVICE THRU DATE > STATEMENT THRU DATE

This edit is posted to an outpatient (claim type 03) or home health (claim type 06) encounter claim if the service thru date is greater than the statement thru date.

EDIT 068 - ADMISSION SOURCE MISSING/INVALID

This edit is posted to an inpatient (claim type 01) or outpatient (claim type 03) encounter claim if the source of admission is either missing or not one of the following values:

If the admission is 1, 2, or 3, the admission source must be valued:

- 1 - Physician referral
- 2 - Clinic referral
- 3 - HMO referral
- 4 - Transfer from a hospital (acute)
- 5 - Transfer from a skilled nursing facility
- 6 - Transfer from another facility
- 7 - Emergency room
- 8 - Court/law enforcement
- 9 - Information not available

If the admission type is 4, the admission source must be valued:

- 1 - Normal delivery
- 2 - Premature delivery
- 3 - Sick baby
- 4 - Extramural birth
- 5 - Born inside the hospital
- 6 - Born outside the hospital

EDIT 069 - OCCURRENCE DATE MISSING/INVALID

This edit is posted to an inpatient (claim type 01), outpatient (claim type 03), or home health (claim type 06) encounter claim if the occurrence date is invalid or missing. In other words, the occurrence date is non-numeric, equal to zeros, or failed standard date editing routines.

EDIT 071 - STATEMENT COVERS FROM DATE MISSING/INVALID

This edit is posted to an outpatient (claim type 03) or home health (claim type 06) encounter claim if the statement covers from date is invalid or missing. In other words, the statement covers thru date is non-numeric, equal to zeros, or failed standard date editing routines.

EDIT 072 - STATEMENT COVERS THRU DATE MISSING/INVALID

This edit is posted to an outpatient (claim type 03) or home health (claim type 06) encounter claim if the statement covers thru date is invalid or missing. In other words, the statement covers thru date is non-numeric, equal to zeros, or failed standard date editing routines.

EDIT 073 - SERVICE COVERS FROM DATE < STATEMENT FROM DATE

This edit is posted to an outpatient (claim type 03) or home health (claim type 06) claim if the service from date is less than the statement covers from date.

EDIT 074 - STATEMENT COVERS FROM DATE > SERVICE THRU DATE

This edit is posted to an outpatient (claim type 03) or home health (claim type 06) claim if the statement covers thru date is greater than the service thru date.

EDIT 081 - CLINIC CODE INVALID

This edit is posted to an outpatient (claim type 03) encounter claim if the clinic code is not spaces and not one of the following values:

- 01 - Alcoholism
- 02 - Allergy
- 03 - Arthritis, Rheumatology
- 04 - Cardiac, Cardiovascular Pacemaker
- 05 - Chest, TB
- 06 - Dental
- 07 - Dermatology
- 08 - Diabetic, Endocrine
- 09 - Eye, Ent
- 10 - Family Planning
- 11 - Gynecology
- 12 - Hematology
- 13 - Medical Gastrointestinal Gastroenterology
- 14 - Neurology, Neurosurgery
- 15 - OB, Prenatal
- 16 - Orthopedic
- 17 - Pediatric
- 18 - Physical Therapy, Physical Medicine, Rehabilitation
- 19 - Podiatry
- 20 - Proctology
- 21 - Psychiatry, Mental Health
- 22 - Speech and Hearing, Speech Pathology
- 23 - Surgery, Plastic Surgery
- 24 - Tumor
- 25 - Urology
- 26 - Other
- 27 - EPSDT
- 28 - Partial Hospitalization

EDIT 083 - SURGICAL PROCEDURE CODE MISSING

This edit is posted to an outpatient (claim type 03) or inpatient (claim type 01) claim if the first occurrence of surgical procedure codes is equal to spaces and the billed revenue code is one of the following: 099, 360, 361, 362, 367, 369, 370, 374, 379, 490, 499, 710, 719.

EDIT 085 - DAYS/UNITS/VISITS MISSING/INVALID

This edit is posted to any encounter claim if the following is true:

- the revenue units is non-numeric or zeros for outpatient (claim type 03) or home health (claim type 06) claims, or
- the drug quantity is non-numeric or zeros for pharmacy (claim type 12) claims, or
- the service units is non-numeric or zeros for all other claims.

Note: This edit can also post to a Pharmacy Encounter claim when edit 545 (NDC not on File) posts as the units cannot be correctly calculated for an invalid NDC. The units would be zero in this case even if the submitter input a metric quantity on the transaction. Also, for compound Pharmacy Encounters, this edit will post if any of the compound ingredient quantities is not greater than zero.

EDIT 087 - SURGICAL PROVIDER MISSING/INVALID

This edit is posted to an inpatient (claim type 01) or outpatient (claim type 03) claim if any of the surgical procedure codes billed is 8700 thru 9999, and the other physician is equal to spaces or zeros.

EDIT 088 - DATE OF SURGERY < SERVICE/STATEMENT FROM DATE

This edit is posted to an inpatient (claim type 01) or outpatient (claim type 03) claim if there is a valid surgical procedure code and surgery date, and the surgery date is less than a valid service from date (inpatient) or the statement covers from date (outpatient).

EDIT 089 - DATE OF SURGERY > SERVICE/STATEMENT THRU DATE

This edit is posted to an inpatient (claim type 01) or outpatient (claim type 03) claim if there is a valid surgical procedure code and surgery date is greater than a valid service thru date (inpatient) or the statement covers thru date (outpatient).

EDIT 100 - NO REVENUE CODE FOUND EXCEPT 001

This edit is posted to an inpatient (claim type 01), outpatient (claim type 03), or home health (claim type 06) claim if the only occurrence of revenue code data found was revenue code 001.

This edit is also posted to an inpatient claim if the revenue code is not numeric or if the revenue code is equal to 000 but there are revenue units and/or revenue charges greater than zero.

EDIT 101 - ORIGINAL RECIPIENT ID HAS BEEN CHANGED DUE TO LINK/UNLINK

This EOB is posted on a claim when the original recipient ID has been updated. This is the result of a link/unlink process having been performed on the Recipient Master File.

EDIT 102 - TOOTH SURFACE MISSING/INVALID

This edit is posted to a dental (claim type 11) encounter claim if an occurrence of tooth surface is not spaces and the previous occurrence is spaces, or if the tooth surface value does not match one of the following values:

- M - Mestal
- I - Incisal
- B - Buccal
- O - Occlusal
- D - Distal
- L - Lingual

EDIT 107 - ENC CATEGORY OF SERVICE MISSING/INVALID

This edit is posted for any encounter claim if the category of service billed by the HMO is missing or not one of the following values:

COS	Description
01A	- Primary Care Physician
01B	- Nurse Practitioner
01C	- Physician Assistant
01D	- Specialty Physician
002	- EPSDT
003	- Inpatient Hospital
004	- Outpatient Hospital
005	- Laboratory
006	- Radiology
007	- Prescription Drugs
008	- Family Planning
009	- Rehabilitation Services
010	- Podiatrist Services
011	- Chiropractor Services
012	- Optometrist Services
013	- Optical Appliances
014	- Hearing Aids
015	- Home Health Agency Services
016	- Hospice Services
018	- Medical Supplies
019	- Prosthetics & Othotics
020	- Dental Services
021	- Organ Transplant
022	- Transportation

EDIT 108 - DRG OUTLIER INDICATOR MISSING/INVALID

This edit is posted to inpatient (claim type 01) encounter claims if a DRG code is billed and the DRG outlier code is not one of the following values:

- Spaces - Optional Field
- C - Clinical
- N - Inlier
- H - High Trim
- V - Low Volume
- L - Low Trim
- S - Same Day Stay
- T - Transfer

EDIT 109 - ENCOUNTER COS INVALID FOR CLAIM TYPE

This edit is posted to any encounter claim if the category of service billed by the HMO is invalid for the claim type billed. The valid claim type for each category of service is as follows:

COS	Description	CT
01A	Primary Care Physician	04
01B	Nurse Practitioner	04
01C	Physician Assistant	04
01D	Specialty Physician	04
002	EPSDT	04
003	Inpatient Hospital	01
004	Outpatient Hospital	03
005	Laboratory	04
006	Radiology	04
007	Prescription Drugs	12
008	Family Planning	04
009	Rehabilitation Services	04
010	Podiatrist Services	04
011	Chiropractor Services	04
012	Optometrist Services	04
013	Optical Appliances	08
014	Hearing Aids	04
015	Home Health Agency Services	06
016	Hospice Services	04
018	Medical Supplies	04
019	Prosthetics & Othotics	04
020	Dental Services	11
021	Organ Transplant	04
022	Transportation	07

EDIT 110 - ENC TAXONOMY MISSING/INVALID

This edit is posted to any encounter claim if the claim is a professional claim and the taxonomy field is not populated or is invalid.

EDIT 123 - MEDICAL RECORD NUMBER MISSING/INVALID

This edit is posted to an inpatient (claim type 01), outpatient (claim type 03), or home health (claim type 06) encounter claim if the medical record number is spaces or less than four characters in length.

EDIT 124 - PATIENT ACCOUNT NUMBER MISSING/INVALID

This edit posted to any encounter claim if the patient account number is spaces, zeros, or is less than four characters in length.

EDIT 125 - PHARMACY REFILL INDICATOR MISSING/INVALID

This edit is posted to a pharmacy (claim type 12) encounter claim if the refill indicator is missing, spaces, or not one of the following values:

00	New prescription
01-99	Number of refills

EDIT 126 - COMPOUND DRUG INDICATOR MISSING/INVALID

This edit is posted to a pharmacy (claim type 12) encounter claim if the compound drug indicator is missing, spaces, or not one of the following values:

Y Yes
N No

EDIT 127 - NATIONAL DRUG CODE MISSING/INVALID

This edit is posted to a pharmacy (claim type 12) encounter claim if the compound drug indicator is not equal to "Y", and the NDC either missing, non-numeric, zeros, the first five positions are zeros, or positions six thru nine are zeros.

EDIT 130 - PHARMACY DAYS SUPPLY MISSING/INVALID

This edit is posted to a pharmacy (claim type 12) encounter claim if the days supply is missing, non-numeric, or zeros.

EDIT 131 - PRESCRIPTION NUMBER MISSING/INVALID

This edit is posted to a pharmacy (claim type 12) encounter claim if the prescription number is missing, spaces, or zeros.

EDIT 133 - EMPLOYMENT RELATED INDICATOR MISSING/INVALID

This edit is posted any encounter claim if the patient employment related indicator is missing or not one of the following values:

Y Yes
N No

EDIT 135 - CURRENT EXAM DATE MISSING/INVALID

This edit is posted to a vision (claim type 08) encounter claim if the current exam date is invalid or missing. In other words, the current exam date is non-numeric, equal to zeros, or failed standard date editing routines.

EDIT 136 - PREVIOUS EXAM DATE INV

This edit is posted to a vision (claim type 08) encounter claim if the previous exam date is invalid. In other words, the previous exam date is non-numeric, other than spaces, or failed standard date editing routines.

EDIT 138 - ACCIDENT INDICATOR MISSING/INVALID

This edit is posted any encounter claim if the accident indicator is missing or not one of the following values:

Y Yes
N No

EDIT 139 - EPSDT INDICATOR INVALID

This edit is posted to a professional (claim type 04), transportation (claim type 07), vision (claim type 08), and dental (claim type 11) encounter claim if the EPSDT indicator is not one of the following values:

Y Yes
N No

EDIT 141 - PLACE OF SERVICE MISSING/INVALID

This edit is posted to a professional (claim type 04), vision (claim type 08), and dental (claim type 11) encounter claim if the place of service is missing or not one of the following values:

- 0 - Emergency Room
- 1 - Doctor's Office
- 2 - Patient's Home
- 3 - Inpatient Hospital
- 4 - Boarding Home
- 5 - Skilled Nursing Home
- 6 - Independent Laboratory
- 7 - Outpatient Hospital
- 8 - Clinic
- 9 - Other

Note: Value 9 (Other) can include day care facility, night care facility, nursing home, ambulance, other medical surgical facility, residential treatment center, specialized treatment facility, and independent kidney treatment center.

EDIT 142 - ORIGIN CODE MISSING/INVALID

This edit is posted to a transportation (claim type 07) encounter claim if the origin code is missing or not one of the following values:

- 0 - Emergency room
- 1 - Doctor's office
- 2 - Patient's home
- 3 - Inpatient hospital
- 4 - Boarding home
- 5 - Nursing facility
- 6 - Independent laboratory
- 7 - Outpatient hospital
- 8 - Clinic
- 9 - Other

EDIT 143 - DESTINATION CODE MISSING/INVALID

This edit is posted to a transportation (claim type 07) encounter claim if the destination code is missing or not one of the following values:

- 0 - Emergency room
- 1 - Doctor's office
- 2 - Patient's home
- 3 - Inpatient hospital
- 4 - Boarding home
- 5 - Nursing facility
- 6 - Independent laboratory
- 7 - Outpatient hospital
- 8 - Clinic
- 9 - Other

EDIT 144 - PATIENT ACCOUNT NUMBER IDENTIFIES HMO-DENIED CLAIM

This edit is posted to an encounter claim if the patient account number identifies an HMO-denied claim (i.e., the last/rightmost character of the patient account number is a 'D').

EDIT 151 - CLAIM CHARGE MISSING/INVALID

This edit is posted to any encounter claim if the claim line charge is non-numeric or is less than zero.

Note: This amount represents the actual payment made by the HMO to their provider for the service represented on the encounter claim. The HMO is permitted to state a zero amount for those providers that are capitated or receive special incentives/bonuses.

However, if zero payment encounter claims are present, the HMO is responsible for providing capitation summary or capitation detail encounter claims. Capitation encounter claims specify a monthly aggregate payment amount (usually the capitated amount) for a specific provider (capitation summary) or provider/recipient combination (capitation detail) and are identified by "SUMRY" or "CAPDT" in the service code field.

EDIT 152 - TOTAL CHARGE MISSING/INVALID

This edit is posted to any encounter claim if the claim total charge is non-numeric.

Note: This amount represents the actual payment made by the HMO to their provider for the service represented on the encounter claim. The HMO is permitted to state a zero amount for those providers that are capitated or receive special incentives/bonuses.

However, if zero payment encounter claims are present, the HMO is responsible for providing capitation summary or capitation detail encounter claims. Capitation encounter claims specify a monthly aggregate payment amount (usually the capitated amount) for a specific provider (capitation summary) or provider/recipient combination (capitation detail) and are identified by "SUMRY" or "CAPDT" in the service code field.

EDIT 153 - CLAIM PAYMENT MISSING/INVALID

This edit is posted to any encounter claim if the claim payment amount is equal to 9999999.99. This value indicates that one of the following conditions is found:

- (1) a line level payment was not submitted
- (2) a submitted line level payment amount is greater than 9999999.99
- (3) for inpatient claims, the claim payment amount, which is computed as the total of all line level payment amounts, is greater than 9999999.99
- (4) Other Payer ID equal to 'HMO' was not found on a pharmacy encounter claim.
- (5) For pharmacy encounter claims, the Other Payer Amount submitted with Other Payer ID equal to 'HMO' is a non-numeric amount.

NOTE: This amount represents the actual payment made by the HMO to their provider for the services identified on the encounter claim. The HMO is permitted to state a zero amount for those providers that are capitated or receive special incentives or bonuses.

However, if zero payment encounter claims are present, the HMO is responsible for providing capitation summary or capitation detail encounter claims. Capitation encounter claims specify a monthly aggregate payment amount (usually the capitated amount) for a specific provider (capitation summary) or provider/recipient combination (capitation detail) and are identified by "SUMRY" or "CAPDT" in the service code field.

EDIT 161 - PROCEDURE CODE MISSING/INVALID

This edit is posted to a professional (claim type 04), transportation (claim type 07), vision (claim type 08), and dental (claim type 11) encounter claim if the procedure code is missing, spaces, or any character of the five position procedure code is a space.

In addition, this edit is posted to outpatient (claim type 03) encounter claims if the revenue code indicates a laboratory procedure, the laboratory procedure code is not one of the following values: 36415, 36430, 36440, 36450, 36455, 36460, 80000-89999, G0001, G0026, G0027, G0054, G0060, P0000-P9999, P9615, Q0111-Q0116, or W8000-W8999.

EDIT 162 - PROCEDURE CODE MODIFIER MISSING/INVALID

This edit is posted if a procedure modifier is not equal to spaces and contains a value that does not meet the following criteria when comparing the claim against the NJMMIS Modifier Table:

- a) The modifier exists in the NJMMIS Modifier Table and is defined as valid in the NJMMIS Modifier Table (i.e., the "VALID/INVALID CODE" is equal to "V").
- b) The beginning (FROM) date of service and the end (TO) date of service for the claim fall within the allowable modifier begin (FROM) and end (TO) date range.

Modifiers in the NJMMIS Modifier Table can be displayed via NJMMIS on-line inquiry. The following menu options would be selected to access this inquiry function:

- a) NJMMIS MAIN MENU - Option 04 ("REFERENCE")
- b) NJMMIS REFERENCE SUBSYSTEM MENU - Option 12 ("REFERENCE VALID VALUE")
- c) NJMMIS VALID VALUE AND ASSIGNMENT INQUIRY AND MAINTENANCE MENU - Option 01 ("PROC CODE MODIFIER").

EDIT 166 - DIAGNOSIS CODE MISSING/INVALID

This edit is posted to an inpatient (claim type 01), outpatient (claim type 03), professional (claim type 04), home health (claim type 06), or vision (claim type 08) encounter claim if the any of the following is true:

- The first occurrence of diagnosis codes is spaces.
- The first character of any of the diagnosis codes contains a value other than "0" thru "9" or "V".
- The second or third digit of any of the diagnosis codes contains a value other than "0" thru "9".
- The fifth digit is not a space and the fourth digit is a space.

This edit is posted to an inpatient (claim type 01), outpatient (claim type 03), or home health (claim type 06) encounter claim if the current occurrence of diagnosis codes is not spaces, and a previous occurrence of diagnosis code is spaces.

EDIT 168 - GESTATION INDICATOR INVALID FOR PROC/DIAG/REV CODES

For claim types 01, 03 and 04 having a Gestation Indicator = 'Y' and a Claim Service Date from 10-01-2000, this edit will post if one of the following conditions don't exist:

Procedure Code equal to:

'59400', '59409', '59410', '59412', '59414', '59430', '59510', '59514', '59515', '59525', '59610', '59612', '59614', '59618', '59620', '59622', or '59821'

OR

Diagnosis Code equal to:

'64001', '64081', '64091', '64101', '64111', '64121', '64131', '64181', '64191', '64201', '64211', '64221', '64231', '64241', '64251', '64261', '64271', '64291', '64202', '64212', '64222', '64232', '64242', '64252', '64262', '64272', '64292', '64301', '64311', '64321', '64381', '64391', '64421', '64501', '64511', '64521', '64601', '64611', '64621', '64631', '64641', '64651', '64661', '64671', '64681', '64691', '64612', '64622', '64642', '64652', '64662', '64682', '64701', '64711', '64721', '64731', '64741', '64751', '64761', '64781', '64791', '64702', '64712', '64722', '64732', '64742', '64752', '64762', '64782', '64792', '64801', '64811', '64821', '64831', '64841', '64851', '64861', '64871', '64881', '64891', '64802', '64812', '64822', '64832', '64842', '64852', '64862', '64872', '64882', '64892',

'650 ' THRU '65099'

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'664 ' THRU '66499'

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OR

Revenue equal to: 720, 722, 724, or 729

For claim types 01, 03 and 04 with a Claim Service Date of 10-01-2000 or greater and a Gestation Indicator not = 'Y', this edit will post if:

Procedure Code equal to: 'W9027', 'W9029', or 'W9031'

EDIT 172 - PAYOR ID MISSING/INVALID

This edit is posted to an inpatient (claim type 01), outpatient (claim type 03), or home health (claim type 06) encounter claim if the payor id is missing or not valued with "12" for Medicaid.

EDIT 183 - HMO PAYMENT DATE MISSING/ INVALID

This edit is posted to an encounter claim if one of the following conditions is found:

1. The HMO payment date was not submitted at either the service line level or the claim level.
2. The HMO payment date was submitted, but is an invalid date.
3. For regular encounters, the HMO payment date is either:
 - A. equal to or less than the service end date, or
 - B. to or greater than the encounter claim ICN date.
4. For capitation summary or capitation detail encounter claims, the HMO payment date is greater than (older than) one year prior to the service start date.

This edit is posted to either original encounter claims or voids of encounter claims, as the HMO payment date in a void indicates the date that the original encounter was voided by the HMO.

NOTE: An HMO payment date is required for encounter claims with an HMO payment amount of zero.

EDIT 184 - ADJUSTMENT REASON CODE MISSING/INVALID

This edit is posted to any encounter claim if the transaction type is valued with "2" (adjustment) and the adjustment reason is not one of the following values:

- 04 - Claim correction
- 37 - Insurance recovery, or

The transaction type is valued with "4" (void) and the adjustment reason is not one of the following values:

- 05 - Void - wrong provider
- 06 - Void - wrong recipient
- 07 - Void - service not provided

EDIT 185 - FORMER ICN # MISSING/INVALID

This edit is posted to any encounter claim if the transaction type is "2" (adjustment) or "4" (void) and the former ICN field missing, spaces, or zeros, the ICN year is equal to zero, the ICN day is not equal to 001 thru 366, or the ICN batch is equal to zero.

EDIT 197 - COMPOUND DRUG OR METRIC QUANTITY ERROR

This edit is posted to Pharmacy claims only (CT 12). This edit is posted for two reasons as follows:

1. Because the drug/service code (NDC) on the in-coming claim indicates that it's not a compound, but the compound code submitted says it is.
2. Because the metric quantity on the in-coming encounter claim is not numeric. Metric quantity must have ten numeric digits.

NOTE: This edit is being posted in POS/createposclm.pc

EDIT 206 - BILLING PROVIDER NUMBER NOT ON FILE

This edit is posted to any encounter claim if the billing provider number is not matched against the Provider Master File.

Note: The billing provider number represents the HMO's Medicaid provider number for encounter claims.

EDIT 207 - BILLING PROVIDER INELIGIBLE ON DATE OF SERVICE

This edit is posted to any encounter claim if the billing provider number (the HMO submitting the claim) is not eligible on the date of service.

EDIT 217 - TAXONOMY CODE IS MISSING FOR THE BILLING PROVIDER

This edit is posted if the Billing Provider's Taxonomy Code is missing and the crosswalk of the NPI to a single Medicaid Provider ID was unsuccessful.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 218 - TAXONOMY CODE IS INVALID FOR THE BILLING PROVIDER

This edit is posted if the billing provider's taxonomy code is present (must be greater than spaces and not zero) but the taxonomy code is not a valid taxonomy code.

To verify a taxonomy code, use CICS Reference option 23 (FFS only) and enter a specific value in the taxonomy code field.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
4. Voided claims

EDIT 219 - TAXONOMY CODE IS MISSING FOR SERVICE PROVIDER

This edit is posted if the Servicing Provider's Taxonomy Code is missing and the Crosswalk of the NPI to a single Medicaid Provider ID was unsuccessful.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 220 - TAXONOMY CODE IS INVALID FOR SERVICE PROVIDER

This edit is posted if the servicing provider's taxonomy code is present (must be greater than spaces and not zero) but the taxonomy code is not a valid taxonomy code. To verify a taxonomy code, use CICS Reference option 23 (FFS only) and enter a specific value in the taxonomy code field.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
5. Voided claims

EDIT 221 - NPI IS MISSING FOR SERVICE/RENDERING PROVIDER

This edit is posted if the servicing providers NPI was not submitted on the claim. The NPI must be greater than spaces and not equal to zeros.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 222 - NPI IS INVALID FOR SERVICE/RENDERING PROVIDER

This edit is posted if the servicing provider's NPI was submitted on the claim (the NPI was not spaces or zeros), but the NPI was not numeric or did not have a valid NPI check digit.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
5. Voided claims

EDIT 223 - NPI IS MISSING FOR THE ATTENDING PROVIDER

This edit is posted if the attending provider's NPI was not submitted on the claim. The NPI must be greater than spaces and not equal to zeros.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 224 - NPI IS INVALID FOR THE ATTENDING PROVIDER

This edit is posted if the attending provider's NPI was submitted on the claim (the NPI is not spaces or zeros), but the NPI was not numeric or did not have a valid NPI check digit.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
5. Voided claims

EDIT 225 - NPI IS MISSING FOR THE REFERRING PROVIDER

This edit is posted if the referring provider's NPI was not submitted on the claim. The NPI must be greater than spaces and not equal to zeros.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 226 - NPI IS INVALID FOR THE REFERRING PROVIDER

This edit is posted if the referring provider's NPI was submitted on the claim (the NPI is not spaces or zeros), but the NPI was not numeric or did not have a valid NPI check digit.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
5. Voided claims

EDIT 227 - NPI IS MISSING FOR THE OPERATING PROVIDER

This edit is posted if the operating provider's NPI was not submitted on the claim. The NPI must be greater than spaces and not equal to zeros.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 228 - NPI IS INVALID FOR THE OPERATING PROVIDER

This edit is posted if the operating provider's NPI was submitted on the claim (the NPI is not spaces or zeros), but the NPI was not numeric or did not have a valid NPI check digit.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
5. Voided claims

EDIT 229 - NPI IS MISSING FOR BILLING PROVIDER

This edit is posted if the billing provider's NPI was not submitted on the claim. The NPI must be greater than spaces and not equal to zeros.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 230 - NPI IS INVALID FOR BILLING PROVIDER

This edit is posted if the billing provider's NPI was submitted on the claim (the NPI was not spaces or zeros), but the NPI was not numeric or did not have a valid NPI check digit.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
5. Voided claims

EDIT 231 - NPI IS MISSING FOR OTHER PROVIDER

This edit is posted if the other provider's NPI was not submitted on the claim. The NPI must be greater than spaces and not equal to zeros.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 232 - NPI IS INVALID FOR OTHER PROVIDER

This edit is posted if the other provider's NPI was submitted on the claim (the NPI was not spaces or zeros), but the NPI was not numeric or did not have a valid NPI check digit.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
5. Voided claims

EDIT 233 - NPI IS MISSING FOR PRESCRIBING PROVIDER

This edit is posted if the prescribing provider's NPI was not submitted on the claim. The NPI must be greater than spaces and not equal to zeros.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 234 - NPI IS INVALID FOR PRESCRIBING PROVIDER

This edit is posted if the prescribing provider's NPI was submitted on the claim (the NPI was not spaces or zeros), but the NPI was not numeric or did not have a valid NPI check digit.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
5. Voided claims

EDIT 235 - NPI NOT ON FILE FOR SERVICE/RENDERING PROVIDER

This edit is posted to the claim if the providers NPI was submitted on the claim but the return code from the NPI MAPPING MODULE indicated a not found condition.

EDIT 236 - ZIP CODE MISSING OR INVALID

This edit is posted if the service providers ZIPCODE is not numeric or the ZIPCODE is equal to zeros.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
4. Voided claims

EDIT 237 - NPI NOT CROSSWALKED - SERV/REND

This edit is posted, if the call to the NPI MAPPING MODULE determined that the NPI submitted on the claim was not on the NPI Mapping Table, or the NPI was on the NPI Mapping Table, but the MAPPING MODULE was unable to return a Provider ID based on the search criteria from the claim of NPI, Zip Code and Taxonomy Code, and a default provider was not found.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 238 - PROVIDER NOT MATCHED-SERV/REND

This edit is posted if the provider number submitted on the claim is not equal to the provider number on the NJMMIS NPI database.

This is determined from a call to the NPI MAPPING MODULE in order to obtain a Medicaid Provider ID.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 240 - NPI NOT CROSSWALKED - BILLING

This edit is posted, if the call to the NPI MAPPING MODULE determined that the NPI submitted on the claim was not on the NPI Mapping Table, or the NPI was on the NPI Mapping Table, but the MAPPING MODULE was unable to return a Provider ID based on the search criteria from the claim of NPI, Zip Code and Taxonomy Code, and a default provider was not found.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 241 - PROVIDER NOT MATCHED-BILLING

This edit is posted if the provider number submitted on the claim is not equal to the provider number on the NJMMIS NPI database. This is determined from a call to the NPI MAPPING MODULE in order to obtain a Medicaid Provider ID.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 243 - NPI NOT CROSSWALKED-ATTENDING

This edit is posted, if the call to the NPI MAPPING MODULE determined that the NPI submitted on the claim was not on the NPI Mapping Table, or the NPI was on the NPI Mapping Table, but the MAPPING MODULE was unable to return a Provider ID based on the search criteria from the claim of NPI, Zip Code and Taxonomy Code, and a default provider was not found.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 244 - PROVIDER NOT MATCHED-ATTENDING

This edit is posted if the provider number submitted on the claim is not equal to the provider number on the NJMMIS NPI database. This is determined from a call to the NPI MAPPING MODULE in order to obtain a Medicaid Provider ID.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 246 - NPI NOT CROSSWALKED - REFERRING

This edit is posted, if the call to the NPI MAPPING MODULE determined that the NPI submitted on the claim was not on the NPI Mapping Table, or the NPI was on the NPI Mapping Table, but the MAPPING MODULE was unable to return a Provider ID based on the search criteria from the claim of NPI, Zip Code and Taxonomy Code, and a default provider was not found.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 247 - PROVIDER NOT MATCHED-REFERRING

This edit is posted if the provider number submitted on the claim is not equal to the provider number on the NJMMIS NPI database. This is determined from a call to the NPI MAPPING MODULE in order to obtain a Medicaid Provider ID.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 248 - SURGICAL PROCEDURE CODE NOT ON FILE

This edit is posted to an inpatient (claim type 01) or outpatient (claim type 03) encounter claim if the primary or secondary procedure code is not on the procedure code file.

EDIT 253 - PROCEDURE NOT VALID ON DATE(S) OF SERVICE

The procedure code must be valid on the date of service.

EDIT 254 - PROCEDURE CODE AND AGE RESTRICTED

This edit is posted to enforce age restrictions on Encounter maternity claims. The edit will post under the following conditions:

1. Claim Type = 01, 03 or 04, and
2. Gestation Indicator = Y or Procedure Code = W9027, W9029, or W9031, and
3. Patient Calculated Age is not in the range of 11-50.

EDIT 255 - PROCEDURE CODE AND SEX RESTRICTION

This edit is posted to enforce sex restrictions on Encounter maternity claims. The edit will post under the following conditions:

1. Claim Type = 01, 03 or 04, and
2. Gestation Indicator = Y or Procedure Code - W9027, W9029, or W9031, and
3. Recipient Sex Code not = F.

EDIT 259 - PROCEDURE CODE NOT ON FILE

The edit is posted to any encounter claim if the procedure code billed is not on the procedure code file.

Note: For outpatient (claim type 03) encounter claims, if the revenue code is 300-319 and the procedure code billed is not on the procedure code file.

EDIT 261 - NPI NOT CROSSWALKED - OPERATING

This edit is posted, if the call to the NPI MAPPING MODULE determined that the NPI submitted on the claim was not on the NPI Mapping Table, or the NPI was on the NPI Mapping Table, but the MAPPING MODULE was unable to return a Provider ID based on the search criteria from the claim of NPI, Zip Code and Taxonomy Code, and a default provider was not found.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 262 - PROVIDER NOT MATCHED-OPERATING

This edit is posted if the provider number submitted on the claim is not equal to the provider number on the NJMMIS NPI database. This is determined from a call to the NPI MAPPING MODULE in order to obtain a Medicaid Provider ID.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 264 - NPI NOT CROSSWALKED - OTHER

This edit is posted, if the call to the NPI MAPPING MODULE determined that the NPI submitted on the claim was not on the NPI Mapping Table, or the NPI was on the NPI Mapping Table, but the MAPPING MODULE was unable to return a Provider ID based on the search criteria from the claim of NPI, Zip Code and Taxonomy Code, and a default provider was not found.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 265 - PROVIDER NOT MATCHED-OTHER

This edit is posted if the provider number submitted on the claim is not equal to the provider number on the NJMMIS NPI database. This is determined from a call to the NPI MAPPING MODULE in order to obtain a Medicaid Provider ID.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 267 - NPI NOT CROSSWALKED - PRESCRIBING

This edit is posted, if the call to the NPI MAPPING MODULE determined that the NPI submitted on the claim was not on the NPI Mapping Table, or the NPI was on the NPI Mapping Table, but the MAPPING MODULE was unable to return a Provider ID based on the search criteria from the claim of NPI, Zip Code and Taxonomy Code, and a default provider was not found.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 268 - PROVIDER NOT MATCHED-PRESCRIBING

This edit is posted if the provider number submitted on the claim is not equal to the provider number on the NJMMIS NPI database. This is determined from a call to the NPI MAPPING MODULE in order to obtain a Medicaid Provider ID.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Non-covered entities (providers not required to obtain NPIS)
4. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
5. Claims with Summary Procedure Codes (first 5 characters are 'SUMRY')
6. Voided claims

EDIT 269 - ATTENDING NPI SAME AS BILLING/SERVICING NPI

This edit is posted if the attending NPI is the same as the billing and/or servicing NPI.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
4. Voided claims

EDIT 271 - OTHER NPI SAME AS BILLING/SERVICING NPI

This edit is posted if the other NPI is the same as the billing and/or servicing NPI.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
4. Voided claims

EDIT 272 - PRESCRIBING NPI SAME AS BILLING/SERVICING NPI

This edit is posted if the prescribing NPI is the same as the billing and/or servicing NPI.

Exceptions:

1. Claim media code is not "8" (HIPAA)
2. Electronic claims processed (ICNed) before May 23, 2008
3. Recycles (Saturday or Sunday ICN Julian Date) of claims processed before May 23, 2008
4. Voided claims

EDIT 296 - DIAGNOSIS CODE NOT ON FILE

The edit is posted to an inpatient (claim type 01), outpatient (claim type 03), Professional (claim type 04), home health (claim type 06), or vision (claim type 08) encounter claim if the diagnosis code billed is not on the diagnosis file.

EDIT 301 - RECIPIENT INELIGIBLE ON DATES OF SERVICE

This edit is posted to any encounter claim if the recipient is not eligible on date of service.

EDIT 321 - RECIPIENT NUMBER NOT ON FILE

This edit is posted to any encounter claim if the recipient is not on the recipient master file.

EDIT 329 - HEALTHCARE PROVIDER FEDERALLY EXCLUDED FROM NJMM PARTICIPATION

This edit is posted to claims where any of the NPI entries are on the Federally excluded database.

EDIT 334 - HEALTHCARE PRVDR FEDERALLY EXCLUDED FROM NJMM PARTICIPATION

This edit is posted to claims where the provider has a cancel reason code of 10.

EDIT 400 - RECIPIENT NOT IN HMO ON DATE OF SERVICE

This edit is posted to any encounter claim if the recipient is not in the HMO on the dates of service.

EDIT 421 - SERVICE UNITS FACTORED FOR PROCESSING

The four-digit service units data element in the NJMMIS claim format can accommodate a maximum value of 9999. However, the service units data element in the HIPAA 837 professional claim format can accommodate a maximum value greater than 9999.

For professional encounters, this error code indicates that (1) the submitted service units for a "blood product" (procedure codes J7190, J7191, J7192, J7194, J7198 or Q0187) were greater than 9999, (2) the submitted service units were factored by 10% (i.e., the service units value stored in the NJMMIS encounter is 10% of the submitted value), and (3) the service units will be un-factored (i.e., multiplied by 10) for specification in the HIPAA 835 remittance advice.

EDIT 466 - COMPOUND CLAIM WITH ONLY 1 INGREDIENT

This edit is posted if:

1. This is an encounter pharmacy claims (CT 12).
2. This is a compound claim with only one ingredient or no ingredients. Pharmacy must submit all ingredients.

EDIT 479 - GROUPER COULD NOT ASSIGN A DRG CODE

This edit will post if:

Based on the following claim input items:

- a. Diagnosis codes
- b. Procedure codes
- c. Sex code
- d. Discharge status code
- e. Birth date
- f. Birth weight
- g. Admit date
- h. Discharge date

the All-Patient Grouper subroutine is called to calculate a DRG (diagnosis related group) code but is not able to do so for any reason.

EDIT 480 - GROUPER ASSIGNED A NEW DRG CODE

This edit will post if:

Based on the following claim input items:

- a. Diagnosis codes
- b. Procedure codes
- c. Sex code
- d. Discharge status code
- e. Birth date
- f. Birth weight
- g. Admit date
- h. Discharge date

the All-Patient Grouper subroutine calculates a DRG (diagnosis related group) code that differs from the DRG code entered on the claim. This "new" DRG code will replace the DRG code originally entered on the claim (the original DRG will be stored in another location on the claim history record) and will become the "pricing" DRG.

EXCEPTIONS:

This edit is bypassed for inpatient adjustment or void claims if the financial reason code = '21'.

EDIT 503 - REVENUE CODE NOT ON FILE

This edit is posted to an inpatient (claim type 01), outpatient (claim type 03), or home health (claim type 06) encounter claim if the revenue code billed is not on the revenue (procedure) code file.

Note: A revenue code can be located on the procedure code file by appending a prefix of "IP" (inpatient), "OP" (outpatient), or "HH" (home health) to the three digit revenue code.

Exclusion: For inpatient claims, revenue code 514 will bypass this edit.

EDIT 545 - NATIONAL DRUG CODE NOT ON FILE

This edit is posted to a pharmacy (claim type 12) encounter claim if the National Drug Code (NDC) billed is not on the NDC file.

EDIT 553 - COMPOUND DRUG DID NOT CONTAIN LEGEND DRUG

After a review of the pharmacy claim, it was determined that this prescription did not contain at least one legend ingredient in a therapeutic quantity.

EDIT 554 - COMPOUND CONTAINS DUPLICATE INGREDIENTS

This edit will post if the PH-COMPOUND-IND = '2' and 2 ingredients within the compound claim has the same GCN as another ingredient. If the drug class = '0', this edit will only post if the ingredients have the same NDC.

EDIT 555 - COMPOUND DRUG – INCORRECT INGREDIENT QUANTITY/COST

This edit will post to a pharmacy encounter Claim if all the following is true:

1. Claim type 12 (Pharmacy Claim) with compound drug and
2. Any of the ingredient cost (AM10 449 EE) is greater than the usual Customary Charge (AM11 426 DQ).

EDIT 556 - INVALID COMPOUND – CONTAINS ONE INGREDIENT + WATER

This edit is applicable to pharmacy claims only.

This edit is posted if the claim is for a compound with no more than two ingredients and one of the ingredients has GCN = 2670 (water).

Pharmacy should resubmit the claim without the compound segment.

Compound Indicator should be corrected.

EDIT 582 - TOOTH NUMBER/SURFACE INVALID

This edit is posted to dental (claim type 11) encounter claims if the tooth number/surface indicator on the procedure code file equals

"2" (tooth number and surface) and the tooth surface is not one of the following values:

- M - Mestal
- I - Incisal
- B - Buccal
- O - Occlusal
- D - Distal
- L - Lingual

EDIT 587 - TOOTH NUMBER INVALID

This edit is posted to a dental (claim type 11) encounter claim if the tooth number/surface indicator on the procedure code file equals

"1" (tooth number) or "2" (tooth number and surface) and the tooth number or tooth quadrant billed is not one of the following values:

- 0A-0T Primary Teeth
- 01-32 Permanent Teeth
- SN Supernumery

EDIT 602 - DRG CODE MISSING

This edit is posted to an inpatient (claim type 01) encounter claim if the hospital (servicing provider number) is a New Jersey, New York, or Pennsylvania DRG hospital and the billed DRG is spaces or zeros, or the hospital is not a DRG hospital and the DRG is not spaces or zeros.

Note: The determination of a hospital as a "DRG hospital" is based on a match of the billed servicing provider SSN/EIN against the provider master file.

EDIT 621 - DRG CODE NOT ON FILE

This edit is posted to an inpatient (claim type 01) encounter claim if the hospital (servicing provider number) is a New Jersey, New York, or Pennsylvania DRG hospital and the billed DRG is on the DRG Trim File.

Note: The determination of a hospital as a "DRG hospital" is based on a match of the billed servicing provider SSN/EIN against the provider master file.

EDIT 661 - DRG CODE INVALID

This edit is posted to an inpatient (claim type 01) encounter claim if the DRG code is non-numeric or spaces.

EDIT 666 - UNABLE TO PRICE CLAIM

Presently, this edit is tuned off for all encounter claims. As pricing logic is implemented by claim type, this edit will be activated appropriately.

EDIT 786 - PREVIOUSLY DENIED CLM CANNOT BE ADJUSTED-RESUBMIT CLAIM

The adjustment or void matched a claim on the History File that was denied. The adjustment or void transaction is denied.

EDIT 787 - ADJUSTMENT CLM TYPE NOT MATCHED

The adjustment request matched a claim on the History File, but the claim types did not match.

EDIT 796 - SUBMITTER NOT MATCHED ON HISTORY

This edit is posted to any adjustment encounter claim if the submitter number does not equal the provider number located on the matching history claim.

EDIT 797 - DUPLICATE ADJUSTMENT

This edit is posted to any adjustment encounter claim that has the same original recipient number and former ICN as a previous transaction.

EDIT 798 - HISTORY RECORD ALREADY ADJUSTED OR VOIDED

This edit is posted to any adjustment encounter claim if the matching history claim has already been adjusted or voided.

EDIT 799 - NO CLAIM IN HISTORY FILE MATCHES ADJUSTMENT

This edit is posted to any adjustment encounter claim if no match is found in claims history based on the original recipient number and former ICN.

EDIT 800 - EXACT DUPLICATE BILL

This edit is posted to any encounter claim that is a duplicate of a claim already in history. The logic used to determine an exact bill is based on the following fields:

Inpatient (claim type 01) - same submitter, same servicing provider number, same recipient number, same claim type, same statement dates. See NOTE 3.

Outpatient (claim type 03) - same submitter, same servicing provider number, same recipient number, same claim type, same service dates, same revenue code or HCPCS code (if present) and first 13 positions of the ICN are not the same. See NOTES 2 and 3. If the revenue code is 510-515, or 519 the claim is not considered an exact duplicate unless the clinic codes in both claims agree.

Professional (claim type 04) - same submitter, same servicing provider number, same recipient number, same claim type, same service dates, same procedure code, and same procedure code modifier. See NOTE 1.

Home Health (claim type 06) - same submitter, same servicing provider number, same recipient number, same claim type, same service dates, same revenue code.

Transportation (claim type 07) - same submitter, same servicing provider number, same recipient number, same claim type, same service dates, same procedure code, same procedure code modifier, same origin code, and same destination code. See NOTE 1.

Vision (claim type 08) - same submitter, same servicing provider number, same recipient number, same claim type, same service dates, same procedure code, and same procedure code modifier. See NOTE 1.

Dental (claim type 11) - same submitter, same servicing provider number, same recipient number, same claim type, same service dates, same tooth surface. HCPCS codes 00310, 04210, 04220, 04260, 04272, 04341, 04999, 07310, 07320, 07340, 07350, 07470, or 09951 with a modifier of 22 are excluded from the edit logic except those claims whose tooth number equals UR, UL, LR, or LL or the Julian date on the ICN is greater than or equal to 10/01/93 (93274) or the Julian date on the original ICN (if not an original transaction) is greater than or equal to 10/01/93 (93274). Also, see NOTE 1.

Pharmacy (claim type 12) - same submitter, same servicing provider number, same recipient number, same claim service date, same prescription number and same drug code (non-compound drug).

Capitation Detail - same submitter, same original recipient ID, same servicing provider EIN/SSN number, same claim type, same procedure code of 'CAPDT', same capitation code, same capitation provider type and same capitation month/year.

NOTE 1: The following procedure modifiers are the only ones considered as part of this edit logic:

- AA, DD, LT, RT, TC, YF, YL (dental only), YU, 26, 76, 80, 81, 82
- Modifiers '81' and '82' are considered as modifier '80' for duplicate processing.
- Modifiers 'LT"RT"YL"YU' and '26' are to be considered as invalid (spaces) in matching against paid claims without a modifier.

NOTE 2: Type of Bill '13X' and '83X' are considered equal for this edit. Type of Bill is not considered when the claim is LTC. Bypass this edit for Outpatient Crossover with Bill Type 72X if the condition code on the claim is different from that on the claim in history.

NOTE 3: For multiple birth claims - only one claim will have the newborn indicator set to "Y". The remaining newborn claims will use condition codes 82 thru 84.

EDIT 826 - TIMELY FILING DETERMINED BY PREVIOUS CLAIM

This edit is posted to any encounter claim with timely filing edit 026 if a previously submitted claim was within the timely filing window. If the service date (or as of 7/1/2009 service Date thru for inpatient encounters) is 365 days less than the Julian date (of previously submitted claim) in the first seven positions of the ICN.

NOTE: Effective 07/01/2009 when other payers are involved (TPL) the time limit is extended from 12 months to 18 months.