EXCD_ID	EXCD_TYPE	EXCD_STS	EXCD_SHORT_TEXT	EXCD_LONG_TEXT1	EXCD_LONG_TEXT2	EXCD_PT_LIAB_IND	EXCD_HC_ADJ_CD	EXCD_REMIT_REMARK	EXCD_PROV_ADJ_CD	EXCD_REMIT_REMARK2
c01		P	Add-On Code Requires Primary Service	This procedure was denied because it is an add-on code that requires a	primary procedure		234	M51	CO	N122
c02		P	Lifetime Maximum Exceeded	Lifetime Maximum Exceeded			35	N14	OA	
c03		P	Yearly Maximum	Yearly Maximum Exceeded			119	N14	OA	
c04		P	Age exceeds normal range for procedure	This service is not normally performed for members in this age range			6	N129	CO	
c05		P	Invalid Diagnosis for Procedure	This service is not covered when performed for the reported diagnosis			11		CO	
c06		P	Invalid place of service for procedure	This service is not covered when performed in this setting			5	M77	CO	
c07		P	Procedure code frequency is exceed	Based upon clinical guidelines for this procedure code, the frequency	is exceeded		198	UTM	OA	
c08		P	Modifier required for this	Modifier required for this procedure			4	9X3	OA	
c09		P	Non-covered service per Local Carrier	Non-covered service per Local Carrier Determination			96	N130		
c10		P	Procedure denied based on modifier	Procedure denied based on modifier billed			236	z34	OA	
c11		P	Limitation applied per Local Carrier	Determination			96	N130		
c13		S	Payment included in primary procedure	Reimbursement for this code is included in the primary procedure						
c14	GD	P	Medical Necessity not met per LCD	Medical Necessity not met per LCD/ Local Carrier Determination			50	N661		
c15		P	LTSS Limitation applied	LTSS Limitation applied			222	N362		
c16		P	LTSS Yearly Maximum Exceeded	LTSS Yearly Maximum Exceeded			222	N362		
c17		P	LTSS Monthly Maximum Exceeded	LTSS Monthly Maximum Exceeded			222	N362		
c18		P	Procedure to procedure edit per LCD	Procedure to procedure limit applied per Local Carrier Determination			222	N362		
c50		S	History to Current PAM	History to Current PAM Edit						

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p01		P	Required Px or Mod is missing or invalid	A required procedure code or modifier is missing or invalid	on the current line or an associated claim line					

p02		P	Age conflict with px or dx	The patient's age conflicts with the procedure and/or diagnosis code		C	9		CO	
p03		P	Diagnosis code missing or invalid	A diagnosis code which meets medical necessity for this	procedure code is missing or invalid					
p04		P	Documentation/ authorization is required	Documentation or authorization is required to be	submitted and/or reviewed					
p05		P	Possible duplicate claim or claim line	This is a possible duplicate claim line of another claim line	in history					
p06		P	E/M code inappropriately reported	This E/M procedure code is inappropriately	reported for an established or new patient					
p07		P	Maximum frequency exceeded	The units have exceeded the allowable	maximum frequency per time span					
p08		P	Required modifier is missing or invalid	The required modifier is missing or the modifier is invalid	for the procedure code					
p09		P	Non-covered, restricted or bundled code	This is a non-covered, restricted, reporting only, or bundled	procedure code or service					
p10		P	Place of service is missing or invalid	The place of service code is missing or invalid for the	procedure code					
p11		P	Missing or invalid provider specialty.	The provider specialty is missing or invalid for the place of	service or procedure code					
p12		P	A procedure reduction should be applied	A procedure reduction should be applied to this claim line	based on the procedure code or modifier submitted					
p13		P	Revenue, TOB or code conflicts	The type of bill, procedure code, or revenue code	are conflicting					
p14		P	Unbundle relationship with another px	The procedure code has an unbundle relationship with another procedure	on this claim or on a claim in history					
p15		P	Missing required claim/line data	This claim or claim line is missing information which is needed	for editing					
p16		P	Occurrence, value, cond. code conflicts	There is a conflict with the occurrence, value or condition	code and the procedure, revenue code or TOB on the claim					

p17		P	Potential Overpayment identified	A potential overpayment has been	identified on this claim					
p18		P	Claim Sequencing Error	Claims must be submitted in the same sequence in which the services	are furnished for certain facilities	C	107	N674	CO	
p19		P	Claim does not meet criteria for an	emergent claim		C	40		CO	
p22		P	Token Charge Less Than 1.01 Billed	by Provider		C	96	N130	CO	
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s01		P	The patient status is not	The patient status	is not valid.					
s02		P	The patient status code is missing	The patient status	code is missing.					
s03		P	Procedure is a limited coverage code	Procedure code is	limited coverage code.					
s04		P	Limited coverage procedure due to dx	Procedure code is limited coverage since there is an	associated limited diagnosis code on the claim.					
s05		P	Limited coverage procedure due to dx	Procedure codes 02RK0JZ and 02RL0JZ are	limited coverage when Z006 diagnosis code is present.					
s06		P	Diagnosis indicates wrong procedure	The Other diagnosis code	indicates that a wrong procedure was performed.					
s07		P	Diagnosis indicates wrong procedure	The Principal diagnosis code	indicates that a wrong procedure was performed.					
s08		P	Px not reported due to length of stay	Procedure code 9672 should not be reported when the	patient's length of stay is less than four days					

s09		P	Facility submitted diagnosis with HAC	Non-exempt facility submitted admission diagnosis	with Hospital Acquired Condition					
s10		P	Facility submitted principle dx with HAC	Non-exempt facility submitted principle	diagnosis code with Hospital Acquired Condition					
s11		P	Non-exempt dx w/POA of 1 or X submitted	Non-exempt facility submitted	Non-exempt diagnosis w/POA of 1 or X					
s12		P	Principal dx requires non-exempt POA	The Principal diagnosis code	requires a non-exempt POA indicator of 1 or X					
s13		P	Other diagnosis requires non-exempt POA	The Other diagnosis code requires	a non-exempt POA indicator of 1 or X					
s14		P	Facility submitted diagnosis with HAC	Non-exempt facility submitted other diagnosis	code with Hospital Acquired Condition					
t01		P	Modifier required at this pos	This edit occurred because the procedure code requires a specific	modifier when billed at this place of service					
t02		P	LCD Part B code to code missing or inval	LCD NCD: CMS ID needs additional procedure code						
t03		P	LCD Part B missing or invalid provider S	LCD NCD: provider specialty does not meet policy for procedure code.						
t04		P	Deny addon procedure	Addon procedure code billed with primary procedure on claim ID line						
t05		P	History unbundle procedure, incidental	History procedure code has incidental relationship	with this procedure code					
t06		P	LCD Part B missing or invalid policy RE	LCD NCD: policy requirements are not met for procedure code.						
t07		P	LCD Part B deny	LCD NCD: procedure code has a denied relationship.						
t08		P	LCD Part B profile	LCD NCD: procedure code is a profiled relationship. Please review						
t09		P	LCD Part B review/request documents	LCD NCD: documentation should be requested or reviewed						

t10		P	Medicare deny addon procedure	Primary procedure code on history that is associated with this	addon procedure code received an edit with a deny or review					
t11		P	Medicare bilateral procedure reduction	Bilateral surgeries were performed; reimbursement for this procedure	or second procedure should be reduced by 50%.					
t12		P	Medicare diagnostic radiology reduction	Procedure code and history procedure code indicate multiple imaging	services. A 25% reduction of the technical component applies.					
t13		P	Medicare diagnostic radiology reduct H	Procedure code and history procedure code indicate multiple imaging	a 25% reduction of the technical component applies.					
t14		P	Medicare E/M and surgery without modifi	History E/M code was billed on a date of service as a minor or	procedure without appropriate modifier.					
t15		P	Medicare E/M and surgery without modifi	E/M code billed on a date of service as a minor or major procedure	without an appropriate modifier.					
t16		P	Medicare multiple endoscopy reduction	Procedure qualifies for multiple endoscopy reduction and payment	should be reduced. RVU value for this line should be reduced.					
t17		P	Medicare bilateral procedure reduct I	For procedure code and history code a multiple endoscopy reduction	applies to the history claim and payment should have been reduced					
t18		P	Maximum frequency exceeded	The maximum frequency for procedure code has been exceeded.						
t19		P	Medicare multiple procedure reduction	A multiple procedure reduction of 50% of the allowed amount should	be applied to this claim line					
t20		P	Medicare multiple procedure reduction	Medicare requires that an operative report be reviewed when more	than 5 procedures have been performed on the dos					

t21		P	Medicare multiple procedure reduction	A multiple procedure reduction of 50% of the allowed amount should	be applied to history claim					
t22		P	Medicare add-on procedure without prim	Add-on procedure code has been submitted without appropriate	primary procedure					
t23		P	Non-covered service	Procedure code is a non-covered service per the non-covered service	list					
t24		P	Add-on procedure without primary proc	Add-on procedure code has been submitted without an appropriate	primary procedure code					
t25		P	Unbundle procedure - incidental	Procedure code has an incidental relationship with another procedure	code					
t26		P	Medicare intraoperative care only reduct	Medicare: only intraoperative portion of global payment is allowed.						
t27		P	Medicare postoperative care only reducti	Medicare: only postoperative portion of global payment is allowed.						
t28		P	Medicare preoperative care only reductio	Medicare: only preoperative portion of global payment is allowed.						
t29		P	Medicare return to operating room reduct	Medicare: only intraoperative portion of global payment is allowed.						
t30		P	Medicare medically unlikely edits	Medicare: the units for this service exceeds the allowed units.						
t31		P	Medicare anesthesia reduction	The presence of an anesthesia modifier indicates a reduction	in payment.					
t32		P	Medicare anesthesia modifiers	Anesthesia code on this line requires an appropriate modifier.						
t33		P	Medicare diagnostic testing in a hospita	Medicare: professional componenet modifier needed in place of service	for this diagnostic procedure code.					
t34		P	Invalid modifier for physician service.	Per the MPFS, procedure code describes the physician services.	Use of a modifier is not appropriate.					

t35		P	Invalid modifier for Technical Component	Per the MPFS, procedure code describes only the technical portion of	a service or diagnostic test. A modifier is not appropriate.					
t36		P	Invalid Modifier for global services.	Per the MPFS, procedure code describes the global code of a service	or diagnostic test. The modifier is not appropriate.					
t37		P	Physician interpretation is invalid.	Per the MPFS, procedure code describes a physician	interpretation for service and is not appropriate in place of service					
t38		P	Invalid Modifier for Prof. Component.	Per the MPFS, procedure code describes the physician	work portion of a diagnostic test. The modifier is not appropriate.					
t39		P	Invalid Mod with 'incident to' service.	Per Medicare guidelines, procedure code is a service covered incident	to a physician's service and modifier is not appropriate.		182	M78		
t40		P	Invalid modifier-procedure use.	Per Medicare, use of a modifier	is not typical for the billed procedure.		182	M78		
t41		P	Non-covered procedure code	Per LCD or NCD guidelines,	the procedure code is non covered.					
t42		P	Physician order or prescription required	Per Medicare guidelines, Medicare does not pay for a service	or items that do not have a physician order or prescription.					
t43		P	DME Max frequency has been exceeded	Per Medicare guidelines, the maximum frequency	for the DME procedure code has been exceeded.					
t44		P	DME Max frequency has been exceeded	Per Medicare guidelines, the maximum frequency for	the DME procedure code has been exceeded					
t45		P	Procedure performed for same condition	The procedure was performed on the same day of a history procedure	by the same provider. The diagnosis indicates it is the same condition					

t46		P	Diagnosis code is missing or invalid	Per Medicare guidelines, a diagnosis code(s), which	meets medical necessity for the procedure code is missing or invalid.		16	M76	CO	
t47		P	Procedure in global follow-up period	Per Medicare guidelines a history procedure code by the same provider	is in the global period of the procedure code for the same condition					
t48		P	Diagnosis code is missing or invalid	Per Medicare guidelines, a diagnosis code(s), which meets	medical necessity for the procedure code is missing or invalid.		16	M76	CO	
t49		P	Modifier EY is required	Per Medicare guidelines, all claim lines on	the same claim must contain the modifier EY.					
t50		P	Modifier GK can't be submitted alone	Modifier GK cannot be submitted alone, another	line with GA or GZ must be present on the same claim.					
t51		P	Modifier GY not eligible for payment	The presence of modifier GY	indicates this is not eligible for payment.					
t52		P	Non covered procedure code or modifier	Per Medicare guidelines, the procedure code is a non	covered code or the modifier is a non covered modifier.					
t53		P	Non covered per medical necessity	Per Medicare these are non-covered services	because this is not deemed a medical necessity by the payer.					
t54		P	Diagnosis code is missing or invalid	Per Medicare guidelines, a diagnosis code(s), which	meets medical necessity for the procedure code is missing or invalid.		16	M76	CO	
t55		P	Non covered without injury or exposure	Per Medicare, in the absence of injury or direct exposure,	preventive immunization and its administration is not covered.					
t56		P	A history procedure code is within the	global period of the procedure code on this line		C	97	N525	CO	

t57		P	Date past Medicare timely filing date	The date of service is	past Medicare timely filing guidelines.					
t58		S	Units exceed medically unlikely units	Per Medicaid Medically Unlikely Edits, the units of service						
t59		S	Unbundle relationship in history	Per Medicaid NCCI edits, the a history procedure						
t60		S	Procedure has an unbundle relationship	Per Medicaid NCCI edits, the procedure code						
t61		P	ICD-9 hist. code compared to ICD-10 code	An ICD-9 Diagnosis code in history was compared to	an ICD-10 diagnosis code on the current claim	C	16	M76	CO	
t62		P	Inappropriate diagnosis to modifier	The Diagnosis code and modifier	combination are inappropriate	C	16	M76	CO	
t63		P	Unbundle relationship with history code	Per Medicare guidelines, the procedure code has	an unbundle relationship with a history procedure code	C	97	N525	CO	
t64		P	Unbundle relationship with history code	Per Medicare guidelines, a history procedure code has	an unbundle relationship with the code on the current line	C	97	N19	CO	
t65		P	Maximum frequency has been exceeded	The frequency of the procedure code has exceeded	the allowable maximum frequency for this code	C	273	N362	CO	
t66		P	Procedure requires an ambulance modifier	Per Medicare, procedure is identified as an ambulance	code and requires an ambulance modifier					
t67		P	Not eligible due to modifier GZ	The presence of modifier GZ indicates	this is not eligible for payment.					
t68		P	Reduction for multiple imaging services	Procedures indicate multiple imaging services were performed.	Per CMS, a 25% reduction of the professional component applies					
t69		P	Reduction for multiple imaging services	Procedures indicate that multiple imaging services were performed. Per	CMS, a 25% reduction of the professional component applies to history					

t70		P	Medicare multiple therapy reduction	Per Medicare guidelines, a multiple procedure	reduction should be applied to this claim line					
t71		P	Medicare multiple therapy reduction	Based on this claim line, a multiple procedure	reduction should be applied to history					
u01	CO	P	Discharge date is not covered	The date of discharge is not reimbursed by Medicaid.		C	16	N332		
u02		P	Nursery/Non-Nursery Accomm Must Bill Sep	Nursery and non-nursery accommodations must be billed separate		C	32	N15	CO	
u03		P	Diagnostic or Therapeutic Codes	Medicare coinsurance is reduced or waived		C	45		CO	
u04		P	Invalid billing for multiple surgeries	Multiple surgeries performed on the same day must be billed on a	single claim form	C	16	N149	CO	
u05	EX	P	Resubmit to Behavioral Health	Resubmit to Behavioral Health Contractor		C	109	N130	CO	
u06		P	Procedural Reduction	A procedure reduction is being applied to this claim line based on the	Medicaid Guidelines	C	45		CO	
u07		P	Resubmit to Transportation Vendor	Resubmit to Transportation Vendor		C	109	N193	CO	
w01		P	Digits 4,5 not needed for date	Invalid diagnosis code unnecessary 4th/5th digit for patient's	admission/discharge date					
w02		P	Missing 4th/5th digit for date	Invalid diagnosis code missing 4th/5th digit for patient's	admission/discharge date					
w03		P	Not found in valid code table	Invalid procedure code. Not found on table of valid ICD-9-CM codes			181	M151		
w04		P	Invalid, 4th digit not needed	Invalid procedure code. Unnecessary 4th digit						
w05		P	Invalid, missing 4th digit	Invalid procedure code. Missing 4th digit						
w06		P	Invalid admit/discharge date	Invalid procedure code. Found on ICD-9-CM table but not valid for	patient's admission/discharge date					
w07		P	Digit 4 not needed for date	Invalid procedure code. Unnecessary 4th digit for patient's	admission/discharge date					
w08		P	Digit 4 missing for date	Invalid procedure code. Missing 4th digit for patient's	admission/discharge date					

w09		P	Missing code for radiopharmaceutical dr	Claim lacks required HCPCS level ii code for radiopharmaceutical drug						
w10		P	Incorrect billing of rev code w/HCPCS	Revenue codes 381 and 382 can only be used when billing for packed red	blood cells (381) and whole blood (382)					
w11		P	Mental health not approved in php	Non-approved partial hospitalization mental health services cannot be	submitted with a bill type of 13x and condition code 41					
w12		P	Mental health not payable outside php	Approved partial hospitalization mental health services submitted with	TOB 12x, 13x or 14x must have condition code 41 on the claim					
w13		P	Charge exceeds token charge	The charged amount for HCPCS code C9898 cannot exceed $1.01						
w14		P	NCD coverage not effective	This service was provided after the end date of the approved coverage	in the national coverage determination					
w15		P	Revenue code used only for whole blood.	Whole blood revenue codes can	only be used when billing for whole blood.					
w16		P	Not approved for partial hospitializatio	Billed HCPCS code is not	approved for a partial hospitalization claim.					
w17		P	Code is only for partial hospitializatio	Billed HCPCS code can	only be billed on a partial hospitalization claim.					
w18		P	Charge exceeds token charge ($1.01).	Charge exceeds token charge ($1.01).						
w19		P	Service is after NCD coverage date.	This service was provided after the end date of coverage for the NCD						
w20		P	Medicare Unlikely Edits. Units exceeded	Per CMS Medically Unlikely Edits, the units billed for submitted	procedure code exceed the defined allowable units.					
w21		P	Invalid patient age	Per LCD or NCD, the patient's age does not meet policy requirements	for the procedure code and/or a diagnosis code.					

w22		P	LCD Code to Code Missing or Invalid	Per LCD or NCD guidelines, an additional procedure code	is needed to meet policy requirements.					
w23		P	Procedure code has a denied relationship	Per LCD or NCD guidelines, procedure code has a denied relationship.						
w24		P	Procedure frequency has been exceeded	Per LCD or NCD, the frequency does not meet policy requirements	for the procedure code					
w25		P	Inappropriate Gender	Per LCD or NCD, the patient's gender does not meet policy requirements	for the procedure code and/or a diagnosis code.					
w26		P	Missing or invalid diagnosis code	Per LCD or NCD guidelines, a diagnosis code(s), which meets medical	necessity for the procedure code is missing or invalid.		16	M76	CO	
w27		P	Required modifer is missing	Per LCD or NCD guidelines, a modifier, which meets medical necessity	for the procedure code is missing or invalid.		182	M78		
w28		P	Invalid or missing condition code(s)	Per LCD or NCD, the condition code(s) is missing or does not	meet policy requirements for the procedure code		16	M76	CO	
w29		P	Missing primary diagnosis code	Per LCD or NCD guidelines, a primary diagnosis code, which meets	medical necessity for the procedure code is missing or invalid.		16	M76	CO	
w30		P	Procedure code has profiled relationship	Per LCD or NCD guidelines, procedure code has a profiled	relationship. Please review the policy.					
w31		P	Documentation needed for procedure code	Per LCD or NCD guidelines, documentation should be requested	or reviewed for the procedure code					
w32		P	Missing secondary diagnosis code	Per LCD or NCD guidelines, a secondary diagnosis code, which meets	medical necessity for the procedure code, is missing or invalid.		16	M76	CO	

w33		P	Missing tertiary diagnosis code	Per LCD or NCD guidelines, a tertiary diagnosis code, which	meets medical necessity for the procedure code is missing or invalid.		16	M76	CO	
w34		P	Missing or invalid revenue code	Per LCD or NCD, the revenue code does not meet	policy requirements for the procedure code.					
w35		P	Invalid type of bill	Per LCD or NCD, the type of bill does	not meet policy requirements for the procedure code.		5	MA30		
w36		P	Missing or invalid value code(s)	Per LCD or NCD, the value code(s) is missing or	does not meet policy requirements for the procedure code.					
w37		P	Units exceed medically unlikely units	Per Medicaid Medically Unlikely Edits, the units of service	billed for the procedure code exceed the allowed units	C	222		CO	
w38		P	Unbundle relationship in history	Per Medicaid NCCI edits, a history procedure	has an unbundle relationship with the procedure code on this line	C	97	N525	CO	
w39		P	Procedure has an unbundle relationship	Per Medicaid NCCI edits, the procedure code	has an unbundle relationship with one in history	C	236		CO	
w40		P	Date past Medicare timely filing date	The Statement Covers Period Through Date	of Service is past the Medicare facility timely filing limit.					
w41		P	ICD-9 hist. code compared to ICD-10 code	An ICD-9 Diagnosis code in history was compared to	an ICD-10 diagnosis code on the current claim	C	16	M76	CO	
w42		P	The HCPCS add on code is	required primary code on the claim		C	107	N122	CO	
w43		P	Claim lacks required device or procedure	Procedure code must be submitted with required device	or procedure code on the same date of service.					

w44		P	Bilateral procedure adjustment	Review the conditional or independent bilateral	procedure code for possible payment adjustment					
w45		P	Procedure retained from transfer	Procedure code is retained	from the transfer relationship					
w46		P	History procedure retained from	History procedure code is retained	from the transfer relationship					
w47		P	Maximum frequency exceeded	The units have exceeded the allowable	maximum frequency per time span					
w48		P	Maximum frequency exceeded	The units (including history) have exceeded the allowable	maximum frequency per time span					
w49		P	Maximum frequency exceeded	The units have exceeded the allowable	maximum frequency per time span					
w50		P	Maximum frequency exceeded	The units have exceeded the allowable	maximum frequency per time span					
w51		P	Multiple procedure reduction	Multiple procedures billed for the same Service Date	in which a reduction is applicable, per CMS guidelines.					
w52		P	Rebundle into another code	Procedure Code should be denied due to	a rebundle into another code					
w53		P	Rebundle into another code - history	History procedure should be denied due	to a rebundle into another code					
w54		P	Terminated procedure claim	The surgical procedure code contains a termination modifier, and all	other services on this claim should be denied based on CMS guidelines.					
w55		P	Terminated procedure claim line	The surgical procedure code contains a	terminated modifier and should be reviewed for a 50% reduction.					
w56		P	Codes transfer into new procedure	Bundled codes transfer into new procedure	to be added to this claim					
w57		P	Diagnosis conflict with age and gender	Age and gender conflict; the Admission diagnosis code	is not permissible for the patient's age and gender					

w58		P	Diagnosis conflict with age and gender	Age and gender conflict; the Other diagnosis code	is not permissible for the patient's age and gender.					
w59		P	Diagnosis conflict with age and gender	Age and gender conflict; the Principal diagnosis code	is not permissible for the patient's age and gender.					
w60		P	Incomplete num of digits in diagnosis	The Admission diagnosis code is invalid	because it has an incomplete number of digits.					
w61		P	The Admission diagnosis code is invalid	The Admission diagnosis	code is invalid					
w62		P	The Admission diagnosis code is missing	The Admission diagnosis	code is missing					
w63		P	The Other procedure code is invalid	The Other procedure code is invalid	based on the Admission date					
w64		P	Incomplete num of digits in diagnosis	The Other diagnosis code is invalid because	it has an incomplete number of digits.					
w65		P	Incomplete num of digits in diagnosis	The Other procedure code must contain	a fourth or fifth digit in order to be valid.					
w66		P	The Other diagnoses codes are invalid	The Other diagnosis code must be valid and is effective	based on the through date on the claim.					
w67		P	The Other procedure code is invalid	The Other procedure code must be in	the ICD-PSC code Table.					
w68		P	Procedure contains unnecessary	The Other procedure code contains	an unnecessary digit.					
w69		P	The Principal procedure code is invalid	The Principal procedure code must be valid and is effective	based on the admission date on the claim.					
w70		P	Incomplete principal diagnosis code	The Principal diagnosis code does not	contain a complete number of digits.					
w71		P	Incomplete principal procedure code	The Principal procedure code must	be complete in order to be valid.					
w72		P	The Principal diagnosis code is invalid	The Principal diagnosis code is not valid	based on the 'through' date on the claim.					
w73		P	The Principal procedure code is invalid	The Principal procedure code must	be in the ICD-PSC code Table.					

w74		P	Principal diagnosis code is missing	The Principal diagnosis code	is missing on the claim					
w75		P	Unnnecessary digit in procedure	The Principal procedure code	contains an unnecessary digit.					
w76		P	Other dx is a duplicate of the principal	The Other diagnosis code is a duplicate	of the Principal diagnosis code					
w77		P	Other diagnosis is a duplicate	The Other diagnosis code is a duplicate of	another Other diagnosis code on the claim.					
w78		P	Admission diagnosis not allowed for age	Age conflict; the Admission	diagnosis is not permissible for the patient's age.					
w79		P	Other diagnosis is not allowed for age	Age conflict; the Other diagnoses is	not permissible for the patient's age.					
w80		P	Principal diagnosis not allowed for age	Age conflict; the Principal diagnosis	is not permissible for the patient's age.					
w81		P	Gender and Admission dx not allowed	Gender conflict; the patient's gender and	Admission diagnosis code, on the claim are not permissible.					
w82		P	Gender and other diagnosis not allowed	Gender conflict; the patient's gender and other	diagnosis code, on the claim are not permissible.					
w83		P	Gender and Other procedure not allowed	Gender conflict; the patient's gender and Other	procedure code on the claim are not permissible.					
w84		P	Gender and Principal dx not allowed	Gender conflict; the patient's gender and	Principal diagnosis code, on the claim are not permissible.					
w85		P	Gender and Principal px not allowed	Gender conflict; the patient's gender and	Principal procedure code, on the claim are not permissible.					

w86		P	Manifestation code used as admission dx	Manifestation codes cannot be	used as the Admission diagnosis.					
w87		P	Manifestation code used as principal dx	Manifestation codes cannot be	used as the Principal diagnosis.					
w88		P	Questionable admission per diagnosis	Principal diagnosis code indicates	a questionable admission.					
w89		P	Diagnosis not allowed as principal	Diagnosis code is unacceptable as a principal diagnosis unless	a required secondary diagnosis is included on the claim.					
w90		P	Diagnosis code not allowed as principal	Diagnosis code is unacceptable	as a principal diagnosis.					
w91		P	E-code not allowed as Admit diagnosis	An E-code cannot be used as the	Admission diagnosis code.					
w92		P	E-code not allowed as principal dx	An E-code cannot be used as	the Principal diagnosis code.					
w93		P	Procedure is non-covered due to age	A non-covered over age 60 ICD procedure code is on the	claim and the patient is older than 60 years of age.					
w94		P	Non-covered with designated diagnosis	Procedure code is non-covered when	a designated diagnosis code is present.					
w95		P	Non-covered w/out exemption code present	Procedure code is non-covered unless the exemption ICD-9	Procedure code or exemption ICD Diagnosis code is present.					
w96		P	Procedure codes may be bilateral	Claim contains procedure codes that may be bilateral	procedures: The documentation for procedures, should be reviewed.					
w97		P	Age invalid	Age invalid; Must be in	range 0-124 years.					
w98		P	The patient gender is	The patient	gender is missing.					
w99		P	The Patient Gender is invalid	The Patient Gender is invalid.	Gender must be M, F, or U.					
x01		P	No Precert/Preauth /Notifcatin/Refe	No Precert/Preauth/Notifc atin/Referral			16	M119	CO	
x02		P	Clm Pend: illegible records sub	Clm Pend: illegible records sub			251	N205	CO	

x03		P	Clm Pend: rept req for non spec code	Clm Pend: rept req for non spec code			16	M51	CO	
x04		P	Clm Pend: correct NDC	Clm Pend: correct NDC Code req			16	M119	CO	
x05		P	ClmPend:invalid /del code,mod or desc	ClmPend:invalid/del code,mod or desc			4	N657	CO	
x06		P	Clm Pend: itemized bill required	Clm Pend: itemized bill required			252	N26	CO	
x07		P	Svcs essential to Px not coded	Services essential to procedure are not coded. This edit indicates	that services essential to a procedure should not be separately coded					
x08		P	ClmPend:diag inv/missing/del 4thor5th	ClmPend:diag inv/missing/del 4thor5th	that services essential to a procedure should not be separately coded		146	M64	CO	
x09		P	RequestedHospitalDocuments not rec'd	RequestedHospitalDocuments not rec'd	formed separately, are generally included in more comprehensive procs		252	M127	CO	
x10		P	CPT separate procedure	Code is a CPT separate proc. Some procs, although they can be per	formed separately, are generally included in more comprehensive procs					
x11		P	Clm Pend: EOB from prim carrier req	Clm Pend: EOB from prim carrier req			252	N4	CO	
x12		P	Motor Vehicle Accident - Auto Primary	Motor Vehicle Accident - Auto Primary			20	MA04	CO	
x13		P	Workers Comp Primary Carrier	Workers Comp Primary Carrier	that "with" and "without" codes should not be used together		19		CO	
x14		P	With/without code not together	With and without codes are not used together. This edit indicates	that "with" and "without" codes should not be used together					

x15		P	ClmPend:need new visit codes&charges	ClmPend:need new visit codes&charges	the operating physician		16	M51	CO	
x16		P	Clm Pend: Medicare EOB req	Clm Pend: Medicare EOB req	the operating physician		22	N4	CO	
x17		P	Do not code lab separately	Do not code lab service separately; code lab panel. Individual lab	tests should not be reported separately when a lab panel exists					
x18		P	No Referral	No Referral	tests should not be reported separately when a lab panel exists		288		CO	
x19		P	Report code completed svc only	Report code for completed service only. Only the code for the	more invasive service should be reported					
x20		P	Report code completed svc only	Report code for completed service only. Only the code for the	more invasive service should be reported					
x21		P	Do not code svc integral to px	Do not code service integral to proc. Prep/monitor svcs that are int	egral to performance of proc should not be coded in addition to proc					
x22		P	62:Authorizatio n Expired	62:Authorization Expired	egral to performance of proc should not be coded in addition to proc		197		CO	
x23		P	Codes should not be reported	Codes should not be reported together per CPT coding guidelines. Guide	lines should be followed when coding a proc or svc from that section					
x24		P	Codes should not be reported	Codes should not be reported together per CPT coding guidelines. Guide	lines should be followed when coding a proc or svc from that section					
x25	MB	P	DME Denial based on clinical review	DME Denial based on clinical review	definition specifies other procs included in the comprehensive code		39		CO	

x26		P	Codes should not be used	These codes should not be used together per code definition. Code	definition specifies other procs included in the comprehensive code					
x27		P	Included in Settlement	Included in Settlement Period			45	N664	CO	
x28		P	Svcs not typically performed	Certain services are not typically performed together						
x29		P	Mutually exclusive services	Codes indicate mutually exclusive services considered reasonably imp	ossible or improbable to perform on the same patient at the same time					
x30		P	Mutually exclusive services	Codes indicate mutually exclusive services considered reasonably imp	ossible or improbable to perform on the same patient at the same time					
x31		P	Codes indicate sex conflict	Codes indicate sex conflict. Two codes with opposing sex designations	cannot be reported for the same patient visit					
x32		P	Codes indicate sex conflict	Codes indicate sex conflict. Two codes with opposing sex designations	cannot be reported for the same patient visit					
x33		P	Mutually exclusive services	Supporting information for OCE /mutually exclusive procedures edits	019MEP					
x34		P	Correct coding edits	Supporting information for OCE /mutually exclusive procedures edits	020CCP					
x35		P	Authorization Denied for this DOS	Authorization Denied for this DOS	affect edit		39		CO	
x36		P	Capitated Service	Capitated Service	Medicare (Medicare specific)		24		CO	
x37		P	Code is not currently valid	This HCPCS code is not valid or not valid for the service date on	the claim line					
x38		P	Need Newborn Member	Need Newborn Member Number	the claim line		32	N15	CO	
x39		P	DupClaimPrevPd at Correct Rate/Cap	DupClaimPrevPd at Correct Rate/Cap	ERAGE policy or based on a statutory requirement (Medicare specific)		B13	M86	CO	
x40		P	DupClm-Orig Still Under Investigatio	DupClm-Orig Still Under Investigatio	statutory requirement (Medicare specific)		B13	M86	CO	

x41		P	Code does not have support Dx	This service does not have a supporting diagnosis code under	applicable medical necessity policy (LCD or NCD) requirements					
x42		P	Code violates age constraints	Code violates age constraints of applicable medical necessity policy	(LCD or NCD), or the patient age is missing or invalid					
x43		P	Bi-Lat proc prev paid w/mod "50"	Bi-Lat proc prev paid w/mod "50"	(LCD or NCD), or the patient age is missing or invalid		B13	M86	CO	
x44		P	Resubmit w/ICD/9 princ proc code/date	Resubmit w/ICD/9 princ proc code/date	(LCD or NCD), or the patient sex on claim is missing or invalid		16	MA66	CO	
x45		P	Clm Pend: complete med recs req'd	Clm Pend: complete med recs req'd	(LCD or NCD), or the patient sex on claim is missing or invalid		252	M127	CO	
x46		P	Over Max Procedure/Benefit Limit	Over Max Procedure/Benefit Limit	requires a specific accompanying procedure on the claim		119	N362	CO	
x47		P	B12: Submit with spec coding or med rec	B12: Submit with spec coding or med rec	a specific secondary dx on the claim, but no secondary dx available		B12	N199	CO	
x48		P	Invalid patient age	Age invalid; not in range 0-124 years						
x49		P	PreviousPayments = to Purchase Price	PreviousPayments = to Purchase Price			119	M7	CO	
x50		P	Same Procedure Pd to Different Prov	Same Procedure Pd to Different Prov			B13	N472	CO	
x51		P	Service Not Covered	Service Not Covered			96	N30	CO	
x52		P	Principal Dx invalid	Principal diagnosis invalid. 'E' code cannot be used as principal	Diagnosis		16	MA63	CO	
x53		P	Services were not Provided	Services were not Provided	Principal diagnosis		16	N99	CO	
x54		P	NotEligible forTotalComponentPayment	NotEligible forTotalComponentPayment	as principal diagnosis		B10		CO	
x55		P	Principal Dx invalid	Principal diagnosis invalid. Principal diagnosis indicates	questionable admission		16	MA63	CO	

x56		P	Clinic Clm Submt w/o phys	Clinic Clm Submt w/o phys nam			16	N252	CO	
x57		P	Principal Dx invalid	Principal diagnosis invalid. Unacceptable principal diagnosis	without required secondary diagnosis		16	MA63	CO	
x58		P	Principal Dx suggests surgery	Principal diagnosis suggests surgery but there are no O R procedure	codes on this claim					
x59		P	Referral Expired	Referral Expired			288		CO	
x60		P	Dates and/or ServicesOutside Ref/Auth	Dates and/or ServicesOutsideRef/Auth	the claim		197		CO	
x61		P	No PCP Referral	No PCP Referral	unnecessary 4th/5th digit		288		CO	
x62		P	Admit Dx age conflict	Age conflict; patient's age and diagnosis are inconsistent						
x63		P	Non-Emergent; No PCP Auth	Non-Emergent; No PCP Auth			197		CO	
x64	MB	P	Adj Based on Medical Asst Pymt Limit	Adj Based on Medical Asst Pymt Limit	the patient's diagnosis		119	N130	CO	
x65		P	Incorrect form type for svc submitted	Incorrect form type for svc submitted			16	N34	CO	
x66		P	E code cannot be admit Dx	"E" code as admit diagnosis						
x67		P	Discrep with Level of Care-AppealReq	Discrep with Level of Care-AppealReq			150	N640	CO	
x68		P	Invalid Units Submitted	Invalid Units Submitted	unnecessary 4th/5th digit		16	M53	CO	
x69		P	AttendingPhys ID/Name Missing/Invalid	AttendingPhys ID/Name Missing/Invalid			16	N253	CO	
x70		P	5:Billed with Invalid Bill Type	5:Billed with Invalid Bill Type			16	MA30	CO	
x71		P	DupPreviouslySubmittedEPSDT Screening	DupPreviouslySubmittedEPSDTScreening			B13	M86	CO	
x72		P	Provider was Not Member's PCP	Provider was Not Member's PCP	this diagnosis code		184	N574	CO	
x73		P	EPSDT Form was Incomplete	EPSDT Form was Incomplete	insurance, workers' comp, no fault, etc		16	N34	CO	
x74		P	Dx duplicate to secondary Dx	Diagnosis code is a duplicate of another secondary diagnosis code	on this claim					
x75		P	Capitated to Another	Capitated to Another Provider	unnecessary 4th/5th digit		24		CO	
x76		P	Procedure-sex conflict	Sex conflict; patient's sex and procedure are inconsistent						
x77		P	Provider TIN ID is missing or	Provider TIN ID is missing or invalid			16	N209	CO	

x78		P	Closed biopsy code may be appropriate	Open biopsy code was used when closed biopsy code may be appropriate						
x79		P	Proc-limited coverage proc	Medicare covers this procedure in limited circumstances only						
x80		P	Procedure-bilateral code	Identifies bilateral procedures						
x81		P	ChrgsConsidered Included InpatAdmis	ChrgsConsidered Included InpatAdmis			97	M15	CO	
x82		P	Units>1 for mod 50 bilat proc	Units > 1 for bilateral procedure with modifier 50						
x83		P	Mother's Bill not Received;	Mother's Bill not Received; Refile	atatus S, T, V or X		16	N182	CO	
x84		P	No rev cd 068x and proc 99291	Revenue code 068X and CPT code 99291 not submitted on the same date	of service as G0390					
x85		P	Missing proc cd for device	Claim lacks allowed accompanying procedure code for device						
x86		P	Clm Pend: invalid/miss rev code	Clm Pend: invalid/miss rev code	another claim		16	M50	CO	
x87		P	Medicare/Medicaid Sanctioned Provider	Medicare/Medicaid Sanctioned Provider	has a missing date, or has an invalid date		184	N574	CO	
x88		P	Medicare/Third Party Denial on File	Medicare/Third Party Denial on File			129	N48	CO	
x89		P	4:Modifier is Invalid or Inapprop W/Proc	4:Modifier is Invalid or Inapprop W/Proc	include in DPNC2 message if non-blank		4		CO	
x90		P	Not found on table of valid Dx	Admit Dx code invalid. Not found on table of valid ICD-9 CM codes						
x91		P	4th/5th digit not needed	Admit Dx code invalid, unnecessary 4th/5th digit						
x92		P	Invalid, missing 4th/5th digit	Admit Dx code invalid: missing 4th/5th digit.			16	MA65	CO	
x93		P	NursingHomeConfined >30 Days - Disenr	NursingHomeConfined >30 Days - Disenr	but not valid for patient's admission date.		27	N30	CO	
x94		P	Prov#Submitted viaEDI Incorrect/Termd	Prov#Submitted viaEDI Incorrect/Termd	unnecessary 4th/5th digit		16	N77	CO	
x95		P	Clm Pend: clinic claim w/o phys name	Clm Pend: clinic claim w/o phys name	missing 4th/5th digit		16	N252	CO	

x96		P	Not found in table of valid Dx	Invalid diagnosis code not found on table of valid ICD-9 -CM codes						
x97		P	DOS Cannot be Greater than Recv Date	DOS Cannot be Greater than Recv Date			110		CO	
x98		P	Invalid, missing 4th/5th digit	Invalid diagnosis code, missing 4th/5th digit			16	M76	CO	
x99		P	Invalid Gender for Procedure	Invalid Gender for Procedure	patient admit/discharg e date		7		CO	
y01		P	Missing or invalid account ID	The account ID field is missing or invalid						
y02		P	Missing or invalid service dt	The BDSF edit validates the service date at the line level						
y03		P	Missing/invalid from/thru dt	The FTD edit validates the from (admission) and through (discharge)	dates at the claim level					
y04		P	Invalid condition code	The CCA edit verifies that the condition code(s) on the claim are	valid		16	M76	CO	
y05		P	Missing/invalid pat stat code	The PSC edit identifies claims that are missing or contains an	invalid patient discharge status code					
y06		P	Missing or invalid rev code	The Rev edit identifies line items that contain missing or invalid	Revenue codes					
y07		P	Missing or invalid TOB code	The TOB edit identifies claims that are missing or contains	an invalid type of bill			MA30		
y08		P	Invalid value code	The Val edit confirms that the value codes on the claim are valid						
y09		P	Missing principle diagnosis	The ICMF edit validates that the claim contains the required	primary diagnosis prior to hss processing		16	MA63	CO	
y10		P	Missing provider ID	The PATF edit identifies a claim that has a missing patient ID.	analysis cannot be performed without a patient id					
y11		P	Missing or invalid DOB	The DOBF edit identifies a claim that has a missing or invalid	DOB. Certain edits cannot be performed without the patient DOB					

y12		P	Patient gender EMPT/invalid	The PSXF edit identifies a claim with a missing or invalid patient	gender. Certain edits cannot be performed without the patient gender					
y13		P	Blank provider ID	This edit identifies a claim missing a provider id. Analysis	cannot be performed without a provider id					
y14		P	Invalid ICD-9 procedure code	The IPA edit validates that the ICD-9 procedure codes on the claim	are valid		181	MA66		
y15		P	Invalid occurrence code	The OCC edit validates that the occurrence codes on the	claim are valid		181	M45		
y16		P	Invalid occurrence span code	The OSC edit validates that the occurrence span codes on	the claim are valid					
y17		P	Invalid source of admission	The SOA edit identifies claims that contain an invalid source	of admission code					
y18		P	Invalid type of admission	The TOA edit identifies claims that contain an invalid type	of admission code					
y19		P	Line is a possible duplicate	Identifies line items that are potentially duplicates when two lines	entered on one or more claims have identical submitted data					
y20		P	Opt claim possible duplicate	Identifies an entire outpatient claim that is a potential duplicate	of a previously submitted outpatient claim					
y21		P	Inpat claim possible duplicate	Identifies an entire inpatient claim that is a potential duplicate	of a previously submitted inpatient claim					
y22		P	Overlaps previous inpat claim	Identifies an entire inpatient claim that is a potential duplicate	of a previously submitted inpatient claim					
y23		P	Invalid diagnosis code	This edit occurred because the first listed diagnosis field is blank	or any Diagnosis code is not valid for the service dates on the claim		146	M76		
y24		P	Diagnosis and age conflict	This edit occurred because the diagnosis code includes an age range	and the patient age is outside of that range					

y25		P	Diagnosis and sex conflict	This edit occurred because the diagnosis code includes sex	designation and the patient sex does not match					
y26		P	Medicare as secondary payer	This edit occurred because the diagnosis code has an MSP alert	warning indicator	C	16	M76	CO	
y27		P	E-code as reason for visit	This edit occurred because the first letter of the first listed	Diagnosis code is an E					
y28		P	Invalid HCPCS procedure	This edit occurred because the submitted HCPCS code is not valid for	the service dates on the claim		181	MA66		
y29		P	Procedure and age conflict	This edit occurred because the procedure code includes an age range	and the patient age is outside of that range					
y30		P	Procedure and sex conflict	This edit occurred because the procedure code includes sex	designation and the patient sex does not match					
y31		P	Non-covered service	This edit occurred because the procedure code has a non-covered servi	ce indicator, meaning that it is non-covered based on Medicare policy					
y32		P	N/c svc verification denial	This edit occurred because the claim was submitted with cond code	21 indicating that the provider is requesting verification of denial					
y33		P	N/c service for review	This edit occurred because the claim was submitted with condition	code 20					
y34		P	Questionable covered service	This edit occurred because the procedure code has a questionable	covered svc indicator Medicare will cover only in certain conditions					
y35		P	No addl payment by Medicare	This edit occurred because a procedure code indicates a service n/c	by Medicare based on the type of bill and condition codes on the claim					
y36		P	Site of svc not incl in opps	This edit occurred because the procedure code does not have an OPPS	indicator, but may be payable in other settings					

y37		P	Service units out of range	This edit occurred because the sum of units or all lines with the	same proc except lab with mod 91, exceeds the max allowed for proc					
y38		P	Multiple bilat px w/o mod 50	This edit occurred because multiple exclusive bilateral proc codes	are present, 2 or more times on the same svc date, without a mod 50					
y39		P	Inappropriate bilateral proc	This edit occurred because multiple exclusive bilat proc codes are	present, 2 or more times on the same svc date, with or w/o mod 50					
y40		P	Inpatient procedure	This edit occurred because the proc has been designated by Medicare	as pay status "C", the proc is not covered when performed as outpt					
y41		P	Mutually excl proc not allowed	This edit occurred because the proc is one of a pair of mutually	exclusive procs and both codes are on the claim with the same svc dt					
y42		P	Mutually excl proc not allowed	This edit occurred because the proc is one of a pair of mutually	exclusive procs and both codes are on the claim with the same svc dt					
y43		P	Comprehensive proc not allowed	This edit occurred because the procedure is identified as a compo	nent of another proc also on the claim for the same service date					
y44		P	Comprehensive proc not allowed	This edit occurred because the procedure is identified as a component	of another procedure also on the claim for the same service date					
y45		P	Med visit same day w/o mod 25	This edit occurred because one or more type t or s procs occur on the	same day as a line item containing an e/m code without modifier 25					
y46		P	Invalid HCPCS modifier	This edit occurred because the modifier is not in the list of	valid OOPS modifiers		182	M78		

y47		P	Invalid date	Only edits for valid modifiers; not specific to outpatient facility	claims					
y48		P	Date out of OCE range	This edit occurred because the from, thru, or service date is	invalid or service dt falls outside range of the from and thru dates					
y49		P	Invalid age	This edit occurred because the from date is prior to	36739					
y50		P	Invalid sex	This edit occurred because the age is non-numeric or outside the	range of 0-124 years					
y51		P	Only incidental svc reported	This edit occurred because patient sex has any alpha value but f or	m, or any numeric entry that is outside the range of 0-2					
y52		P	Code not accepted by Medicare	This edit occurred because the proc code indicator not recognized by	Medicare-OOPS. Medicare will not accept code, but may accept alternate					
y53		P	Partial hosp for non-MH Dx	This edit occurred because the principal diagnosis is not related	to mental health on a partial hospitalization claim					
y54		P	Insuff svcs for partial hosp	This edit occurred because APC 323, 324, or 325 is present and three	or more qualifying criteria are present					
y55		P	Part hospital same day as ECT	This edit occurred because electroconvulsive therapy or a significant	procedure occurs on the same day as partial hospitalization					
y56		P	Part hospital spans 3 or less	This edit occurred because a partial hospitalization claim is suspend	ed for medical review and does not span more than three days					
y57		P	Part hosp exceeds more 3 days	This edit occurred because claims suspended for medical review, spans	more than three days, and mental health svcs not 57% of the days					

y58		P	Part hosp exceeds more 3 days	This edit occurred because claims suspended for medical review, spans	more than three days, and mental health svcs not 57% of the days					
y59		P	Only activity or ot provided	This edit occurred because a mental health education and/or training	services but does not contain any svcs assigned to APC 323,324,or 325					
y60		P	Mental Hlth svc on day of et	This edit occurred because electroconvulsive therapy or a non-mental	health proc is present on the same day as extensive mental hlth svcs					
y61		P	Term bilat px or px/units > 1	This edit occurred because mod 73 is present, an independent or	conditional bilateral proc with mod 50 or a proc with units>1					
y62		P	Inconsistant implant device/px	This edit occurred because the claim contains an implanted device,	But no surgical or other service to implant the device					
y63		P	Mut excl Px allowed w/appr mod	This edit occurred because the proc is one of a pair of mutually exc	lusive procs, with the same svc date, without a qualifying NCCI mod					
y64		P	Mut excl Px allowed w/appr mod	This edit occurred because the proc is one of a pair of mutually exc	lusive procs, with the same svc date, without a qualifying NCCI mod					
y65		P	Comprehensive proc w/ app mod	This edit occurred because the proc is a component of another proc on	The claim coded on the same day, without a qualifying NCCI mod					
y66		P	Comprehensive proc w/ app mod	This edit occurred because the proc is a component of another proc	On the claim coded on the same day, without a qualifying NCCI mod					
y67		P	Invalid revenue code	This edit occurred because the revenue code is not in Medicare's	list of valid OOPS revenue codes			M50		

y68		P	Mult visits, rev code/cond go	This edit occurred because multiple medical visits are present on the	same day with the same revenue code, without condition code G0					
y69		P	Blood transfusion w/o product	This edit occurred because a blood transfusion or exchange is coded	but no blood product is coded					
y70		P	Observ room rev code w/o svc	This edit occurred because rev code 762 (observation) is used with	a HCPCS code that does not represent an observation svc					
y71		P	Inpt separate proc is not paid	This edit occurred because services with service indicator "C" which	are on Medicare's 'separate procedures' list					
y72		P	Partial hosp condition code	This edit occurred because TOB 12x or 14x is present with condition	code 41					
y73		P	Svc is not separately payable	This edit occurred because claim consists entirely of a combination	of lines that are denied or rejected or are considered "packaged"					
y74		P	Revenue code req HCPCS code	This edit occurred because claim line contains revenue center and	charges center is one for which Medicare requires a HCPCS code					
y75		P	Svc on same day as inpat proc	This edit is assigned to all other claim lines when one or more	claim lines received edit 018					
y76		P	Non-covered based on statutory	This edit occurred because a claim line contains a CPT/HCPCS code	which is non-covered by Medicare based on statute					
y77		P	Overlapping observation period	This edit occurred because multiple observations on claim are paid	separately if the required criteria are met for each one					
y78		P	Obs svc not separately payable	This edit occurred because claim shows billable observation but Dx is	not in the list of Dx codes that qualify for separate observation pymt					

y79		P	Obs svc only allowed with 13x	This edit occurred because observation "G" codes (G0243, G0244) are	billed on a claim with TOB not equal to 13x					
y80		P	Mult codes for same service	This edit occurred because blood components that are not allowed to	be coded together are reported on the same dos					
y81		P	Not reportable for site of svc	This edit occurred because HCPCS code beginning with the letter C is	used with TOB that is not hospital outpt (12x, 13x, 14x)					
y82		P	Observ svc E&M reqs not met	This edit occurred because no E/M visit the day of or the day before	the observation and the date of observation is not 12/31 or 1/1					
y83		P	Observ svc E&M reqs not met	This edit occurred because no E/M visit the day of or the day before	the observation and the date of observation is 12/31 or 1/1					
y84		P	G0379 only allowed with G0378 Detected	This edit occurred because code G0379 is present w/o code G0378	for same claim with bill type 13x					
y85		P	Requires diagnosis code V707	This edit occurred because code G0292, G0293, or G0294 is present on	the claim and Dx code V707 is not present as admit or secondary Dx					
y86		P	Mod CA w/more than one proc	This edit occurred because mod CA is on more than 1 line with service	indicator c and same line item dos or mod ca with multiple units					
y87		P	Code billed only DME carrier	This edit occurred because proc code reported has a status indicator	of Y indicating item can only be billed to the DME regional carrier					
y88		P	Code not allowed, alternate	This edit occurred because proc is not reportable on an OPPS	claim but may be accepted for other types of claims					

y89		P	OT billed only on partial hosp	This edit occurred because HCPCS code G0129 occupational therapy is	furnished as a component of a partial hospitalization treatment prog					
y90		P	Act therapy svcs not payable	This edit occurred because HCPCS code G0176 activity therapy furnish	ed as a component of partial hospitalization treatment program per day					
y91		P	Rev not recog by Medicare	This edit occurred because the line item contains a revenue code	not recognized by Medicare					
y92		P	Code requires manual pricing	This edit occurred because the line item contains c9399, identifying	a drug that received FDA approval but does not have a HCPCS assigned					
y93		P	Svc prior to FDA approval	This edit occurred because the item, service, or procedure was	administered or performed prior to the date of FDA approval					
y94		P	Svc prior to date of NCD	This edit occurred because the item, service, or procedure was admin	istered or performed prior to the eff date as specified in the NCD					
y95		P	Svc outside approval period	This edit occurred because the item, service, or procedure was admin	istered or performed outside a clinical trial period approved by CMS					
y96		P	Ca mod reqs patient status 20	This edit occurred because modifier ca has been reported and the	patient status code in FL 22 is not 20 (expired)					
y97		P	Claim lacks req device code	This edit occurred because proc was performed that must be reported	with 1 or more associated device codes, but the codes are missing					

y98		P	Service not billable to fi	This edit occurred because a procedure code has a status indicator of	m and not be reported when submitting to the fiscal intermediary					
y99		P	Incorrect billing of blood	This edit occurred because blood products are billed with rc 39x and	modifier BL without a line billed with RC 38x					
z01		P	Missing account id	The account ID is missing.						
z02		P	Anesthesia crosswalk	The procedure code was crosswalked to an appropriate anesthesia code.						
z03		P	Anes performed by non-anes pro	This claim line is being disallowed because the anesthesia procedure	code was performed by a non-anesthesia provider					
z04		P	Anesthesia secondary procedure	This claim line is being disallowed because more than one anesthesia	procedure code was billed on the same DOS					
z05		P	Anes secondary procedure in HX	A history claim line is disallowed because more than one anesthesia	procedure code was billed on the same DOS.					
z06		P	Missing or invalid DOS	This claim line is being disallowed because there is a missing or	invalid beginning or ending date of service (DOS).					
z07		P	Bilateral procedure reduction	This line is eligible for a bilateral procedure reduction.						
z08		P	Missing or bad pos	The place of service (pos) code is missing or invalid.			16	M77	CO	
z09		P	Anesthesia crosswalk by report	The surgical procedure cannot be crosswalked to an anesthesia code	because it is by report.					
z10		P	Procedure not typical for age	This claim line is being disallowed because the procedure	code is not typical for the patients age.					
z11		P	Deleted procedure code	This claim line is being disallowed because the procedure code has	been deleted.					
z12		P	Invalid procedure code	This claim line is being disallowed because the procedure code is	missing or invalid.		181	M67		

z13		P	Px not typical for gender	This claim line is being disallowed because the procedure code is	not typical for the patients gender.					
z14		P	Documentation needed w/ mod 59	Documentation is required when a modifier 59 is billed with the	procedure code.					
z15		P	Duplicate line by provider	This claim line is being disallowed because it is a duplicate of	another claim line.					
z16		P	Missing or invalid DOB	This claim line is being disallowed because the patients date of	birth is missing, invalid, or after the date of service.					
z17		P	DOS to units discrepancy	Claim line is being disallowed due to the number of units not mat	ching the date span between the beginning and ending dates of service					
z18		P	Duplicate claim	This claim line is being disallowed because it is an exact duplicate	of a claim in history submitted by the same provider.		18	N111		
z19		P	No results	The system was unable to obtain results for this claim line.						
z20		P	Global follow-up by provider	This claim line is being disallowed because an E&M code is within the	global period with a same diagnosis category by the same provider.					
z21		P	Retained code from transfer	The procedure code on this claim line is retained from a transfer	relationship.					
z22		P	Post-op surgery by provider	Claim line is disallowed because a surgical code was submitted w/	in the global period w/ a Dx from same category by the same provider.					
z23		P	Unbundled Hx Px - exclusive	A history claim line is disallowed because its procedure code is	inbundled and is considered exclusive.					
z24		P	Unbundled Hx proc - unbundle	A history claim line is disallowed because its procedure code is	unbundled and is considered unbundled.					

z25		P	Hx rebundle to correct code	A history claim line is disallowed because its procedure code is	disallowed as part of a rebundle relationship.					
z26		P	Retained Hx code part of group	A procedure code on a history claim line was part of a transfer	relationship, but the procedure code was retained.					
z27		P	Diagnosis not typical for age	This claim line is being disallowed because one of the diagnosis	Codes is not typical for the patients age.					
z28		P	Not a freq Dx code w/procedure	A diagnosis code on the line is not commonly associated with the	procedure code.					
z29		P	Invalid diagnosis code	A diagnosis code on the line is invalid.			146	M76		
z30		P	Missing diagnosis code	This claim line is being disallowed because there is no primary	diagnosis code.		146	M76		
z31		P	Anes x-walk individual review	The procedure can be crosswalked to two or more anesthesia codes so	review is required to determine the appropriate code.					
z32		P	Nonspecific diagnosis code	Nonspecific Diagnosis Code						
z33		P	Inappropriate mod combination	The claim line contains an inappropriate modifier combination.						
z34		P	Invalid modifier code	A modifier on the line is invalid.			182	M78		
z35		P	Dx not typical for gender	This claim line is being disallowed because a diagnosis code is not	typical for the patients gender.					
z36		P	Modifier 26 required	The procedure code requires a modifier 26.						
z37		P	Assist surgeon pay restriction	Claim line is being disallowed because Medicare typically does not	allow reimbursement for surgical assistants on this procedure code					
z38		P	Bilateral adj does not apply	Medicare does not allow typical payment adjustments for this	procedure code.					

z39		P	Bundled code - Medicare	This claim line is being disallowed because the procedure code has no	Medicare relative value unit and may be considered incidental.					
z40		P	Medicare bundled item or service	Procedure code has no separate payment under physician fee schedule						
z41		P	Co-surgeons not permitted	This claim line is being disallowed because Medicare typically does	not allow reimbursement for co-surgeon on this procedure code.					
z42		P	Document assistant surgeon	Medicare requires the procedure to have supporting documentation	for an assistant surgeon.					
z43		P	Document co-surgeon	Medicare requires the procedure to have supporting documentation	for a co-surgeon.					
z44		P	Document team surgery	Medicare requires the procedure to have supporting documentation	for team surgery					
z45		P	Typical daily frequency exceeded	Procedure code with an allowed daily frequency has been exceeded						
z46		P	Global follow-up by provider	This claim line is disallowed because the E&M procedure was submitted	within the global period w/ a Dx from same category by same provider.					
z47		P	Inappropriate mod - Medicare	This claim line contains a modifier that is inappropriate per	Medicare.					
z48		P	Injection service - Medicare	This claim line is being disallowed because the injection service is	bundled into other payable services when billed on the same dos.					
z49		P	Non-phys service - Medicare	This claim line is being disallowed because Medicare defines the	service to be a non-physician service					
z50		P	Non-covered service - Medicare	This claim line is being disallowed because the services are	not covered by Medicare.					
z51		P	Not valid for Medicare	This claim line is being disallowed because the procedure	code is not valid for Medicare.					

z52		P	Mod not typical for procedure	A modifier on the line is not typical for the procedure code.						
z53		P	Multiple procedure reduction	This line is eligible for a multiple procedure reduction.						
z54		P	Physical therapy service	This claim line is being disallowed because the physical therapy	services are not covered by Medicare.					
z55		P	Post-op related surg by prov	This claim line is disallowed because a surgical code was submitted	w/in the global period w/ a Dx from same category by same provider.					
z56		P	Team surgeons not permitted	This claim line is being disallowed because team surgeons are	not permitted with this procedure code per Medicare.					
z57		P	Medicare unb for history line	A history claim line is disallowed because its procedure code is	unbundled per Medicare.					
z58		P	Medicare unbundled scenario	This claim line is being disallowed because its procedure code is	unbundled per Medicare.					
z59		P	Medicare ventilator mgmt	A ventilation management service was billed on the same date as an	E&M service per Medicare.					
z60		P	Not a primary diagnosis code	A non-primary diagnosis code was submitted as the primary diagnosis	code.					
z61		P	New pt code billed for Est pt	This claim line is being disallowed because a new patient E&M	service was billed for an established patient.					
z62		P	Missing patient id	This claim line is being disallowed because the patient ID is	missing or invalid.					
z63		P	Invalid prof component mod	The professional component modifier 26 is not appropriate with	a 100% technical procedure.		182	N519		
z64		P	Pos not typical for procedure	The place of service is not typical for the procedure code.			58	M77		
z65		P	Assist/co/team surg reduction	This line is eligible for a assistant/co/team surgery	modifier reduction.					

z66		P	Surgical pre-op E&M procedure	This claim line is being disallowed because the pre-operative E&M	was billed the day before or same day as a surgical procedure.					
z67		P	Hx surgical pre-op E&M proc	A history line is disallowed because a pre-operative E&M was	billed the day before or same day as a surgical procedure in history.					
z68		P	Missing provider id	This claim line is being disallowed because the provider ID is	missing or invalid.					
z69		P	Missing patient gender	The patient gender is missing or invalid.						
z70		P	Rebundle to approp procedure	This claim line is being disallowed because the procedure code is	disallowed as part of a rebundle relationship.					
z71		P	Multiple assistant surgery	This claim line is being disallowed because only one surgical	assistant is allowed per procedure code.					
z72		P	Typically no surgical assist	This claim line is being disallowed because the procedure code does	not typically allow an assistant surgeon modifier.					
z73		P	Timed out	The system timed out on this claim line.						
z74		P	Dx may involve 3rd party liab	A diagnosis code on the line is a possible third-party liability.						
z75		P	Transfer to approp procedure	A transfer to an appropriate procedure occurred. This claim	lines procedure was part of the transfer group.					
z76		P	Unbundled proc - exclusive	This claim line is being disallowed because the procedure code is	unbundled and is considered exclusive.					
z77		P	Unbundled proc - unbundle	This claim line is being disallowed because the procedure code is	unbundled and is considered unbundle.					
z78		P	Unlisted procedure code	The procedure code is unlisted.						
z79		P	Typically cosmetic procedure	This claim line is being disallowed because the procedure code is	considered cosmetic.					
z80		P	Investigational procedure	This claim line is being disallowed because the procedure code is	considered investigational or experimental.					

z81		P	Unbundled proc - incidental	Unbundled proc - incidental					
z82		P	Unbundled Hx proc-incidental	Unbundled hx proc - incidental					
z83		P	Medicare bilat proc reduction	Medicare bilateral procedure reduction					
z84		P	Medicare mult proc reduction	Medicare multiple procedure reduction					
z85		P	Ca mod req pt status code 20	Ca modifier requires patient status code 20					
z86		P	Missing or invalid addtl proc	Missing or invalid additional procedure			16	M51	CO
z87		P	Missing/invalid code to code DS	Missing or invalid diagnosis for code to code			146	M76	
z88		P	LCD Part B missing or invalid diagnosis	LCD/ NCD: diagnosis code(s), for procedure code is missing or invalid			146	M76	
z89		P	LCD Part B missing required modifier	LCD/ NCD: a modifier for procedure code is missing or invalid			146	M76	
z90		P	LCD Part B Dx not in prim pos	LCD Part B diagnosis not in primary position					
z91		P	LCD Part B missing required primary dia	LCD/ NCD: a primary diagnosis code is missing or invalid			146	M76	
z92		P	LCD Part B missing required secondary d	LCD/ NCD: a secondary diagnosis code is missing or invalid			146	M76	
z93		P	LCD Part B missing required tertiary d	LCD/ NCD: a tertiary diagnosis code which meets medical necessity	for procedure code is missing or invalid.		146	M76	
z94		P	Part B	Part B					
z95		P	LCD Part B procedure frequency exceeded	LCD/ NCD: frequency does not meet policy requirements for procedure	code.				
z96		P	LCD Part B freq w/Dx override	LCD Part B frequency with diagnosis override					
z97		P	LCD Part B invalid place of service	LCD/ NCD: pos does not meet policy requirements for procedure code			16	M77	CO
z98		P	LCD Part B missing or invalid patient G	LCD/ NCD: patient's gender does not meet policy requirements					
z99		P	LCD Part B procedure not typical with P	LCD/ NCD: age does not meet policy requirements for procedure or Dx					