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, 0336971, 0398799, 5451302, 6228704, 6228607, 6700403, 6231004).

EDIT 003 - PROCEDURE CODE/CAPITATION PROVIDER TYPE UNMATCHED
This edit is posted to a capitation true-up encounter (procedure code TRUUP) if the capitation provider type is not 997, 998, or 999.

This edit is posted to a capitation detail encounter (procedure code CAPDT) or a capitation summary encounter (procedure code SUMRY) if the capitation provider type is not 100, 200, 300, 400, 500, 600, 700, 800, 900, 910, 920, 930, 940, 950, 960, 970, 980, or 990.

EDIT 004 - PRESCRIBING PROVIDER MISSING/INVALID
This edit is posted to a pharmacy (claim type 12) encounter claim if the 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 attending SSN or EIN is either invalid (non-numeric or spaces) or missing.

EDIT 006 - REFERRING/OPERATING/OTHER PROVIDER MISSING/INVALID
This edit is posted as follows:

1. Professional, Dental and Inpatient Referring Provider
This edit is posted to an encounter professional or Inpatient claim if the referring provider EIN/SSN was submitted (not zeroes or spaces), but is invalid (non-numeric).

2. Inpatient Operating Provider
This edit is posted to an inpatient encounter claim if the operating provider EIN/SSN was submitted (not zeroes or spaces), but is invalid (non-numeric).

3. Outpatient Other Provider
This edit is posted to an outpatient encounter claim if the Other Provider EIN/SSN was submitted (not zeroes or spaces), but is invalid (non-numeric).

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 differently depending on the HIPAA version of the encounter:

1. This edit is posted to any 4010A1 version encounter claim if the servicing provider SSN or EIN is missing or invalid.

   The servicing provider EIN or SSN is required on all 4010A1 encounter claims submitted.

2. This edit is posted to any 5010 version encounter claim if both the servicing provider NPI and EIN or SSN are missing.

   Either the Servicing Provider NPI or EIN or SSN is required on all 5010 encounter claims submitted.

EDIT 011 - RECIPIENT NUMBER MISSING OR INVALID
This edit is posted to an encounter claim if the Recipient ID (E-CURRENT-RECIP-ID-NUM) is not numeric or the Person Number of the Recipient ID (11th and 12th digits) is not 01 – 49.

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 014 - PPP SERVICE SUBMITTED AS OVERTIME
This edit is set on CT04 Encounters with the following:

1. DOS is after 3/29/2020

AND

2. Service code/modifier is T1019/SE, T1019/SE/U1, S5125/SE/HQ or S5125/SE/U3

AND

3. TU modifier for overtime is present.

Note: If #2 and #3 are present but the DOS is after 7/3/2023, the encounter will be denied and rejected with Edit 028.

EDIT 015 - STATEMENT THRU DATE < STATEMENT FROM DATE
This edit is posted to an outpatient (claim type 03) 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 019 - SERVICE PERIOD IS MORE THAN 3 YEARS OLD
This edit is posted to any encounter claim if the service period is more than three years prior to the date of processing.

EDIT 020 - SERVICE THRU DATE > DATE RECEIVED
This Edit 020 is posted for the following:

1. For Non - CAPDT:
   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.

2. For CAPDT:
   This edit is posted to any encounter claim if the service thru date is greater than the current system date year and month.

EDIT 021 - INVALID CLAIM FORMAT-NCPDP D.0 IS IN MANDATORY PERIOD
This edit is applicable to Encounter pharmacy claims only.

This edit will be applied on or after April 1, 2012, based on Claim Cycle Date. It will be applied to pharmacy claims submitted electronically that are not in NCPDP D.0 format. After March 31, 2011, the Version Number on the claim must contain 'D0' or the claim will receive this edit.

EDIT 022 - CAPITATION SERVICE PERIOD INVALID
This edit is posted to a capitation detail encounter (procedure code CAPDT) if the service period is prior to July, 2009.

This edit is posted to a capitation true-up encounter (procedure code TRUUP) if the service period is prior to September, 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.

NOTE: Encounters for HMO denied claims submitted on or after June 1, 2013 bypass edits 023 and 024. Encounters for denied HMO claims are identified with edit 144.

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.

NOTE: Encounters for HMO denied claims submitted on or after June 1, 2013 bypass edits 023 and 024. Encounters for denied HMO claims are identified with edit 144.

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 027 - NO MATCHING CLAIM FOR ENC VOID/ADJ ON PHARMACY VSAM FILE
This edit is posted to any pharmacy void or adjustment encounter claim if no match is found on the Pharmacy VSAM file for NPI, Date of Service, RX number, and HMO ICN Number (from D.0 A7 segment). Claim types other than Pharmacy will continue to receive edit code 799.

NOTE: Encounters for HMO denied claims submitted on or after June 1, 2013 bypass edits 023 and 024. Encounters for denied HMO claims are identified with edit 144.

Encounters for HMO denied claims submitted on or after June 24, 2013 bypass edit 027.

EDIT 028 - PPP SERVICE SUBMITTED AS OVERTIME DENIED
This edit is set on CT04 Encounters with the following:

1. DOS is after 7/3/2023

AND

2. Service code/modifier is T1019/SE, T1019/SE/U1, S5125/SE/HQ or S5125/SE/U3

AND

3. TU modifier for overtime is present.

Note: Posting of this edit will cause the encounter to be denied and rejected.

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	111-115, 117, 118, 121-125, 127, 128, 181-185, 187, 188, 211-219, 281-289, 651-669, 841-845, 847, 848
Outpatient	131-135, 137, 138, 141-145, 147, 148, 221-225, 227, 228, 231-235, 237, 238, 711-715, 717, 718, 721-725, 727, 728, 731-735, 737, 738, 741-745, 747, 748, 751-755, 757, 758, 761-765, 767, 768, 771-775, 777, 778, 791-795, 797, 798, 821-825, 827, 828, 831-835, 837, 838, 851-855, 857, 858
Home Health	with date of service < 01/01/2014 321-325, 327, 328, 329, 331-335, 337, 338, 339, 341-345, 347, 348, 349, 811-815, 817, 818, 819

EDIT 042 - TYPE OF BILL CODE MISSING/INVALID (cont.)

Home Health with date of service => 01/01/2014
321-325, 327, 328, 329, 341-345, 347, 348, 349, 811-815, 817, 818, 819

EDIT 043 - INVALID MISSING BIRTH WEIGHT

The edit is posted to the claim if the admit date is equal to the date of birth that comes in on the claim (indicating a newborn), and

A. The birth weight is equal to zeroes, or
B. The birth weight is not numeric, or
C. The birth weight is not in the range of 100-9000 (grams).

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 Home/Self Care
02 - Discharged/Transferred Short Term Hospital
03 - Discharged/Transferred to SNF
04 - Discharged/Transferred to ICF
05 - Discharged/Transferred Another Institution Type
06 - Discharged/Transferred Home-Home Health Agency
07 - Left Against Medical Advice
08 - Discharged/Transferred to Home Under Care of a Home IV Provider
20 - Expired
30 - Still Patient
43 - Discharged/Transferred to a Federal Health Care Facility
50 - Hospice-Home
51 - Hospice-Medical Facility
61 - Discharged/Transferred to hospital-based Medicare approved Swing Bed
62 - Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF)
63 - Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH)
64 - Discharged/Transferred to a Nursing Facility Certified by Medicaid but not Medicare
65 - Discharged/Transferred to a Psychiatric Hospital
66 - Discharged/Transferred to a Critical Access Hospital
70 - Discharged/Transferred to another type of healthcare facility not defined elsewhere

NOTE: 01-08, 20, 30, 43, 50, 51, 61, 62, 63, 64, 65, 66, 70 are the current valid entries. However, 08 is not valid on UB-04 inpatient claims/encounters.

EDIT 046 - INVALID/MISSING OCCURRENCE SPAN CODE

The program checks each occurrence of occurrence span data on the Claim Activity Record. This edit is posted if one of the conditions listed below is encountered:

1. The occurrence span from or thru date is greater than zeros and the occurrence span code within the same occurrence of occurrence span data is equal to spaces.
2. The occurrence span code on the claim is not equal to spaces and is not equal to one of the following values:

   70 - Qualifying Stay Dates for SNF Use Only
   71 - Prior Stay Dates
   72 - First/Last Visit Dates
   73 - Benefit Eligibility Period
   74 - Non-Covered Level of Care/Leave of Absence Dates
   75 - SNF Level of Care Dates
   76 - Patient Liability Period
   77 - Provider Liability Period
   78 - SNF Prior Stay Dates
   79 - Payer Code
   80 - Prior Same-SNF Stay Dates for Payment Ban Purposes
   M0 - QIO/UR Approved Stay Dates
   M1 - Provider Liability - No Utilization
   M2 - Inpatient Respite Dates
   M3 - ICF Level of Care Dates
   M4 - Residential Level of Care Dates
   MR - Reserved for Disaster Related Occurrence Span Code

EDIT 047 - INVALID/OCCURRENCE SPAN FROM OR THRU DATE

The program checks each occurrence of occurrence span data (4 occurrences) on the Encounter Claim. This edit is posted to an Encounter Claim if:

1. The occurrence span code is not equal to spaces, and the occurrence span FROM date or the occurrence span THRU date is numeric and greater than zero, but does not pass standard date editing, or

2. The occurrence span code is other than 70, 71, 72, 78, or 80 and any part of the occurrence date span falls outside the service period (i.e. the occurrence span FROM or THRU date is either less than the service FROM date or greater than the service THRU date).

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 then 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 059 – MULTIPLE OCCURRING PROCEDURE WITH ARC 59
This edit is posted to a dental (claim type 11) encounter if an Adjustment Reason Code '59' was submitted on the 837 Dental transaction, marking the claim as one that the HMO paid their provider $0 because the service is a multiple occurring service that is paid only for the final service delivery.

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 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
09 - Start Of Infertility Treatment Cycle
10 - Last Menstrual Period
11 - Onset of Symptoms/Illness
12 - Date Of Onset For A Chronically Dependent Individual
16 - Date Of Last Therapy
17 - Date Outpatient Occupational Therapy Plan Established Or Last Reviewed
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
37 - Date Of Inpatient Hospital Discharge For Non-Covered Transplant Patient
38 - Date Treatment Started For Home IV Therapy

EDIT 060 - OCCURRENCE CODE MISSING/INVALID (cont'd)
39 - Date Discharged On A Continuous Course Of IV Therapy
42 - Date of Discharge
43 - Scheduled Date of Canceled Surgery
44 - Date Treatment Started Occupational Therapy
45 - Accident Hour
46 - Date Treatment Started For Cardiac Rehabilitation
47 - Date Cost Outlier Status Begins
50 - Assessment Date (Effective 1/1/11)
51 - KT/V Reading (Valid for CT 03)
52 - Medical Certification/Recertification Date (Effective 1/1/11)
54 - Physician Follow-Up Date (Effective 1/1/11)
55 - Date Of Death (Effective 10/1/12)
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
A4 - Split Bill Date

For Outpatient and Home Health claims with a Service thru date that is on or after October 12, 2015, occurrence codes '70', '74' '79' are no longer valid. For inpatient claims with a Service thru date on or after October 12, 2015, Occurrence Codes '60' '61' '70', '74' '79' are no longer valid.

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 then the statement thru date.

EDIT 068 - ADMISSION SOURCE MISSING/INVALID
This edit is posted to an inpatient (claim type 01) encounter claim if the source of admission is either missing or not one of the following values:

1, 2, 4, 5, 6, 8, 9, D, E, F or G.

OR

If the admission type is 4, this edit is posted if the source of admission is not one of the following values:

5 or 6.

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 from 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

EDIT 081 - CLINIC CODE INVALID (cont.)

25 - Urology
26 - Other
27 - EPSDT
28 - Partial Hospitalization

EDIT 083 - SURGICAL PROCEDURE CODE MISSING

This edit is posted to inpatient (claim type 01) claim if the first occurrence of surgical procedure code 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(s) if the following is true:

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

Note: For compound pharmacy encounter claims, this edit will post if any of the compound ingredient quantities is not greater than zero.

EDIT 086 - ASSISTED LIVING SERVICE UNITS NOT EQUAL TO SERVICE DAYS

This Edit gets posted if the following conditions are met

1. If the Encounter Claim is an Encounter professional claim (CT = 04) AND

2. Procedure code on the Encounter claim is T2031 (Assisted Living) AND

3. Service Units on the Encounter claim are either -
   a) Greater than Service Days Span calculated as (SERVICE THROUGH DATE - SERVICE FROM DATE + 2) OR
   b) Less than (SERVICE THROUGH DATE - SERVICE FROM DATE)

EDIT 087 - SURGICAL PROVIDER MISSING/INVALID

1. Inpatient Operating Provider NPI
   This edit is posted to an inpatient encounter claim if (1) surgery is indicated (either an ICD-9 surgical procedure code is present or an ICD-10 surgical procedure code and surgery indicator are present), and (2) the Operating Provider NPI is missing (less than or equal zeroes).

2. Outpatient Other Provider NPI
   This edit is posted to an outpatient encounter claim if surgery is indicated, and the Other Provider NPI is missing (less than or equal zeroes).

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 103 - ORIG RECIP ID CORRECTED DUE TO LINK/UNLINK SPECIAL PROCESS
This edit was applied to any claim identified as incorrectly updated during the normal Link/Unlink process in error. A special correction to claims was run and edit 101 was replaced with edit 103 to identify claims corrected.

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

EDIT 107 - ENC CATEGORY OF SERVICE MISSING/INVALID (cont.)

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

EDIT 109 - ENCOUNTER COS INVALID FOR CLAIM TYPE (cont.)

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.

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, or the first five positions 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 indictor 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, independent kidney treatment center, and telehealth place of service and Outreach Site/Street.

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

EDIT 142 - ORIGIN CODE MISSING/INVALID (cont.)

8 - Clinic
9 - Other

EXCEPTIONS:
This Edit is bypassed for partial care transportation codes A0120UC and A0425UC for service dates on or after 1.1.2025.

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

EXCEPTIONS:
This Edit is bypassed for partial care transportation codes A0120UC and A0425UC for service dates on or after 1.1.2025.

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').

NOTE: Encounters for HMO denied claims submitted on or after June 1, 2013 bypass edits 023 and 024.

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 outpatient (claim type 03), professional (claim type 04), transportation (claim type 07), vision (claim type 08), and dental (claim type 11) encounter claims if either of the following two conditions is true:

1. The procedure code is spaces, or any character of the five position procedure code is a space.

2. The claim is a HIPAA claim (E-CLM-MEDIA-CDE = 8), the claim service date (E-CLM-SERVICE-DTE) is 04/01/2004 or later, and the procedure code (E-PROC-CDE) is within the range W0000-Z9999.

Note: For outpatient (claim type 03) encounter claims with non-lab service revenue codes, (i.e. revenue codes other than 300-319 or 380-399), the following applies.

System logic will populate a blank procedure code with the HIPAA submitted procedure code when it is non-blank, or value ‘OPxxx’ when it is blank, (where xxx equals the claim revenue code), before applying the above rules.

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), transportation (claim type 07), or vision (claim type 08) encounter claim, if any of the following is true:

ICD9

- 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.

For ICD10 diagnosis codes:

1. The first occurrence of diagnosis code is equal to spaces, OR
2. 1st digit is not alphabetic OR
3. 2nd digit is not alphabetic or numeric OR
4. 3rd-7th digits are not alphabetic, numeric or spaces OR
5. Spaces in anywhere but ending digits OR

For pharmacy, the edit will be bypassed if a diagnosis code is not present. If a diagnosis code is populated, it will be checked for validity following the same rules defined above.

EDIT 167 - DIAGNOSIS CODE MISSING

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'
'65101', '65111', '65121', '65131', '65141', '65151', '65161', '65181', '65191', '65201', '65211', '65221', '65231', '65241', '65251', '65261', '65271', '65281', '65291', '65301', '65311', '65321', '65331', '65341', '65351', '65361', '65371', '65381', '65391', '65401', '65411', '65421', '65431', '65441', '65451', '65461', '65471', '65481', '65491', '65402', '65412', '65422', '65432', '65442', '65452', '65462', '65472', '65482', '65492', '65501', '65511', '65521', '65531', '65541', '65551', '65561', '65571', '65581', '65591', '65601', '65611', '65621', '65631', '65641', '65651', '65661', '65671', '65681', '65691', '65701', '65801', '65811', '65821', '65831', '65841', '65881', '65891', '65901', '65911', '65921', '65931', '65941', '65951', '65961', '65971', '65981', '65991', '66001', '66011', '66021', '66031', '66041', '66051', '66061', '66071', '66081', '66091', '66101', '66111', '66121', '66131', '66141', '66191', '66201', '66211', '66221', '66231', '66301', '66311', '66321', '66331', '66341', '66351', '66361', '66381', '66391'
'664 ' THRU '66499'
'66501', '66511', '66531', '66541', '66551', '66561', '66571', '66581', '66591', '66522', '66572', '66582', '66592', '66602', '66612', '66622', '66632', '66702', '66712', '66801', '66811', '66821', '66881', '66802', '66812', '66822', '66882', '66891', '66892', '66901', '66911', '66921', '66931', '66941', '66951', '66961', '66971', '66981', '66991', '66902', '66912', '66922', '66932', '66942', '66982', '66992', '67002', '67101', '67111', '67121', '67131', '67151', '67181', '67191', '67102', '67112', '67122', '67142', '67152', '67182', '67192', '67202', '67301', '67311', '67321', '67331', '67381', '67302', '67312', '67322', '67332', '67382', '67401', '67402', '67412', '67422', '67432', '67442', '67482', '67492', '67501', '67511', '67521', '67581', '67591', '67502', '67512', '67522', '67582', '67592', '67601', '67611', '67621', '67631', '67641', '67651', '67661', '67681', '67691', '67602', '67612', '67622', '67632', '67642', '67652', '67662', '67682', '67692', '677', 'V27', 'V270', 'V271', 'V272', 'V273', 'V274', 'V275', 'V276', 'V277', 'V279'

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. less than the service end date, or
   B. equal to or greater than the encounter claim ICN date.

4. For transportation encounters, (claim type 07), from Logisticare, (submitter #7700164), where the HMO payment date is either:

   A. less than the service end date, or
   B. equal to or greater than the encounter claim ICN date.

5. 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
The Former ICN on an adjustment or void failed one or more validations:

1. First four digits (Year) must be 1964 - 9999;
2. Julian day (digits 5-7) must be 001 - 366;
3. Batch (digits 8-11) must be 0001 - 9999;
4. Sequence/Document (digits 12-13) must be 01-99;
5. Line (digits 14-15) must be 01-99.

Note: 00 is allowed in Sequence/Document number if the batch range is 7001 - 7799. Year, Julian Day, and Batch components must all be valid before making this exception check.

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 214 - INVALID NDC OR NDC NOT ON FILE

This edit is posted to the claim if the claim has a procedure code:

J0120 thru J9999
Q0144 thru Q0181
Q2041 thru Q2043
Q2053 thru Q2056
Q3025 thru Q3028
Q4079 thru Q4081
Q5103 thru Q5130
Q9945 thru Q9999
Q2009, Q2017
Q0138, Q0139, Q0222, Q4074, Q2049, Q2050, Q2051, Q5101,
Q5131 thru Q5146

AND

1. NDC code is not numeric or Zero

OR

2. The FDB Add Date and FDB Unit Price Date is zero.

OR

3. NDC is not found on the Drug Master File (EF200V1)

OR

4. Either or both the FDB Add Date or the FDB Unit Price Date are > zero and
   the Claim Service Date is < FDB Add Date or FDB Unit Price Date (use the lesser of the 2 dates)

OR

5. NDC has an active E542 Auto Error Code for the Claim Service Date

Number 5 was removed from the POS edit logic with TSU15506/MOD9686 in November 2017.

This edit was changed to deny effective 4/28/2017.

EDIT 215 - PROCEDURE/NDC COMBINATION IS INVALID OR NOT ON FILE

1. This edit is posted to the claim if the procedure code and NDC combination does not exist on the PROC/NDC CROSS REFERENCE FILE

OR

2. The Encounter claim Service Date does not fall within the XREF Begin Date and XREF End date for any of the 20 possible ranges for which the PROC/NDC relationship has been defined.

NOTE:
The claims NDC (Professional) is stored in E-PR-NDC-CDE. The claims NDC (Outpatient) is stored in E-OP-NDC-CDE.

EXCEPTION:
This edit is bypassed for the following procedure codes: J3490, J3590, and J9999. These are considered unlisted procedures which are used for new drugs that are not assigned a specific 'J' code.

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 NPI's)
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
7. Claims with Service Date after June 30, 2011 AND
   Claim Type 07 (Transportation) AND
   Submitter is Logisticare (Submitter ID 7700164)
8. Claims with Service Date after June 30, 2014 AND
   Claim Proc Code/Proc Modifier is one of the following:

S5111	S5120	S5121	S5165	S5165U1	S5165U2	S5165U3	S5170
S5199U1	S9977HIU8	S9977U1	S9977U2	T1005	T1028	T2002	T2003
T2038	T2038U1	T2038U6	T2039	T2039U7	T5999U1	T5999U2	T5999U3
T5999U8							

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
7. Outpatient 5010 claim with revenue code 540-549.

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

Professional and Inpatient Encounter claims

This edit is posted if a valid referring EIN/SSN was submitted (numeric and greater than zero) on an Inpatient or professional Encounter claim, but the referring provider's NPI was not submitted (is spaces or zeroes).

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

This edit will apply to Inpatient claims where the ICN Julian Date is on or after October 12, 2015 where the referring provider's NPI was submitted, but the NPI was not numeric.

EDIT 227 - NPI IS MISSING FOR THE OPERATING PROVIDER

Inpatient Encounter claims

This edit is posted if a valid operating EIN/SSN was submitted (numeric and greater than zero) on an Inpatient Encounter claim, but the operating provider's NPI was not submitted (is spaces or zeroes).

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

This edit will apply to Inpatient claims where the ICN Julian Date is on or after October 12, 2015 where the operating provider's NPI was submitted.

For inpatient claims with ICN Julian date prior to October 12, 2015, edit 231 for 'other' will continue to be posted when the 'Other' providers NPI is not greater than spaces or is equal to zeros.

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

This edit will apply to Inpatient claims where the ICN Julian Date is on or after October 12, 2015 where the operating provider's NPI was submitted but is not numeric or has an invalid check digit.

For inpatient claims with ICN Julian date prior to October 12, 2015, edit 232 for 'other' NPI will continue to be posted when the NPI is not numeric or has an invalid check digit.

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
7. Claims with Service Date after June 30, 2014 AND Claim Proc Code/Proc Modifier is one of the following:

S5111	S5120	S5121	S5165	S5165U1	S5165U2	S5165U3	S5170
S5199U1	S9977HIU8	S9977U1	S9977U2	T1005	T1028	T2002	T2003
T2038	T2038U1	T2038U6	T2039	T2039U7	T5999U1	T5999U2	T5999U3
T5999U8							

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

Outpatient Encounter Claims

This edit is posted if a valid 'Other' EIN/SSN was submitted (numeric and greater than zero) on an Outpatient Encounter claim, but the 'Other' provider's NPI was not submitted (is spaces or zeroes).

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

This edit will apply to Inpatient claims where the ICN Julian Date is on or after October 12, 2015 where the referring provider's NPI was submitted but could not be crosswalked to a Provider ID.

For inpatient claims with ICN Julian prior to October 12, 2015, No referring provider edits are posted.

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. For inpatient claims with a surgical procedure code, the Claim Service Through Date must be on or within the begin/end dates of the surgical procedure code.

Media 7 MFP claims apply to this edit and have hard coded logic to deny Claim type 4, if the procedure is not valid on the date service.

EDIT 254 - DRG 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,
2. Patient Calculated Age is not in the range of 11-50.

EDIT 255 - DRG 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,
2. Recipient Sex Code not = F.

The Edit Dispositions for the Claim Type 01 were changed from Deny 'D' to Pay and Report 'R' on 11/21/2022 as approved by Dr. Lind, S. Tunney, Z Desai, Hospital Reimbursement, OBI, ECPS, and Asst. Commissioner.

EDIT 259 - PROCEDURE CODE NOT ON FILE

The edit is posted to any encounter claim if the procedure code billed or derived from the submitted revenue code 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

This edit will apply to Inpatient claims where the ICN Julian Date is on or after October 12, 2015 where the operating provider's NPI was submitted but could not be crosswalked to a Provider ID.

For inpatient claims with ICN Julian prior to October 12, 2015, edit 264 for 'other' will continue to be posted when the NPI could not be crosswalked.

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 263 - NON-COVERED SERVICE FOR SPECIAL PROGRAM CODE

This edit is posted to any encounter claim if it is determined that the recipient is enrolled in either special program code,

12 Cover All Kits (CAK) for NJ InCK services (G9919 33 and G9920 33) EFF:1.1.2023 or
19 through 21, 23 through 26, 39 Community Support Services (CSS) for Housing Support Services (H0044 U1/ U3/ U4/ U6, T1028, S5165 U2/ U3 and T2038 U1/ U6) or
98 Incarcerated State Prison or
99 Incarcerated County Prison,

for any of the dates covered by the claim admit date/claim service date, through claim service date thru.

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 270 - REFERRING NPI SAME AS BILLING/SERVICING NPI

This edit is posted if the referring NPI is submitted and is the same as the billing and/or servicing NPI. This edit only applies to Inpatient claims with an ICN Julian date on or after October 12, 2015.

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 281 - OPERATING 1 NPI SAME AS BILLING/SERVICING NPI

This edit is posted if the operating NPI is submitted and is the same as the billing and/or servicing NPI. This edit only applies to Inpatient claims with an ICN Julian date on or after October 12, 2015.

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 289 - ADMITTING DIAGNOSIS CODE NOT ON FILE

This edit is posted to an inpatient encounter claim if the admitting diagnosis code is not found on the NJMMIS diagnosis master file.

Exception:
Outpatient birthing centers - bill type 84x.

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), transportation (claim type 07), vision (claim type 08), or pharmacy (claim type 12) encounter claim, if the diagnosis code is not on the diagnosis master file for the ICD version indicated. Or Claim Service Date Thru (Claim Service Date From for DME) is not on or within the effective/end dates of the diagnosis code.

Diagnosis codes will not be found on the file if the ICD Version indicates 9 but the diagnosis code is ICD10 and vice versa.

ICD10 diagnosis codes will not be found on the file if a more specific diagnosis code exists. (For example, 3 digit code A00 is not found because A000, A001 and A009 are more specific and should be used instead.)

EDIT 297 - BILLING ZIP CODE IS MISSING OR INVALID

This edit is posted if the billing provider's ZIPCODE is not numeric or the ZIPCODE is greater than zeros.

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
4. Voided claims

NOTE: This edit is applied only to version 5010 HIPAA claims.

EDIT 298 - TAXONOMY CODE IS INVALID FOR ATTENDING PROVIDER

This edit is posted if the attending 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. Recycles (Saturday or Sunday ICN Julian Date
4. Voided claims

NOTE: This edit is applied only to version 5010 HIPAA claims.

EDIT 299 - TAXONOMY CODE IS INVALID FOR REFERRING PROVIDER

This edit is posted if the referring 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. Recycles (Saturday or Sunday ICN Julian Date
4. Voided claims

NOTE: This edit is applied only to version 5010 HIPAA claims.

EDIT 300 - MAXIMUM DAILY DOSAGE EXCEEDED: CHECK DRUG QTY

This edit is posted for:

1 - Professional claims
2 - that have an injectable procedure code - see below
3 - that have a NDC on the Maximum Daily Dosage File for the claims date of service that has been exceeded by the NDC-Metric Quantity reported on the claims.

OR

1 - Outpatient claims
2 - that have a revenue code = 631 thru 637 or 25X
3 - that have an injectable procedure code - see below
4 - that have a NDC on the Maximum Daily Dosage File for the claims date of service that has been exceeded by the NDC- Metric Quantity reported on the claims.

- Injectable Procedure Code values J0120 thru J9999
  Q0138 thru Q0139
  Q0144 thru Q0181
  Q0222, Q2009, Q2017
  Q2041 thru Q2043
  Q2049 thru Q2051
  Q2053 thru Q2056
  Q3025 thru Q3028
  Q4074
  Q4079 thru Q4081
  Q5101
  Q5103 thru Q5130
  Q5131 thru Q5146
  Q9945 thru Q9999

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 310 - HMO SENT 'M' TO REQUEST MEDIA 7 KICK PAYMENT AND MMIS PAID

This EOB edit is posted if the following are true:

a. The encounter was submitted with an 'M' following the Patient Account Number to indicate that the HMO expected to be reimbursed for the drug or maternity/delivery,

And

b. The MMIS did generate a Media 7 reimbursement claim to the HMO.

NOTE: Media 7 reimbursement claims are only generated for Pharmacy CT 12, drug in Professional CT 04, or Inpatient CT 01 Maternity/Delivery.

EDIT 311 - HMO SENT 'M' TO REQUEST MEDIA 7 REIMBURSEMENT CLAIM NOT ELG

This EOB edit is posted for Pharmacy CT 12, Inpatient Hospital CT 01 or Professional drug claims, Claim Type 04 if the following are true:

a. The encounter was submitted with an 'M' following the Patient Account Number to indicate that the HMO expected to be reimbursed for the drug or maternity/delivery,

And

b. The MMIS did NOT generate a Media 7 reimbursement claim to the HMO.

HMO ACTION: Review the claim for other posted edits to determine the reason the Media 7 was not generated.

EDIT 312 - MEDIA 7 CONFLICT RECIPIENT MHC PAYMENT CODE MISSING/INVAL

This EOB edit is posted for Pharmacy CT 12, Inpatient Hospital CT 01 or Professional drug claims, Claim Type 04 if the following are true:

a. The encounter was submitted for an reimbursable drug

And

b. The MMIS did NOT generate a Media 7 reimbursement claim to the HMO because the appropriate MHC Payment Code was not found for the service:

Blood products MHC Payment Code:

E, F, G, I, J, K, L, R, T, V, X, Z, 3

HIV/AIDS Medication MHC Payment Code:

A, B, C, E, G, H, I, J, L, P, Q, T, U, V, W, X, 2

High Cost Drugs MHC Payment Code:

1, 2, 3, 4

HMO ACTION: Review the drug and MHC Payment Code combination.

EDIT 313 - MCO SENT 'M' TO REQUEST MEDIA 7 PAYMENT CAP CODE INELIGIBLE
This EOB edit is posted for Inpatient Hospital CT 01 if the following are true:

a. The encounter was submitted with an 'M' following the Patient Account Number to indicate that the MCO expected to be reimbursed for maternity/delivery service,

And

b. Claim had one of the following excluded CAP codes
'77399' '79599' '79699' '78199' '78399' '78499' '79399' '88199' '88399' '88499' '89399'

MCO ACTION: Review the claim for other posted edits to determine the reason the Media 7 was not generated.

EDIT 317 - INVALID/MISSING METRIC QUANTITY
This edit is posted to the claim when the metric decimal quantity is invalid, missing or zero.
This edit was changed to deny effective 4/28/2017.

EDIT 319 - MISSING OR INVALID PRESENT ON ADMISSION INDICATOR
This edit will be posted to Encounter inpatient claims with Service date thru on or after October 12, 2015, patient status is not '30' on the Service thru date and a Present on Admission Indicator (POA) was not submitted, but the corresponding submitted diagnosis is not exempt from reporting.

A POA may be blank on a HIPAA claim, as long as the corresponding diagnosis is exempt from reporting. A blank POA on a HIPAA claim will be changed to a '1' for processing in claims front end. A '1' should not be submitted.

The valid values that may be submitted on a HIPAA claim are as follows:

N	=	Not present at time of admission
U	=	Undetermined if the condition was present at the time of admission
W	=	Clinically undetermined
Y	=	Present at the time of admission
Blank	=	Unreported

If a POA indicator of '1' is submitted, the claim will be rejected. In preprocessor; however, if a diagnosis is submitted and no corresponding valid (N, U, W or Y) POA is submitted, a value of '1' will be used to populate the POA for claims processing purposes, and the corresponding diagnosis must be exempt from reporting, or edit 319 will post.

EDIT 320 - POA INDICATOR HAS NO CORRESPONDING DIAGNOSIS CODE
This edit will be posted to Encounter inpatient claims with Service date thru on or after October 12, 2015 when the recipient is not active on Service date thru (HNI-PAT-STATUS not = 30) and the claim is submitted with Present on Admission indicator that does not have a corresponding diagnosis code.

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 322 - CLAIM UOM INVALID OR NOT=NDC UOM - SEE WWW.NJMMIS.COM

For medical injectable claims, the valid unit of measure submitted on the claim must be one of the following:

UN - UNITS
ML - MILLILITERS
GR - GRAMS
If any other value is submitted, the edit is posted.

In addition, the above values must correspond to the Drug Form Code Value (on DRUGMSTR) for the submitted NDC:

FORM CODE	TRANSLATED VALUE
1	UN
2	ML
3	GR

For example, if the claim was submitted with ML, then the Drug Form Code for the NDC must equal 2. If there is a mismatch between the claim and the DRUGMSTR, the edit is posted.

Quantity should be consistent with Unit Of Measure.

Edit was set to deny on 4/28/2017.

EDIT 323 - MAXIMUM DAILY DOSAGE NOT FOUND

This edit is posted for:

1 - Professional claims
2 - that have an injectable procedure code - see below
3 - that DO NOT have an NDC on the Maximum Daily Dosage File for the claims date of service.
OR
1 - Outpatient claims
2 - that have a revenue code = 631 thru 637 or 25X
3 - that have an injectable procedure code - see below
4 - that DO NOT have an NDC on the Maximum Daily Dosage File for the claims date of service.

- Injectable Procedure Code values J0120 thru J9999
  Q0138 thru Q0139
  Q0144 thru Q0181
  Q0222, Q2009, Q2017
  Q2041 thru Q2043
  Q2049 thru Q2051
  Q2053 thru Q2056
  Q3025 thru Q3028
  Q4074
  Q4079 thru Q4081
  Q5101
  Q5103 thru Q5130
  Q5131 thru Q5146
  Q9945 thru Q9999

EDIT 326 - RECIPIENT INELIGIBLE FOR MFP SERVICES AND GOODS
This edit is posted to encounter claims with MFP Procedure Codes:

S9977U2 or S9977U1 or S5199U1 or S5165U1
T5999U1 or T5999U2 or T5999U3

When recipient is not eligible for:
SPC 60 and SPC 75 on DOS or within 60 days grace period.
This grace period is calculated based on the start date of SPC 60 and SPC 75 minus 60 days.

EDIT 327 - DISCONTINUED PROC CODES MFP MEDIA 7 PAYMENT
This edit is posted to discontinued encounter claims with MFP Procedure Codes and modifiers.

EDIT 328 - BILL OP DRUG CLAIMS USING REVENUE CODES 631-637, 891, OR 25X
For outpatient medical injectable claims, the revenue code submitted on the claim must be 631 thru 637, 891, or in 25x range.

If any other revenue code is submitted, the edit is posted.

This edit was set to deny on 4/28/2017.

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 330 - METRIC QUANTITY INCORRECTLY REPORTED FOR DRUG BILLED
This edit is posted to:

1. Medical Injectable Professional and Outpatient (CT 03, 04) claims if two times the claim charge is less than the calculated drug cost allowance.

*NOTE: Tell the provider to verify the metric quantity.

Edit was set to deny on 4/28/2017.

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 or 11.

EDIT 339 - RECIPIENT ENROLLMENT IN MULTIPLE MANAGED CARE PLANS
This edit is posted to an encounter claim if any combination of two or more active recipient plan enrollment segments are found for PACE, D-SNP, or HMO Managed Care that cover any part of the encounter claim service period.

NOTE: The segment combinations must include at least two of the three plans listed above.

EDIT 344 - BIRTH WEIGHT ON CLAIM AND DRG CONFLICT

This edit is posted when

- The original DRG is a newborn DRG equal to one of the following DRG listed below
- The birth weight submitted on the claim for the original newborn DRG does not conform to the allowed birth weights defined below.

1. If Claim DOS Thru <= 9/30/2018

DRG	Birth Weight Range in Grams
602,603	less than 750
604,605	750 thru 999
606 thru 608	1000 thru 1499
609 thru 614	1500 thru 1999
615 thru 621	2000 thru 2499
622 thru 624, 626 thru 630, 641	greater than 2499

2. If Claim DOS Thru > 9/30/2018

DRG	Birth Weight Range in Grams
589	less than 500
591	500 thru 749
593	750 thru 999
602,603	1000 thru 1249
588	less than 1500
607,608	1250 thru 1499
611 thru 614	1500 thru 1999
609	1500 thru 2499
622,623,625,626	2000 thru 2499
630,631,634,636,639,640	greater than 2499

EDIT 349- VERIFY METRIC QUANTITY REPORTED

This edit is posted for:

Prof and OP (J/Q) medical injectable that have:

a- The Form Code indicator on the Drug Master file is equal to 2 indicating a liquid drug.

b- The route description on the Drug Master file is equal to 'INTRAVEN' or 'INJECTION'

c- The STC on the Drug Master file identified by THERAP- CLASS-SP PIC X(03) is equal to one of the following 'C1A', 'C1B', 'C1D', 'C5J', 'C5K', 'C5L', 'C5M', 'C5R', 'C1U', 'C1W'.

AND
- metric quantity on the claim is less than the package size of the NDC on the drug file

OR
- A remainder when the metric quantity on the claim is divided the package size listed for the NDC on the drug file.

OR
- Has a Daily Dose (NDC Package Size listed for NDC on the drug file/claim metric quantity listed on the claim) that exceeds the maximum units listed below for the corresponding package size.

Package Size	Maximum Units
50	8
100	8
150	8
200	8
250	8
500	4
1000	4
2000	2

EDIT 364 - CANNOT ADJ LINE LEVEL SURGERY

This edit is posted if a line level surgical procedure code is adjusted on an outpatient claim when the ICD-ALLOWED-IND is equal 'N' on the approved paid claim.

The ICD-ALLOWED-IND is set to 'N' for all Outpatient and Outpatient Crossover HIPAA 5010 claims and paper or Web claims with an ICN Julian Date > 2011364.

If the original claim revenue code is a valid surgical revenue code and the original procedure code is a valid HCPCS surgical procedure code, edit 364 is posted if an adjustment is submitted that either changes the HCPCS surgical procedure code, or changes the revenue code to a non-surgical revenue code.

Edit 364 is also posted if the original revenue and procedure code is not a valid surgical procedure code, and the adjustment revenue and procedure code is a valid surgery.

Valid surgical revenue codes:

360, 361, 369, 370, 374, 379, 490, 499, 710, 719

Valid HCPCS surgical procedure codes:

10000-69999, W0000-W6999, 90870, W9027, W9029, W9030, W9031

EDIT 385 - LOGISTICARE TRANSPORTATION SERVICE NOT COVERED FOR RECIPIENT

This edit is posted to an encounter if

1. The encounter is a Transportation Claim

AND

2. The Submitter is Logisticare

AND

3. The Claim Service Date is on or after July 1, 2011

AND

4. The Recipient is Medicaid Eligible

AND

5. Any one of the following conditions is true:
   - a. The recipient is enrolled in PACE
   - OR b. The Recipient does NOT have one of the following Covered Program Status Codes:

     For Claim Service date before 2014-01-01

110-295	310-370	380 (and under age 21)		
390	410-485	486-489	490-492	499
510-594	600	620	630	640
650	761			

     For Claim Service date on or after 2014-01-01

110-295	310-370	380		
390	410-485	486-489	490-492	499
510-594	600	620	630	640
650	761	762		

   - OR c. The recipient county of residence is 99.
   - OR d. The county code in the Current Recipient ID (positions 1 and 2) is 51.
   - OR e. The following three conditions are true:
     - The county code in the Current Recipient ID (positions 1 and 2) is 50 or 52 - 57 or 59.
     - The Program Status Code equals 761
     - The Person Number (position 12-13) in the Current Recipient ID is 00.
   - OR f. The following two conditions are true:
     - The recipient county of supervision is 31, 32, 34, 37, 38, or 39.
     - The recipient program status code is 120, 220, or 240.

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 416 - ICD VERSION MISMATCH

This edit is posted to the claim, if the claim ICD version indicator is set to B. This occurs if there is a mixture of ICD9 and ICD10 fields on a given claim.

For example, if the qualifier for one field is an ICD9 qualifier but the qualifier for another field is an ICD10 qualifier.

Claims cannot contain a mixture of ICD9 and ICD10 values or this edit will post.

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 425 - INVALID DIAGNOSIS FOR SERVICE

The procedure code is restricted to certain Diagnosis Codes and the Claim does not meet the restriction.

For Doulas, the following restrictions apply:

Perinatal visits (99600HDU7, 99600HD, 99600HD22), Postpartum visits (99199HD22, 99199HD), Labor & Delivery codes (59409HD, 59514HD) require diagnosis code Z322.

For Diabetes, the following restrictions apply for Claims with Service Dates on or after 07/01/2023:

- Claims for NDPP codes '0403T' 'G9880' 'G9881' must be accompanied with a Diagnosis code that begins with 'E66', 'R73', 'Z131', 'Z683', 'Z684', 'Z713', 'E8881'.

- Claims for DSMES codes 'G0108' 'G0109' and MNT Codes '97802' '97803' '97804' must be accompanied with a Diagnosis code that begins with 'E08', 'E09', 'E10', 'E11', 'E13', 'O24', 'Z794', 'Z7984'.

EDIT 426 - EARLY ELECTIVE DELIVERY

This edit is set on professional and hospital claims for delivery services as of date of service through 01/01/2021.

Hospital delivery claims are identified as inpatient or outpatient with

a. If any diagnosis code starts with Z37 OR
b. If inpatient claim and HNI-DRG-CDE is 540, 541, 542, 560 or 539(service thru date >= 01/01/2025) OR
c. If inpatient claim and HNI-DRG-CDE is 791,861,950,951,952,955 or 792,793,794(service thru date >= 01/01/2025) AND any diag code starting with Z370, Z372, Z373, Z375, Z736, Z378, or Z379

Professional delivery claims are identified as any diagnosis code in range Z37 AND Proc code is one of these

59400 59409 59410 59412 59414
59510 59514 59515 59610 59612
59618 59620 59622

Edit is set

1. If no diagnosis code is present to indicate the weeks of gestation (diagnosis code category Z3A excluding Z3A00) OR

2. The diagnosis code indicates less than 39 weeks of gestation (diagnosis code range Z3A01 - Z3A38) and without another diagnosis code from one of these identified categories (supporting medical necessity): O10, O11, O12, O13, O14, O15, O16, O24, O30, O31, O32, O33, O35, O36, O41, O42, O43, O44, O45, O71, O80 (only with Z3A37 or Z3A38), R03, O64, O68, O69, O76, O623, O666, O670, O678, O679, O750, O751, O771, O778, O779, O2642, O2643, O3429, O4692, O4693, O6010, O6012, O6013, O6014, O6020, O6023, O9812, O9813, O9822, O9823, O9872, O9873, O26612, O26613, O34212, O34519, O34533, O46002, O46003, O46012, O46013, O46022, O46023, O46092, O46093, O468X2, O468X3, O98112, O98113, O98212, O98213, O98712, O98713, O99322, O99323, O99324, O99325

EXCEPTION:

From 01/01/2021 going forward, if Surgical Procedure codes 10E0XZZ, 10D07Z3, 10D07Z4, 10D07Z5, 10D07Z6,10D07Z7 or 10D07Z8 are present, and/or when CONDITION CODE '81' and/or PROCEDURE CODE MODIFIER 'SC' is present, suppress Edit Code '426' and Post Edit Code '427'.

EDIT 427 - EARLY ELECTIVE DELIVERY DENIAL OVERRIDE

This edit is set to override EED Denial edit '426' on professional and hospital claims for obstetricians, midwives and hospitals deemed non-medically indicated early elective deliveries as of date of service of 01/01/2021 going forward.

The presence of Surgical Procedure Codes 10E0XZZ, 10D07Z3, 10D07Z4, 10D07Z5, 10D07Z6, 10D07Z7 or 10D07Z8, and/or Condition Code '81' and/or Procedure Code Modifier 'SC' will cause this EOB edit to replace denial edit '426'.

EDIT 428 - UNSPECIFIED DIAGNOSIS CODE

This edit is posted to the claim, if the first occurrence of the diagnosis code contains a 'U' in the Unspecified-Indicator on the diagnosis master file. A more specific diagnosis code exists that should be used instead. This edit applies to ICD10 diagnosis codes only.

EDIT 448 - SUBMITTER NOT ELIGIBLE FOR CLM TYPE OR DOS <20110701

This edit is posted to the claim if:

1. The Claim is a Transportation Claim

AND

The Submitter is Logisticare

AND

The Claim Service Date is before July 1, 2011

OR

2. The Claim is NOT a Transportation Claim

AND

The Submitter IS Logisticare

EDIT 451 - UNKNOWN FIELD POPULATED WITH INVALID DATA

This edit will cause the claim to reject and appear on the WC033R03 report. Cause for rejection is for a data overflow of a numeric field(s) or the submission of a TAB character represented by the '~' symbol. Both conditions cause mainframe abnormal end of jobs. Claim raw data and WebSphere upload claim data should be examined to determine source field(s) causing the rejection.

EDIT 459 - PRA INVALID - NO RECIPIENT FOUND FOR PRENATAL SERVICE

This error will post when the recipient on a prenatal claim does not have a recipient match on a Prenatal Risk Assessment (PRA).

EDIT 464 - PRA INVALID-NO BILLING NPI NUM FOUND FOR PRENATAL SERVICE

This error will post to prenatal claims when

- The recipient from the claim and the PRA match

AND

- The billing NPI number from the claim and the PRA DO NOT Match

EDIT 465 - PRA INVALID - CLAIM DOS NOT WITHIN PRA DOS

This error will post to prenatal claims when

- The recipient from the claim and the PRA match

AND

- The billing NPI number from the claim and the PRA match

BUT

- Claim service dates are not within the effective dates of the PRA with the matching recipient and billing NPI number

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

For Claims with DOS Thru <= 9/30/2018

The AP Grouper subroutine performs DRG verification editing and/or reassignment.

For Claims with DOS Thru > 10/01/2018

The APR Grouper subroutine performs DRG verification editing and/or reassignment.

EXCEPTIONS:
None

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

For claims with DOS Thru <= 9/30/2018

The AP Grouper subroutine calculates a 3 Byte DRG (diagnosis related group) code that differs from the a 3 Byte DRG code entered on the claim.

For claims with DOS Thru > 9/30/2018

The APR Grouper calculates a 4 Byte DRG code that differs from the 4 Byte DRG code entered on the claim. The 4 byte DRG is a 3 byte DRG code followed by a 1 byte Severity Code.

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:
None

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 be 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 544 - DRUG NOT PAYABLE FEDERAL DESI
Professional and OP (J/Q) medical injectable

This edit is posted to the claim if:

a. The FDB DESI (Federal) indicator on the Drug Master is equal to '1' and

b. The Claim Service Date is greater than or equal to the FDB DESI Date.

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 551 - NDC PROBABLY OBSOLETE, CHECK LABEL/COMPUTER
The NDC on this claim is no longer valid for the dates of Services on this claim. The claim date of service is > than the NDC obsolete date.

Effective 1/28/2011, the obsolete date is based on the HCFA-TRMC
date or the FDB obsolete date if HCFA-TRMC is not available.

Prior to that, the obsolete date was extended one year. Some records had no obsolete date but did have a HCFA-TRMC date.

These will now be marked with an obsolete date. (MOD 7952/TSU 8577).

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 597 - VERIFY OR CORRECT PROC CODE/NDC FOR DATE(S) OF SERVICE
For the Date of Service of the procedure (HCPCS, NDC) no price was found on the appropriate rate file.

EDIT 601 - NO ADJUSTMENTS ALLOWED FOR MEDIA 7 ELIGIBLE CLAIMS
This edit will post if either the adjustment or the target of the adjustment is/was Media 7 eligible.

The HMO will be directed to void and then resubmit the claim.

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 603 - MOTHER VS. BABY CLAIM. NEWBORN INDICATORS DO NOT MATCH
The edit will post to deny an Adjustment request when the Newborn Indicator is different (Y vs. N) between the original claim and the new adjustment debit.

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 660 - SERVICE UNITS NOT EQUAL TO ACCOMMODATION DAYS
This is a balancing edit for Inpatient Encounter claims (CT=01). The Edit posts if the total Accommodation days are NOT EQUAL to the Service Units.

Service Units for an Inpatient Encounter are calculated as:

1. Service Thru Date – Service From Date if Patient Status NOT = 30 (Not Still a Patient)

2. Service Thru Date – Service From Date + 1 if Patient Status = 30 (Still Patient)

3. For a single day Inpatient Encounter (Service From Date = Service Thru Date), the Service Units are set to 1

Total Accommodation days are calculated as a sum of Revenue Units for Revenue codes 100-219.

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 700 - FFS PAYMENT FOR ENCOUNTER NOT ALLOWED-SEE OTHER EDITS ON ENC
This edit applies to pharmacy claim (claim type 12) only. This edit will block the creation of a Media 7 claim for fee-for-service payment of an Encounter claim. This edit will be applied if all of the following is true:

* One of these edits is applied to the Encounter claim: 710, 711, 712, 714
* The Service Date on the claim is after 12/22/2014.
* The claim is for a drug that is included in the list of drugs that would otherwise generate a Media 7 claim for fee-for-service payment of an Encounter claim.

NOTES: This edit will inform the HMOs that the Encounter claim will not generate any FFS payment.

EDIT 701 - DATE OF SERVICE LATER THAN DATE OF DEATH
This edit is posted if the date of service (A-CLM-SERVICE-DTE) in the Claim is greater than the R33-3112-DTE-DEATH on the Recipient History Master File.

EDIT 702 - PAYMENT EXPECTED PAYOR ID ON CLAIM BUT NO TPL AMOUNT
This edit will post if any of the OTHER PAYER AMOUNT PAID fields is zero and the related OTHER PAYER ID field does not contain one of the valid PBM codes. See NCPDP 5.1 HIPAA Companion Guide Section 3 for a complete list of private TPL and Part D values for other payer ID 340-7c.

EDIT 703 - DRUG NOT PAYABLE - NO REBATE AGREEMENT

NOTE: This edit was turned to deny for Encounter Pharmacy claims with dates of service beginning 7/1/2020. While the pharmacy edit disposition is 'D' for Deny, it will be changed internally on the claim to 'E' for EOB, if the Encounter pharmacy claim is for an NDC where the Drug Class = 'O' (over-the counter). It will remain a 'D' for claims where the Drug Class is 'F' (legend, or requiring prescription).

There will be a new POS table that applies the exceptions noted below. The table is FEDERAL_REBATE_EXCEPTIONS. For Encounters with Dates of Service prior to 7/1/2020, the below listed exceptions would have been applied. This was implemented into production on 7/17/2020, but would still apply to claims with dates of service as of 7/1/2020.

This edit is posted to the claim if the claim is a pharmacy claim and

1. The Drug Class on the drug master record is not equal to 'V' APS Drug), and

2. A drug rebate agreement is not in place for the Claim Service Date. (Claim Service Date is greater than or equal to Rebate Effective Date and Rebate Code is Not equal to '1' and not equal to '2').

Effective 4/15/2011, a GA waiver for PSC 761 from 19-64 years of age required use of the Federal Drug Rebate.

Edit Exemptions:
1. Pharmacy claims with NDC of '99999999999' and Compound Drug Ind equal to Y.

2. Drug Therapy Class SP equal to 'Y3A' and Drug Category Code = 'S' (Medical Supplies).

3. Biologicals Drug Therapy Class SP equal to:
'W7B' VIRAL/TUMORIGENIC VACCINES
'W7C' INFLUENZA VIRUS VACCINES
'W7F' MUMPS AND RELATED VIRUS VACCINES
'W7H' ENTERIC VIRUS VACCINES
'W7J' NEUROTOXIC VIRUS VACCINES
'W7K' ANTISERA
'W7L' GRAM POSITIVE COCCI VACCINES
'W7M' GRAM NEGATIVE BACILLI (NON-ENTERIC) VACCINES
'W7N' TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS
'W7P' RICKETTSIAL VACCINES
'W7Q' GRAM NEGATIVE COCCI VACCINES
'W7R' SPIROCHETE VACCINES
'W7T' ANTIGENIC SKIN TESTS
'W7U' HYMENOPTERA-DERIVED AGENTS
'W7V' RHUS EXTRACTS (POISON IVY, POISON OAK)
'W7W' ALLERGENIC EXTRACTS, THERAPEUTICS
'W7Z' VACCINE/TOXOID PREPARATIONS, COMBINATIONS

Or Drug Therapy Class SP equal to:
'C1A' ELECTROLYTE DEPLETERS
'C1P' PHOSPHATE REPLACEMENT
'C1W' ELECTROLYTE MAINTENANCE
'C1Z' ELECTROLYTE MAINTENANCE
'C5B' PROTEIN REPLACEMENT
'C5C' INFANT FORMULAS

EDIT 703 - DRUG NOT PAYABLE - NO REBATE AGREEMENT (cont'd)

'C5E' GERIATRIC SUPPLEMENTS
'C5F' DIETARY SUPPLEMENTS, MISC
'C5G' FOOD OILS
'C5X' NUTRITIONAL TX, PHENYLKETONURIA (PKU) FORMULATIONS
'C6R' VITAMIN B12 PREPARATIONS
'C5U' MULTIVITAMIN PREPARATIONS
'D4D' ANTIDIARRHEAL MICROORGANISMS AGENTS
'M4A' BLOOD SUGAR DIAGNOSTICS
'Q3S' LAXATIVES, LOCAL/RECTAL
'Q6T' ARTIFICIAL TEARS
'Q6Y' EYE PREPARATIONS, MISC. (OTC)
'R3U' URINE GLUCOSE TEST AIDS
'R3V' URINE TEST AIDS, MISC
'R3W' URINE ACETONE TEST AIDS
'R3Y' URINE MULTIPLE TEST AIDS
'R3Z' URINE GLUCOSE/ACETONE TEST AIDS, STRIPS
'U6C' THICKENING AGENTS, ORAL
'X0A' BLOOD TESTING PREPARATIONS
'X1A' CONDOMS
'X2A' NEEDLES/NEEDLELESS DEVICES
'X2B' SYRINGES AND ACCESSORIES
'X5B' BANDAGES AND RELATED SUPPLIES
'X1D' PREGNANCY/OVULATION TESTS (OBSOLETE)
'X8V' MEDICAL SUPPLIES, MISC. (GROUP 4)
'Y7A' RESPIRATORY AIDS, DEVICES, EQUIPMENT
'Y9A' DIABETIC SUPPLIES

4. Drugs with Generic Code Number of '33700' (SCHIRMER TEAR TEST) Obsolete anti-cancer.

5. Iron:
'04695' '04701' '04694' '04711' '04690' '04710'
'92331' '04693' '04743' '04740' '04620' '04732'
'04623' '04621' '04627' '04743' '04652' '04564'
'04561' '04562' '10510' '04560' '04530' '04751'
'04515' '13042' '04513' '04481' '04514' '51168'
'13395' '04501' '17706' '33667' '20419' '20135'
'04580' '04591'

6. Drug with the 1st 9 digits of the NDC:
548684219 DILTIAZEM calcium channel blockers/angina
555664100 EUFLEXXA
002470781 Epipen
495020501 Epipen
499990718 Epipen
545691391 Epipen
545691392 Epipen
548682804 Epipen
548684819 Epipen
550453780 Epipen
680309069 Epipen
680309079 Epipen

EDIT 703 - DRUG NOT PAYABLE - NO REBATE AGREEMENT

080240724 Synvisc
083637761 like Synvisc
083637765 like Synvisc
584680090 like Synvisc
596760360 like Synvisc
662670921 Synvisc
681150535 Synvisc

7. Bypass Edit for DSNP members claims which meets the below criteria:
   DSNP Members - HBI Code M2012
   Legend Drug - Drug Class F (Requires Prescription)
   NDC Federal Rebate Indicator = 0
   Part D Secondary Claims
   Media 9 Encounter Claims

EDIT 704 - NDC PROBABLY OBSOLETE, CHECK LABEL/COMPUTER

The NDC on this claim is no longer valid for the dates of services on this claim. The claim date of service is > than the NDC obsolete date.

Effective 1/28/2011, the obsolete date is based on the HCFA-TRMC date or the FDB obsolete date if HCFA-TRMC is not available. Prior to that, the obsolete date was extended one year. Some records had no obsolete date but did have a HCFA-TRMC date. These will now be mark with an obsolete date. (MOD 7952/TSU 8577)

EDIT 705 - PAYMENT DENIED; VACCINE AVAILABLE FROM THE VFC PROGRAM

This edit posts if the submitted NDC is for a vaccine that is covered under the Vaccine for Children program, and will not be payable as a separate claim. The POS table is called VACCINE.

For Encounter claims, a change was made effective 04/12/2022 to bypass this edit for members in Plan B, C, D (PSC's 485, 486, 487, 488, 489, 493, 494, 495, 496, 497, 498, 499) as the VFC program does not apply to non-Plan A members.

Note: This edit was turned off on 3/12/2021 to allow for system changes to be made to bypass the posting for members in Plan B, C, and D since the VFC program does not apply to them.

Note: This edit was turned back to deny effective 04/12/2022 to correspond with the implementation of the POS change to bypass for Plan B, C, D members as noted above.

EDIT 706 - INSURANCE COVERAGE KNOWN, OTHER COVERAGE CODE - O

This edit will post if the following is true:

A. The A-CLM-TYPE field on the claim is 12 (Pharmacy)
AND
B. The A-CLM-MEDIA-CDE field on the claim is 4 (POS)
AND
C. There is TPL for the recipient, according to the TPL Insurer Code Table on the POS system
AND
D. The first occurrence of A-CARRIER-BILLED on the claim is equal to '0' (no coverage specified) or the first occurrence of A-CARRIER-BILLED is equal to '1' (no other coverage or claim billing for copay) and the version number is not '3C' and the claim has Activity Date earlier than 07/24/2012 or the A-CARRIER-BILLED on the claim = '4' and the recipient is enrolled in transitional assistance (Employer code = 'PA1', Insurer code = 'MED').

EXCEPTIONS:

1. This edit will not post if the compound drug indicator (PH- COMPOUND-DRUG-IND) = 'Y' and the TPL payment amount (A-CLM- TPL-PAID) is greater than zero.

2. This edit will not post if the Current Recipient ID indicates Cystic Fibrosis (A-CURRENT-RECIP-ID-NUM (1:2) = '58').

3. This edit will not post if the EOB Edit 885 is posted to the claim.

4. This edit will not post if the Special Program Code (A- SPECIAL-PROG-CDE) = '51' or '59'.

5. This edit will not post when provider is '4428901'.

EDIT 707 - MEDICAID PAYMENT REDUCED BY OTHER INSURANCE

The Medicaid Payment Amount is reduced by the amount of any Third Party Liability (Not Medicare).

EDIT 708 - ADDITIONAL CONTRACEPTIVE ADMIN FEE PAID

This Edit applies to the Encounter Claims where additional Administration fee is paid in addition to the existing Dispense fee when the following criteria is true:

-Submission Clarification Code (Field 420-DK) Value = '10'
-Professional Service Code (Field 440-E5) Value = ‘PE'
-Submitted Prescriber is Standing Order NPI = ‘1639464696’
-NDC/GCN from Admin Fee table
-Medicaid Beneficiary (All Beneficiaries excluding PAAD/SG/ADDP)

EDIT 709 - MAX NUMBER OF CLAIMS LIMITED TO 2 PER 12 MONTHS

This Edit applies to the Encounter Claims identified as self-administered Hormonal Contraceptives products when the following criteria is true:

-Submission Clarification Code (Field 420-DK) Value = '10'
-Professional Service Code (Field 440-E5) Value = 'PE'
-Submitted Prescriber is Standing order NPI = '1639464696'
-NDC/GCN from Admin Fee table
-Medicaid Beneficiary (All Beneficiaries excluding PAAD/SG/ADDP)

AND

There are two paid history claims with:

- The same recipient, billing provider, and GCN within the last 12 months
- Additional admin fee was paid for these claims

EDIT 710 - PART D COVERAGE KNOWN BILL FOR PART D PLAN

This edit is posted if the following are true:

a. The claim is for a Medicare Part D covered drug, and
b. The date of service on the incoming claim is within a period of Medicare Part D PDP enrollment, and
c. The claim has not been submitted to the Medicare Part D PDP or the claim was submitted to the Medicare Part D PDP but the Medicare Part D PDP did not approve the claim.

EXCEPTIONS:

1. If the claim is for a beneficiary and there is an entry on the POS Part D Override Table that will allow the claim to be paid.
2. If the service being billed is for a service approved for payment as a wraparound service without prior authorization and the incoming claim contains an NCPDP Reject Code equal to AC, 60, 61, 66, 70, 80 or MR. The Specific Therapeutic Classes for drugs approved for wraparound coverage without prior authorization are included in POS Part D Wraparound table (PA not required).
3. If the Claim is for other than a PAAD, Senior Gold or ADDP beneficiary this edit is not to be posted if the service being billed is for a drug that is not contained in POS Part D Wraparound table (with PA required or without PA) and the days supply on the incoming claim is less than 7.

EDIT 711 - PHARMACY BILLED FOR PART D DEDUCTIBLE AND CO-PAY/COINSURANCE

This edit applies to pharmacy claim (claim type 12) only. This edit posts for part D PDP approved Part D claims where the Tent-Pay is the sum of co-insurance and the deductible amounts.

EDIT 712 - RECIPIENT ELIGIBLE FOR MEDICARE PART D

This edit is applicable to pharmacy claims only.
This edit is posted if the following are true:

1. The recipient is Title XIX (see definition below) and
2. The claim is a Medicare Part D drug and
3. The recipient has either Medicare Part A or Medicare Part B on the Claim Date Of Service (DOS) and
4. The recipient is not enrolled with Medicare Part D on DOS and
5. The recipient has not affirmatively declined the Medicare Part D

NOTE: Title XIX definition (Dual Eligibles) are recipients who are in one of the following Program Status Codes (PSC):
'110', '120', '170', '180', '190', '210', '220', '270', '280', '290, '291', '292', '293', '294', '295' '310', '320', '330', '340', '350', 360', '370', '380', '390', '410', '420', '460', '461', '462', '480', '481', '482','483', '484', '485', '490', '491', '492', '510', '520', '570', '580', '590', '591', '592', '593', '594', '600', '620', '630'
Also if the recipient is NOT in one of the Special Program Codes (SPC): 10, 11, 18, and 40

Corrective Action:
Obtain Part D coverage info/or/begin facilitated
Enrollment process. Per Newsletter Vol. 16 No 14 Nov. 2006

EDIT 713 - INCORRECT UNIT OF MEASURE REPORTED FOR DRUG

This edit is applicable to pharmacy claims (claim type 12) only. It identifies Encounter claims where the incorrect unit of measure is reported for the claimed drug.

This edit is posted if the NCPDP transaction for the claim contains a unit of measure (EA/ML/GM) in field 600-28 that does not match the drug form code for the drug on the drug file. The mapping of the Unit of Measure to the Drug Form code is as follows:

EA = '1'
ML = '2'
GM = '3'

This edit does not apply to claims for compound drugs.

Action: Pharmacy should use correct Unit of Measure: EA, ML, or GM.

NOTES: This edit shows that edit 2099 would have been applied to this Encounter claim based on fee for service (FFS) editing. To view the results of testing this claim against POS FFS logic, use POSWeb and click on the Media 9 check-box. Media 9 claims are Encounter claims that were run through the FFS logic to determine what the outcome would have been if the claim was subject to FFS editing and pricing.

This edit will start being applied on 05/11/2015.

EDIT 714 - PART D COPAY NOT COVERED AS OF FY2011

This edit applies to pharmacy claim (claim type 12) only. This edit posts if all of the following conditions are true:

The claim has Part D as the primary payer, and the remaining liability represents copay, coinsurance or deductible.

The Service Date on the claim is after 12/22/2014.

EDIT 715 - BENEFIT STAGE AMOUNT IS NOT NUMERIC

This edit is applicable to pharmacy claims only, submitted in NCPDP D.0 format.

This edit is applied when a Benefit Stage Amount is not numeric. The Benefit Stage Amounts are: Deductible, Initial Stage, Donut Hole, Catastrophic.

Note: Benefit Stage data applies to Part D claims only.

EDIT 716 - PARTD PDP ON CLAIM AND NO BENEFIT STAGES SUBMITTED

This edit is applicable to pharmacy claims only, Submitted in NCPDP D.0 format. This edit is informational only. It is applied when there are no Benefit Stage Amount fields on the submitted claim, but the claim has a Part D PDP. The Benefit Stage Amount field represents the Medicare benefit stage that the beneficiary is in at the time the claim was paid by the Medicare PDP (deductible, initial, donut hole, etc). The State can use the presence of this edit to make sure the claim was processed through Medicare. Claims that receive this edit should be for a Part D supplemental drug.

EXCEPTION:

1. This edit will be bypassed if all of the following are true:

- The claim is for a drug that is found on the Part B Drug Table.
- The beneficiary has Part B coverage on date of service, as seen on the Medicare file. Edit 2027 is applied to the claim.
- OR

2. The PTD_PLAN_ID on the PartD_PDP_HISTORY table = '801' and the claim DOS < 20120801
- OR

3. The claim DOS < 01/01/2012. (began June 12, 2012)

NOTES: Part D enhanced/Premier plans may cover OTC and non Part D drugs. This edit is changed to deny starting May 1, 2012.

For claims with Service Date on or after 7/1/2013, this edit will deny claims with Benefit Stage 60 because this Benefit Stage became obsolete due to NCPDP External Code List changes effective 7/1/2013.

EDIT 717 - BENEFIT STAGE COUNT DOES NOT MATCH NUMBER OF REPETITIONS
This edit is applicable to pharmacy claims only, submitted in NCPDP D.0 format.

This edit is applied when all of the following are true:

- Benefit Stage Count is not equal to zero
- The Benefit Stage Count does not match the actual number of repetitions of benefit stage data

These amounts show the Part D Benefit Stage represented by the patient's remaining liability on a Part D claim.

ACTION: The software vendor should verify the D.O. transaction response.

EDIT 718 - INVALID BENEFIT STAGE AMOUNT, NO PARTD PAYER SUBMITTED
This edit is applicable to pharmacy claims only, submitted in NCPDP D.0 format.

This edit is applied when one or more Benefit Stage Amount is present and the claim does not contain an Other Payer ID that represents a Part D payer. Benefit Stage Amounts are only valid for Part D insurance.

Benefits Stage Valid Values:
01 - Deductible
02 - Initial Benefit
03 - Coverage Gap (Donut Hole)
04 - Catastrophic
50 - Not paid under Part D, paid under Part C
60 - Not paid under Part D, paid under supplemental benefit only
70 - Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing
80 - Non-Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing

ACTION: Pharmacy should refer to list in NCPDP companion guide for other Payer ID.

EDIT 719 - BNFT STG 70-NOT PARTD CLM-PD BY NEGOTIATED PRICE-PARTD DRUG
This edit applies to pharmacy claim (claim type 12) submitted as NCPDP D.0 claims only. This edit posts if the following is true:

The claim has Benefit Stage Amount with Benefit Stage Qualifier equal to '70'.

Notes:
'70' represents claims that are not paid under Part D. They are for Part D drugs but the claim was paid based on a plan-sponsored negotiated price. Rebate could be collected on these claims, but the edit should be set to deny because NJMMIS does not allow payment for Benefit Stage '70'. Either the provider can be directed to fill the prescription with an NDC that is covered by Part D, or the beneficiary or provider must absorb the cost of the negotiated price.

EDIT 720 - BNFT STG 60/62/80/90 NOT ON FORMULARY EXCEPTION

This edit applies to pharmacy claim (claim type 12) submitted as NCPDP D.0 claims only. This edit posts if all of the following are true:

- The claim has Benefit Stage Amount with Benefit Stage Qualifier equal to '60', '62', '80', or '90'.
- The drug is not a Part D Excluded drug. Part D Excluded drugs are listed on the TD_FORMULARY_TABLE that can be viewed in POSWeb Table Maintenance.

Notes:

'60' represents claims that are not paid under Part D. They are paid under a supplemental benefit only. This is no longer allowed starting 7/1/2013.

'62' represents claims that are not paid under Part D. They are paid under a supplemental benefit only for drugs that are not Part D drugs. Value '62' may be used starting 1/1/2013 and was added to NJMMIS as of 4/30/2013.

'80' represents claims that are not paid under Part D. They are also not Part D drugs. The claim was paid based on a plan sponsored negotiated price.

'90' represents claims for enhanced or OTC drugs not applicable to the Part D drug spend, but these drugs are covered by the Part D plan. Value '90' may be used starting 7/1/2012 and was added to NJMMIS as of 4/30/2013.

EDIT 721 - PROVIDER NOT AUTHORIZED TO PRESCRIBE AS PER ACA REQUIREMENT

This edit applies to pharmacy claim (claim type 12). This edit posts if any of the following are true for the Medicaid Prescriber ID on the claim:

- The prescriber has Cancel Reason Code 41 (death) and no other Cancel Reason Code on file.
- The prescriber has Cancel Reason Code 41 (death) and the claim has Prescription Written Date during the period of eligibility where the Cancel Reason Code was 41.
- The prescriber has Cancel Reason Code 30, 32, 35 or 37 and the claim has Date of Service during the period of eligibility where the Cancel Reason Code was one of these codes.
- The prescriber has a Provider Type that is not '20', '27', '28', '32', '60', '70' or '90'.
- The prescriber has a Provider Type'70' with Provider Specialty 611.

EDIT 722 - BNFT STG 61-NOT PARTD CLM-PD BY COADMIN PLAN BNFT-PARTD DRUG

This edit applies to pharmacy claim (claim type 12) submitted as NCPDP D.0 claims only. This edit posts if the following is true:

The claim has Benefit Stage Amount with Benefit Stage Qualifier equal to '61'.

Notes:

'61' represents claims that are not paid under Part D. They are for Part D drugs but the claim was paid using a co-administered insured benefit. Rebate could be collected on these claims, but the edit will be set to deny for certain benefit programs because these programs do not allow payment for Benefit Stage '61'. Either the provider can be directed to fill the prescription with an NDC that is covered by Part D, or the beneficiary or provider must absorb the cost of the remaining patient liability for the co-administered benefit.

EDIT 723 - BNFT STG 90-NOT PARTD CLM-OTC/ENH-NO TROOP BUT PTD COVERED

This edit applies to pharmacy claim (claim type 12) submitted as NCPDP D.0 claims only. This edit posts if the following is true:

The claim has Benefit Stage Amount with Benefit Stage Qualifier equal to '90'.

Notes:
'90' represents claims that are paid under Part D but are not applicable to the Part D drug spend (TrOOP). They are not for Part D drugs but the claim was paid under a Part D plan. Rebate can be collected on these claims.

EDIT 724 - CLAIM SUBMITTED AS A 340B CLAIM

This edit is posted to:

1. Pharmacy Encounter Claims with a date of service of 4/1/2017 and later, that are submitted as a 340B claim (NCPDP version D.0, field 420-DK Submission Clarification Code valued with '20'), and the 340B ceiling price was used by the HMO to price the claim.

EDIT 725 - CLAIM VOIDED/ADJUSTED DUE TO INCORRECT HMO PAYMENT AMOUNT

This edit is posted to:

1. Voided and adjusted encounter claims that were recycled via TSU 15874.

Notes: During pharmacy inventory audits conducted by MFD in 2017, it was discovered that Pharmacy Encounter claims submitted by United HealthCare, Aetna, and Amerigroup - some going back to 2011 - contained an HMO payment amount which incorrectly included the administrative costs associated with processing the claims through their PBM. It did not reflect the actual payment to the HMO provider.

Claims with this edit will have undergone a recycle process that corrected the HMO payment amounts on the claims for selected pharmacies.

EDIT 726 - SUBMITTED PRESCRIBER NPI MAPS TO A GROUP ENTITY

This edit is applicable to pharmacy Encounter claims only.

This edit is posted if the submitted Prescriber NPI - NCPDP field 411 DB Prescriber ID - maps to an NPI on the POS table NPI_NPPES that contains an entity code of '2', indicating the NPI is assigned to a group and not an individual entity.

Exceptions:

Claims that already received the following edits:
- 711 (PHARMACY BILLED FOR PART D DEDUCTIBLE AND CO - PAY/COINSURANCE)
- 710 (PART D COVERAGE KNOWN BILL FOR PART D PLAN)
- 714 (PART D COPAY NOT COVERED AS OF FY2012)

-or-

Claims that have any of the following conditions:
- The drug on the claim has STC 'W7C'. These are flu vaccines that are administered by a pharmacist and do not require prescription.
- The drug is a Plan B drug (GCNs 23549 or 93226) and prescriber is a pharmacy.

Note - edit 2298 will actually post to the Encounter Media 9 claim in POS and will be translated to Encounter edit 726 when the claim is sent up to the mainframe.

EDIT 728 - 415-DF NUMBER OF REFILLS AUTHORIZED IS NOT NUMERIC

This edit applies to electronic pharmacy claims (claim type 12).

This edit is posted on a claim if 415-DF, number of refills authorized is not Numeric or is not submitted.

EDIT 729 - DATE RX WRITTEN > 30 DAYS OLD SCHED II – V
This edit posts if 414-DE Date Rx written is > 30 days prior to the claim's DOS (for the initial fill) and the NDC is for a Schedule II - V drug (DEA code = 2 - 5).

This edit was turned to deny on 7/1/2022

Exceptions:

For Schedule II drugs, (DEA code = '2') - The claim contains the submission clarification code (NCPDP field 420-DK) value of '10' (Meets Plan Limitations: The pharmacy certifies that the transaction is in compliance with the program's policies and rules that are specific to the particular product being billed).

This is to cover the Division of Consumer Affairs allowance of multiple prescriptions being written by a prescriber on a single member visit. Per DCA regulation:

13:45H-7.5 (MANNER OF ISSUANCE OF PRESCRIPTIONS)

When up to three separate prescriptions for a total of up to a 90-day supply of a Schedule II

Controlled substances are issued to a patient by a physician pursuant to N.J.S.A. 45:9-22.19 (P.L. 2009, c. 165), a pharmacist shall fill such prescriptions.

All three prescriptions may be accepted at one time and held pending filling as indicated below:

1) The first prescription shall be filled no later than 30 days after the date of issuance;

AND

2) The second and third prescriptions shall be filled no later than 30 days after the date indicated on the prescription as the earliest date on which the prescription may be filled.

Since the NCPDP transaction does not allow for the 'earliest date on which a prescription can be filled', the Division is allowing for the submission clarification code of '10' to properly note that.

EDIT 730 - DATE RX WRITTEN > 30 DAYS OLD NON SCHED DRUG
This edit applies to electronic pharmacy claims (claim type 12).

This edit is posted on a claim if 414-DE, Date Rx written is > 365 days prior to the claim’s DOS (for initial fill). This applies only to NDC for a Non Schedule (DEA code = 0).

This edit was turned to deny eff 8/2/2021.

EDIT 731 - 460-ET QTY PRESCRIBED NOT NUMERIC OR NOT SUBMITTED
This edit applies to electronic pharmacy claims (claim type 12).

This edit posts if 460-ET Quantity Prescribed is not submitted or is not numeric.

This edit was turned to deny eff 8/2/2021.

EDIT 732 - QTY PRESCRIBED DOES NOT MATCH PREVIOUSLY SUBMITTED CLAIM
This edit applies to electronic pharmacy claims (claim type 12).

This edit posts if 460-ET Quantity Prescribed on the current claim does not match the Quantity.

Prescribed on all history claims for the same Rx number, provider id, NDC, and recipient id.

This edit was turned to deny eff 8/2/2021.

EDIT 733 - QTY DISPENSED > QTY PRESCRIBED
This edit applies to electronic pharmacy claims (claim type 12).

This edit posts if 442-E7 Qty dispensed is > 460-ET Qty prescribed.

Only (DEA code = '2') For completion of partial fill transactions, the metric Quantity of the history claims, partial fill transaction will be added to the current claim's metric Quantity for comparison to Quantity prescribed.

This edit was turned to deny eff 8/2/2021.

EDIT 734 - NUM OF REFILLS AUTH > 0 SCHED II
This edit applies to electronic pharmacy claims (claim type 12).

This edit posts if 415-DF Num of Refills authorized is > 0 and the NDC is for a Schedule II drug (DEA code = 2).

This edit was turned to deny eff 8/2/2021.

EDIT 735 - 403-D3 FILL NUMBER M/I
This edit applies to electronic pharmacy claims (claim type 12).

This edit posts if 403-D3 Fill number is not numeric or is not submitted.

This edit was turned to deny eff 8/2/2021.

EDIT 736 - 403-D3 FILL NUMBER > 0 ON SCHED II
This edit applies to electronic pharmacy claims (claim type 12).

This edit posts if 403-D3 Fill number is > 0 (0 = initial fill) if NDC is for a Schedule II drug (DEA code = 2).

This edit was turned from EOB to off eff 8/2/2021. The fill number may be incremented on claims submitted for a Schedule II drug, but since the qty dispensed across a single or multiple fills will never be allowed to exceed the qty prescribed (edit 733), and since the number of refills authorized for a Schedule II drug can never be greater than zero (edit 734), this particular edit is not necessary.

EDIT 737 - FILL NUMBER > NUM OF REFILLS AUTH
This edit applies to electronic pharmacy claims (claim type 12).

This edit is posted on a claim if 403-D3, Fill number > 415-DF Number of Refills authorized.

This edit was turned from EOB to Off eff 8/2/2021.

EDIT 738 - 343 - HD DISPENSING STATUS INVALID

This edit applies to electronic pharmacy claims (claim type 12).

This edit is posted on a claim if 343-HD, Dispensing Status = 'P' (partial) or 'C' (Completion of Partial fill) and

344-HF Quantity Intended to be Dispensed is not greater than 442-E7 Quantity dispensed

or

if 343-HD = space and 344-HF Quantity Intended to be dispensed is not equal to 442-E7 Quantity dispensed.

This edit was turned to deny eff 8/2/2021.

EDIT 739 - MULTIPLE PARTIAL FILLS NOT ALLOWED

This edit applies to electronic pharmacy claims (claim type 12).

This edit is posted on a claim if 343-HD, Dispensing Status deny claim if value = 'P' (partial) and another paid history claim found for same Rx number, provider id, NDC, and recipient id, which also contained a 'P' for the dispensing status.
Or
343-HD Dispensing Status = 'C', and a prior history claim does not exist for the same Rx number, provider id, GCN, and recipient id, which did not contain a Dispensing status of 'P'. The completion of a partial fill transaction had to have been preceded by an actual partial fill.

Note: For FFS claims (edit 2341), this will limit paying a dispense fee payment on only one partial fill transaction. Any dispensing fee should only be paid one time for a partial fill transaction. The subsequent completion fill should only reimburse for the calculated drug price. DMAHS will only allow a single partial fill transaction for an incomplete dispense, per drug.

MCO's must follow FFS logic. So for Encounter claims this will gauge accurate reporting of Partial fill transactions on the HMO side.

This edit was turned from EOB to off eff 8/2/2021. The decision was to allow the HMOs the flexibility to have as many partial fills as they deem necessary.

EDIT 740 - ACCUM OF MED EXCEEDS 30 DAYS SUPPLY

This edit applies to electronic pharmacy claims (claim type 12).

This edit is posted on a claim as an accumulation edit to limit the total accumulation of medication to max 30 days supply 'excess'. This is for those recipients who refill at points where the system authorizes, but leaves unused medication in the recipient's hands before they have to start taking meds from the refill. The earliest point they can normally refill (existing edits 830 and 832 in POS) uses an 85% threshold of what was used from a previous fill, before that refill will be allowed.

How excess meds accumulate with the 85% threshold for early refill:

Claim is received and paid where the date of service is 1/01/2020 and the prescription is for a 30 day supply. The system multiplies the days supply (30) by .85. The result of this calculation is 25.5 days. The system drops any partial days, adding 25 days to the service date of 1/01/2020 to determine that a claim for the same drug product is to be considered an early refill if the service date on the new claim is prior to 1/26/2020. So the earliest it can be refilled is 1/26/2020 based on how existing early refill edits 830 and 832 are systemically applied. In this example, the recipient would still have 4 days supply left from the initial fill, when they get their refill on 1/26/2020.

This new edit will look at all of the previous claims for the same GCN and same recipient within the last 12 months, regardless of the Rx number or provider, and add all of the remainder of the days supply for what was left in each of those fills. If the sum of that remainder is greater than 30, then this new edit should be applied.

Example:

1st claim 1/1/20 - 30 days supply
2nd claim 1/26/20 - 30 days supply (4 days left from 1st claim)
3rd claim 2/19/20 - 30 days supply (4 days left from 2nd claim)

total accum = 8 to this point.

How POS will calculate for Edit 740

1) within the last 365 days (366 for leap year), calculate the cumulative number of days supply on all history claims for the same recipient and the same GCN, regardless of provider or Rx number;

2) of those claims found in #1, calculate the number of calendar days between the history claim with the earliest service date, and the current claim's service date;

3) subtract #2 from #1 giving how many days supply for that drug is still on hand, as of the DOS of the current claim being submitted;

4) if the result is > 30, post the new edit 740 on the current claim.

This one new edit will apply to only solid dose forms (tab, cap, supp, etc.). Exceptions: anything on the days_supply_exception table that currently exceeds 30. The edit will be set as Pay and Report initially to allow for a review of the new logic and impact to providers/members.

EDIT 741 - M/I INCENTIVE AMOUNT SUBMITTED FIELD (438-E3)
This edit applies to electronic pharmacy claims (claim type 12).

This edit posts if 440-E5 (Professional Service Code) is submitted without 438-E3 (Incentive Amount Submitted).

EDIT 742 - M/I PROFESSIONAL SERVICE CODE (445-E5)
This edit applies to electronic pharmacy claims (claim type 12).

This edit posts if a vaccine administration claim is submitted without 'MA' in the 440-E5 (Professional Service Code) field.

EDIT 743 - M/I SUBMISSION CLARIFICATION CODE (420-DK)
This edit applies to electronic pharmacy claims (claim type 12).

Either 440-E5 (Professional Service Code) or 438-E3 (Incentive Amount Submitted) submitted without 420-DK (Submission Clarification Code).

EDIT 744 - COVID VACCINE ADMINISTRATION CONFLICT
This edit applies to electronic pharmacy claims (claim type 12).

If a pharmacy claim for a two dose vaccine is submitted with a Submission Clarifier Code (SCC) = '02'

OR

'06' and another claim is found in history for a conflicting vaccine (first 5 bytes of NDC on history claim is not equal to the first 5 bytes on current claim), regardless of SCC value on history claim.

A Submission Clarification Code of '02' = first dose of vaccine and '06' = second dose of vaccine.

Since doses of a multi-dose vaccine have to come from the same manufacturer, the first 5 bytes (Labeler code) will be matched to ensure vaccines are not split between doses. This edit will initially apply to the COVID-19 vaccine NDCs on the POS table COVID 19 Vaccine table. COVID-19 NDC codes will not be listed here as there will be more added and some possibly changed after the initial rollout.

NOTE: Eff August 13, 2021, pharmacy claims for additional and booster shots will be submitted with a Submission Clarifier Code (SCC) = ‘07’. Those claims will not be subject to this edit.

Eff March 23, 2022, pharmacy claims for booster dose will be recognized with a single Submission Clarifier Code (SCC) = '10', or '07' and '10'. Those claims will not be subject to this edit.

EDIT 745 - VACCINE ADMINISTRATION EXCEEDED FOR MEMBER

This edit applies to electronic pharmacy claims (claim type 12).

This edit will limit vaccine administration claims for certain vaccines on the POS COVID Vaccine Table based on the maximum number of days having to have passed between the current claim and any history claim on file for the same type of vaccine. The maximum number of days is defined by the Max Days Reqd value - currently defined as 180 days for all COVID Vaccines; subject to change.

A Submission Clarification Code (SCC) of '02' = first dose of vaccine and '06' = second dose of vaccine.

This edit will post if:

If a claim is submitted with SCC = '02' (first dose) and another history claim is found for the same member where the dates of service between the current claim and the history claim is within 180 days (Max Days Reqd value on the POS COVID Vaccine table), for any NDC on that table (regardless of SCC value on the history claim)

OR

If a claim is submitted with SCC = '06' (second dose) and another history claim is found for the same member where the dates of service between the current claim and the history claim is within 180 days (Max Days Reqd value on the POS COVID Vaccine table), for any NDC on that table, where the history claim also has an SCC value of '06'.

OR

A claim is submitted with SCC = '07' (additional or booster dose) and another history claim is found for the same member where the difference in the date of service between the current claim and the history claim is within 120 days (Max Days Reqd value on the POS COVID Vaccine table), for any NDC on that table, where the history claim also has an SCC value of '07' or '10'.

OR

A claim is submitted with SCC = '10' (booster dose) and another history claim is found for the same member where the difference in the date of service between the current claim and the history claim is within 120 days (Max Days Reqd value on the POS COVID Vaccine table), for any NDC on that table, where the history claim also has an SCC value of '07' or '10'.

EDIT 746 - MINIMUM DAYS REQUIRED BETWEEN VACCINE DOSES

This edit applies to electronic pharmacy claims (claim type 12).

This edit will deny pharmacy claims for vaccines, when the second (or additional/booster) dose of the vaccine is trying to be administered without the minimum number of days having passed as defined by the MIN DAYS REQUIRED value on the POS COVID Vaccine Table - currently defined as either 21 or 27 depending on type and manufacturer of the vaccine - 180 days for all COVID vaccines; subject to change.

A Submission Clarification Code (SCC) of '02' = first dose of vaccine and '06' = second dose of vaccine.

If a claim is submitted with SCC = '06' (second dose) and another history claim is found for same member for the same NDC, with an SCC - '02' (first dose), where the dates of service between the current and history claims in not >= Min Days Reqd value on the new POS COVID Vaccine table, (currently 15).

OR

A Submission Clarification Code (SCC) = '07' (additional or booster dose) and another history claim is found for the same member for the same NDC, with an SCC - '06' (second dose), where the dates of service between the current and history claims is not >= Min Days Reqd value on the new POS COVID Vaccine table, (currently 21).

OR

A Submission Clarification Code (SCC) = '10' (additional or booster dose) and another history claim is found for the same member for the same NDC, with an SCC - '06' (second dose), where the dates of service between the current and history claims is not >= Min Days Reqd value on the new POS COVID Vaccine table, (currently 21).

EDIT 747 - EXCEEDS PROG MAX-GREATER THAN SIX FILLS 6 IN A MONTH PERIOD

The current claim is matched against paid pharmacy claims for the recipient by prescription number. If any combination of six matched claims fall within a six-month (6) window before, spanning, or after the service date of the current claim and the claim indicates the recipient is Medicaid, the error is set.

This only applies to Schedule III - IV drugs; unlike FFS claims where edit 0738 applies to all drugs.

EXCEPTION:
This edit will not post to claims having a TPL amount (A-CLM-TPL-PAID) greater than zero and a service date (A-CLM-SERVICE-DTE) greater than or equal to 20010301.

Effective 10/16/2006 - This edit will not post if the Part D Payment Amount or Part D Deduct Amount or Part D Coinsurance Amount is greater than zeroes.

EDIT 748 - DATE RX WRITTEN > 30 DAYS OLD SCHED II - V

This edit applies to electronic pharmacy claims (claim type 12).

This edit posts if 414-DE Date Rx written is > 30 days prior to the claim's DOS (for the initial fill)

AND

The NDC is for a Schedule II - V drug (DEA code = 2 - 5) and an exception was made to edit 729 for:

Schedule II drugs, (DEA code = '2') - The claim contains the submission clarification code (NCPDP field 420-DK) value of '10' (Meets Plan Limitations: The pharmacy certifies that the transaction is in compliance with the program's policies and rules that are specific to the particular product being billed). This is to cover the Division of Consumer Affairs allowance of multiple prescriptions being written by a prescriber on a single member visit. Per DCA regulation: 13:45H-7.5 (MANNER OF ISSUANCE OF PRESCRIPTIONS)

When up to three separate prescriptions for a total of up to a 90-day supply of a Schedule II Controlled substance are issued to a patient by a physician pursuant to N.J.S.A. 45:9-22.19 (P.L. 2009, c. 165), a pharmacist shall fill such prescriptions.

All three prescriptions may be accepted at one time and held pending filling as indicated below:

(1) The first prescription shall be filled no later than 30 days after the date of issuance; and
(2) The second and third prescriptions shall be filled no later than 30 days after the date indicated on the prescription as the earliest date on which the prescription may be filled.

Since the NCPDP transaction does not allow for the 'earliest date on which a prescription can be filled', the Division is allowing for the submission clarification code of '10' to properly note that.

EDIT 749 - DAILY MORPHINE MILLIGRAM EQUIVALENT > 50

This edit is applicable to pharmacy claims where the daily Morphine Milligram Equivalent (MME) of the opioid drug being dispensed exceeds 50, and there is no other pharmacy claim in POS history in the preceding 90 days for an opioid.

Exceptions:

1) Cancer patients, those with Sickle Cell Anemia, Hospice patients, or those under palliative care, should not have MME threshold editing applied, and the new edit should be completely bypassed.

   A query for diagnosis codes on non-pharmacy claims downloaded from the mainframe is done to exclude those recipients using the following diagnosis codes - beginning with 'D57', 'Z51' or 'C'.

   D57 = Sickle Cell
   Z51 = Radiation, Chemo, Immunotherapy (ANTINEOPLASTIC)
   C = Cancer

2) Compound claims are excluded.

EDIT 750 - DAILY MORPHINE MILLIGRAM EQUIVALENT > 120

This edit is applicable to pharmacy claims where the daily Morphine Milligram Equivalent (MME) of the opioid drug being dispensed, along with the daily MME for POS claims in history within the last 90 days for another opioid dispense, exceeds 120 for claims with service date < 08/09/2022 or 90 with service date on, or after 08/09/2022.

Exceptions:

1) Cancer patients, those with Sickle Cell Anemia, Hospice patients, or those under palliative care, should not have MME threshold editing applied, and the new edit should be completely bypassed.

   A query for diagnosis codes on non-pharmacy claims downloaded from the mainframe is done to exclude those recipients using the following diagnosis codes - beginning with 'D57', 'Z51' or 'C'.

   D57 = Sickle Cell
   Z51 = Radiation, Chemo, Immunotherapy (ANTINEOPLASTIC)
   C = Cancer

2) Compound claims are excluded.

EDIT 753 - OTC COVID TEST LIMIT EXCEEDED- LIMIT 4 KITS PER MONTH

This edit is applicable to pharmacy claims only.

- Total Limit exceeds 4 test kits per month (8 tests), per member for the NDC in Specific Therapeutic Class (STC) X6C.

EDIT 754 - BYPASS OF MED EXCEEDS 30 DAYS SUPPLY

This Edit applies to pharmacy claims (claim type 12) that have bypassed posting the accumulation Edit 740 for one of the following reasons and would have otherwise posted Edit 740 due to the calculated on-hand supply is > 30:

Drugs on Days Supply Exception table that exceeds 30 days.
Claim has Part D or TPL
LTC claim identified by patient residence = '03','04',or '09'

This edit applies to electronic pharmacy claims (Claim type 12). This Edit posts as an accumulation edit, to limit the total accumulation of medication to max 30 days' supply 'excess' for those recipients who refill at points where the system allows but would leave unused medication in the recipient's hands before they must start taking meds from the refill. The earliest point they can normally refill (existing edits 830 and 832 in POS) uses an 85% threshold of what was used from a previous fill, before that refill will be allowed. How excess meds accumulate with the 85% threshold for early refill:

This edit will look at all the previous claims for the same GCN and same recipient within the last 12 months, regardless of the Rx number or provider, and add all the remainder of the days' supply for what was left in each of those fills. If the sum of that remainder is greater than 30 and drug is on the Accumulation Edit Exception table, then this edit should be applied. If the drug is not on the Accumulation Edit Exception table, then 740 Edit will be applied.

This edit will apply to only solid dose forms (tab, cap, supp, etc.).

EDIT 755 - SUBMITTED PRESCRIBER NPI DOESN'T MATCH STANDING ORDER NPI

This Edit applies to Encounter Claims when submitted for the additional Administration Fee and the following criteria is true:

-Submission Clarification Code (Field 420-DK) Value = '10'
-Professional Service Code (Field 440-E5) Value = 'PE'
-NDC/GCN from Admin Fee table
-Medicaid Beneficiary (All Beneficiaries excluding PAAD/SG/ADDP)

AND

Submitted Prescriber is NOT the Standing Order NPI = '1639464696'

EDIT 757 - AMDC SERVICE EXCEEDS PROGRAM FREQUENCY GUIDELINES

1. The AMDC claim (CT 04) exceeds the frequency guidelines for the periodicity of services as established.

PHYSICIAN:
a. The AMDC claim (CT 04) exceeds 5 service units within calendar week (Sunday thru Saturday).

OR

b. The AMDC claim exceeds 1 service unit per day.

NOTE: AMDC claims are identified as follows:
Claim Type = 04
Procedure Code = S5102

EDIT 785 - ENCOUNTER INCLUDED IN PAST FINANCIAL SETTLEMENT

Void did not have matching Media 7 FFS claim in History. Edit will post to deny a Void request for Encounter Claims that have a value of 'F' in the MHC203-IND.

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 788 - VOID REQUEST DENIED AGAINST RECONCILED CLAIM

The edit will post to deny a Void request for Encounter Claims that have a Value of 'R' in the MHC203-IND. An MHC203-IND of 'R' identifies that the claim was part of a Maternity reconciliation process between the State and the HMO's.

EDIT 789 - INCENTIVE PAYMENT SUPPRESSED AGAINST RECONCILED CLAIM
The edit will post to an Adjustment request for Encounter Claims that have a value of 'R' in the MHC203-IND. An MHC203-IND of 'R' identifies that the claim was part of a Maternity reconciliation process between the State and the HMO's.

Adjustment requests that receive this edit will not generate a media 7 claim even if it qualifies.

EDIT 796 - SUBMITTER NOT MATCHED ON HISTORY
This edit is posted to any adjustment encounter claim if the submitter on the adjustment request does not match the submitter 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 non pharmacy adjustment encounter claim if no match is found in claims history based on the original recipient number and former ICN.

Pharmacy voids and adjustments with no matching original on the Pharmacy VSAM file will post edit 027.

EDIT 800 - EXACT DUPLICATE BILL

This edit is posted to an encounter claim that is identified as a duplicate of an encounter claim in history. The logic that is used to identify a duplicate encounter claim requires that the fields listed for each of the following claim types have matching values in the encounter claim being processed and the encounter claim in history. All exceptions and exclusions are specifically indicated.

INPATIENT (claim type 01):
submitter ID, servicing provider ID, servicing provider NPI, original recipient ID, claim type, and statement dates.
See NOTES 1 - 3.

OUTPATIENT (claim type 03):
submitter ID, servicing provider ID, servicing provider NPI, original recipient ID, claim type, service dates, revenue code, HCPCS procedure code (if present), and the first 13 digits of the ICNs do not match. If the revenue code is 510-515 or 519, the encounter claim being processed is not considered a duplicate unless all of the clinic codes match those in the historical encounter claim.
See NOTES 1- 4.

PROFESSIONAL (claim type 04):
submitter ID, servicing provider ID, servicing provider NPI, original recipient ID, claim type, service dates, procedure code, and procedure modifiers 1 and 2.
See NOTES 1, 4 and 5.

HOME HEALTH (claim type 06):
submitter ID, servicing provider ID, servicing provider NPI, original recipient ID, claim type, service dates, procedure code, and revenue code.
See NOTE 1 and 4.

TRANSPORTATION (claim type 07):
submitter ID, servicing provider ID, servicing provider NPI, original recipient ID, claim type, service dates, procedure code, procedure modifiers 1 and 2, origin code, and destination code.
See NOTE 1.

VISION (claim type 08):
submitter ID, servicing provider ID, servicing provider NPI, original recipient ID, claim type, service dates, procedure code, and procedure modifiers 1 and 2.
See NOTE 1.

DENTAL (claim type 11):
submitter ID, servicing provider ID, servicing provider NPI, original recipient ID, claim type, service dates, Procedure Code (includes modifiers), tooth surface, and tooth number.
See NOTE 1.

EDIT 800 - EXACT DUPLICATE BILL (cont'd)

PHARMACY (claim type 12):
submitter ID, servicing provider ID, servicing provider NPI, original recipient ID, claim type, service dates, prescription number, and drug code (non-compound drug).
See NOTE 1 and 6.

CAPITATION DETAIL (claim type 04):
submitter ID, servicing provider EIN/SSN, original recipient ID, claim type, procedure code ('CAPDT'), recipient capitation code, capitation provider type, and capitation month/year.
See NOTE 5.

NOTE 1 (all claim types):
If the servicing provider ID's are not equal or if they both contain '9999999' or '0000000' then the Servicing provider NPIs are compared. Then, if the Servicing Provider NPIs are equal and all other fields listed are equal, the encounter claim being processed is considered a duplicate of the encounter claim in history.

NOTE 2 (claim types 01, 03):
For multiple birth encounter claims, only one encounter claim will have the newborn indicator set to 'Y'. The remaining newborn encounter claims will use condition codes M2, M3, and M4.

NOTE 3 (claim types 01, 03):
Encounter claims for both mother and baby with the newborn indicator equal to 'Y' are excluded from duplicate encounter claim identification logic.

NOTE 4 (claim types 03, 04, 06):
Procedure codes A4649, E0450, E1399, K0108, 90460, and 90461 are excluded from duplicate encounter claim identification logic.

NOTE 5 (claim type 04):
Procedure code 'CAPDT' is excluded from duplicate encounter claim identification logic for professional service encounter claims. However, procedure code 'CAPDT' is the only procedure code included in duplicate encounter claim identification logic for capitation detail encounter claims.

NOTE 6 (claim type 12):
NDC '99999999999' is excluded from duplicate encounter claim identification logic.

NOTE 7 (claim types, 03, 04):
For outpatient and physician encounters with service dates on or after 6/1/2017 and with Jxxxx/Qxxxx procedure codes (injectable drugs), the NDC fields are also compared. The encounter being processed is considered a duplicate if the NDCs and all other fields compared for that claim type are equal.

EDIT 802 - DOULA VISITS EXCEED LIMIT
This edit is set on claims for doula visits if the number of visits exceed the maximum per pregnancy.

If the member is 19 or younger at the time of the first doula visit, they are allowed an initial visit (99600HDU7) and 11 other pre and postpartum visits. If there is no initial visit, they are allowed 12 total visits.

If the member is 20 or older at the time of the first doula visit, they are allowed an initial visit (99600HDU7) and seven other pre/postpartum visits. If there is no initial visit, they are allowed eight total visits.

Visit codes include the initial visit 99600HDU7 and visit codes 99600HD, 99199HD, 99600HD22, 99199HD22.

EDIT 803 - POSTPARTUM VISIT EXCEEDS 6 MONTHS FROM L&D
This edit is set on claims for doula postpartum visits (99199HD, 99199HD22) if the visit is more than six months from the Labor & Delivery claim or no L&D claim exists. The L&D claim is identified as either a doula L&D claim 59409HD, 59514HD or the facility delivery claim with DRG 540, 541, 542 or 560.

EDIT 804 - DOULA INCENTIVE PAYMENT MISSING REQUIRED CLAIMS
This edit is set on claims for the doula incentive payment, 99199HDU8, when qualifying claims are not present. The qualifying claims that must be present are:

- A delivery claim within six weeks prior to the incentive payment (delivery claim identified as claim with proc 59409HD, 59514HD or Inpatient with DRG 540, 541, 542 or 560)

- A doula visit (99199HD or 99199HD22) within six weeks of the delivery claim

- An OB visit defined as

Claim with proc 59430 within six weeks following delivery

Claim with procs 59410, 59515, 59614, 59622, 59400, 59510, 59610, or 59618 – if one of these codes exist during prenatal period (nine months prior to delivery) thru six weeks after delivery.

EDIT 805 - DOULA VISIT EXCEEDS AGE LIMIT
This edit is set on claims for doula visits 99600HD22 and 99199HD22, if the mother's age at the first doula visit is 20 years old or older. These visit codes are for extra visits for mother's aged 19 and younger at the time of the first doula visit.

EDIT 806 - INPATIENT AND OUTPATIENT DUPLICATE ERROR
This edit will post if an incoming inpatient or outpatient claim meets the following criteria when matched against a previously paid claim:

Same Recipient Number, same or overlapping dates of service (the Outpatient service date falls within the Inpatient claim service dates on history, or
Inpatient dates overlap the Outpatient service date on history), Servicing provider is the same or servicing NPI is the same and the Submitter ID is the same.

EXCEPTIONS:

This edit does not apply if:
For Outpatient claim going against Inpatient historical claims:

1. The Outpatient claim has bill type '131' or '137' and the Outpatient revenue code for MICA (542 or 543),or

2. The Outpatient from date of service is equal to the Inpatient thru date of service and the inpatient patient status is not 30, or

3. The Outpatient thru date of service is equal to the Inpatient from date of service, and the Outpatient servicing provider number is not equal to the Inpatient servicing provider number, or servicing NPI is not the same and the Submitter ID is not the same

EDIT 806 - INPATIENT AND OUTPATIENT DUPLICATE ERROR (cont'd)

4. The Outpatient claim contains one of the following procedure/revenue codes for PERS:

	Rev Cde	Proc Cde
On-Site Episode of Care	911	S9480
On-Site Follow Up	911	S9484
Off-Site Episode of Care	900	T2034
Off-Site Follow Up	900	90839

For Inpatient claim going against Outpatient historical claims:

1. Outpatient claim has bill type '131' or '137' and the Outpatient revenue code for MICA (542 or 543), or

2. The Inpatient from date of service is equal to the Outpatient thru date of service and the servicing provider numbers are not equal, or servicing NPI is not the same and the Submitter ID is not the same

3. The Inpatient thru date of service is equal to the Outpatient from date of service.

This edit will also not post if:

1. The incoming Inpatient claim contains dates identified by Occurrence Span Code 74 (Date of First Discharge and Date of Readmission) and the previously paid Outpatient claim falls within and includes that date range, or

2. The incoming Outpatient claim falls within dates identified by Occurrence Span Code 74 on a previously paid Inpatient claim.

3. Inpatient claims identified as a Long-Term Care with the following Bill Types: 211-219, 281-289, 651-669.

3. Inpatient claims identified as Outpatient birthing centers with the following Bill Types 84X (1-9).

EDIT 807 - INPATIENT TO INPATIENT POSSIBLE DUPLICATE ERROR

This edit will post if an incoming Inpatient claim meets the following criteria when matched against a previously paid Inpatient claim:

Same submitter, Different Service Provider # or Service NPI #, same Recipient Number, same Claim Type, same/overlapping statement dates.

Exceptions:

1. The from date of service on one inpatient claim is equal to the thru date of service of the second inpatient claim with a patient status not = 30.

2. The incoming Inpatient claim contains dates identified by Occurrence Span Code 74 (Date of First Discharge and Date of Readmission) and the previously paid Inpatient claim falls within and includes that date range, **or**

3. The incoming Inpatient claim falls within dates identified by Occurrence Span Code 74 on a previously paid Inpatient claim.

EDIT 807 - INPATIENT TO INPATIENT POSSIBLE DUPLICATE ERROR (cont'd)

4. Inpatient claims identified as a Long-Term Care with the following Bill Types: 211219, 281-289, 651-669.

5. Inpatient claims identified as Outpatient birthing centers with the following Bill Types 84X (1-9).

EDIT 808 - AMDC/INPATIENT CLAIM DATE CONFLICT

This edit is posted when the Inpatient date of service and the AMDC date of service occur on the same date, excluding the Inpatient admission and discharge dates:

1. This edit is posted to an active Inpatient claim when an AMDC claim is found in history having a date of service which has a Date of Service within the Dates covering the Inpatient stay.

2. This edit is posted to an active AMDC claim when an Inpatient claim is found in history having dates of service which includes the Date of the AMDC claim.

NOTE: AMDC claims are identified as follows:
Claim Type = 04
Procedure Code = S5102

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.

EDIT 871 - MEDIA 7 SERVICE LIMIT ERROR

This edit will post when the system determines that a Media 7 supplemental payment cannot be made due to service limits.

1) Only one maternity payment for payment for each client, based on original recipient number for a specified number of weeks as defined in the MCO contract.

2) EPSDT - Regardless of the number of encounters, the system will only generate paid claims according to service limitation rules based on recipient age. The following service limitations apply to all encounters with the same original recipient number and servicing provider number (SSN):

RECIPIENT AGE	ALLOWABLE PAYMENTS
0-11 months	7
12-24 months	3
26 months - 239 months	1 per year

EDIT 911 - MANAGED CARE SUB-VENDOR REPORTING CAPITATED PAYMENT
This edit is posting to any encounter claim that contains a reported sub vendor payment to a provider. This payment is found in the Medicaid Tent Pay field.

In 837 Professional (CT04,CT08,CT07) and Dental claims, a tertiary loop with Payer ID CAP will be sent with a payment amount made by a MCO sub contractor to a provider.

EDIT 920 - CLAIM CHECK: COSMETIC PROCEDURE
This edit is set by Claim Check if the procedure code on the claim is classified as a cosmetic procedure.

EDIT 921 - CLAIM CHECK: UNLISTED PROCEDURE CODE
This edit is set by Claim Check if the procedure code is unlisted.

EDIT 922 - CLAIM CHECK: PROCEDURE CODE IS COSMETIC AND UNLISTED
This edit is set by Claim Check if the procedure code is classified as both a cosmetic procedure and an unlisted procedure.

EDIT 923 - CLAIM CHECK: PROCEDURE CODE IS EXPERIMENTAL
This edit is set by Claim Check if the procedure code is classified as experimental.

EDIT 924 - CLAIM CHECK: PROCEDURE CODE IS OBSOLETE
This edit is set by Claim Check if the procedure code is classified as obsolete.

EDIT 925 - CLAIM CHECK: MODIFIER 26 NOT ALLOWED FOR PROCEDURE CODE
This edit is set by Claim Check if the claim had modifier 26 but the procedure code did not have a professional component. Modifier 26 should not be used with this procedure.

EDIT 926 - CLAIM CHECK: DUPLICATE PROCEDURE FOR SAME DATE OF SERVICE
This edit is set by Claim Check if there is a duplicate procedure code on the same date of service.

EDIT 927 - CLAIM CHECK: INVALID PROCEDURE CODE
This edit is set by Claim Check if the procedure code is invalid.

EDIT 929 - CLAIM CHECK: PROCEDURE INDICATED FOR NEONATE PATIENT
This edit is set by Claim Check because the procedure code is not valid for this claim because it should be used only for a neonate patient (0-30 days old).

EDIT 930 - CLAIM CHECK: PROCEDURE INDICATED FOR PEDIATRIC PATIENT
This edit is set by Claim Check because the procedure code is not valid for this claim because it should be used only for a pediatric patient (31 days-17 years old).

EDIT 931 - CLAIM CHECK: PROCEDURE INDICATED FOR MATERNITY PATIENT
This edit is set by Claim Check because the procedure code is not valid for this claim because it should be used only for a maternity patient (12-55 years old).

EDIT 932 - CLAIM CHECK: PROCEDURE INDICATED FOR ADULT PATIENT
This edit is set by Claim Check because the procedure code is not valid for this claim because it should be used only for an adult patient (over 14 years old).

EDIT 933 - CLAIM CHECK: PROCEDURE NOT INDICATED FOR A MALE
This edit is set by Claim Check because the procedure code is not valid for this claim because it should be used only for a female patient.

EDIT 934 - CLAIM CHECK: PROCEDURE NOT INDICATED FOR A FEMALE
This edit is set by Claim Check because the procedure code is not valid for this claim because it should be used only for a male patient.

EDIT 935 - CLAIM CHECK: CLAIM WAS BYPASSED
This edit is put on the claim when the claim cannot be sent to Claim Check because there are more than 100 lines. This is an internal edit.

EDIT 936 - CLAIM CHECK: ASSISTANT SURGEON NOT ALLOWED FOR PROCEDURE
This edit is put on the claim for procedures which Claim Check sometimes allows an assistant surgeon, but not always.

EDIT 937 - CLAIM CHECK: DIAGNOSIS INDICATES POSSIBLE TPL
This edit is set by Claim Check because a diagnosis code indicates possible coverage of the service by a third party payor.

EDIT 938 - CLAIM CHECK: PROCEDURE CODE INDICATES POSSIBLE TPL
This edit is set by Claim Check because the procedure code indicates possible coverage of the service by a third party payor.

EDIT 939 - CLAIM CHECK: PROCEDURE NOT EXPECTED FOR DIAGNOSIS
This edit is set by Claim Check if the procedure code is not expected for the diagnosis code.

EDIT 940 - CLAIM CHECK: MEDICALLY UNLIKELY EDIT (EXCESSIVE UNITS)
The Medically Unlikely edit (MUE) represents the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. If the units are exceeded, the edit will post. This edit references the number of units on a single claim line.

EDIT 941 - CLAIM CHECK: PROCEDURE CODE AGE RESTRICTED
This edit is set by Claim Check if there is a discrepancy between the procedure code and the patient's age.

EDIT 942 - CLAIM CHECK: ASSISTANT SURGEON DENIED
This edit is set by Claim Check if the assistant surgeon was denied for this claim.

EDIT 943 - CLAIM CHECK: ASSISTANT AT SURGERY DENIED
This edit is set by Claim Check if the assistant at surgery was denied for this claim.

EDIT 944 - CLAIM CHECK: NEW PATIENT PROC NOT APPROPRIATE
This edit is set if Claim Check determines that a new patient evaluation and management service was not warranted. An established patient procedure should have been used instead.

EDIT 945 - CLAIM CHECK: CCI INCIDENTAL PROCEDURE
This edit indicates a National Correct Coding Initiative Incidental procedure. Certain procedures are commonly performed in conjunction with other procedures as a component of the overall service provided. An incidental procedure is one that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.

EDIT 946 - CLAIM CHECK: CCI MUTUALLY EXCLUSIVE PROCEDURE
This edit indicates a National Correct Coding Initiative mutually exclusive edit. A mutually exclusive relationship involves procedures that would not reasonably be performed during the same session, or combinations of procedures that are medically improbable or impossible to be performed at the same time.

EDIT 947 - CLAIM CHECK: INCIDENTAL PROCEDURE
This edit is set by Claim Check if the procedure was determined to be an incidental procedure. Certain procedures are commonly performed in conjunction with other procedures as a component of the overall service provided. An incidental procedure is one that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.

EDIT 948 - CLAIM CHECK: HISTORY DENIED PROCEDURE
This edit is set by Claim Check if the history procedure was denied.

EDIT 949 - CLAIM CHECK: MUTUALLY EXCLUSIVE PROCEDURE
This edit is set by Claim Check if the procedure code is mutually exclusive to another procedure. A mutually exclusive relationship involves procedures that would not reasonably be performed during the same session, or combination of procedures that are medically improbable or impossible to be performed at the same time.

EDIT 950 - CLAIM CHECK: POST OPERATIVE PROCEDURE CODE
This edit is set by Claim Check if the procedure code was determined to be a post-operative procedure.

EDIT 951 - CLAIM CHECK: PRE OPERATIVE PROCEDURE CODE
This edit is set by Claim Check if the procedure was determined to be a pre-operative procedure.

EDIT 952 - CLAIM CHECK: PROCEDURE NOT VALID DUE TO REBUNDLING
This edit will post if the procedure code should not be used when billed with another, similar procedure code on the same date of service. Rebundling occurs when one procedure code can be used instead of two procedure codes.

EDIT 953 - CLAIM CHECK: PROCEDURE GENDER RESTRICTION
This edit is set by Claim Check if there is a discrepancy between the procedure code and the patient's gender.

EDIT 954 - CLAIM CHECK: INTENSITY OF SERVICE
This edit is set by Claim Check if it deems the procedure should be replaced by a different procedure code due to intensity of service. Claim Check screens for over-utilization of comprehensive and detailed Evaluation & Management services.

EDIT 955 - CLAIM CHECK: DUPLICATE PROCEDURE
This edit is set by Claim Check if a duplicate procedure code exists.

EDIT 956 - CLAIM CHECK: MEDICAL VISIT PROCEDURE
This edit will post if the medical visit was billed on the same date of service as another paid diagnostic or therapeutic procedure. The evaluation and management service is included in the global surgical period of the paid procedure, as defined by CMS.

EDIT 957 - CLAIM CHECK: DIAGNOSIS NOT EXPECTED FOR PROCEDURE
This edit is set by Claim Check if the diagnosis code is not expected for the procedure code.

EDIT 958 - CLAIMSXTEN: ADD ON EDIT
This edit is set by ClaimsXten when the claim has an add on procedure code and another claim does not exist with the appropriate base code for the same provider, same recipient, and same date of service per CMS rules.

EDIT 959 - CLAIM CHECK: SERVICE DAYS EXCEED NUMBER OF UNITS
This edit is set by the Claim Check process if the inclusive number of service days exceeds the number of units on the claim.

EDIT 960 - CLAIM CHECK: NUMBER OF UNITS EXCEED NUMBER OF SERVICE DAYS
This edit is set by the Claim Check process if the number of units on the claim exceeds the inclusive number of service days.

EDIT 961 - CLAIM CHECK: INVALID MODIFIER
This edit is set by Claim Check because the claim had an invalid modifier.

EDIT 962 - CLAIM CHECK: INVALID MODIFIER/PROCEDURE CODE COMBINATION
This edit is set by Claim Check because the modifier and procedure code combination is not valid.

EDIT 963 - CLAIM CHECK: INVALID DIAGNOSIS CODE
This edit is set by Claim Check because the diagnosis code is invalid.

EDIT 964 - CLAIM CHECK: DIAGNOSIS CODE MISSING
This edit is set by Claim Check because line level diagnosis did not exist on the claim level. This is an internal error - notify Systems.

EDIT 965 - CLAIM CHECK: INVALID CLAIM DIAGNOSIS CODE
This edit is set by Claim Check because the diagnosis code is invalid.

EDIT 966 - CLAIM CHECK: CLAIM LINES EXCEED THE MAXIMUM
This edit is set by Claim Check because the number of claim lines sent to Claim Check exceeds the 100 line maximum. This is an internal error - notify Systems.

EDIT 968 - CLAIMSXTEN: MISSING MODIFIER 26
This edit is set by ClaimsXten when a modifier 26, denoting professional component, should have been reported for the procedure.

EDIT 969 - CLAIMSXTEN: PROCEDURE TO DIAGNOSIS COVERAGE
This edit is set by ClaimsXten due to the PXDX coverage rule.
This identifies claims for procedure codes associated with diagnosis codes, modifiers, age, and frequency requirements where the procedure is not considered medically necessary or has payment constraints according to National Coverage Determinations (NCDs).

EDIT 970 - CLAIM CHECK: INTERNAL ERROR
This edit is set because Claim Check returned an internal error. This is a technical error - notify Systems.

EDIT 971 - CLAIM CHECK: BYPASS CLAIM CHECK
If this edit is placed on a claim, Claim Check is bypassed.