Introduction

The CPSI Insurance System integrates information from Registration, Health Information Management and Account Detail to assist in the creation and the filing of insurance claims. The goal of the Insurance System is to organize and simplify the functions associated with the billing process.

The CPSI Billing System recommends using daily and weekly procedures to assist personnel in the billing activities. Within the billing procedures are UB04 and 1500 claim edits. These edits help the Business Office to determine what additional information should be included on the insurance claims prior to billing. After determining the billing process for the claims, follow up should be done by using the Insurance Tickler.

Insurance Procedures

Overview

CPSI is a daily billing system. The following procedures are recommended for the daily activities of the insurance billing personnel. To use the CPSI system most effectively, claims must be processed on a daily basis.

Daily Procedures

Daily procedures will vary based on claims being billed from the facility or billed through CPSI Electronic Billing Outsourcing.

Daily Procedures

The printing of these reports will advance the proper claims to the necessary status and provide a listing of claims that requires attention during the Primary Billing process. There are other reports that should be printed and worked after the Primary Billing process has been completed.

1. Print the Insurance Reports:

   AutoGen Insurance Claims
   UB92 Edit List
   1500 Edit List

Primary Billing

Primary Billing should be done first thing each morning and completed prior to moving on to any other billing function.

2. The **Late Charge/Credit Report** is spooled once the day is closed. This report will show all unbilled charges for accounts that have insurance claims that have been generated or billed at the time of charge. Billers will need to review this report to see accounts that may need the insurance claims adjusted or reversed due to late charges.

3. Correct all errors from the **UB92 Edit List** and the **1500 Edit List**, and reprint the edits to ensure that all errors have been corrected. This is the first step in making sure a claim is complete prior to the claim being sent.

4. To print UB04 forms, select **Print UBs**. To print 1500 forms, select **Print 1500s**. This step will advance the claims to the Billed status.

Follow-up Procedures

Any claims previously held out of the Primary Billing process will be worked at this time. Claims corrected during this step will fall back into the Primary Billing process for the following day.

5. **Claims with Missing Information:** Run this report to process claims.

   If a claim appears on this report, it was manually set back from the Ready to Bill status and the reason should be in the comment field. It must be manually reset to Ready to Bill when ready.

   A. Select **Generate Claim** to pick up any late charges which may have occurred after initial generation.

   B. Select **Detail Charges** to change the status of the claim to Ready to Bill by selecting the **Ready to Bill** and **Print Form** fields.

   C. Repeat steps A and B above for any secondary claims, but do not select the Print Form field. All claims should be at the Ready to Bill status, and the total expected pay of all the claims should be equal to the total charges from the primary claim.

   D. Select **UB92 Coding** and verify all Condition, Occurrence and Value codes. All necessary codes must be present in order to print on the UB04.

Secondary Billing

6. Process all Secondary claims.

   A. If using the Automated Secondary Billing, print the **Secondary Billing Auto Reverse** report. Secondary claims at the Billed status with Primary claims that have been paid in full and an account balance greater than zero will be automatically reversed by the system. The Expected Pay will be adjusted to equal the amounts receipted to the Non-covered, Deductible, Co-Pay and Coinsurance of the primary claim, and the claim will be set to Ready to Bill and Print Form, depending upon the setting in the Insurance Company Table page 4, field 19.

   B. To manually process Secondary claims, print the **Secondary Billing Report** to get a listing of paid Primary claims with non-Primary claims at the Billed status. Reverse the Billed date, and enter the correct Expected Pay on the Detail Charges screen.

Adjustment Claims/Re-Billing

7. Process all Rejected claims and rebill.

   A. If using Rejection Codes, print the **Rejection Code Summary Report**. When in **Receipting,** select **Update Work Area from Electronic RA File** to locate this report. Rejected claims will be listed along with the Rejection Code Description to assist in easier processing of the claim.

   B. If using the Insurance Tickler, the system will update the Insurance Tickler File Maintenance screen with a review code of I94 - Claim Rejected.

Weekly Procedures

1. Print the Insurance Reports

   Approved Claims (Chgs Needed)
   Billed But Unpaid & A/R Bal = 0
   Billed But Unpaid Claims (by Ins) or **Billed But Unpaid Claims (by Phy)**

2. **Approved Claims:** Review claims on this report weekly. Claims should move from this report to the Ready to Bill status once the claim meets the criteria for autogenning. Any claim that remains on the report after lag days have been met or once that day has been closed should be researched further.

3. **Billed But Unpaid & A/R Bal = 0:** The report should first be run as an edit to determine which accounts to reject and then as an update to actually reject those selected accounts. This report should be run on a weekly basis to keep the Billed But Unpaid report as clean as possible.

   The edit version is an alpha listing of accounts that have a claim at the billed status with an A/R balance of zero. The update version is an alpha listing of accounts with a billed claim that has been rejected.

4. **Billed But Unpaid Claims:** The report provides an alpha listing by insurance of all outstanding insurance claims. Financial Classes that do not have any unpaid claims or claims that meet the report's criteria are excluded. The aging columns are Current, 30, 60 and 90 days. The last page of the report lists an aging break down of total dollars for each insurance company over each aging column. This report is helpful in showing which insurance is outstanding and how much payment is expected.

Daily Procedures - EBOS

Primary Billing should be done first thing each morning and completed prior to moving on to any other billing function.

1. Print EBOS Edits (Select Other Applications and Functions > Electronic Billing Outsourcing > Edit with Standard Codes Only or Edit with Payer Specific Codes and Other Applications and Functions > Electronic Billing Outsourcing > Process Commercial EBOS Claims for Commercial) and correct all errors. This is the final step in making sure a claim is complete prior to being sent to the intermediary.

If utilizing EBOS, please refer to the EBOS User Guide.

Primary Billing

2. The **Late Charge/Credit Report** is spooled once the day is closed. This report will show all unbilled charges for accounts that have insurance claims that have been generated or billed at the time of charge. Billers will need to review this report to see accounts that may need the insurance claims adjusted or reversed due to late charges.

Follow-up Procedures

Any claims previously held out of the Primary Billing process will be worked at this time. Claims corrected during this step will fall back into the Primary Billing process for the following day.

3. **Claims with Missing Information:** Run this report to process claims.

   If a claim appears on this report, it should be for one of two reasons. First, it was manually set back from the Ready to Bill status, and the reason should be placed in the comment field. It must be manually reset to Ready to Bill. Second, the claim may move back to Unchecked due to fatal ANSI edits. These claims would have "ANSI EDIT" in the comment field. They must be manually reset to Ready to Bill when ready.

   A. Select **Generate Claim** to pick up any late charges which may have occurred after initial generation.

   B. Select **Detail Charges** to change the status of the claim to Ready to Bill by selecting the **Ready to Bill** and **Print Form** fields. If this claim is to be transmitted electronically, select the **Elect Bill** field.

   C. Repeat steps A and B above for any secondary claims, but do not select the Print Form field. All claims should be at the Ready to Bill status, and the total expected pay of all the claims should be approximately equal to the total charges from the primary claim.

   D. Select **UB92 Coding** and verify all Condition, Occurrence and Value codes. All necessary codes must be present in order to print on the UB04.

Please refer to the EBOS User Guide.

Secondary Billing

4. Process all Secondary claims.

   A. If using the Automated Secondary Billing, print the **Secondary Billing Auto Reverse** report. Secondary claims at the Billed status with Primary claims that have been paid in full and an account balance greater than zero will be automatically reversed by the system. The Expected Pay will be adjusted to equal the amounts receipted to the Non-covered, Deductible, Co-Pay and Coinsurance of the primary claim, and the claim will be set to Ready to Bill and Print Form, depending upon the setting in the Insurance Company Table page 4, field 19.

B. To manually process Secondary claims, print the **Secondary Billing Report** to get a listing of paid Primary claims with non-Primary claims at the Billed status. Reverse the Billed date, and enter the correct Expected Pay on the Detail Charges screen.

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Form Locators

Overview

Form Locators are used to show where billing information is located on the UB04 and 1500. CPSI determines where information pulls from the system to these locators. The following information will show the description of the locator and where the information is pulled from in the system.

UB04 Locators

UB04 Locators

LOC	DESCRIPTION	PULLED FROM/DETERMINED BY CPSI SYSTEM
1	PROVIDER NAME, ADDRESS, TELEPHONE, FAX & COUNTY CODE	CLINIC CODE TABLE PHYSICIAN TABLE #999999 - fields 41-44 INSURANCE CO. TABLE - page 2 fields 1-4
2	PAY-TO NAME, ADDRESS	CLINIC TABLE - fields 1-5 & 15
3a	PATIENT CONTROL NUMBER	PATIENT ACCOUNT NUMBER
3b	MEDICAL RECORD NUMBER	STAY INFORMATION – MED REC# field
4	TYPE OF BILL	DETAIL CHARGES SCREEN – UB BILL TYPE; may be affected by INSURANCE CO. TABLE - page 1 field 32
5	FED TAX NUMBER	INSURANCE COMPANY TABLE - page 2 field 17 PHYSICIAN TABLE #999999 - page 1 field 11
6	STMT COVERS PERIOD	INSURANCE CLAIMS STATUS SCREEN Service From/To Dates
7	UNLABELED	STATE SPECIFIC (COVERED DAYS)
8a	PATIENT NAME ID	FOR FUTURE USE
8b	PATIENT NAME	REGISTRATION - PATIENT TAB - FULL NAME field
9a	PATIENT ADDRESS – STREET	REGISTRATION - PATIENT TAB - ADDRESS 1 & 2 field
9b	PATIENT ADDRESS – CITY	REGISTRATION - PATIENT TAB - CITY field
9c	PATIENT ADDRESS – STATE	REGISTRATION - PATIENT TAB - STATE field
9d	PATIENT ADDRESS – ZIP	REGISTRATION - PATIENT TAB - ZIP field

9e	PATIENT ADDRESS – COUNTY CODE	REGISTRATION - PATIENT TAB - COUNTY CODE field
10	PATIENT BIRTHDAY	REGISTRATION - PATIENT TAB - BIRTH DATE field
11	PATIENT SEX	REGISTRATION - PATIENT TAB - SEX field
12	ADMISSION DATE	REGISTRATION - STAY TAB - ADMISSION DATE/TIME field
13	ADMISSION HOUR	REGISTRATION - STAY TAB - ADMISSION DATE/TIME field
14	TYPE OF ADMISSION/VISIT	REGISTRATION - STAY TAB - ADMISSION CODE field
15	SOURCE OF ADMISSION	REGISTRATION - STAY TAB - ADMISSION ORIGIN field
16	DISCHARGE HOUR	REGISTRATION - STAY TAB - DISCHARGE HOUR field
17	PATIENT/STATUS DISCHARGE CODE	REGISTRATION - STAY TAB - DISCHARGE CODE field
18-28	CONDITION CODES	UB92 CODING
29	ACCIDENT STATE	REGISTRATION - STAY TAB - ACCIDENT/THERAPY STATE field
30	UNLABELED	
31-34	OCCURRENCE CODE/DATE	UB92 CODING
35-36	OCCURRENCE SPAN CODE	PRIOR STAY INFORMATION
37	UNLABELED	
38	RESPONSIBLE PARTY - NAME/ADDRESS	POLICY INFORMATION - SUBSCRIBER fields
39-41	VALUE CODE/AMOUNT	UB92 CODING
42	REVENUE CODE	SUMMARY CODE TABLE - field 8; DETAIL CHARGES
43	REVENUE CODE DESCRIPTION	SUMM CD TABLE - field 1; ITEM MASTER - field 1; DETAIL CHARGES
43-44	PAGE OF PAGE; CREATION DATE	NUMBER OF PAGES OF UB04; DATE CLAIM WAS PRINTED

44	HCPCS/RATES/HIPPS RATE CODES	ITEM MASTER - field 9 (CPTS), DRG GROUPER SCREEN (HCPCS), DETAIL CHARGES (RATES), ROOM RATE(for Revenue Codes 1001 and 1002)
45	SERVICE DATE	DETAIL CHARGES
46	UNITS OF SERVICE	DETAIL CHARGES
47	TOTAL CHARGES	DETAIL CHARGES
48	NON-COVERED CHARGES	DETAIL CHARGES
49	UNLABELED	
50	PAYER – PRIMARY, SECONDARY & TERTIARY	POLICY INFORMATION - INSURANCE COMPANY field; INSURANCE COMPANY TABLE - page 1 field 1
51	HEALTH PLAN ID	FOR FUTURE USE
52	RELEASE OF INFO - PRIMARY, SECONDARY & TERTIARY	Defaults to "Y"; POLICY INFORMATION - RELEASE OF INFORMATION
53	ASSIGNMENT OF BENEFITS - PRIMARY, SECONDARY & TERTIARY	STATE SPECIFIC
54	PRIOR PAYMENTS - PRIMARY, SECONDARY & TERTIARY	DETAIL BENEFITS - PRIOR PAYMENT field
55	EST. AMOUNT DUE - PRIMARY, SECONDARY & TERTIARY	DETAIL CHARGES - EXPECTED PAY
56	NPI	CLINIC CODE TABLE - field 11 if a clinic code is associated with the claim; otherwise, will pull from PHYSICIAN TABLE #999999 - page 1 field 18 or page 2, field code = N
57	OTHER PROVIDER - PRIMARY, SECONDARY & TERTIARY	INSURANCE COMPANY TABLE - page 1 field 9
58	INSURED'S NAME- PRIMARY, SECONDARY & TERTIARY	POLICY INFORMATION - SUBSCRIBER NAME

59	PAT.'S RELATION TO SUBSC - PRIMARY, SECONDARY & TERTIARY	POLICY INFORMATION - PAT'S RELATION TO SUB
60	INSURED'S UNIQUE ID - PRIMARY, SECONDARY & TERTIARY	POLICY INFORMATION - CONTRACT#
61	GROUP NAME - PRIMARY, SECONDARY & TERTIARY	POLICY INFORMATION - GROUP INFO (GROUP NAME)
62	INSURANCE GROUP NO. - PRIMARY, SECONDARY & TERTIARY	POLICY INFORMATION - GROUP INFO (GROUP NUMBER)
63	TREATMENT AUTH. CDS - PRIMARY, SECONDARY & TERTIARY	POLICY INFORMATION - PRECERT#
64	DOCUMENT CONTROL NO	STAY INFORMATION - ICN
65	EMPLOYER NAME - PRIMARY, SECONDARY & TERTIARY	POLICY INFORMATION - EMPLOYER
66	DIAG VERSION QUALIFIER	QUALIFIER 9 REQUIRED
67A-Q	PRIN. DIAG. CD. and PRESENT AT ADMISSION	STAY INFORMATION and DRG GROUPER SCREEN; the eighth digit (Present at Admission) pulls from the DRG GROUPER SCREEN @ ADM column
68	UNLABELED	
69	ADMITTING DIAG. CODE	DRG GROUPER SCREEN and STAY INFORMATION
70a-c	PATIENT'S REASON FOR VISIT	DRG GROUPER SCREEN - page 1 field 33
71	PPS CODES	STAY INFORMATION - PPS field
72	ECI (EXTERNAL CAUSE OF INJURY CD)	PULLS ECODES FROM DIAG LIST ON GROUPER
73	UNLABELED	
74	PRINCIPAL PROCEDURE CODE/DATE	STAY INFORMATION; DRG GROUPER SCREEN

74a-e	OTHER PROCEDURE CODE/DATE	STAY INFORMATION; DRG GROUPER SCREEN
75	UNLABELED	
76	ATTENDING – NPI/QUAL/ID & LAST/FIRST	PHYSICIAN TABLE, NPI - page 1 field 18 QUAL/ID - page 1 fields 11&19, QUAL may be overwritten from page 2 fld code U with phy type as the QUAL
77	OPERATING – NPI/QUAL/ID & LAST/FIRST	PHYSICIAN TABLE, NPI - page 1 field 18 QUAL/ID - page 1 fields 11&19, QUAL may be overwritten from page 2 fld code U with phy type as the QUAL
78-79	OTHER – NPI/QUAL/ID & LAST/FIRST	PHYSICIAN TABLE, NPI - page 1 field 18 QUAL/ID - page 1 fields 11&19, QUAL may be overwritten from page 2 fld code U with phy type as the QUAL or REFERRING PHY TABLE
80	REMARKS	POLICY INFORMATION - BENEFIT DESC, INS COMPANY TABLE - page 4 field 32
81CC a-d	CODE - CODE - QUAL/CODE/VALUE	TAXONOMY CODE 208D00000X pulls unless a different code is loaded in the PHYSICIAN #999999 TABLE - page 2 using a field code T; OVERFLOW pulls from UB92 CODING

UB04 Example Form

1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME a
b
9 PATIENT ADDRESS a
b c d e
10 BIRTHDATE
11 SEX
ADMISSION 12 DATE 13 HR 14 TYPE 15 SRC
16 DHR
17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
a
b
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
a
b
c
d

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23	PAGE ____ OF ____	CREATION DATE		TOTALS			

50 PAYER NAME
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
A
B
C
58 INSURED'S NAME
59 P.REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
A
B
C
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
A
B
C
66 DX
67 A B C D E F G H
I J K L M N O P Q
68
69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
76 ATTENDING NPI QUAL
LAST FIRST
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
77 OPERATING NPI QUAL
LAST FIRST
80 REMARKS
81CC a
b
c
d
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

UB-04 CMS-1450 APPROVED OMB NO. NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

1500 Locators

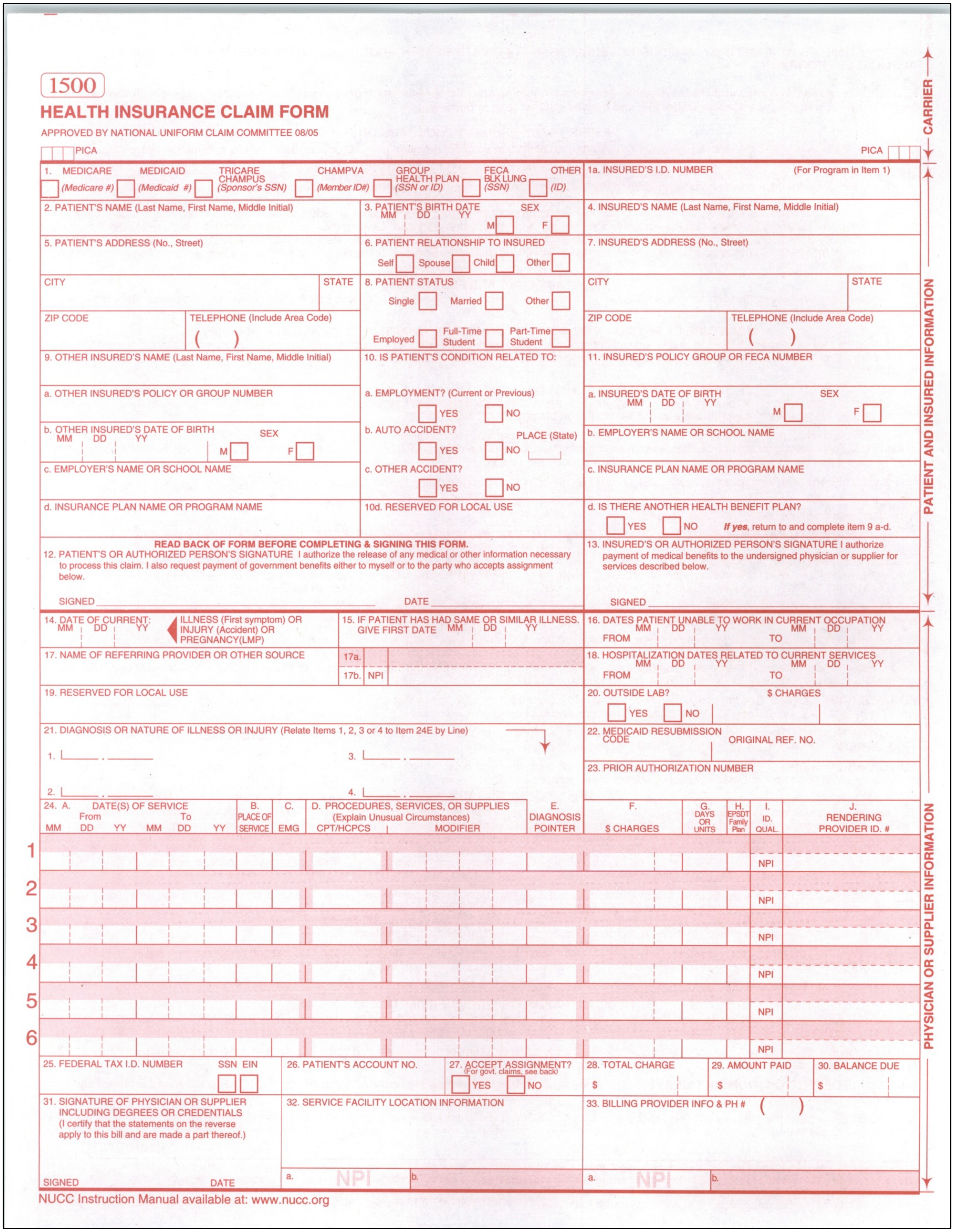
1500 Locators

LOC	DESCRIPTION	PULLED FROM/DETERMINED BY CPSI SYSTEM
1	FINANCIAL CLASS	REGISTRATION - GUARANTOR/INS TAB; POLICY INFORMATION
1a	INSURED'S I.D. NUMBER	POLICY INFORMATION - CONTRACT #
2	PATIENT'S NAME	REGISTRATION - PATIENT TAB - FULL NAME field
3	PATIENT'S BIRTHDAY and SEX	REGISTRATION - PATIENT TAB - BIRTH DATE and SEX field; STAY INFORMATION
4	INSURED'S NAME	POLICY INFORMATION - SUBSCRIBER NAME
5	PATIENT'S ADDRESS	STAY INFORMATION - PATIENT'S ADDRESS
6	PAT REL TO INSURED	POLICY INFORMATION - REL field
7	INSURED'S ADDRESS	REGISTRATION - GUARANTOR/INS TAB; POLICY INFORMATION - SUBSCRIBER ADDRESS
8	PATIENT STATUS	STAY INFORMATION - MARITAL STATUS ESC CODE
9	OTHER INSURED'S NAME	POLICY INFORMATION (Additional insurance claim)
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	POLICY INFORMATION (Additional insurance claim)
9b	OTHER INSURED'S DATE OF BIRTH and SEX	POLICY INFORMATION (Additional insurance claim)
9c	EMPLOYER'S NAME	POLICY INFORMATION (Additional insurance claim)
9d	INSURANCE PLAN	POLICY INFORMATION (Additional insurance claim)
10	CONDITION RELATED TO:	REGISTRATION - STAY TAB - ACCIDENT/THERAPY SECTION; STAY INFORMATION
11	INSURED'S POLICY	POLICY INFORMATION - GROUP
11a	INSURED'S BIRTHDAY & SEX	POLICY INFORMATION
11b	EMPLOYER'S NAME	POLICY INFORMATION
11c	INSURANCE PLAN NAME	POLICY INFORMATION
11d	ANOTHER CLAIM?	HARD CODED (if "Y", system will complete 9-9d)
12	SIGNATURE	HARD CODED to pull "SIGNATURE ON FILE" and Admit Date

13	SIGNATURE	HARD CODED to pull "SIGNATURE ON FILE"
14	DATE OF CURRENT ILLNESS	STAY INFORMATION - ACCIDENT INFORMATION DATE FIELD
15	DATE OF SAME ILLNESS	NOT CURRENTLY USED
16	DATES UNABLE TO WORK	NOT CURRENTLY USED
17	REFERRING PHYSICIAN	REFERRING DATA - PHYSICIAN or STAY INFORMATION - ADMITTING PHYSICIAN
17a	OTHER ID# AND QUALIFIER	REFERRING PHYSICIAN TABLE field code 1 or PHYSICIAN TABLE - page 2 field code 1 or page 1 field 19
17b	NPI	REFERRING PHYSICIAN TABLE - NPI populated with field code 1, or PHYSICIAN TABLE - page 1 field 18
18	HOSPITALIZATION DATES	STAY INFORMATION (for I/P's only)
19	RESERVED FOR LOCAL USE	STATE SPECIFIC
20	OUTSIDE LAB	NOT CURRENTLY USED
21	DIAGNOSIS	STAY INFORMATION, DRG GROUPER SCREEN
22	MEDIC AID RESUBMISSION	NOT CURRENTLY USED
23	PRIOR AUTHORIZATION NUM	POLICY INFORMATION - PERCERT #
24A	DATES OF SERVICE	DETAIL CHARGES SCREEN
24B	PLACE OF SERVICE	SUMMARY CODE TABLE - field 21 or specified on page 2 or CLINIC CODE TABLE - page 2
24C	EMG	EMERGENCY VISIT
24D	PROCEDURES and SERVICES	ITEM MASTER or DRG GROUPER SCREEN
24E	DIAGNOSIS POINTER	INSURANCE STATUS SCREEN - DIA
24F	CHARGES	DETAIL CHARGES SCREEN
24G	DAYS or UNITS	DETAIL CHARGES SCREEN
24H	EPSDT FAMILY PLAN	HARD CODED
24I	ID QUAL	HARD CODED
24J	RENDERING PROVIDER ID. #	(shaded portion) PHYSICIAN TABLE - page 2 field code 3 or page 1 field 11 (unshaded portion) PHYSICIAN TABLE - page 1 field

		18
25	FEDERAL TAX ID NUMBER	INSURANCE COMPANY TABLE - page 2 field 25; PHYSICIAN TABLE #999999 - page 1 field 11; if blank will pull from PHYSICIAN TABLE - page 1 field 20, Social Security Number
26	PATIENTS ACCOUNT NO	PATIENT FUNCTIONS SCREEN
27	ACCEPT ASSIGNMENT	NOT CURRENTLY USED
28	TOTAL CHARGES	DETAIL CHARGES SCREEN
29	AMOUNT PAID	DETAIL BENEFITS - PRIOR PAYMENT
30	BALANCE DUE	DETAIL CHARGES SCREEN - EXPECTED PAY
31	SIGNATURE OF PHY	HARD CODED to pull BILLED date, INSURANCE COMPANY TABLE - page 4 field 3
32	SERVICE FACILITY LOCATION INFO	PHYSICIAN TABLE #999999 - fields 41 - 44 or CLINIC CODE TABLE - fields 1-5
32a	NPI NUMBER	CLINIC CODE TABLE - fields 11 &12
32b	OTHER ID NUMBER	CLINIC CODE TABLE - fields 13 & 14
33	PHYSICIAN NAME and ADDRESS	CLINIC CODE TABLE; PHYSICIAN TABLE and/or INSURANCE COMPANY TABLE - page 2 fields 1-4
33a	NPI NUMBER	PHYSICIAN TABLE #999999 - field 18 or page 2 field code N
33b	OTHER ID NUMBER	PHYSICIAN TABLE - page 2 field code 5; if does not exist will pull from PHYSICIAN TABLE - page 2 field code 6; if does not exist will pull from INSURANCE COMPANY TABLE - page 1 field 9 or PHYSICIAN #999999 TABLE - page 2 field code 5; if does not exist will pull from PHYSICIAN #999999 TABLE - page 2 field code 6; if does not exist will pull from PHYSICIAN #999999 TABLE - page 2 field code T

1500 Example Form



1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY STATE
8. PATIENT STATUS Single Married Other
CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )
Employed Full-Time Student Part-Time Student
ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. AUTO ACCIDENT? YES NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 3.
2. 4.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #
1 NPI
2 NPI
3 NPI
4 NPI
5 NPI
6 NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

UB04 Insurance Claim Edits

Overview

Within the billing procedures are UB04 claim edits. These edits help the Business Office to determine what additional information should be included on the insurance claims prior to billing.

Edits 1 - 100

EDIT 1 - TWO OUTPATIENT CLAIMS W/ THE SAME SERVICE DATES

Scenario: The above edit appears if a patient has two claims on the Insurance screen with the same F/C, Service Dates, and the Bill Type is 131.
To Correct: All charges on the two claims will need to be manually generated onto one claim and billed on hard copy.

EDIT 2, 3 and 4 - PROVIDER INFORMATION BLANK

EDIT 2 - PROVIDER NAME BLANK
EDIT 3 - PROVIDER ADDRESS BLANK
EDIT 4 - PROVIDER PHONE NUMBER BLANK

Locator: 1 - Provider Name/Address/Phone
Scenario: The above edits appear if a claim does not have a Provider Name, Address, or Phone number printing on the UB in locator 1.
To Correct: Verify which of the above is missing. Load the missing information in fields 41 - 45 of the Physician 999999 table.

EDIT 5 - TYPE OF BILL BLANK

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim does not have a Bill Type on the claim's Detail Charges screen.
To Correct: Verify the correct Bill Type and load in Detail Charges screen of the Claim. The claim does not have to be regenerated.

EDIT 6 - TYPE OF BILL INVALID

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim does not have a valid Bill Type. The Bill Type must meet the following criteria:
1st Digit is Type of Facility: 1, 2, 3, 7 or 8 only.
2nd Digit is Bill Classification: If 1st digit = 1 - 1, 2, 3, 4 or 8 only.
If 1st digit = 2 - 1, 2, 3 or 4 only.
If 1st digit = 7 - 1, 2, 4 or 5 only.
If 1st digit = 8 - 3 or 5 only.
3rd Digit is Frequency: 0, 1, 2, 3, 4, 5, 7, 8 or 9 only.
To Correct: Verify the correct Bill Type and load it in Detail Charges screen of the claim. The claim does not have to be regenerated.

EDIT 7 - TYPE OF BILL INVALID

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has a charge with Revenue Code 54X and the Bill Type is 11X.
To Correct: Verify the Bill Type is correct. If not, change Bill Type on the claim's Detail Charges screen. If Bill Type is correct, verify the account has the correct charges. If charges with the above Revenue Code are incorrect, have Data Processing back the charges off the account and regenerate the claim.

EDIT 8 - TYPE OF BILL INVALID - REV CODE 84X

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has a charge with Revenue Code 84X and the Bill Type is 11X.
To Correct: Verify Bill Type is correct. If not, change Bill Type on the claim's Detail Charges screen. If Bill Type is correct, verify account has the correct charges. If charges with the above Revenue Code is incorrect, have Data Processing back the charges off the account and regenerate the claim.

EDIT 9 - TYPE OF BILL INVALID - REV CODE 23X

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has a charge with Revenue Code 23X and the Bill Type is 11X.
To Correct: Verify Bill Type is correct. If not, change the Bill Type on the claim's Detail Charges screen. If Bill Type is correct, verify the account has the correct charges. If charges with the above Revenue Codes are incorrect, have Data Processing back the charges off the account and regenerate the claim.

EDIT 10 - TYPE OF BILL INVALID - REV CODE 322 OR 323

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has a charge with Revenue Code 322 or 323 and the Bill Type is 11X, 12X or 13X.
To Correct: Verify Bill Type is correct. If not, change Bill Type on the claim's Detail Charges screen. If Bill Type is correct, verify the account has the correct charges. If charges with the above Revenue Codes are incorrect, have Data Processing back the charges off the account and regenerate the claim.

EDIT 11 - BILL TYPE NOT X1X OR X8X; OCC-CD 20,21,22,23, OR 26

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has an Occurrence Code of 20, 21, 22, 23 or 26, and the Bill Type is not X1X or X8X.
To Correct: Verify Occurrence Codes are correct. If incorrect, change codes in the UB92 Coding screen of the claim. If the Occurrence Codes are correct, change Bill Type on the claim's Detail Charges screen. There is no need to regenerate the claim.

EDIT 12 - BILL TYPE NOT X3X OR X8X; OCC-CD 40 OR 41

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has an Occurrence Code of 40 or 41 and the Bill Type is not X3X or X8X.
To Correct: Verify Occurrence Codes are correct. If incorrect, change codes on the UB92 coding screen of the claim. If the Occurrence Codes are correct, change the Bill Type on the claim's Detail Charges screen. There is no need to regenerate the claim.

EDIT 13 - BILL TYPE INVALID; OCC-SPAN-CD = 70

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has an Occurrence Span Code of 70 and the Bill Type is not 11X, 18X or 21X.
To Correct: Verify the Occurrence Span Code is correct. If incorrect, change on the Stay Information screen of the claim. If correct, change the Bill Type on the claim's Detail Charges screen. The claim does not have to be regenerated.

EDIT 14 - BILL TYPE INVALID; OCC-SPAN-CD = 71

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has an Occurrence Span Code of 71 and the Bill Type is not 11X or 21X.
To Correct: Verify Occurrence Span Code is correct. If incorrect, change on the Stay Information screen of the claim. If correct, change the Bill Type on the claim's Detail Charges screen. The claim does not have to be regenerated.

EDIT 15 - BILL TYPE INVALID; OCC-SPAN-CD = 72

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has an Occurrence Span Code of 72 and the Bill Type is not 13X, 14X, 71X, 74X or 75X.
To Correct: Verify Occurrence Span Code is correct. If incorrect, change on the Stay Information screen of the claim. If correct, change the Bill Type on the claim's Detail Charges screen. The claim does not have to be regenerated.

EDIT 16 - BILL TYPE NOT 11X; OCC-SPAN-CD = 75

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has an Occurrence Span Code of 75 and the Bill Type is not 11X.
To Correct: Verify Occurrence Span Code is correct. If incorrect, change on the Stay Information screen of the claim. If correct, change the Bill Type on the claim's Detail Charges screen. The claim does not have to be regenerated.

EDIT 17 - NEED COND CODE C3 WITH OCCUR SPAN OF MO

Locator: 24-30 Condition Codes
Scenario: The above edit appears if a Medicare, Blue Cross or Medicaid claim has an Occurrence Span Code = "MO," but does not have a Condition Code of "C3."
To Correct: Verify Occurrence Span Code is correct. If incorrect, change on the Stay Information screen of the claim. If correct, enter a Condition Code of C3 in the UB92 Coding screen of the claim. There is no need to regenerate the claim.

EDIT 18 - CANNOT HAVE OCCUR SPAN THRU DATE OF 999999

Locator: 36 - Occurrence Span
Scenario: The above edit appears if a Champus claim for a patient whose age is greater than 10 years old and the patient's relation to subscriber is not 03, 04, 05 or 10 or new relation codes 19, 43, 17 or 22 & has an Occurrence Span Thru date = 999999.
To Correct: Verify Patient relation to subscriber. If incorrect, change on the Policy Information screen of the claim. If correct, verify the Occurrence Span Thru date and correct on the Stay Information screen. There is no need to regenerate the claim.

EDIT 19 - VALUE CD = 15; BILL TYPE INVALID

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has a Value Code = 15 and the Bill Type is not equal to 11X, 12X, 13X, 14X, 18X, 21X or 83X.
To Correct: Verify Value Code is correct. If incorrect, change on the UB92 Coding screen. If correct, enter the correct Bill Type on the claim's Detail Charges screen. There is no need to regenerate the claim.

EDIT 20 - BILL TYPE INVALID WITH COND CODE

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has a Condition Code of D0, D1, D2, D3, D4, D7, D8, D9 or E0 and the Bill Type is not XX7. This same edit appears if a claim has a Condition Code of D5 or D6 and the Bill Type is not XX8.
To Correct: Verify the Condition Code is correct. If incorrect, make corrections on the UB92 Coding screen of the claim. If correct, change the Bill Type on the claim's Detail Charges screen. The claim does not have to be regenerated.

EDIT 21 - FEDERAL TAX NUMBER FROM INS TABLE IS NOT NUMERIC

Locator: 5 - Federal Tax Number
Scenario: The above edit appears if a claim has a Federal Tax number loaded in the Financial Class Table, page 2, that is not numeric or is blank.
To Correct: Verify the Federal Tax Number is correct and load it in the Financial Class Table, page 2. There is no need to regenerate the claim.

EDIT 22 - FEDERAL TAX NUMBER IS NOT NUMERIC

Locator: 5 - Federal Tax Number
Scenario: The above edit appears if a claim has a physician loaded on the Stay Information screen with a tax number from the Physician Table that is not numeric or is blank.
To Correct: Verify the Federal Tax number and load it in the Physician Table, field 11, for the particular physician. There is no need to regenerate the claim.

EDIT 23 - STMT 'FROM' DATE = 000000

Locator: 6 - Statement Covers Period
Scenario: The above edit appears if a claim does not have a date in the “Service From” field of the Insurance Claim Status screen.
To Correct: Verify the Admit date is correct. If not, have admitting correct the admit date through Census. If correct, regenerate the insurance claim and key in the correct service FROM date.

EDIT 24 - STMT 'THROUGH' DATE = 000000

Locator: 6 - Statement Covers Period
Scenario: The above edit appears if a claim does not have a date in the “Service To” field of the Insurance Claim Status screen.
To Correct: Verify the Discharge date is correct. If not, have admitting correct the discharge date through Census. If correct, regenerate the insurance claim and key in the correct “Service To” date.

EDIT 25 - STMT 'FROM' DATE > STMT 'THROUGH' DATE

Locator: 6 – Statement Covers Period
Scenario: The above edit appears if a claim has a “Service From” date after the claim's “Service To” date. Example: From date = 08/15/05 and To date = 08/12/05.
To Correct: Verify Admit and Discharge dates are correct. If incorrect, have admitting correct through Census. If dates are correct, regenerate insurance claim and key in the correct service From and To dates.

EDIT 26 - STMT "THROUGH" DATE > CURRENT DATE

Locator: 6 - Statement Covers Period
Scenario: The above edit appears if a claim has a “Service To” date > than the current date. Example: Current date is 8/1/05 and To date is 8/2/05.
To Correct: Verify Discharge date is correct. If incorrect, have admitting make corrections through Census. If date is correct, then regenerate the insurance claim and key in the correct "To" date. If correct, change the Bill Type on the Claims Detail Charges screen. The claim does not have to be regenerated.

EDIT 27 - STMT 'FROM' YEAR NOT = STMT 'THROUGH' YEAR

Locator: 6 - Statement Covers Period
Scenario: The above edit appears if a claim has a Service From date in a different year than the Service To date and the Bill Type is 12X, 13X, 14X, 18X, 21X, 72X or 83X.
To Correct: Verify the admit and discharge dates are correct. If incorrect, have admitting change through Census Functions. If correct, then verify the Bill Type. The Bill Type can't be those listed above. If the Bill Type is correct then two claims will need to be setup; one from the admit date to the end of the year and the other from the beginning of the year until the discharge date.

EDIT 28 - COV DAYS + NONCOV NOT = STMT PERIOD DAYS

Locator: 7 - Covered days
Scenario: The above edit appears if a claim has Covered days + Non-Covered days not equal to the total period days and the Bill Type is 11X, 18X or 21X.
To Correct: Verify admit and discharge dates are correct. If incorrect, have admitting change through Census. If correct, verify Covered days and Non-Covered days and enter them on the Insurance Claim's Detail Benefits screen.

EDIT 29 - COV DAYS > 100; BILL TYPE 21X

Locator: 7 - Covered days
Scenario: The above edit appears if a claim has Covered days greater than 100 and the Bill Type is 21X.
To Correct: Verify that the Bill Type is correct. If incorrect, change on the claim's Detail Charges screen. If correct, then the Covered days can not exceed 100.

EDIT 30 - COV DAYS > 150; BILL TYPE = 11X

Locator: 7 - Covered days
Scenario: The above edit appears if a claim has Covered days greater than 150 and the Bill Type is 11X.
To Correct: Verify that the Bill Type is correct. If incorrect, it can be changed on the claim's Detail Charges screen. If correct, then the Covered days can not exceed 150.

EDIT 31 - MEDICARE; COND CD = 40; CHECK COV DAYS

Scenario: The above edit appears if a Medicare claim has a Condition Code of 40 and the Covered days do not equal zero and Non-Covered days equals 1.
To Correct: Verify Condition Code is correct. If incorrect, delete the Condition Code on the UB92 Coding screen of the insurance claim. If the Condition Code is correct, the Covered days must be zero and the Non-Covered days must be one.

EDIT 32 - COINS DAYS > COVERED DAYS

Scenario: The above edit appears if a Medicare claim has Co-Insurance Days Used (Co Days Used on the claim's Detail Benefits screen) greater than the Covered days.
To Correct: Verify claim has the correct amount of Co-Insurance days used on the Detail Benefits screen and it is not greater then the Covered days. The claim does not have to be regenerated.

EDIT 33 - CO-INS DAYS > 0; NEED VALUE CD 09 OR 11

Scenario: The above edit appears if a Medicare claim has Co-Insurance Days Used loaded in the claim's Detail Benefits screen which are greater than 0 and does not have Value Code 09 or 11 loaded on the UB92 Coding screen.
To Correct: Verify that the amount of Co-Insurance days used is the correct amount. If correct, then load Value Code 09 or 11 on the UB92 Coding screen of the claim. There is no need to regenerate the claim.

EDIT 34 - LIFE DAYS > 60

Locator: 10 - Life Reserve Days
Scenario: The above edit appears if a Medicare claim has Life Days Used loaded on the Detail Benefits screen of the claim and life days used is greater than 60.
To Correct: Verify the correct amount of Life Days Used is loaded and it's less than 60 days. The claim will need to be regenerated.

EDIT 35 - LIFE DAYS > COVERED DAYS

Scenario: The above edit appears if a Medicare claim has Life Days Used in the claim's Detail Benefits screen which are greater than the Covered days.
To Correct: Verify the claim has the correct amount of Life Days Used in the Detail Benefits screen and that they are not greater than the Covered days. The claim does not have to be regenerated.

EDIT 36 - COVERED DAYS > 365 ON CHAMPUS CLAIM

Scenario: The above edit appears if a Champus claim has Covered days greater than 365.
To Correct: Verify that the Financial Class is correct. If incorrect, enter the correct insurance on the Insurance screen of the patient. If correct, the Covered days can not exceed 365 days.

EDIT 37 - LIFE DAYS > 0; NEED VALUE CD 08 OR 10

Scenario: The above edit appears if a Medicare claim has Life Days Used in the Detail Benefits screen and does not have Value Code 08 or 10 on the UB92 coding screen.
To Correct: Verify the correct amount of Life Days Used. If incorrect, change in the Detail Benefits screen of the claim. If correct, load Value Code 08 or 10 on the UB92 Coding screen of the insurance claim. If the Life Days Used are changed, the claim will need to be regenerated. If the Value Code is entered, there is no need to regenerate the claim.

EDIT 38 - PATIENT'S NAME NOT ENTERED

Locator: 8b - Patient Name
Scenario: The above edit appears if a claim does not have a patient's name.
To Correct: Verify the patient's name and load it in the Patient tab on the Registration and ADT screen. The claim will have to be regenerated.

EDIT 39 - PATIENT NAME MUST INCLUDE LAST NAME AND FIRST INIT

Locator: 8b - Patient Name
Scenario: The above edit appears if a claim has only the last name of a patient loaded in the Patient tab on the Registration and ADT screen.
To Correct: Verify the patient's name. The name must include at a minimum, the last name and first initial. The claim will need to be regenerated.

EDIT 40 - PATIENT'S STREET NOT ENTERED

Locator: 9a - Patient Address
Scenario: The above edit appears if a claim does not have a patient street address loaded in the Patient tab on the Registration and ADT screen - "Address1."
To Correct: Verify the correct street and load in the Patient tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 41 - PATIENT'S CITY NOT ENTERED

Locator: 9b - Patient Address
Scenario: The above edit appears if a claim does not have a patient's city loaded in the Patient tab on the Registration and ADT screen.
To Correct: Verify the city is correct and load it in the Patient tab on the Registration and ADT screen and then regenerate the insurance claim.

EDIT 42 - PATIENT'S STATE NOT ENTERED

Locator: 9c - Patient Address
Scenario: The above edit appears if a claim does not have the patient's state loaded in the Patient tab on the Registration and ADT screen.
To Correct: Verify the state is correct and load it in the Patient tab on the Registration and ADT screen. Regenerate the insurance claim.

EDIT 43 - PATIENT'S ZIP CODE NOT ENTERED

Locator: 9d - Patient Address
Scenario: The above edit appears if a claim does not have the patient's zip code loaded in the Patient tab on the Registration and ADT screen.
To Correct: Verify the zip code is correct and load it in the Patient tab on the Registration and ADT screen. Regenerate the insurance claim.

EDIT 44 - PATIENT'S ZIP IS INVALID FOR PATIENT STATE

Locator: 9d - Patient Address
Scenario: The above edit appears if a claim has a zip code loaded that is invalid for the state code loaded. The edit verifies this based on a range of zip codes obtained by the Post Office for each state.
To Correct: Verify the zip code is correct for the state loaded. Change either the state code or zip code, whichever is incorrect, in the Patient tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 45 - PATIENT'S BIRTHDATE IS MISSING

Locator: 10 - Birthdate
Scenario: The above edit appears if a claim does not have a date of birth loaded for the patient.
To Correct: Verify the patient's date of birth and load in the Patient tab on the Registration and ADT screen. Regenerate the claim.

EDIT 46 - BIRTH CENTURY INVALID

Locator: 10 - Birthdate
Scenario: The above edit appears if a claim has a birthdate loaded in the Patient tab on the Registration and ADT screen that is less than 1800 or greater than 2000.
To Correct: Verify the birthdate is correct and load in the Patient tab on the Registration and ADT screen. Regenerate the insurance claim.

EDIT 47 - AGE MUST BE > 65; VALUE CODE 12 LISTED

Locator: 10 - Birthdate
Scenario: The above edit appears if any claim except Medicare that has a Value Code of 12 listed on the UB92 Coding screen and the age is not greater than 65.
To Correct: Verify the Value Code is correct. If incorrect, delete the code from the UB92 Coding screen of the claim. If correct, verify the birthdate is correct and load in the Patient tab on the Registration and ADT screen. If the Value Code is corrected, there is no need to regenerate the claim. If the birthdate is corrected, the claim will need to be regenerated.

EDIT 48 - AGE MUST BE < 65; VALUE CODE 43 LISTED

Locator: 10 - Birthdate
Scenario: The above edit appears if any claim except Commercial has a Value Code of 43 listed on the UB92 Coding screen and the age is not less than 65.
To Correct: Verify the Value Code is correct. If incorrect, delete the code from the UB92 Coding screen of the claim. If correct, verify the birthdate is correct and load in the Patient tab on the Registration and ADT screen. If the Value Code is corrected, there is no need to regenerate the claim. If the birthdate is corrected, the claim will need to be regenerated.

EDIT 49 - BIRTHDATE > ADMISSION DATE

Locator: 10 - Birthdate
Scenario: The above edit appears if any claim except Medicare, Blue Cross or Medicaid shows the date of birth is greater than the admission date.
To Correct: Verify the birth and admission dates are correct. If the date of birth is incorrect, enter the correct date in the Patient tab on the Registration and ADT screen. If admission date is incorrect, then have admissions correct through Census. The claim will need to be regenerated.

EDIT 50 - INVALID PATIENT SEX

Locator: 11 - Sex
Scenario: The above edit appears if a claim has a patient's sex that is not "M" - Male or "F" - Female.
To Correct: Verify the sex of the patient is correct and load it in the Patient tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 51 - INVALID MARITAL STATUS

Scenario: The above edit appears if a claim does not have any of the following marital status codes in the Patient tab on the Registration and ADT screen: "S" - Single, "M" - Married, "D" - Divorced, "X" - Separated, "W" - Widowed, "U" - Unknown or "P" - Life Time Partner.
To Correct: Check the marital status and load it in the Patient tab on the Registration and ADT screen. Regenerate the insurance claim.

EDIT 52 - MUST ENTER ADMIT DATE FOR THIS BILL TYPE

Locator: 12 - Admission Date
Scenario: The above edit appears if a claim has a Bill Type of 11X, 18X, 21X or 82X and there is no admit date.
To Correct: Verify the Bill Type. If incorrect, change on the claim's Detail Charges screen. If the Bill Type is correct, have admissions enter the correct admit date through Census. The claim will need to be regenerated.

EDIT 53 - ADMIT DATE > STMT 'FROM' DATE

Locator: 12 - Admission Date
Scenario: The above edit appears if a claim has an admit date after the service "From" date on the claim.
To Correct: Verify the admit date is correct. If incorrect, have admissions correct the date through the Stay tab on the Registration and ADT screen. If admit date is correct, regen the insurance claim and enter the correct "From" date.

EDIT 54 - ADMISSION DATE > CURRENT DATE

Locator: 12 - Admission Date
Scenario: The above edit appears if a claim has an admit date greater than the current date.
To Correct: Verify the admit date and have admissions change the date through the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 55 - INVALID ADMIT HOUR

Locator: 13 - Admission Hour
Scenario: The above edit appears if a claim has an admit hour other than 00 - 23 or 99.
To Correct: Verify the admission hour falls within the 24 hour time period and is valid. If it needs to be changed, correct on the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 56 - ADMIT HOUR NOT ENTERED

Locator: 13 - Admission Hour
Scenario: The above edit appears if a claim other than Blue Cross, Medicare or Medicaid does not have an admit hour loaded in the Stay tab on the Registration and ADT screen.
To Correct: Verify the admit hour is correct and load in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 57 - ADMIT TYPE MISSING

Locator: 14 - Admission Type
Scenario: The above edit appears if a claim has a Bill Type of 11X, 18X or 21X and does not have an admission code.
To Correct: Verify the Bill Type. If incorrect, change on the claim's Detail Charges screen. If correct, verify the admission code and enter it on the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 58 - ADMIT TYPE INVALID

Locator: 14 - Admission Type
Scenario: The above edit appears if a claim has an admission type other than a 1, 2, 3, 4, 5 or 9.
To Correct: Verify the admission type in the Stay tab on the Registration and ADT screen. The first number of the admission code in the Stay tab on the Registration and ADT screen must be a 1, 2, 3 or 9. The claim will need to be regenerated.

EDIT 59 - ADMISSION TYPE BLANK

Locator: 14 - Admission Type
Scenario: The above edit appears if a claim does not have an admission type loaded.
To Correct: Verify the correct admission type and load the code in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 60 - ADMIT SOURCE MISSING

Locator: 15 - Admission Source
Scenario: The above edit appears if a claim does not have an admission source loaded on the Stay tab on the Registration and ADT screen. The last number of the admission code is the admission source.
To Correct: Verify the correct admission source is loaded and load it in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 61 - ADMIT SOURCE INVALID

Locator: 15 - Admission Source
Scenario: The above edit appears if a claim has an admission source that is not a 1-9 and A.
To Correct: Verify the admission source is correct and enter it in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 62 - ADMIT SOURCE OF 9 INVALID FOR BILL TYPE

Locator: 15 - Admission Source
Scenario: The above edit appears if a claim has an admit source of 9 and the Bill Type is 13X or 83X.
To Correct: Verify the Bill Type is correct. If incorrect, it can be changed in the claim's Detail Charges screen. If Bill Type is correct, the admission source can not be a 9. The admission source will need to be changed in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 63 - ADMIT SOURCE BLANK

Locator: 15 - Admission Source
Scenario: The above edit appears if a claim does not have an admission source loaded in the Stay tab on the Registration and ADT screen.
To Correct: Verify the admission source is correct and load it in Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 64 - ADM SOURCE NOT VALID WITH ADMIT TYPE

Locator: 15 - Admission Source
Scenario: The above edits appear if a Champus claim has an admit type of 1 and does not have an admit source of 4 - 7.
To Correct: Verify the admission type is correct. If incorrect, change on the Stay tab on the Registration and ADT screen. If admission type is correct, the source can only be 4 - 7. The claim will need to be regenerated.

EDIT 65 - ADM TYPE = 4; ADM SOURCE UNACCEPTABLE

Locator: 15 - Admission Source
Scenario: The above edit appears if a claim is not Blue Cross, Medicare or Medicaid, the admission type is 4, and the admission source is not 1-4 or 9.
To Correct: Verify the admission type is correct. If incorrect, then change on the Stay tab on the Registration and ADT screen. If correct, then the admit source must be 1-4 or 9. The claim will need to be regenerated.

EDIT 66 - INVALID DISCHARGE HOUR

Locator: 16 - Discharge Hour
Scenario: The above edit appears if a claim has a discharge hour that is not 00 - 23 or 99.
To Correct: Verify the discharge time is correct in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 67 - DISCHARGE HOUR NOT ENTERED

Locator: 16 - Discharge Hour
Scenario: The above edit appears if a claim is not Medicare, Blue Cross or Medicaid and does not have a discharge hour loaded.
To Correct: Verify the discharge hour is correct and load it in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 68 - DISCHARGE STATUS MISSING

Locator: 17 - Discharge Status
Scenario: The above edit appears if a claim has a Bill Type of 11X, 13X, 18X, 21X or 83X and does not have a discharge status loaded.
To Correct: Verify the Bill Type is correct. If incorrect, it can be changed in the claim's Detail Charges screen. If the Bill Type is correct, verify the discharge status and load it in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 69 - INVALID DISCHARGE STATUS

Locator: 17 - Discharge Status
Scenario: The above edit appears if a claim has a discharge status not equal to 01 - 09, 20, 30, 40 – 43, 50, 51, 61 – 66, 71 or 72.
To Correct: Verify the discharge status is correct and load it in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 70 - DISCHARGE STATUS BLANK

Locator: 17 - Discharge Status
Scenario: The above edits appear if a Champus claim does not have a discharge status code loaded.
To Correct: Verify the discharge status and load it in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 71 - CANNOT HAVE DISC STATUS = 30 WITH THIS BILL TYPE

Locator: 17 - Discharge Status
Scenario: The above edits appear if a claim for a Stay Type 1 patient has a Bill Type with the third digit as a 1 or 4 and the discharge status code equals 30.
To Correct: Verify the Bill Type is correct. If incorrect, it can be changed on the claim's Detail Charges screen. If Bill Type is correct, the discharge status code cannot be a 30. The status can be changed in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 72 - INVALID DISC STAT FOR LISTED BILL TYPE

Locator: 17 - Discharge Status
Scenario: The above edit appears if there is a claim for a Stay Type 1 patient with the third digit of the Bill Type being a 1 or 4 and the discharge status does not equal to 01-07, 20, 40-43, 50, 61-63, 65, 71 or 72.
To Correct: Verify the Bill Type is correct. If incorrect, change the Bill Type on the claim's Detail Charges screen. If the Bill Type is correct, the discharge status code has to be a 01-07, 40-42 or 20. The status can be changed in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 73 - CANNOT HAVE LISTED DISC STAT WITH THIS BILL TYPE

Locator: 17 - Discharge Status
Scenario: The above edit appears if a claim for a Stay Type 1 patient has the third digit of the Bill Type as a 2 or 3 and the discharge code is a 01-08.
To Correct: Verify the Bill Type is correct. If incorrect, change the Bill Type in the claim's Detail Charges screen. If the Bill Type is correct, then the discharge status code cannot be a 01-08. The status can be changed in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 74 – DISCHARGE STATUS 09 NOT VALID FOR BILL TYPE

Locator: 17 - Discharge Status
Scenario: The above edit appears if a claim does not have a Bill Type of 13X, 14X, 83X or 85X and has a discharge status of 09 loaded.
To Correct: Verify the Bill Type is correct. If incorrect, it can be changed on the claim's Detail Charges screen. If the Bill Type is correct, verify the discharge status is correct and load it in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 75 - INVALID CONDITION CODE ON ACCOUNT

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Condition Code that is not equal to 01-11, 18-24, 26-29, 31-34 or 36-41 on the UB92 Coding screen.
To Correct: Check to see if the claim needs a Condition Code and load the correct code in the UB92 Coding screen. If the claim does not need a Condition Code, delete the Condition Code. The claim does not need to be regenerated.

EDIT 76 - NEED COND CD = 02 FOR VALUE CD = 14 OR 41

Locator: 18 - 28 Condition Codes
Scenario: The above edits appear if a claim has Value Code 15 or 41 in the UB92 Coding screen and does not have a Condition Code 02.
To Correct: Verify Value Code. If incorrect, change the code on the UB92 Coding screen. If correct, the claim must have an 02 Condition Code loaded on the UB92 Coding screen. The claim does not need to be regenerated.

EDIT 77 - ESC = 1 OR 2; MISSING COND CD, OCC CD OR VALUE CD

Locator: 18 - 28 Condition Codes
Scenario: A claim has an Employment Status Code (ESC) of 1 or 2 and does not have at least one of the following: a Condition Code 10 or 11, an Occurrence Code 24 or Value Code of 12, 13 or 43 in the UB92 Coding screen.
To Correct: Verify the Employment Status Code on the Policy Information screen. If incorrect, enter the correct code. If the ESC is correct, the claim must have one of the codes listed above. The claim does not need to be regenerated.

EDIT 78 - BILL TYPE = XX7; NEED CHANGE REQUEST CODE

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Bill Type of XX7 and does not have a Condition Code of D0, D1, D2, D3, D4, D7, D8, D9 or E0 in the UB92 Coding screen.
To Correct: Verify the Bill Type is correct. If incorrect, it can be changed on the claim's Detail Charges screen. If the Bill Type is correct, then the Condition Code must be a D0, D1, D2, D3, D4, D7, D8, D9 or E0 in the UB92 Coding screen. The claim does not need to be regenerated.

EDIT 79 - BILL TYPE = XX7; SHOULD HAVE ONLY ONE ADJUST CODE

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Bill Type of XX7 and has at least two or more of the following Condition Codes: D0, D1, D2, D3, D4, D7, D8, D9 or E0 on the UB92 Coding screen.
To Correct: Verify the Bill Type is correct. If incorrect, it can be changed on the claim's Detail Charges screen. If the Bill Type is correct, then the claim can only have one of the Condition Codes. The claim does not need to be regenerated.

EDIT 80 - MEDICARE CLAIM - NEEDS COND CODE C1 - C7

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a Medicare Stay Type 1 claim does not have a Condition Code of C1 - C7 in the UB92 Coding screen.
To Correct: Verify the correct Condition Code and load in the UB92 Coding screen of the claim. The claim does not need to be regenerated.

EDIT 81 - BILL TYPE = XX8; NEED CHANGE REQUEST CODE D5 OR D6

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Bill Type XX8 and does not have a Condition Code D5 or D6 in the UB92 Coding screen.
To Correct: Verify the Bill Type is correct. If incorrect, it can be changed on the claim's Detail Charges screen. If correct, the claim must have a Condition Code of D5 or D6 on the UB92 Coding screen. The claim does not need to be regenerated.

EDIT 82 - BILL TYPE = XX8; SHOULD HAVE ONLY ONE ADJUST CODE

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Bill Type of XX8 and has both Condition Codes D5 and D6 on the UB92 Coding screen.
To Correct: Verify the Bill Type is correct. If incorrect, it can be changed on the claim's Detail Charges screen. If correct, the claim can only have one of the Condition Codes. Verify which code is correct and delete the incorrect one from the UB92 Coding screen. The claim does not need to be regenerated.

EDIT 83 - NEEDS A6 CONDITION CODE; PRIN DIAG = V0481

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim with service dates after 10/01/03 has a diagnosis "V0481" and does not have a Condition Code of "A6" in the UB92 Coding screen.
To Correct: Verify the Diagnosis is correct. If not, have Medical Records change the Diagnosis on the Grouper screen. If the diagnosis is correct, load Condition Code A6 on the UB92 Coding screen. If the Diagnosis Code is corrected, the claim will need to be regenerated. If the Condition Code is entered, the claim does not have to be regenerated.

EDIT 84 - NEEDS A6 CONDITION CODE; HAS REV CDS 636 AND 771

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim, with service dates after 10/01/94, has charges with Revenue Codes 636 and 771, and does not have a Condition Code of "A6" in the UB92 Coding screen.
To Correct: Verify charges are correct. If incorrect, have Data Processing correct through Charge Entry. If charges are correct, load a Condition Code of A6 in the UB92 Coding screen. If the charges are corrected, the claim will need to be regenerated. If Condition Code is entered, the claim does not have to be regenerated.

EDIT 85 - ADJ COND CD; BILL TYPE SHOULD END IN 7 OR 8

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Condition Code of any one of the following: D0, D1, D2, D3, D4, D5, D6, D7, D8, D9 or E0, and the Bill Type does not end in a 7 or 8.
To Correct: Verify Condition Code is correct. If incorrect, delete code from the UB92 Coding screen of the claim. If correct, the Bill Type must end in a 7 or 8. Correct the Bill Type in the claim's Detail Charges screen. The claim will not need to be regenerated.

EDIT 86 - CAN'T USE COND CD 70,71,73,74, OR 76 W/PRIN DIAG

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Condition Code of 70, 71, 73, 74 or 76 and the Principal Diagnosis is not 585.
To Correct: Verify the Condition Code is correct. If incorrect, delete code from the UB92 Coding screen of the claim. If correct, the Principal Diagnosis Code must be 585. Have Medical records verify and correct on the Medical Records Grouper screen. The claim will need to be regenerated.

EDIT 87 - NEED COND CD 70,71,73,74, OR 76 W/PRIN DIAG

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Principal Diagnosis of 585 and does not have a Condition Code of 70, 71, 73, 74 or 76 on the UB92 Coding screen of the claim.
To Correct: Verify Principal Diagnosis Code. If incorrect, have Medical Records correct on the Medical Records Grouper screen. If diagnosis is correct, load one of the Condition Codes in the UB92 Coding screen of the claim. If diagnosis is corrected, the claim will need to be regenerated. If the Condition Code is added, there is no need to regenerate the claim.

EDIT 88 - CAN'T USE COND CD 81 - 86 WITH BILL TYPE LISTED

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Condition Code of 81 - 86 and the Bill Type is X3X (except 73X or 83X).
To Correct: Verify the Condition Code. If incorrect, delete code from the UB92 Coding screen of the claim. If correct, the Bill Type cannot be X3X except 73X or 83X. The Bill Type can be changed on the claim's Detail Charges screen. The claim does not need to be regenerated.

EDIT 89 - NEED COND CD 02 WITH OCC CD 04

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has an Occurrence Code of 04 and is missing a Condition Code of 02.
To Correct: Verify Occurrence Code is correct. If incorrect, delete code from the UB92 Coding screen of the claim. If correct, the claim needs a Condition Code of 02 loaded in the UB92 Coding screen. The claim does not need to be regenerated.

EDIT 90 - INVALID OCCURRENCE CODE ON ACCOUNT

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an Occurrence Code on the UB92 Coding screen and it is not one of the following: 01-06, 09-12, 17-22, 24-46, A1-A3, B1-B3 or C1-C3.
To Correct: Verify the claim needs a Condition Code. Correct the code in the UB92 Coding screen. The claim does not need to be regenerated.

EDIT 91 - NEED TO ENTER OCCURRENCE DATE FOR OCCURRENCE CODE

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an Occurrence Code in the UB92 Coding screen and is missing an Occurrence Date.
To Correct: If Occurrence Code is not needed, delete from the UB92 Coding screen. If Occurrence Code is correct, then verify the date and load in the UB92 Coding screen. The claim does not need to be regenerated.

EDIT 92 - NEED TO ENTER OCCURRENCE CODE FOR OCCURRENCE DATE

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an Occurrence Date in the UB92 Coding screen and is missing an Occurrence Code.
To Correct: Verify the Occurrence Code is needed. If Occurrence Code is not needed, delete date from the UB92 Coding screen. If Occurrence Code is correct, verify the code and load in the UB92 Coding screen. The claim does not need to be regenerated.

EDIT 93 - OCCURRENCE DATE > CURRENT DATE

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an Occurrence Date in the UB92 Coding screen that is greater than the current date.
To Correct: Verify the Occurrence Date and change in the UB92 Coding screen. The Occurrence Date cannot be a future date. The claim does not need to be regenerated.

EDIT 94 - TRAUMA DIAGNOSIS - NEED OCCURRENCE CODE

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a trauma Diagnosis Code of 80000-99899 and does not have an Occurrence Code of 01 - 05 in the UB92 Coding screen of the claim.
To Correct: Verify the diagnosis is correct. If incorrect, have Medical Records change in the Grouper screen and the claim will need to be regenerated. If diagnosis is correct, the claim must have an Occurrence Code of 01 - 05. The claim does not need to be regenerated.

EDIT 95 - VALUE CODE = 15; NEED OCCUR CD = 04

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Value Code of 15 in the UB92 Coding screen and does not have an Occurrence Code of 04.
To Correct: Verify the Value Code is correct. If incorrect, delete code from UB92 Coding screen. If correct, the claim must have an Occurrence Code of 04 in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 96 - DIAGNOSIS REQUIRES OCCUR CD OF 05 OR 24

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Diagnosis Code of 500 - 506 or 508 and does not have an Occurrence Code of 05 or 24 in the UB92 Coding screen.
To Correct: Verify the Diagnosis Code is correct. If incorrect, have Medical Records change on the Grouper screen. The claim will need to be regenerated. If Diagnosis Code is correct, the claim must have either an 05 or 24 Occurrence Code in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 97 - OCCUR DT > STMT "FROM" DATE; OCC CD 01-06 OR 11

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an Occurrence Date greater than the statement "From" date and the Occurrence Code is 01-06 or 11.
To Correct: Verify the correct Occurrence Date and that it is prior to the statement "From" date. Enter the correct date in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 98 - OCCUR CD = 10; CHECK OCCURRENCE DATE

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim that is not Medicare, Medicaid, Blue Cross or Champus has an Occurrence Code of 10 and an Occurrence Date that is less than one year prior to the statement "From" date.
To Correct: Verify correct Occurrence Date and that it is not less than one year prior to statement "From" date. Enter the correct Occurrence Code and date in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 99 - OCCUR CD 42 NOT CONSISTENT WITH BILL TYPE

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an Occurrence Code of 42 and the third character of the Bill Type is not equal to 1, 4 or 7.
To Correct: Verify the Bill Type is correct. If incorrect, it can be changed on the claim's Detail Charges screen. If correct, the claim can not have an Occurrence Code of 42. Delete the Occurrence Code from the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 100 - OCCUR CD 42 DATE NOT = STMT "TO" DATE

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an Occurrence Code of 42, the third character of the Bill Type is equal to 1, 4 or 7, and the Occurrence Date in the UB92 Coding screen is not equal to the statement "To" date.
To Correct: Verify the Bill Type is correct. If incorrect, it can be changed on the claim's Detail Charges screen. If correct, the claim's Occurrence Date must equal the statement "To" date. Change Occurrence Date in the UB92 Coding screen. The claim will not need to be regenerated.

Edits 101 - 200

EDIT 101 - NEED OCCUR CODE 01 - 06 OR 11

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an admission type of 1 or 2, the Diagnosis Code is not 630-67699 or V22-V24, and does not have an Occurrence Code of 01-06 or 11 in the UB92 Coding screen. This edit will pull for M**, B**, X**, S** and C** claims.
To Correct: Verify which Occurrence Code is needed and load in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 102 - NEED OCCUR CODE 01 - 06

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Value Code of 45 and does not have at least one Occurrence Code of 01 - 06 in the UB92 Coding screen.
To Correct: Verify the Value Code is correct. If incorrect, delete the code from the UB92 Coding screen. If correct, the claim must have at least one Occurrence Code of 01 - 06. Verify which Occurrence Code is correct and enter the code in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 103 - NEED OCCUR CD 11 & 35; HAS REV CD 42X

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 74X, 75X or 83X, has charges with Revenue Code 42X, and does not have both Occurrence Codes of 11 & 35 on the UB92 Coding screen.
To Correct: Verify the Bill Type is correct. If incorrect, it can be changed in the claim's Detail Charges screen. If Bill Type and the Revenue Code are correct, the claim must have both Occurrence Codes of 11 and 35 in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 104 - NEED OCCUR CD 11,17 & 44; HAS REV CD 43X

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 74X, 75X or 83X, has charges with Revenue Code 43X, and does not have all three Occurrence Codes 11, 17 & 44 in the UB92 Coding screen.
To Correct: Verify that the Bill Type is correct. If incorrect, it can be changed in the claim's Detail Charges screen. If the Bill Type and Revenue Code are correct, the claim must have Occurrence Codes 11, 17 and 44 in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 105 - NEED OCCUR CD 11 & 45; HAS REV CD 44X

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 74X, 75X or 83X, has charges with Revenue Code 44X, and does not have both Occurrence Codes of 11 & 45 in the UB92 Coding screen.
To Correct: Verify that the Bill Type is correct. If incorrect, it can be changed in the claim's Detail Charges screen. If the Bill Type and Revenue Code are correct, the claim must have both Occurrence Codes 11 and 34 in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 106 - NEED OCCUR CD 11 & 46; HAS REV CD 943

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 74X, 75X or 83X, has charges with Revenue Code 943, and does not have both Occurrence Codes 11 and 46 in the UB92 Coding screen.
To Correct: Verify the Bill Type is correct. If incorrect, it can be changed in the claim's Detail Charges screen. If the Bill Type and the Revenue Code is correct, the claim must have both Occurrence Codes 11 and 46 in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 107 - NEED OCCUR CD 18 OR 19; ESC = 5

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an Employment Status Code of 5, does not have a Value Code of 12-16, 41 or 43 in the UB92 Coding screen, and does not have an Occurrence Code of 18 or 19.
To Correct: Verify that the ESC code and Value Codes are correct. If correct, the claim must have an Occurrence Code of 18 or 19 in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 108 - NEED OCCUR CD 33; HAS COND CD = 06

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Condition Code of 06 and does not have an Occurrence Code of 33 in the UB92 Coding screen.
To Correct: Verify the Condition Code is correct. If incorrect, it can be changed in the UB92 Coding screen. If Condition Code is correct, enter an Occurrence Code of 33 in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 109 - NEED OCCUR CD 33; HAS VALUE CD = 13

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Value Code of 13 in the UB92 Coding screen and does not have an Occurrence Code of 33.
To Correct: Verify that the Value Code is correct. If incorrect, it can be changed in the UB92 Coding screen. If Value Code is correct, the claim must have an Occurrence Code of 33. The claim will not need to be regenerated.

EDIT 110 - INVALID OCCURRENCE SPAN CODE

Locator: 35 - 36 - Occurrence Span Codes
Scenario: The above edit appears if a claim has an Occurrence Span Code on the claim's Stay Information screen and it is not 70 - 78 or MO. When M0, and "O" being alpha, the edit will pull. When M0, and "0" is numeric the edit will not pull.
To Correct: Verify the correct Occurrence Span Code and load in the Stay Information screen of the claim. The claim will not need to be regenerated.

EDIT 111 - OCC SPAN "MO" HAS BEGIN DATE PRIOR TO ADMISSION

Locator: 35 - 36 - Occurrence Span Codes
Scenario: The above edit appears if a claim has an Occurrence Span Code of "MO" and the begin date is prior to the admission date in the claim's Stay Information screen.
To Correct: Verify the correct Occurrence Span Code begin date and load in the Stay Information screen of the claim. The claim will not need to be regenerated.

EDIT 112 - NEED OCCUR SPAN CODE OF "MO" WITH COND "C3"

Locator: 35 - 36 - Occurrence Span Codes
Scenario: The above edit appears if a Commercial, Champus, or Workman's Comp claim has a Condition Code of C3 and does not have an Occurrence Span Code of "MO" in the claim's Stay Information screen.
To Correct: Verify the Condition Code is correct. If incorrect, change in the UB92 Coding screen. If correct, enter Occurrence Span Code of "MO" in the Stay Information screen. The claim will not need to be regenerated.

EDIT 113 - NEED OCCUR SPAN CODE OF 70-78 WITH COND "C3"

Locator: 35 - 36 - Occurrence Span Codes
Scenario: The above edit appears if a Medicare claim has a Condition Code of "C3" and does not have an Occurrence Span Code of 70-78 in the claim's Stay Information screen.
To Correct: Verify the Condition Code is correct. If incorrect, change in the UB92 Coding screen. If correct, enter Occurrence Span Code of 70-78 in the Stay Information screen. The claim will not need to be regenerated.

EDIT 114 - OCCUR SPAN "THRU" DATE LESS THAN "FROM" DATE

Locator: 35 - 36 - Occurrence Span Codes
Scenario: The above edit appears if a claim has an Occurrence Span "Thru" date prior to the span "From" date on the claim's Stay Information screen - Prior Stay.
To Correct: Verify the "From" and "Thru" dates. Enter the correct dates in the Stay Information screen - Prior Stay for the claim. The claim will not need to be regenerated.

EDIT 115 - MISSING DATE FOR OCCURRENCE SPAN

Locator: 35 - 36 - Occurrence Span Codes
Scenario: The above edit appears if a claim has an Occurrence Span Code in the Stay Information screen - Prior Stay and is missing a date.
To Correct: Verify the dates are correct and load in the Stay Information screen for the claim. If the Occurrence Span Code is not needed, delete from the Stay Information screen - Prior Stay. The claim will not need to be regenerated.

EDIT 116 - SPAN "THROUGH" DATE LESS THAN SPAN "FROM" DATE

Locator: 35 - 36 - Occurrence Span Codes
Scenario: The above edit appears if a claim has an Occurrence Span "Thru" date prior to the Occurrence Span "From" date on the claim's Stay Information screen - Prior Stay.
To Correct: Verify the correct Occurrence Span dates and correct on the Stay Information screen - Prior Stay for the claim. The claim will not need to be regenerated.

EDIT 117 - OCCUR SPAN "FROM" DATE > ADMIT DATE

Locator: 35 - 36 - Occurrence Span Codes
Scenario: The above edit appears if a Champus claim has an Occurrence Span "From" date on the claim's Stay Information screen - Prior Stay prior to the admission date of the patient.
To Correct: Verify the correct "From" date and enter in the Stay Information screen - Prior Stay. The claim will not need to be regenerated.

EDIT 118 - MISSING ICN # FOR MEDICARE CLAIM

Locator: 37
Scenario: The above edit appears if a Medicare claim has a Bill Type of XX7 or XX8 and is missing an ICN# in the Stay Information screen for the claim.
To Correct: Verify the Bill Type is correct. If incorrect, change on the claim's Detail Charges screen. If correct, enter the Internal Control Number on the Stay Information screen. The claim will not need to be regenerated.

EDIT 119 - MISSING RESPONSIBLE PARTY NAME

Locator: 38 - Responsible Party Name
Scenario: The above edit appears if a claim is missing the subscriber's name and address on the Policy Information screen for the claim.
To Correct: Verify the correct subscriber's name and address and enter in the Policy Information screen of the claim. The claim will not need to be regenerated.

EDIT 120 - INVALID VALUE CODE ON ACCOUNT

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim that is not Commercial and has a Value Code that is not one of the following: 01, 02, 04-06, 08-16, 21-24, 30, 31, 37-53, 56-60, 68, A1-A3, B1-B3, C1-C3 or D3 on the UB92 Coding screen of the claim.
To Correct: Verify a Value Code is needed. If the code is not needed, delete code from the UB92 Coding screen of the claim. If code is required, then it must be one of the valid Value Codes listed above. The claim will not need to be regenerated.

EDIT 121 - VALUE CODE HAS NO VALUE AMOUNT

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Value Code loaded on the UB92 Coding screen and has no amount loaded.
To Correct: Verify the Value Code is needed. If not needed, remove the code from UB92 Coding screen of the claim. If the Value Code is required, the amount must be entered. The claim will not need to be regenerated.

EDIT 122 - VALUE AMOUNT HAS NO VALUE CODE

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a value amount loaded in the UB92 Coding screen and has no code loaded.
To Correct: Verify the Value Code is needed. If not needed, remove the amount from UB92 Coding screen of the claim. If the Value Code is required, it must be entered with the amount. The claim will not need to be regenerated.

EDIT 123 - HAS MORE THAN ONE OF VALUE CODES A1, B1, C1

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a Medicare Inpatient claim has more than one of the following Value Codes: A1, B1 or C1 in the UB92 Coding screen of the claim.
To Correct: Verify the correct Value Code and delete the codes that are not needed from the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 124 - NEED VALUE CD 23 FOR MEDICAID SECONDARY CLAIM

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a Medicaid Secondary claim is missing Value Code 23 from the UB92 Coding screen.
To Correct: Verify the Value Code amount. Enter Value Code 23 and the amount in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 125 - NEED VALUE CODE 05 DUE TO REVENUE CODES

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has Revenue Codes 96X (except 964), 97X, or 98X, and does not have a Value Code of 05 and value amount in the UB92 Coding screen.
To Correct: Verify the correct value amount and load Value Code 05 and the amount in the UB92 Coding screen for the claim. The claim will not need to be regenerated.

EDIT 126 - VALUE CD 05 AMT NOT = SUM OF 96X, 97X, 98X

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has Revenue Codes 96X, 97X (except 978) or 98X and the Value Code 05 amount is not equal to the sum of the listed Revenue Codes.
To Correct: Verify the correct value amount and load the amount with Value Code 05 in the UB92 Coding screen of the claim. The claim will not need to be regenerated.

EDIT 127 - MEDICARE SECONDARY OR TERTIARY- NEED VALUE CODE

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a Medicare secondary or tertiary claim does not have one of the following Value Codes loaded in the UB92 Coding screen: 12, 13, 14, 15, 16, 41, 42 or 43.
To Correct: Verify which Value Code is needed and enter in the UB92 Coding screen for the Medicare secondary or tertiary claim. The claim will not need to be regenerated.

EDIT 128 - OCCUR CD 01,02,03, OR 04 LISTED; NEED VALUE CODE

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has an Occurrence Code of 01, 02, 03 or 04 and does not have one of the following Value Codes in the UB92 coding screen: 12, 13, 14, 15, 16, 41, 42 or 43.
To Correct: Verify which Value Code is needed and enter in the UB92 Coding screen for the Medicare secondary or tertiary claim. The claim does not need to be regenerated.

EDIT 129 - COND CD = 10; CANNOT HAVE VALUE CD = 12,13, OR 43

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Condition Code of 10 in the UB92 Coding screen and has Value Codes 12, 13 or 43.
To Correct: Verify the Condition Code is correct. If incorrect, delete the code from the UB92 Coding screen. If Condition Code is correct, delete the Value Code 12, 13 or 43 from the Coding screen. The claim does not need to be regenerated.

EDIT 130 - COND CD = 09; CANNOT HAVE VALUE CD = 12,15,41 OR 43

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Condition Code of 09 in the UB92 Coding screen and has Value Codes 12, 15, 41 or 43.
To Correct: Verify the Condition Code is correct. If incorrect, delete the code from the UB92 Coding screen. If the Condition Code is correct, delete the Value Code 12, 15, 41 or 43 from the Coding screen. The claim does not need to be regenerated.

EDIT 131 - MISSING VALUE CODE; HAS REV CD = 380, 381, OR 382

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has Revenue Codes 380, 381 or 382 and does not have both Value Codes 37 and 38 in the UB92 Coding screen.
To Correct: Verify the value amount. Load Value Code 37 and 38 and the value amount in the UB92 Coding screen. The claim does not need to be regenerated.

EDIT 132 - HAS VALUE CD = 06; NEEDS VALUE CD 37, 38, OR 39

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Value Code of 06 and does not have a Value Code of 37, 38 or 39 in the UB92 Coding screen.
To Correct: Verify Value Code 06 is required. If it’s not required, delete code from the UB92 Coding screen. If Value Code 06 is required, Value Codes 37, 38 or 39 should be entered.

EDIT 133 - VALUE CODE 38 AMOUNT > (VALUE CODE 39 AMT LESS 3)

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a Medicare claim has an amount for Value Code 38 greater than the Value Code 39 amount minus 3 in the UB92 Coding screen.
To Correct: Verify the correct value amount for Value Codes 38 and 39. Enter the correct amount in the UB92 Coding screen for the claim. The claim does not need to be regenerated.

EDIT 134 - VALUE CODE 38 AMOUNT > VALUE CODE 37 AMOUNT

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim that is not Medicare, Blue Cross or Medicaid has a Value Code 38 amount greater than Value Code 37 amount on the UB92 Coding screen.
To Correct: Verify the correct value amount for Value Codes 38 and 37. Enter the correct amounts in the UB92 Coding screen. The claim does not need to be regenerated.

EDIT 135 - VAL CD 08 OR 10 ENTERED; LIFE DAYS NOT > 0

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Value Code of 08 or 10 in the UB92 Coding screen and does not have Life Reserve Days greater than zero in the claim's Detail Benefits screen.
To Correct: Verify the correct amount of Life Reserve days and load in the Detail Benefits screen of the claim. The claim will need to be regenerated.

EDIT 136 - VAL CD 09 OR 11 ENTERED; COINS DAYS NOT >0

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Value Code of 09 or 11 in the UB92 Coding screen and does not have Co-Insurance days greater than zero in the claim's Detail Benefits screen.
To Correct: Verify the correct amount of Co-Insurance days and load in the Detail Benefits screen for the claim. The claim will need to be regenerated.

EDIT 137 - VALUE CODE 50 INVALID FOR BILL TYPE 18X

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has Value Code of 50 in the UB92 Coding screen and has a Bill Type of 18X.
To Correct: Verify the Bill Type is correct. If incorrect, it can be changed in the claim's Detail Charges screen. If Bill Type is correct, the Value Code of 50 needs to be deleted from the UB92 Coding screen. The claim does not need to be regenerated.

EDIT 138 - MISSING VALUE CODE 06, 37 OR 38 FOR BLOOD CHARGES

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a Medicare or Medicaid claim has charges with Revenue Code 38X and does not have a Value Code of 06, 37, or 38 in the UB92 Coding screen.
To Correct: Verify the correct Value Code and amount and enter in the UB92 Coding screen. The claim does not need to be regenerated.

EDIT 139 - MISSING VALUE CODE 37 or 38 FOR BLOOD CHARGES

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a Medicare or Medicaid claim has charges with Revenue Code 380, 381 or 382 and does not have a Value Code of 37 or 38 in the UB92 Coding screen.
To Correct: Verify the correct Value Code and amount and enter in the UB92 Coding screen. The claim does not need to be regenerated.

EDIT 140 - CANNOT HAVE VALUE CD 43 WITH COND CD 11

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Value Code of 43 and Condition Code of 11 in the UB92 Coding screen.
To Correct: Verify which Value Code is required (either 43 or 11). Delete the Value Code that is not needed in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 141 - MISSING VALUE CODE 68

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has charges for Revenue Codes 634 or 635, the Bill Type is 11X, 13X or 72X, and is missing Value Code 68 in the UB92 Coding screen.
To Correct: Verify that Value Code 68 is entered in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 142 - MISSING VALUE CODE 48 OR 49

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has charges for Revenue Codes 634 or 635, the Bill Type is 11X, 13X or 72X, and is missing Value Codes 48 or 49 in the UB92 Coding screen.
To Correct: Verify the Value Code is correct and enter in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 143 - MISSING VAL CD 50 OR VALUE AMOUNT TOO SMALL

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 74X, 75X or 83X, has charges with Revenue Code 42X, is missing a Value Code of 50, or the Value Code amount is not greater than or equal to the sum of the charges for Revenue Code 42X.
To Correct: If Value Code 50 is entered, verify the amount is greater than or equal to the sum of the charges for Revenue Code 42X. The claim will need to be regenerated.

EDIT 144 - MISSING VAL CD 51 OR VALUE AMOUNT TOO SMALL

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 74X, 75X or 83X, has charges with Revenue Code 43X, is missing Value Code 51, or the Value Code amount is not greater than or equal to the sum of the charges for Revenue Code 43X.
To Correct: If Value Code 51 is entered, verify the amount is greater than or equal to the sum of the charges for Revenue Code 43X. The claim will need to be regenerated.

EDIT 145 - MISSING VAL CD 52 OR VALUE AMOUNT TOO SMALL

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 74X, 75X or 83X, charges for Revenue Code 44X and is either missing Value Code of 52 or the Value Code amount is not greater than or equal to the sum of the charges for Revenue Code 44X.
To Correct: If Value Code 52 is entered, verify the amount is greater than or equal to the sum of the charges for Revenue Code 44X. The claim will need to be regenerated.

EDIT 146 - MISSING VAL CD 53 OR VALUE AMOUNT TOO SMALL

Locators: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 74X, 75X or 83X, charges for Revenue Code 943 and is either missing Value Code of 53, or the Value Code amount is not greater than or equal to the sum of the charges for Revenue Code 943.
To Correct: Verify Value Code 53 is entered and the amount is greater than or equal to the sum of the charges for Revenue Code 943. The claim will need to be regenerated.

EDIT 147 - VALUE AMOUNT GREATER THAN TOTAL CHARGES

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Value Code of any of the following: 05, 12, 13, 14, 15, 16, 41, 42 or 43 and the value amount is greater than the total charges.
To Correct: Verify the Value Code is required. If the code is required, enter the amount of the Value Code. Verify the value amount is not greater than the total charges. The claim will not need to be regenerated.

EDIT 148 - VALUE CD = 37,38,39,50,51,52,53, OR 68; CENTS > 0

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Value Code of 37 - 39, 50 - 53 or 68 and the cents portion of the value amount is greater than zero.
To Correct: Verify the Value Code is required. If the code is required, enter the amount of the Value Code. Verify the code is not greater than zero. The claim will not need to be regenerated.

EDIT 149 - COND CD = D7; NEED VALUE CODE

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Condition Code of D7 and does not have one of the following Value Codes: 12, 13, 14, 15, 16, 41, 42, 43 or 47 in the UB92 Coding screen.
To Correct: Verify the Condition Code is correct. If incorrect, then delete Condition Code from the UB92 Coding screen of the claim. If Condition Code is correct, then one of the Value Codes listed needs to be entered in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 150 - COND CD = D7; VALUE CODE HAS AMOUNT = 0

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Condition Code of D7 and has value amount equal to zero for the following Value Codes: 12, 13, 14, 15, 16, 41, 42, 43 or 47 in the UB92 Coding screen.
To Correct: Verify the Condition Code is correct. If incorrect, delete the Condition Code from the UB92 Coding screen. If correct, the value amount for the listed Value Codes has to be greater than zero. The claim will not need to be regenerated.

EDIT 151 - COND CD = D8; BAD VALUE CODE LISTED

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Condition Code of D8 and also has a Value Code of 12, 13, 14, 15, 16, 41, 42, 43 or 47 in the UB92 Coding screen.
To Correct: Verify the Condition Code is correct. If incorrect, delete code from the UB92 Coding screen. If code is correct, the Value Code listed is invalid with this Condition Code. Delete Value Code from UB92 Coding screen. The claim will not need to be regenerated.

EDIT 152 - HAVE VALUE CODE 37,38, OR 39; NEED VALUE CODE 06

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Value Code of 37, 38 or 39 and does not have a Value Code of 06 in the UB92 Coding screen.
To Correct: Verify the Value Code amount. Enter Value Code 06 and the amount in the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 153 - HAS VALUE CODES 01 AND 02

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a Commercial or Workman's Compensation claim has a Value Code of 01 and 02 in the UB92 Coding screen.
To Correct: Verify which Value Code is the correct code (01 or 02.) Delete the invalid code from the UB92 Coding screen. The claim will not need to be regenerated.

EDIT 154 - COND CD OR PRIN DIAG FOR REV CDS 636 AND 771

Locator: 42 - Revenue Code
Scenario: The above edit appears if the following criteria is not met: Condition Code "A6" is entered in the UB92 Coding screen for a claim, the Principal Diagnosis "V0481" must be present in the Grouper screen, and a charge with Revenue Code 636 or 771 must be entered. Also, the "From" date in statement covers period must be 10/01/03 or After.
To Correct: Verify which of the above is missing. Then load in Stay Information, claim's Detail Charges screen or UB92 Coding screen.

EDIT 155 - PRIN DIAG NOT = 585; CAN'T HAVE LISTED REV CD

Locator: 42 - Revenue Code
Scenario: The above edit appears if a claim has charges with Revenue Codes 820 - 825, 829-835, 839-846, 849-856, 859, 880, 881 or 889 and the Principal Diagnosis Code is not equal to 585.
To Correct: Verify that the charges are correct. If incorrect, have Data Processing back off charges and then regenerate the claim. If charges are correct, the Principal Diagnosis must be 585. Have Medical Records change Principal Diagnosis Code in the Grouper screen and regenerate the claim.

EDIT 157 - NEED ROOM CHARGE SUMMARY CODE WITH THIS BILL TYPE

Locator: 42 - Revenue Code
Scenario: The above edit appears if the following criteria is not met: A claim has a Bill Type of 11X, 18X, or 21X and does not have any of the following Revenue Codes: 10X, 11X, 12X, 13X, 14X, 15X, 16X, 17X, 18X, 20X or 21X.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify Account has Room Charges. If not, have Data Processing enter Charges and then regenerate claim.

EDIT 158 - PRIN DIAG = 585; REV CD LISTED IS NOT ALLOWED

Locator: 42 - Revenue Code
Scenario: The above edit appears if a Medicare claim has a Principal Diagnosis Code of 585 and Revenue Codes other than the following: 250-259, 634, 635, 636, 820-825, 829-835, 839-846, 849-856, 859, 880, 881 or 889. Also the Bill Type is 72X.
To Correct: Verify that the Principal Diagnosis is correct. If correct, then the only valid Revenue Codes are those listed. If Revenue Codes or Principal Diagnosis Code is changed, the claim will need to be regenerated.

EDIT 159 - INVALID REVENUE CODE FOR BILL TYPE 12X

Locator: 42 - Revenue Code
Scenario: The above edit appears if a claim has a Bill Type of 12X and does not have one of the following Revenue Codes: 272, 274, 275, 30X, 31X, 32X, 33X, 34X, 35X, 401, 402, 42X, 43X, 44X, 460, 461, 48X, 610, 612, 619, 73X, 74X, 80X or 921.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify Account has at least one charge with the above Revenue Codes. If not, have Data Processing enter Charges and then regenerate the claim.

EDIT 160 - INVALID REVENUE CODE FOR BILL TYPE 14X

Locator: 42 - Revenue Code
Scenario: The above edit appears if a claim has Bill Type of 14X and does not have charges for Revenue Code 254, 255, 30X, 31X, 32X, 241, 35X, 40X or 46X.
To Correct: Verify the Bill Type is correct. If incorrect, it can be changed in the claim's Detail Charges screen. If the Bill Type is correct, the only valid Revenue Codes that the claim can have are the ones listed. Have Data Processing correct the charges and regenerate the claim.

EDIT 161 - HAS REV CD = 38X; VALUE AMTS FOR 37 AND 39 EQUAL

Locator: 42 - Revenue Code
Scenario: The above edit appears if a claim has Value Codes 37 and 39, the amounts for each code are equal, and there are charges with Revenue Code 38X.
To Correct: Verify Value Codes and amounts are correct. If not, change codes and amounts in the UB92 Coding screen. If they are correct, then the charges with Revenue Code 38X have to be backed off the account detail and the claim must be regenerated.

EDIT 162 - ROOM REV CODE INCONSISTENT WITH VALUE CODE 02

Locator: 42 - Revenue Code
Scenario: The above edit appears if a Champus claim has a Value Code 02 and charges for Revenue Codes 120-139 or 150-159.
To Correct: Verify Value Code in the UB92 Coding screen is correct. If incorrect, delete from the Coding screen. If correct, the room charges on the claim cannot be Revenue Codes 120-139 or 150-159. Have Data Processing correct the charges and regenerate the claim.

EDIT 163 - VALUE CD 05; NEED REV CD 96X, 97X, OR 98X

Locator: 42 - Revenue Code
Scenario: The above edit appears if a Champus claim has Value Code 05 and does not have charges with Revenue Codes 96X, 97X or 98X.
To Correct: Verify Value Code is correct. If incorrect, delete code from the UB92 Coding screen. If code is correct, the charges on the claim must be for Revenue Codes 96X, 97X or 98X. Have Data Processing enter charges and regenerate the claim.

EDIT 164 - REVENUE CODE 762 INVALID FOR CHAMPUS CLAIMS

Locator: 42 - Revenue Code
Scenario: The above edit appears if a Champus claim has charges with Revenue Code 762.
To Correct: Verify the correct charges and have Data Processing correct through patient Charging. The claim will need to be regenerated.

EDIT 165 - VALUE CD 38 LISTED BUT NO CHARGES FOR REV CD 38X

Locator: 42 - Revenue Code
Scenario: The above edit appears if a claim has Value Code 38 entered in the UB92 Coding screen and no charges with Revenue Code 38X.
To Correct: Verify Value Code is correct. If not, delete the Value Code in the UB92 Coding screen. If Value Code is correct and the Charge is missing, have Data Processing enter the correct charge. The claim needs to be regenerated.

EDIT 166 - PHARMACY CANNOT BE THE ONLY SERVICE BILLED

Locator: 42 - Revenue Code
Scenario: The above edit appears if a Blue Cross claim has only charges with Revenue Code 25X.
To Correct: Verify other charges that are needed. Revenue Code 25X cannot be the only charges on the claim. Have Data Processing correct charges through patient Charging. Then regenerate the claim.

EDIT 167 - HAS REV CD 99X; TYPEBILL = 12X, 13X, 14X, or 83X

Locator: 42 - Revenue Code
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 14X or 83X and has any 99X Revenue Codes (excluding 996 and 997).
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify what charge had the Invalid Revenue Code. Either back off the incorrect item or change Revenue Code in the Summary Code Table for that item. Regenerate the claim.

EDIT 168 - HCPC CODE NEEDS A MODIFIER

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a Medicaid or Blue Cross claim has charges for Revenue Code 360 and the items are missing modifiers associated with the CPT codes.
To Correct: Verify which items are for Revenue Code 360 and load the modifiers in the Item Master directly after the CPT code. The claim will need to be regenerated.

EDIT 169 - NEED HCPC CODE WITH LISTED REV CDS AND BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 23X, 74X, 75X or 83X and has any one of the following Revenue Codes: 45X, 46X, 48X, 490, 51X, 73X, 74X, 75X or 92X and the items do not have CPT codes in the Item Master.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with the above Revenue Codes and the items have CPT codes in the Item Master. If the items are missing CPT codes, load the CPT code in the Item Master and regenerated the claim.

EDIT 170 - BILL TYPE SHOULD BE 13X, 14X, OR 83X W/REV & HCPC

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has charges with Revenue Codes: 471, 481, 482, 730, 732, 921, 922, 32X-35X, 40X, 46X, 61X, 74X or 75X and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the charges are correct. If incorrect, have Data Processing correct through patient Charging and regenerate the claim. If correct, then the Bill Type needs to be changed on the Detail Charges screen of the claim to 13X, 14X or 83X. The claim will not need to be regenerated.

EDIT 171 - NEED HCPC CODE WITH REVENUE CD = 274

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 23X, 74X, 75X or 83X, charged with Revenue Code 274, and does not have a CPT code.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has a charge with Revenue Code 274. Verify that the item has a CPT code loaded in Item Master. If it is missing, load the CPT in the Item Master and regenerate the claim.

EDIT 172 - NEED HCPC CODE WITH REVENUE CD = 277

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X or 83X and an item is charged with Revenue Code 277 without a CPT code loaded in the Item Master.
To Correct: Verify Bill Type is Correct. If not, change Bill Type in the Detail Charges screen. If Value Code is correct, and the Charge is missing, have Data Processing enter the correct charge. The claim needs to be regenerated.

EDIT 173 - NEED VALID LAB HCPC CODE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X, 72X or 83X and has Revenue Codes 30x or 31X, and does not have a valid CPT code in the Item Master. A valid CPT code is 80002 – 89399, 99195 or any of the following: P2038, P3000, P3001, P7001, P9604, G0001 or G0103.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify what charge had valid Revenue Code with invalid CPT code. Load the valid CPT code in the Item Master and then regenerate the claim.

EDIT 174 - NEED VALID RADIOLOGY HCPC CODE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X or 83X, has any one of the following Revenue Codes: 32X, 333, 340, 341, 342, 344, 345, 346, 347, 348, 349, 35X, 40X or 61X, and does not have a CPT code of 70000-79999 in the item master.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with the above Revenue Codes and the items have valid CPT codes in the Item Master. If the items are missing CPT codes, load the CPT code in the Item Master and regenerate the Claim.

EDIT 175 - NEED ASC HCPC CD OR ICD9 V641 - V642 W/REV CD = 36X

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X or 83X, is charged with Revenue Code 36X, and does not have either a valid CPT code or ICD9 Diagnosis Code V641 - V643.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has a charge with Revenue Code 36X, a valid CPT code in the Item Master, or one of the ICD9 Diagnosis Codes. If the item is missing a CPT code, load it in the Item Master and regenerate the claim. If the ICD9 code is missing, have Medical Records correct it in the Grouper screen. Regenerate the claim.

EDIT 176 - NEED ASC HCPC - O/P SURGICAL PROCEDURE CD LISTED

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X or 83X and one of the following procedure codes are listed in the Medical Records Grouper screen: 132, 133, 586, 863, 0391, 0392, 0443, 1259, 1319, 1341, 1359, 1361, 1364, 1366, 1369, 1371, 1372, 1424, 1434, 1699, 2103, 3322, 3324, 3491, 3899, 4131, 4292, 4413, 4414, 4513, 4523-4525, 4541, 4823, 5302, 5732, 5794, 5795, 6011, 6909, 7902, 8512, 8521, 8611, 8622 or 8659, and a valid ASC Revenue Code without a valid ASC CPT code is in the Item Master.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has a procedure code listed above. If so then verify that the valid ASC Revenue Code has a valid ASC CPT code loaded in Item Master. If any information is missing, load in appropriate tables and regenerate the claim.

EDITS 177 - HAS REV CD = 636; BILL TYPE = 72X; NEED HCPC CODE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if the following criteria are not met: A claim has a Bill Type of 72X and a charge with Revenue Code 636. The claim must have one of the CPT codes in the Item Master listed in Appendix A (attached.)
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has the correct charges with Revenue Code 636. If charges are correct, verify those items have one of the CPT codes listed in Appendix A is in the Item Master. If any information is missing, load in appropriate tables. Regenerate the insurance claim.

EDIT 178 - NEED CPT CD P9010 WITH REV CD 382

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 72X and a Revenue Code of 382 and does not have a CPT code in the Item Master of P9010.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has at least one charge item with the above Revenue Code. If not, have Data Processing enter charge. If charge is on account detail, verify the item has a CPT of P9010 loaded in the Item Master. If CPT is missing, load in Item master and regenerate the claim.

EDIT 179 - NEED CPT CD P9012 WITH REV CD 387

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 72X and a Revenue Code of 387 and does not have a CPT code in the Item Master of P9012.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has at least one charge item with the above Revenue Code. If not, have Data Processing enter the charge. If charge is on account detail, verify the item has a CPT of P9012 loaded in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

EDIT 180 - NEED CPT CD P9013 WITH REV CD 386

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 72X, Revenue Code of 386, and does not have a CPT code in the Item Master of P9013.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has at least one charge item with the above Revenue Code. If not, have Data Processing enter charge. If charge is on account detail, verify the item has a CPT of P9013 loaded in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

EDIT 181 - NEED CPT CD P9017 OR P9018 WITH REV CD 383

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 72X, a Revenue Code of 383, and does not have a CPT code in the Item Master of P9017 or P9018.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has at least one charge item with the above Revenue Code. If not, have Data Processing enter charge. If charge is on account detail, verify the item has a CPT of P9010 or P9018 loaded in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

EDIT 182 - NEED CPT CD P9019 WITH REV CD 384

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 72X, a Revenue Code of 384, and does not have a CPT code in the Item Master of P9019.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify Account has at least one charge item with the above Revenue Code. If not, have Data Processing enter charge. If charge is on account detail, verify the item has a CPT of P9019 loaded in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

EDIT 183 - NEED CPT CD P9021 WITH REV CD 381

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 72X, a Revenue Code of 381, and does not have a CPT code in the Item Master of P9021.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has at least one charge item with the above Revenue Code. If not, have Data Processing enter charge. If charge is on account detail, verify the item has a CPT of P9010 loaded in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

EDIT 184 - NEED CPT CD P9022 WITH REV CD 380

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 72X, a Revenue Code of 380, and does not have a CPT code in the Item Master of P9022.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim Detail Charges screen. If Bill Type is correct, verify account has at least one charge item with the above Revenue Code. If not, have Data Processing enter charge. If charge is on account detail, verify the item has a CPT of P9022 loaded in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

EDIT 185 - NEED SPECIAL CPT CD WITH REV CD 390

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if the following criteria is not met: A claim has a Bill Type of 72X, a Revenue Code of 390, and it does not have at least one of the following CPT codes loaded in the Item Master for charges entered:
86021, 86022, 86023, 86038, 86060, 86063, 86140, 86155, 86171, 86185, 86287, 86289, 86290, 86291, 86293, 86295, 86296, 86299, 86311, 86353, 86382, 86403, 86590, 86592, 86593, 86687, 86689 or 86800.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify what charge was for the Revenue Code 390 and verify that there is one of the above listed CPT codes in the Item Master. If item is missing a CPT code, load in Item Master and regenerate the claim.

EDIT 186 - CPT 66983 - 66986 ALLOWED WITH REV CD 276 ONLY

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X or 83X, has a CPT code of 66983 - 66986 loaded in the Item Master, and does not have Revenue Code 276.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with the above CPT codes and the Revenue Code associated with those items is 276. If charge is on account detail, verify the item has correct CPT loaded in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

Edit 187 - CPT 66983 - 66986 W/BILL TYPE 13X, 83X ONLY

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with CPT codes 66983 - 66986 and the Bill Type is not 13X or 83X.
To Correct: Verify CPT codes are correct for the items charged. If incorrect, then delete from Item Master and regenerate the claim. If CPT codes are correct, then change the Bill Type in the Detail Charges screen for the claim. The claim does not have to be regenerated.

EDIT 188 - CPT ONLY ALLOWED WITH REVENUE CODE 46X

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X, or 83X, has a Revenue Code of 46X, and is not charged with an item with any of the following CPT codes:
94010, 94060, 94070, 94150, 94160, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94400, 94450, 94620, 94680, 94681, 94690, 94720, 94725, 94750, 94760, 94761, 94762 or 94770.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above CPT code in the Item Master. Verify the Revenue Code associated with those items is 46X. Load missing information in appropriate tables and regenerate the claim.

EDIT 189 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with Revenue Code 46X and any of the following CPT codes:
94010, 94060, 94070, 94150, 94160, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94400, 94450, 94620, 94680, 94681, 94690, 94720, 94725, 94750, 94760, 94761, 94762 or 94770 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, then the above CPT codes are not allowed with a Bill Type other than 13X, 14X or 83X. Delete CPT codes from the items and regenerate the claim.

EDIT 190 - CPT ONLY ALLOWED WITH REVENUE CODE 471

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has CPT codes 92541 - 92547, 92552, 92553, 92555 - 92557, 92561 - 92565, 92567 - 92569, 92571 - 92578, 92580, 92582 - 92585, 92589 or 92596, and the Revenue Code associated with those items is not 471.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 471. If any information is missing, load in appropriate tables and regenerate claim.

EDIT 191 - CPT ONLY ALLOWED WITH REVENUE CODE 75X.

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has CPT codes 91000, 91010, 91011, 91012, 91030, 91032, 91033, 91052, 91055, 91060, 91065 or 91122, and the Revenue Code is not 75X.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with Revenue Code 75X and those items have the above listed CPT codes in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

EDIT 192 - CPT ONLY ALLOWED WITH REVENUE 730

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has CPT code 93005, 93024, 93041, 93202, 93208, 93210 and 93221, and the Revenue Code associated with those items is not 730.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with the above CPT codes and the Revenue Code associated with those items is 730. Verify which information is missing and load in appropriate tables and regenerate the claim.

EDIT 193 - CPT 9301/93014 ONLY ALLOWED WITH REV CODE 732

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, an item with a CPT 93012 or 93014, and the Revenue Code is not 732.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 732. If any information is missing, load in the appropriate tables and regenerate the claim.

EDIT 194 - CPT 93012/93014 NOT ALLOWED WITH BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has charges with CPT code 93012 or 93014 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, the items charged cannot have CPT codes 93012 or 93014. Delete the CPT code from the items and regenerate the claim.

EDIT 195 - CPT 93017/93015 ONLY ALLOWED WITH REV CODE 482

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has an item with a CPT of 93017 or 93015, and the Revenue Code is not 482.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 482. If any information is missing, load in appropriate tables and regenerate claim.

EDIT 196 - CPT 93017/93015 NOT ALLOWED WITH BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with CPT code 93017 or 93015 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, the items charged cannot have CPT codes 93017 or 93015 on the claim. Delete the CPT codes from the item master and regenerate the claim.

EDIT 197 - CPT ONLY ALLOWED WITH REVENUE CODES 480 & 481

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has a CPT code of 93501, 92505, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93555, 93556, 93561, 93562 or Q0035, and the Revenue Code is not 480 or 481.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with above listed CPT codes. Verify the Revenue Codes are 480 or 481. Verify any missing information and load in appropriate tables. Regenerate the claim.

EDIT 198 - CPT ONLY ALLOWED WITH REVENUE CODE 731

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has CPT codes 93225, 93226, 93231, 93232 or 93236, and the Revenue Code associated with those items is not 731.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with the above CPT codes and the Revenue Code associated with those items is 731. Verify which information is missing and load in appropriate tables and regenerate the claim.

EDIT 199 - CPT ONLY ALLOWED WITH REV CODE 480

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has CPT codes 93307, 93308, 93312, 93314, 93320, 93321, 93325, 93350, 93600, 93602, 93603, 93607, 93609, 93610, 93612, 93615, 93616, 93618, 93619, 93620, 93624, 93631, 93640, 93641 or 93642, and the Revenue Code is not 480.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 480. If any information is missing, load in appropriate tables and regenerate the claim.

EDIT 200 - CPT ONLY ALLOWED WITH REV CODE 921

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has any of the following CPT codes: 54240, 93721, 93731, 93732 - 93738, 93740, 93770, 93875, 93880, 93882, 93886, 93888, 93922 - 93926, 93930, 93931, 93965, 93970, 93971, 93975, 93976, 93978, 93979, 93980 or 93981, and the Revenue Code associated with any of these items is not 921.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 921. If any information is missing, load in the appropriate tables and regenerate the claim.

Edits 201 - 300

EDIT 201 - CPT ONLY ALLOWED WITH REVENUE CODE 73X

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has any charge item with a CPT code of 93255, 93268 or 93278, and the Revenue Code is not 73X.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with above listed CPT codes. Verify the Revenue Code is 73X. Any missing information should be loaded in appropriate tables the claim should be regenerated.

EDIT 202 - CPT ONLY ALLOWED WITH REV CODE 74X

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, is with an item with any of the following CPT codes:
95816, 95817, 95819, 95821 - 95824, 95826, 95827, 95829, 95920, 95933, 95950, 95951, 95953 -95956, 95958, 95961 or 95962, and the Revenue Code is not 74X.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 74X. If any information is missing, load in the appropriate tables and regenerate the claim.

EDIT 203 - CPT ONLY ALLOWED WITH REV CODE 922

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, is charged with an item with any of the following CPT codes:
95842, 95858, 95860, 95861, 95863, 95864, 95867, 95868, 95869, 95872, 95875, 95900, 95904, 95925, 95935 or 95937, and the Revenue Code is not 922.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 922. If any information is missing, load in the appropriate tables and regenerate the claim.

EDIT 204 - CPT ONLY ALLOWED WITH REV CODES 74X AND 920

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, charged with an item that has a CPT code of 95805, 95807, 95808 or 95810, and the Revenue Code is not 74X or 920.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 74X or 920. If any information is missing, load in the appropriate tables and regenerate the claim.

EDIT 205 - CPT ONLY ALLOWED WITH REVENUE CODE 920

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has any charge item with one of the following CPT codes:
51736, 51741, 51792, 51795, 51797, 54250, 59020, 59025, 92060, 92065, 92081, 92082, 92083, 92235, 92250, 92265, 92270, 92275, 92280, 92283, 92284, 92285 or 92286, and the Revenue Code is not 920.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with above listed CPT codes and Revenue Code of 920. Verify any missing information and load in appropriate tables. Regenerate the claim.

EDIT 206 - CPT ONLY ALLOWED WITH REV CODE 924

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has any item with any of the following CPT codes: 95004, 95024, 95027, 95028, 95044, 95052, 95056, 95060, 95065, 95070, 95071 or 95078, and the Revenue Code is not 924.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 924. If any information is missing, load in the appropriate tables and regenerate the claim.

EDIT 220 - NEED HCPC CODE WITH REV CD 636 FOR BILL TYPE 11X

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 11X, the item was charged with Revenue Code 636, and does not have a CPT code.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with Revenue Code 636 and a CPT code loaded in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

EDIT 221 - INVALID CPT WITH BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim with service dates after 10/16/91 has items charged with any of the following CPT codes:
90100-90170, 90300-90370, 90400-90470, 90590, 90699, 90750-90778,
90781, 90935-90999, 93000, 93010, 93014, 93015, 93018, 93040, 93042, 93201,
93204, 93205, 93209, 93220, 93222, 93227, 93230, 93233, 93235, 93224, 93237,
96400-96549, 97010-97799, 988900-98922, 99000-99152, 99160-99162, 99171-99174,
99190-99192 or 99199 and the Bill Type is 13X, 14X or 83X.
To Correct: Verify Bill Type is correct. If incorrect, it can be changed on the claim's Detail Charges screen. If correct, the items charged cannot have any of the listed CPT codes if the service from date is greater than 10/16/91. Delete the CPT codes from those items and regenerate the claim.

EDIT 222 - NEED CPT 90655, 90657, 90658 & 90660 WITH REV CD 636

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim with service dates after 10/01/03 has a Condition Code of "A6" or a diagnosis "V0481," a charge item with Revenue Code 636, and does not have a CPT Code of 90655, 90657-58 & 90660 in the Item Master.
To Correct: Verify the Condition Code or Diagnosis is correct. If not, have Medical Records change Diagnosis in the Grouper screen. If Condition Code is incorrect, change on the UB92 Coding screen on the claim. If both are correct, verify the item charged with 636 Revenue Code has a CPT Code of 90655, 90657-58 & 90660 in the Item Master. If the CPT is missing, load in Item Master and regenerate the claim.

EDIT 223 - NEED CPT G0008 WITH REV CD 771

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim with service dates after 10/01/03 has a Condition Code of "A6" or a diagnosis "V0481," a charge item with Revenue Code 771, and does not have a CPT Code of G0008 in the Item Master.
To Correct: Verify the Condition Code or Diagnosis is correct. If not, have Medical Records change Diagnosis in the Grouper screen. If Condition Code is incorrect, change in the UB92 Coding screen in the claim. If both are correct, verify the item charged with 771 Revenue Code has a CPT Code of G0008 in the Item Master. If the CPT is missing, load in Item Master.

EDIT 224 - SERVICE DATE ON CHARGE NOT WITHIN STATEMENT DATES

Locator: 45 - Service Date
Scenario: The above edit appears if a claim has a charge with a service date that does not fall within the "from" and "to" dates.
To Correct: Verify "from" and "to" dates are correct. If those dates are correct, then change the service date in the Detail Charges screen for the insurance claim. There is no need to regenerate the claim.

EDIT 225 - TOTAL CHARGES FOR REV CD 180 SHOULD BE 0

Locator: 47 - Total Charges
Scenario: The above edit appears if a claim has total charges for Revenue Code 180 greater than zero.
To Correct: Verify the total charges for Revenue Code 180 is equal to zero. Enter in the Detail Charges screen on the line with the summary code for Revenue Code 180, 0 total charges. The claim does not have to be regenerated.

EDIT 226 - NEED NONCOVERED CHARGE WITH REV CDS 18X, 99X

Locator: 48 - Non-Covered Charges
Scenario: The above edit appears if a claim has charges with Revenue Code 18X or 99X and does not have Non-Covered charges associated with those Revenue Codes.
To Correct: Verify the correct amount of Non-Covered charges for the Revenue Codes listed and enter the amount on the claim's Detail Charges screen. The claim will not need to be regenerated.

EDIT 227 - NEEDS UNITS OF SERVICE FOR SOME REV CODES

Locator: 46 - Service Units
Scenario: The above edit appears if a claim has a charge with no quantity for the following Revenue Codes:
10X, 11X, 12X, 13X, 14X, 15X, 16X, 18X, 20X, 21X, 380, 360, 381, 382, 54X, 55X, 63X, 80X, 82X, 83X, 84X, 85X or 91X.
To Correct: Verify quantity for those Revenue Codes. If charges need to be added or backed off the account, inform Data Processing. Then regenerate the claim. If charges are correct and the quantity is correct, change in the Detail Charges screen of the claim. The claim will not have to be regenerated.

Edit 228 - NEED RATES WITH SOME REVENUE CODES

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has charges with Revenue Codes: 100-169, 200-219 or 550-599 (except 561) and the rates equal zero.
To Correct: Verify the correct rates for the above listed Revenue Codes and load in the Detail Charges screen. The claim will not need to be regenerated.

EDIT 229 - ACCOMMODATION REV CD > $999.99

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a Blue Cross claim has charges for Revenue Codes 100-219 and an amount greater than $999.99.
To Correct: Verify the correct rate for listed Revenue Codes and enter in the Detail Charges screen. Ensure the amount is less than $999.99. The claim will not need to be regenerated.

EDIT 230 - ACCOMMODATION REV CD > $9999.99

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a Commercial or Workman's Comp claim has charges for Revenue Codes 100-219 and an amount greater than $9999.99.
To Correct: Verify the correct rate for listed Revenue Codes and enter in the Detail Charges screen of the claim. Ensure the amount is less than $9999.99. The claim will not need to be regenerated.

EDIT 231 - ROOM CHARGE QUANTITIES NOT = COVERED DAYS

Locator: 46 - Service Units
Scenario: The above edit appears if a claim has a Bill Type X1X, X2X or X8X, has Revenue Codes 10X, 11X, 12X, 13X, 14X, 15X, 16X, 20X or 21X and the quantity of room charges does not equal the Covered days.
To Correct: Verify quantity for those Revenue Codes is the correct amount. If charges need to be added or backed off the account, inform Data Processing. Then regenerate the claim.

EDIT 232 - COND CD 40 ENTERED; COVERED DAYS NOT = 0

Locator: 46 - Service Units
Scenario: The above edit appears if the following criteria is not met: A claim has a Bill Type X1X, X2X or X8X and has Revenue Codes 10X, 11X, 12X, 13X, 14X, 15X, 16X, 20X or 21X. If there is a Condition Code of 40 in the UB92 Coding screen, (which means Same Day Transfer) then the quantity of those charges must equal zero.
To Correct: Verify quantity for those Revenue Codes is the correct amount. If charges need to be added or backed off the account, inform Data Processing. Verify the Condition Code. If it is incorrect, then delete code from the UB92 coding screen. Regenerate the claim.

EDIT 233 - NEED UNITS OF SERVICE FOR REV CDS 30X, 31X

Locator: 46 - Service Units
Scenario: The above edit appears if a claim has a Bill Type 13X, 14X or 83X, has Revenue Codes 30X or 31X, and the quantity of charges equals zero.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has charges for those Revenue Codes with quantity in the claim's Detail Charges screen.

EDIT 234 - NEED UNITS OF SERVICE FOR SOME REVENUE CDS

Locator: 46 - Service Units
Scenario: The above edit appears if a claim has a Bill Type 13X or 83X, has any of the following Revenue Codes:
255, 291, 293, 32X - 34X, 40X - 48X, 51X - 53X, 61X, 64X, 73X - 75X,
88X, 92X or 94X, and the quantity of charges equals zero.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has charges for those Revenue Codes with quantity on the claim's Detail Charges screen.

EDIT 235 - NEED UNITS OF SERVICE FOR REVENUE CODE 274

Locator: 46 - Service Units
Scenario: The above edit appears if a claim has a Bill Type 12X, 13X, 22X, 23X, 74X, 75X or 83X, has Revenue Code 274, and the quantity of charges equals zero.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has charges for Revenue Code 274 with quantity on the claim's Detail Charges screen.

EDIT 236 - TOTAL CHARGES NOT GREATER THAN ZERO

Locator: 47 - Total Charges
Scenario: The above edit appears if a claim has Total Charges of Zero.
To Correct: Verify Claim is setup correctly and has charges on the Account Detail. If charges are entered, then regenerate the claim. If charges are missing, set claim back to the "UNCHECKED" status and have Data Processing enter charges, then regenerate the claim.

EDIT 237 - NONCOVERED CHARGES EXCEED TOTAL CHARGES

Locator: 48 - Non-Covered Charges
Scenario: The above edit appears if a claim has Non-Covered Charges that exceed Total charges.
To Correct: Verify claim is setup correctly and has charges greater than Non Covered charges on the claim's Detail Charges screen. Choose the sequence number that has more Non-Covered and enter correct amount. There is no need to regenerate the claim.

EDIT 238 - TOTAL CHARGES > $999,999.99

Locator: 47 - Total Charges
Scenario: The above edit appears if a Blue Cross claim has total charges greater than $999,999.99.
To Correct: Verify the correct amount of charges and have Data Processing correct through patient Charging. The claim will need to be regenerated.

EDIT 239 - NONCOVERED CHARGES GREATER THAN ZERO

Locator: 48 - Non-Covered Charges
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 14X, 83X or 851, and there are Non-Covered Charges greater than zero.
To Correct: Verify Bill Type is correct. If Bill Type is incorrect, then change on the claim's Detail Charges screen. If Bill Type is correct, then select the sequence number in the claim's Detail Charges screen and delete the Non-Covered charges. There is no need to regenerate the claim.

EDIT 240 - CHARGES FOR REV CD 99X SHOULD BE NONCOVERED CHARGES

Locator: 48 - Non-Covered Charges
Scenario: The above edit appears if a claim has charges for Revenue Code 99X (excluding 996 and 997) and Total charges equal Non-Covered Charges.
To Correct: Verify charges are correct. If correct, then on the claim's Detail Charges screen select the sequence number for Revenue Code 99X and enter total charges in Non-Covered column. There is no need to regenerate the claim.

EDIT 241 - MISSING PAYER NAME IN FIELD 50A
MISSING PAYER NAME IN FIELD 50B
MISSING PAYER NAME IN FIELD 50C

Locator: 50 - Payer Name
Scenario: The above edit appears if the name of the particular Insurance is not loaded in the Policy Information screen for the claim. The first edit for locator 50A represents the primary insurance. The other two edits appear for the secondary claims.
To Correct: Verify the Insurance Company Name is loaded in the Business Office Tables. If the name is loaded in the table, check the Policy Information screen and verify the name is loaded. There is no need to regenerate the claim.

EDIT 242 - MISSING PAYER NAME IN FIELD 50 - OCC CD = B1, B2 OR B3
EDIT 243 - MISSING PAYER NAME IN FIELD 50 - OCC CD = C1, C2 OR C3

Locator: 50 - Payer Name
Scenario: The above edit appears if the name of the particular Insurance is not loaded on the Policy Information screen of the secondary claims. If there is an Occurrence Code on the Primary claim of B1, B2 or B3 edit 242 appears. If there is an Occurrence Code of C1, C2 or C3, edit 243 appears.
To Correct: Verify Occurrence Codes are correct. If not, delete codes from UB92 Coding screen. If Occurrence Codes are correct, verify Insurance Company Name is loaded in the Business Office Tables. If name is loaded in the table, check Policy Information screen and verify name is loaded. There is no need to regenerate the claim.

EDIT 244 - MISSING PAYER NAME IN FIELD 50B - VAL CD = B1, B2 OR B3
EDIT 245 - MISSING PAYER NAME IN FIELD 50C - VAL CD = C1, C2 OR C3

Locator: 50 - Payer Name
Scenario: The above edit appears if the name of the particular Insurance is not loaded in the Policy Information screen of the secondary claims. If there is a Value Code on the Primary claim of B1, B2 or B3, edit 244 appears. If there is a Value Code of C1, C2 or C3, edit 245 appears.
To Correct: Verify Value Codes are correct. If not, delete codes from UB92 Coding screen. If Value Codes are correct, verify Insurance Company Name is loaded in the Business Office Tables. If name is loaded in the table, check Policy Information screen and verify name is loaded. There is no need to regenerate the claim.

EDIT 246 - MEDICARE CANNOT BE PRIMARY WITH LISTED VALUE CODE

Locator: 50 - Payer Name
Scenario: The above edit appears if a Medicare claim is primary with a Value Code of 12 - 16 or 41 – 43.
To Correct: Verify Value Codes are correct. If Value Code is not correct, delete from UB92 Coding screen. If Value Codes are correct, verify the primary Y/N switch in the Policy Information screen is set to N. There is no need to regenerate the claim.

EDIT 247 - MEDICARE CANNOT BE PRIMARY WITH LISTED OCCUR CD

Locator: 50 - Payer Name
Scenario: The above edit appears if a Medicare claim is primary with an Occurrence Code 01 – 04.
To Correct: Verify Occurrence Codes are correct. If Occurrence Code is not correct, delete from UB92 Coding screen. If Occurrence Code is correct, verify primary Y/N switch in the Policy Information screen is set to N. There is no need to regenerate the claim.

EDIT 248 - MEDICARE CANNOT BE PRIMARY WITH LISTED COND CD

Locator: 50 - Payer Name
Scenario: The above edit appears if a Medicare claim is primary with a Condition Code of 02 or 06.
To Correct: Verify Condition Code is correct. If Condition Code is not correct, delete from UB92 Coding screen. If Condition Code is correct, verify primary Y/N switch in the Policy Information screen is set to N. There is no need to regenerate the claim.

EDIT 249 - MEDICARE SECONDARY - NEED VALUE CD 12-16 OR 41-43

Locator: 50 – Payer Name
Scenario: The above edit appears if a patient has a Medicare Secondary Insurance, but does not have Value Code 12-16 or 41-43.
To Correct: Verify Insurance is setup correctly. If setup correctly, load Value Code 12 - 16 or 41-43 in the UB92 Coding screen. There is no need to regenerate the claim.

EDIT 250 - MISSING PROVIDER NUMBER IN FIELD 51

Locator: 51 - Provider Number
Scenario: The above edit appears if a claim is not a Commercial Insurance and is missing the Provider Number in the Insurance Company Table.
To Correct: Verify Insurance is correct. If Insurance is correct, load the valid Provider Number in the Insurance Company Table. The claim does not have to be regenerated.

EDIT 251 - PRIOR PAYMENTS EXCEED TOTAL CHARGES

Locator: 54 - Prior Payments
Scenario: The above edit appears if a claim has Prior Payments that are greater than Total charges.
To Correct: Verify total charges and prior payments. Correct Prior Payments in the Detail Benefits screen of the claim. There is no need to regenerate the claim.

EDIT 252 - PRIOR PAYMENTS = 0: VAL CD = 12-16 OR 41-43

Locator: 54 - Prior Payments
Scenario: The above edit appears if a claim has Value Code 12-16 or 41-43 and there is not a Prior Payment on the Detail Benefits screen of the Insurance Claim.
To Correct: Verify Value Code is correct. If Value Code, is incorrect, delete from the UB92 Coding screen of the claim. If Value Code is correct, load a prior payment in the Detail Benefits screen of the claim. There is no need to regenerate the claim.

EDIT 253 - MISSING INSURED'S NAME IN FIELD 58

Locator: 58 - Insured's Name
Scenario: The above edit appears if the subscriber's name is missing in the Policy Information screen of the claim.
To Correct: Verify Subscriber's Information in the Policy Information screen. If missing, load insured's name. There is no need to regenerate the claim. Also, load information in the Guarantor/Ins tab on the Registration and ADT screen for future claims/just like accounts.

EDIT 254 - VALUE CD 12-16; NEED INSURED'S NAME IN 58

Locator: 58 - Insured's Name
Scenario: The above edit appears if a claim has Value Codes of 12-16 and does not have insured's name in the Policy Information screen of the claim.
To Correct: Verify Value Codes are correct. If correct, load missing subscriber's name in Policy Information screen of the claim. There is no need to regenerate.

EDIT 255 - MISSING PATIENT REL TO SUBSCRIBER IN 59

Locator: 59 - Patient's Relation to Subscriber
Scenario: The above edit appears if a claim does not have a code to specify what the patient's relationship to the subscriber is.
To Correct: Verify the relationship and load appropriate 2-digit code in the Policy Information screen. There is no need to regenerate the claim.

EDIT 256 - INVALID PATIENT REL TO SUBSCRIBER IN 59

Locator: 59 - Patient's Relation to Subscriber
Scenario: The above edit appears if a claim has a Patient's Relation to Subscriber not equal to 01 – 19. If using new codes they are 18, 01, 19, 43, 17, 10, 15, 20, 22, 39, 40, 05, 07, 41, 23, 24 and 04.
To Correct: Verify the relationship and load appropriate 2-digit code in the Policy Information screen. There is no need to regenerate the claim.

EDIT 257 - FIELD 59 MUST BE 01 OR 02 BASED ON VALUE CODES

Locator: 59 - Patient's Relation to Subscriber
Scenario: The above edit appears if a claim has Value Codes 14, 15, 16, 41 or 42 in the UB92 Coding screen of the claim and the patient's relation to subscriber is not a 01 or 02. If using new relation codes they are 18 and 01.
To Correct: Verify the relationship and load appropriate 2-digit code in the Policy Information screen. There is no need to regenerate the claim.

EDIT 258 - CHAMPUS PAT REL SHOULD BE 01-05, 07, 10 OR 16

Locator: 59 - Patient’s Relation to Subscriber
Scenario: The above edit appears if a Champus claim does not have a Patient's Relation to Subscriber of 01-05, 07, 10 or 16. If using new relationship codes they are 18, 01, 19, 43, 17, 15, 22 or 23.
To Correct: Verify that the Insurance is correct. If correct, then verify Patient's Relationship to subscriber is one of the above. There is no need to regenerate the claim.

EDIT 259 - FIELD 59 MUST BE 01-06 OR 18 BASED ON VALUE CODES

Locator: 59 - Patient’s Relation to Subscriber
Scenario: The above edit appears if a secondary claim has a Value Code of 43, does not have Value Codes 14, 15, 16, 41 or 42, and the patient's Relation to Subscriber is not 01 - 06 or 18 or if using new relationship codes 18, 01, 19, 43, 17, 10, 15, 20, 22, 39, 40, 05, 07, 41, 23 or 24.
To Correct: Verify the Value Code. If correct, then verify the Patient's Relationship to Subscriber is 01 - 06 or 18 or new relationship codes mentioned above and load in the Policy Information screen. There is no need to regenerate the claim.

EDIT 260 - CONTRACT/CERTIFICATE NUMBER BLANK

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if a Workman’s Compensation claim is missing a Contract/Certificate number in the Policy Information screen.
To Correct: Verify the correct Contract/Certificate number and load in the Policy Information screen of the claim. The claim will not need to be regenerated.

Edit 261 - POSITION 8 OF CONTRACT NUMBER NOT BLANK

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if an Oklahoma Medicaid claim has a Contract Number greater than 8 characters.
To Correct: Verify the correct Contract Number and load in the Policy Information screen of the claim. The claim will not need to be regenerated.

EDIT 262 - CONTRACT NBR IS BLANK OR ALL ZEROS

Locator: 60 – Insured's Unique ID
Scenario: The above edit appears if a claim is missing a Contract Number or the Contract Number is all zeros.
To Correct: Verify the correct Contract Number and load in the Policy Information screen of the claim. The claim will not need to be regenerated.

EDIT 264 - FIRST 3 DIGITS OF MEDICARE CERTIFICATE INVALID

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if the first three digits of the Medicare claim certificate number are not alpha.
To Correct: Verify the correct certificate number and that it begins with three alpha characters. Enter it on the Policy Information screen of the claim. The claim will not need to be regenerated.

Edit 265 - MEDICARE SUFFIX IS MISSING OR INVALID

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if a Medicare claim has a Contract Number in which the tenth digit, which is the Medicare suffix, is not an A, B, C, D, E, F, H, J, K, M, T or W.
To Correct: Verify Contract Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

EDIT 266 - MEDICARE SUFFIX OF H MUST BE FOLLOWED BY A,B,OR C

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if a Medicare claim has a suffix (tenth digit of Contract Number) of H and the next digit is not an A, B or C.
To Correct: Verify Contract Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

EDIT 267 - CONTRACT # HAS EMBEDDED SPACES/SPECIAL CHARACTERS

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if a Medicare, Blue Cross or Medicaid claim has a Contract Number with special characters, (i.e., &, *, # or spaces). The number must be alpha or numeric characters.
To Correct: Verify Contract Number and load in Policy Information, insuring that all characters are alpha or numeric. There is no need to regenerate the claim.

EDIT 268 - MISSING CONTRACT NUMBER IN FIELD 60

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if an Insurance Claim does not have a Contract Number in the Policy Information screen.
To Correct: Verify Contract Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

Edit 269 - CHAMPUS CONTRACT NUMBER NOT NUMERIC

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if a Champus Claim has a Contract Number in the Policy Information screen that is not numeric.
To Correct: Verify Contract Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

EDIT 270 - COMMERCIAL CONTRACT NUMBER NOT NUMERIC

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if a Commercial Claim has a Contract Number in the Policy Information screen that is not numeric.
To Correct: Verify Contract Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

Edit 271 - MISSING GROUP NAME IN FIELD 61

Locator: 61 - Group Name
Scenario: The above edit appears if a Claim has a Value Code of 12, 13 or 43 and does not have a Group Name in the Policy Information screen.
To Correct: Verify Value Codes are correct. If Value Codes are correct, verify Group Name and load in Policy Information screen. There is no need to regenerate the claim.

EDIT 272 - COMMERCIAL GROUP NUMBER IS BLANK

Locator: 62 – Insurance Group No.
Scenario: The above edit appears if a Commercial Claim does not have a Group Number in the Policy Information screen.
To Correct: Verify Group Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

EDIT 273 - GROUP NUMBER SHOULD BE 999999

Locator: 62 - Insurance Group No.
Scenario: The above edit appears if a Commercial Claim has the 9th digit of the Contract Number as an M or U and does not have a Group Number equal to 999999 in the Policy Information screen.
To Correct: Verify Group Number and load in Policy Information for the appropriate claim. The claim will need to be regenerated.

Edit 274 - COMMERCIAL CONTRACT # = GROUP

Locator: 62 - Insurance Group No.
Scenario: The above edit appears if a Commercial Claim has a Contract Number that is the same as the Group Number.
To Correct: Verify the correct Contract Number or Group Number and load in the Policy Information screen of the claim. There is no need to regenerate the claim.

EDIT 275 - COMMERCIAL CONTRACT # = EMPLOYER NAME

Locator: 62 - Insurance Group No.
Scenario: The above edit appears if a Commercial Claim has a Contract Number equal to the employer name on the Policy Information screen.
To Correct: Verify Group Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

Edit 276 - INVALID CONTRACT NUMBER FOR COMMERCIAL CLAIM

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if a Commercial Claim has a Contract Number in the Policy Information screen of "Individual", "Unknown", "Self", "None" or "1234567890".
To Correct: Verify the correct Contract Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

EDIT 277 - INVALID GROUP NUMBER FOR COMMERCIAL CLAIM

Locator: 62 - Insurance Group No.
Scenario: The above edit appears if a Commercial Claim has a Group Number in the Policy Information screen of "Individual", "Unknown", "Self", "None" or "1234567890."
To Correct: Verify the correct Group Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

Edit 278 - INVALID CHARACTER IN COMMERCIAL GROUP NAME

Locator: 61 - Group Name
Scenario: The above edit appears if a Commercial Claim has a character in the Group Name that is not alpha or numeric.
To Correct: Verify Commercial Group Name. Enter correct name in the Policy Information screen. There is no need to regenerate the claim.

EDIT 279 - INVALID CHARACTER IN COMMERCIAL GROUP NUMBER

Locator: 62 - Insurance Group No.
Scenario: The above edit appears if a Commercial Claim has a character in the Group Number that is not alpha or numeric.
To Correct: Verify commercial Group Number. Enter correct number in the Policy Information screen. There is no need to regenerate the claim.

EDIT 280 - GROUP NAME SHOULD NOT BE LISTED IN 61 - COND CD

Locator: 61 - Group Name
Scenario: The above edit appears if a claim has a Group Name in the Policy Information screen and has a Condition Code of 09 or 11.
To Correct: Verify Condition Code is correct. If code is correct, delete the Group Name for the particular insurance. There is no need to regenerate the claim.

EDIT 281 - MISSING GROUP NUMBER IN FIELD 62

Locator: 62 - Insurance Group No.
Scenario: The above edit appears if a claim has a Value Code of 12, 13 or 43 and does not have a Group Number in the Policy Information screen.
To Correct: Verify Value Codes are correct. If Value Codes are correct, verify Group Number and load in Policy Information screen. There is no need to regenerate the claim.

EDIT 282 - GROUP NUMBER SHOULD NOT BE LISTED IN 62 - COND CD

Locator: 62 - Insurance Group No.
Scenario: The above edit appears if a claim has a Group Number in the Policy Information screen and has a Condition Code of 09 or 11.
To Correct: Verify Condition Code is correct. If code is correct, delete the Group Number for the particular insurance. There is no need to regenerate the claim.

EDIT 283 - MEDICAID SNF PATIENT - NEED TREAT AUTH IN 63

Locator: 63 - Treatment Authorization Codes
Scenario: The above edit appears if a Medicaid Claim has a Bill Type of 2XX and does not have a Treatment Authorization Code.
To Correct: Verify Bill Type is correct. If not, change in claim's Detail Charges screen. If Bill Type is correct, enter Treatment Authorization Code in Stay Information screen for the claim in the HHPPS Class field. There is no need to regenerate the claim.

EDIT 284 - INVALID ESC CODE IN FIELD 64

Locator: 64 - Document Control Number
Scenario: The above edit appears if a claim has an Employment Status Code (ESC) that is not 1 - 9.
To Correct: Verify ESC code is correct. If not, change in Policy Information screen. There is no need to regenerate the claim.

EDIT 285 - MEDICAID SECONDARY - NEED ESC CODE

Locator: 64 - Document Control Number
Scenario: The above edit appears if a Medicaid secondary claim does not have an Employment Status Code in the Policy Information screen.
To Correct: Verify the ESC code and load it in Policy Information screen. There is no need to regenerate the claim.

EDIT 286 - COMMERCIAL CLAIM - NEED ESC CODE

Locator: 64 - Document Control Number
Scenario: The above edit appears if a Commercial Claim does not have an Employment Status Code in the Policy Information screen.
To Correct: Verify ESC code and enter in Policy Information screen. The claim will need to be regenerated.

EDIT 287 - FOR MEDICARE, ESC COMPLETE; NEED EMP NAME

Locator: 64 - Document Control Number
Scenario: The above edit appears if a Medicare Claim has an Employment Status Code and does not have an Employer Name.
To Correct: Verify ESC code is correct. If not, delete code from Policy Information screen. If code is correct, verify claim has an Employer name loaded in the Policy Information screen. There is no need to regenerate the claim.

EDIT 288 - ESC CODE SHOULD BE BLANK - COND CD 09 LISTED

Locator: 64 - Document Control Number
Scenario: The above edit appears if a Claim has a Condition Code of 09 and has an Employment Status Code.
To Correct: Verify Condition Code. If incorrect, delete from the UB92 Coding screen. If correct, delete ESC code in Policy Information screen. There is no need to regenerate the claim.

EDIT 289 - ESC CODE MISSING - COND CD 10 LISTED

Locator: 64 - Document Control Number
Scenario: The above edit appears if a claim has a Condition Code of 10 and does not have an Employment Status Code.
To Correct: Verify Condition Code is correct. If not, delete code from UB92 Coding screen. If code is correct, verify ESC code and load in the Policy Information screen. There is no need to regenerate the claim.

EDIT 290 - EMPLOYER NAME MUST BE ENTERED IN 65 - COND CD 10

Locator: 65 - Employer Name
Scenario: The above edit appears if a claim has a Condition Code of 10 and does not have an Employer Name loaded in the Policy Information screen.
To Correct: Verify Condition Code is correct. If not, delete code from UB92 Coding screen. If Code is correct, verify Employer Name and load in the Policy Information screen.

EDIT 291 - EMP ADDRESS MUST BE ENTERED IN 66 - COND CD 10

Scenario: The above edit appears if a claim has a Condition Code of 10 and does not have an Employer Address loaded in the Policy Information screen.
To Correct: Verify Condition Code is correct. If not, delete code from UB92 Coding screen. If code is correct, verify Employer Address and load in the Policy Information screen.

EDIT 292 - MISSING DIAGNOSIS CODE IN FIELD 67

Locator: 67 - Prin Diag Cd
Scenario: The above edit appears if a claim that has a Bill Type other than 14X, has Revenue Codes 30X or 31X, and does not have a Principal Diagnosis Code in locator 67.
To Correct: Verify Bill Type. If Bill Type is incorrect, change in Detail Charges screen of the claim. If Bill Type on the claim is correct, verify that Medical Records has completed the coding on this account. Once Medical Records enters the Primary Diagnosis in the Medical Records Grouper screen the claim must be regenerated.

EDIT 293 - INVALID DIAGNOSIS CODE IN FIELD 67, PRIN DIAG

Locator: 67 - Prin Diag Cd
Scenario: The above edit appears if a claim has an invalid ICD9 Diagnosis Code in field 67.
To Correct: Verify Diagnosis Code is correct. If not, have Medical Records correct in the Grouper screen. The claim will then need to be regenerated. If code is a correct ICD9 Diagnosis Code and it is not in the CPSI table, call CPSI Software Support in order to correct the table.

EDIT 294 - PRINCIPAL DIAGNOSIS SHOULD BE V0481

Locator: 67 – Prin Diag Cd
Scenario: The above edit appears if a claim has a Condition Code of A6 or has a Revenue Code of 636 or 771, but does not have a Principal Diagnosis of V0481, V0482 or V0489.
To Correct: Verify Condition Code is correct. If not, delete code from UB92 Coding screen. If code is correct, verify Revenue Codes are correct. If not, have Data Processing correct the charges. If Revenue Codes are correct, have Medical Records enter V048 as the Principal Diagnosis Code in the Medical Records Grouper screen. The claim will need to be regenerated.

EDIT 295 - BASED ON PRIN DIAG, NEED OCCUR CD/SPAN CD 01-06

Locator: 67 - Prin Diag Cd
Scenario: The above edit appears if a Blue Cross, Medicare, Medicaid or Champus Claim has a Principal Diagnosis Code greater than 800 and less than 9999 and does not have an Occurrence Code/Span Code of 01 - 06.
To Correct: Verify Principal Diagnosis is correct. If not, have Medical Records correct in the Grouper screen. If correct, load Occurrence Code/Span code of 01 - 06 in the UB92 Coding screen. If diagnosis has to be corrected, then the claim will need to be regenerated. If Codes are loaded on the claim there is no need to regenerate the claim.

EDIT 296 - INVALID PRINCIPAL DIAGNOSIS; E-CODE

Locator: 67 - Prin Diag Cd
Scenario: The above edit appears if a claim has a Principal Diagnosis Code that begins with an "E."
To Correct: Verify Principal Diagnosis. If an E-code diagnosis is principal, have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

EDIT 297 - INVALID PRINCIPAL DIAGNOSIS; MANIFESTATION CODE

Locator: 67 - Prin Diag Cd
Scenario: The above edit appears if a claim has a Diagnosis Code in Appendix B (attached) listed as the Principal Diagnosis.
To Correct: Verify Principal Diagnosis. If it is one of the codes in Appendix B, have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

EDIT 298 - INVALID DIAGNOSIS CODE IN OTHER DIAG FIELD

Locator: 67A-Q - Other Diagnosis Codes
Scenario: The above edit appears if a claim has an invalid ICD9 Diagnosis Code in fields 68 - 75.
To Correct: Verify Diagnosis Code is correct. If not, have Medical Records correct in the Grouper screen. The claim will then need to be regenerated. If code is a correct ICD9 Diagnosis Code and it is not in the CPSI table, call CPSI Software Support in order to correct the table.

EDIT 299 - DIAGNOSIS CODE LISTED TWICE

Locator: 67A-Q - Other Diagnosis Codes
Scenario: The above edit appears if a claim has duplicated Diagnosis Codes in locators 68 - 75.
To Correct: Verify which Other Diagnosis Codes are duplicated. Then have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

EDIT 300 - E-CODES INVALID FOR CHAMPUS CLAIMS

Locator: 67A-Q - Other Diagnosis Codes
Scenario: The above edit appears if a Champus claim has Diagnosis Codes that begin with an "E" in locators 68 - 75.
To Correct: Verify Diagnosis Codes are correct. Then have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

Edits 301 - 400

EDIT 301 - BLANK LOCATOR BETWEEN OTHER DIAGNOSIS CODES

Locator: 67A-Q - Other Diagnosis Codes
Scenario: The above edit appears if a claim has any blank locators in between Diagnosis Codes in locators 68 - 75. For example, locator 68 should not be blank if there is a Diagnosis Code in locator 69.
To Correct: Verify Other Diagnosis is correct. If not, have Medical Records correct in the Grouper screen. Ensure that there are no blank fields in the Grouper screen for other diagnoses. Verify that the other Diagnosis Codes fill up fields 22 - 30 in order. Claim will need to be regenerated if changes are made.

EDIT 302 - NEED DIAGNOSIS CODE OF 2860, 2861, OR 2864

Locator: 67A-Q - Other Diagnosis Codes
Scenario: The above edit appears if a claim has a Bill Type of 11X, a Revenue Code of 636, and it does not have a Diagnosis Code of 2860, 2861 or 2864.
To Correct: Verify Bill Type is correct. If not, change in the Detail Charges screen in the claim. If Bill Type is correct, verify Revenue Code is correct. If correct, have Medical Records enter the appropriate diagnosis in the Grouper screen. The claim will then need to be regenerated.

EDIT 303 - NEED SECONDARY DIAG WITH THIS PRINCIPAL DIAG

Locator: 67A-Q - Other Diagnosis Codes
Scenario: The above edit appears if a claim has a Bill Type of 1XX or 2XX, a Principal Diagnosis of V571, V572, V573, V579 or V5789, and there is not a secondary diagnosis present.
To Correct: Verify Principal Diagnosis. If correct, have Medical Records enter a secondary diagnosis. The claim will need to be regenerated.

EDIT 304 - ADMITTING DIAGNOSIS MUST BE ENTERED IN FIELD 76
ADMITTING DIAGNOSIS IS NOT A VALID ICD9 CODE

Locator: 69 - Admitting Diagnosis Code
Scenario: The above edit appears if a claim has a Bill Type of 11X and there is not an Admitting Diagnosis Code in locator 69. The second edit appears if there is an invalid Admitting Diagnosis Code entered.
To Correct: Verify Bill Type is correct. If correct, have Medical Records verify and load an Admitting Diagnosis Code in the Medical Records Grouper screen. Verify that the admitting diagnosis is correct. If not, have Medical Records correct in the Grouper screen. If the diagnosis is valid and it is not in the CPSI table, call CPSI Software Support in order to correct the table. The claim will need to be regenerated.

EDIT 305 - ADMIT DIAG E-CODE ARE INVALID FOR CHAMPUS CLAIMS

Locator: 69 – Admitting Diagnosis Code
Scenario: The above edit appears if a Champus Claim has an Admitting Diagnosis Code in locator 69 that begins with an "E".
To Correct: Verify Diagnosis Codes are correct. Then have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

EDIT 306 - MISSING PRINCIPAL PROCEDURE DATE

Locator: 74 - Principal Procedure Code/Date
Scenario: The above edit appears if a claim has a Principal Procedure Code and is missing a date.
To Correct: Verify Principal Procedure Code is correct. If incorrect, have Medical Records correct in the Grouper screen. If code is correct, have Medical Records verify when the procedure was performed and load date in the Grouper screen. The claim will then need to be regenerated.

EDIT 307 - PRINCIPAL PROCEDURE IS NOT A VALID ICD9 CODE

Locator: 74 - Principal Procedure Code/Date
Scenario: The above edit appears if a claim has an invalid Principal Procedure Code loaded in locator 74.
To Correct: Verify Procedure code is correct. If not, have Medical Records correct in the Grouper screen. The claim will then need to be regenerated. If code is a correct ICD9 Procedure code and it is not in the CPSI table, call CPSI Software Support in order to correct the table.

EDIT 308 - HAVE PRIN PROC DATE; MISSING PRIN PROC CODE

Locator: 74 - Principal Procedure Code/Date
Scenario: The above edit appears if a claim has a Principal Procedure Date but not a Principal Procedure Code.
To Correct: Verify Principal Procedure Date is correct. If incorrect, have Medical Records correct in the Grouper screen. If date is correct, have Medical Records verify what procedure was performed and load code in the Grouper screen. The claim will then need to be regenerated.

EDIT 309 - PRINCIPAL PROCEDURE DATE > STMT 'THROUGH' DATE
EDIT 310 - PRINCIPAL PROCEDURE DATE < STMT 'FROM' DATE

Locator: 74 - Principal Procedure Code/Date
Scenario: The above edits appear if a claim has a Principal Procedure date loaded in locator 74 and it does not fall in the date range of the Service "From" and "To" date.
To Correct: Verify Procedure date falls within the Service "From" and "To" Date. If incorrect, have Medical Records correct in the Grouper screen. Then the claim will need to be regenerated.

EDIT 311 - DIAG = MATERNITY COMPLIC; PRIN PROC INCONSISTENT

Locator: 74 - Principal Procedure Code/Date
Scenario: The above edit appears if a Champus Claim has a Diagnosis Code of 630 – 6689 but does not have a Principal Procedure Code of 650 - 7599.
To Correct: Verify Diagnosis Code is correct. If incorrect, have Medical Records correct in the Grouper screen. If code is correct, have Medical Records verify Principal Procedure and load in the Grouper screen. The claim will then need to be regenerated.

EDIT 312 - DIAG = MATERNITY COMPLIC; OTHER PROC INCONSISTENT

Locator: 74a-e - Other Procedure Code/Date
Scenario: The above edit appears if a Champus Claim has a Diagnosis Code of 630 – 6689, but does not have an Other Procedure Code of 650 - 7599.
To Correct: Verify Diagnosis Code is correct. If incorrect, have Medical Records correct in the Grouper screen. If code is correct, have Medical Records verify Other Procedure and load in the Grouper screen. The claim will then need to be regenerated.

EDIT 313 - PROC = CAESAREAN; DIAG CODES INCONSISTENT

Locator: 67A-Q - Diagnosis Codes
Scenario: The above edit appears if a Champus Claim has a Principal Procedure Code of 740 - 749, but does not have a Diagnosis Code of 630 - 6769.
To Correct: Verify Diagnosis Code is correct. If incorrect, have Medical Records correct in the Grouper screen. If code is correct, have Medical Records verify what procedure was performed and load in the Grouper screen. The claim will then need to be regenerated.

EDIT 314 - MISSING PRINCIPAL PROCEDURE CODE

Locator: 74 - Principal Procedure Code/Date
Scenario: There are two different scenarios that will cause this edit to pull. The first is if a claim has a Bill Type of 11X, a Revenue Code of 36X, and a Diagnosis Code other than V641 - V643, but does not have a Procedure Code. The second is if a Champus claim has a charge with Revenue Code 36X or 49X but does not have a Principal Procedure Code.
To Correct: For the first scenario, verify Bill Type is correct. If incorrect, change in the Detail Charges screen of the claim. If correct, verify charges are correct. If incorrect, have Data Processing correct. If correct, verify Diagnosis is correct. If incorrect have Medical Records correct in the Grouper screen. If code is correct, have Medical Records verify what Procedure was done and load in the Grouper screen. The claim will then need to be regenerated. For the second scenario, verify Revenue Code is correct. If incorrect, have Data Processing correct. If charge is correct, have Medical Records verify what principal procedure was done and load in the Grouper screen. The claim will need to be regenerated.

EDIT 315 - 1171, 2095, 375, 5051 NOT VALID AS PRINCIPAL PROC

Locator: 74 - Principal Procedure Code/Date
Scenario: The above edit appears if a claim has a Principal Procedure Code of 1171, 2095, 375 or 5051.
To Correct: Verify Principal Procedure Code and have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

EDIT 316 - MISSING PROCEDURE DATE ON A SECONDARY PROCEDURE
EDIT 317 - HAVE SECONDARY PROC DATE; MISSING SEC PROC CODE

Locator: 74a-e - Other Procedure Code/Date
Scenario: Edit 316 appears if a claim has a Secondary Procedure Code and no Secondary Procedure date. Edit 371 appears if there is a Secondary Procedure Date and no Secondary Procedure Code.
To Correct: Verify which information is missing and have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

EDIT 318 - SECONDARY PROCEDURE IS NOT A VALID ICD9 CODE

Locator: 74a-e - Other Procedure Code/Date
Scenario: The above edit appears if a claim has an invalid Secondary Procedure Code loaded in locator 81.
To Correct: Verify Procedure code is correct. If not, have Medical Records correct in the Grouper screen. The claim will then need to be regenerated. If code is a correct ICD9 Procedure code and it is not in the CPSI table, call CPSI Software Support in order to correct the table.

EDIT 319 - SECONDARY PROCEDURE DATE > STMT 'THROUGH' DATE
EDIT 320 - SECONDARY PROCEDURE DATE < STMT 'FROM' DATE

Locator: 74a-e - Other Procedure Code/Date
Scenario: The above edits appear if a claim has a Secondary Procedure date loaded in locators 74a-e that does not fall in the date range of the Service "From" and "To" date of the claim.
To Correct: Verify Procedure date falls within the Service "From" and "To" date. If incorrect, have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

EDIT 321 - OCCUR CD = 24; MISSING REMARKS IN LOC 84

Locator: 80 - Remarks
Scenario: The above edit appears if a claim has an Occurrence Code of 24 in the UB92 Coding screen but no remarks in locator 80.
To Correct: Verify Occurrence Code is correct. If incorrect, delete code from the UB92 Coding screen of the Insurance Claim. If code is correct, load remarks in the Policy Information screen in the Ben. Desc field. The remarks must be preceded with the phrase "XMIT." There is no need to regenerate the claim.

EDIT 322 - CHARACTER IN REMARK LINE 1 NOT ALPHA/NUMERIC

Locator: 80 - Remarks
Scenario: The above edit appears if a claim has special characters (e.g., $, #, @, etc) in the first line of remarks in locator 80. The remarks should only be alpha or numeric.
To Correct: Verify remarks should be entered. If not, delete remarks from the Policy Information screen in the Ben Desc field. If remarks are required, verify that they do not contain special characters. There is no need to regenerate the claim.

EDIT 323 - CHARACTER IN REMARK LINE 2 NOT ALPHA/NUMERIC

Locator: 80 - Remarks
Scenario: The above edit appears if a claim has special characters (e.g., $, #, @, etc) in the second line of remarks in locator 80. The remarks should only be alpha or numeric.
To Correct: Verify remarks should be entered. If not, delete remarks from the Policy Information screen in the Ben. Desc field. If remarks are required, verify that they do not contain special characters. There is no need to regenerate the claim.

EDIT 324 - CHARACTER IN REMARK LINE 3 NOT ALPHA/NUMERIC

Locator: 80 - Remarks
Scenario: The above edit appears if a claim has special characters (e.g., $, #, @, etc) in the third line of remarks in locator 80. The remarks should only be alpha or numeric.
To Correct: Verify remarks should be entered. If not, delete remarks from the Policy Information screen in the Ben. Desc field. If remarks are required, verify that they do not contain special characters. There is no need to regenerate the claim.

EDIT 325 - LOCATOR 82 IS BLANK

Locator: 76 - Attending Physician ID
Scenario: The above edit appears if a claim does not have an Attending Physician number loaded in the Stay Information screen.
To Correct: Determine the correct Attending Physician and load that number into the Stay Information screen. If the physician is not loaded in the Stay tab on the Registration and ADT screen, then notify the appropriate department.

EDIT 326 - MISSING SURGEON

Locator: 77 - Other Physician ID
Scenario: The above edit appears if a claim has a Principal Procedure Code in the Grouper screen and does not have a Surgeon in Stay Information.
To Correct: Verify with Medical Records that the Procedure Code loaded is correct. If so, they will need to add a Surgeon in the Grouper screen. The Physician number should then be loaded in Stay Information. The claim will not need to be regenerated.

EDIT 327 - MISSING SURGEON'S UPIN NBR

Locator: 77 - Other Physician ID
Scenario: The above edit appears if a claim has a Surgeon loaded in the Stay Information screen with field 19 "UPIN#" blank in the Physician Table.
To Correct: Verify Physician is correct. Verify the "UPIN" of the surgeon and load in the Business Office Tables (Select Hospital Base Menu > Master Selection > Business Office Tables> Maintenance Menu > Physicians) in field 19. There is no need to regenerate the claim.

EDIT 328 - CLAIM CONTAINS INVALID REVENUE CODE

Locator: 42 - Revenue Codes
Scenario: The above edit appears if an Alabama Medicaid claim has a Bill Type of 3XX and contains Revenue Codes other than 55X or 57X.
To Correct: Verify Bill Type is correct. If incorrect, it can be changed in the Detail Charges screen of the claim. If Bill Type is correct, then the only valid Revenue Codes that can be billed is 55X or 57X. Have Data Processing correct charges through patient Charging and regenerate the claim.

EDIT 329 - DUP REV CODE AND CPT CODE

Locator: 42 - Revenue Codes
Scenario: The above edit appears if an Outpatient claim has Revenue Codes detailed and is not pulling CPT codes from Item Master.
To Correct: Verify the type claim and Revenue Codes that need to be detailed and pull CPT codes or summarized and not pull CPT codes. If Revenue Codes need to pull CPT codes, then load the CPT codes in the Item Master for the detailed charges. The claim does not have to be regenerated. If Revenue Codes need to be summarized, then set field 10 in the Summary Code Table to summarize the financial class. The claim will need to be regenerated.

EDIT 330 - EXP PAY NOT = SUM OF DETAIL LINES

Locator: 55 - Est. Amount Due
Scenario: The above edit appears if a claim has a sum total of amounts on the Detail Charges screen that does not equal the Expected Pay.
To Correct: Verify which line in the Detail Charges screen of the claim is incorrect, (i.e., Non-covered, Deductible, Co-pay etc.). Correct the line that is wrong. The claim does not have to be regenerated.

EDIT 331 - EXP PAY NOT GREATER THAN ZERO

Locator: 55 - Est. Amount Due
Scenario: The above edit appears if a claim has an Expected Pay that is not greater than zero.
To Correct: Verify the correct amount that is expected to be received from the Insurance Company. If charges need to be generated on the Detail Charges screen, verify they are posted to the patients account detail. If on account detail, regenerate the claim. If charges are missing, have Data Processing correct through patient Charging and regenerate the claim.

EDIT 332 - OUTPATIENT CHARGE AMOUNT IS LESS THAN 0

Locator: 47 - Total Charges
Scenario: The above edit appears if an Outpatient claim has total charges that are less than 0.
To Correct: Verify the correct charges are on the account detail. If any charges are missing, have Data Processing correct through patient Charging. The claim will need to be regenerated.

EDIT 333 - ROOM CHARGE AMOUNT IS LESS THAN 0

Locator: 42 - Revenue Codes
Scenario: The above edit appears if a claim has charges for a Revenue Code between 100 - 219 and it is less than zero.
To Correct: Verify that room charges are on the account detail. If not, have Data Processing post through transaction entry. The claim will need to be regenerated.

EDIT 334 - PATIENT NAME MUST INCLUDE LAST NAME AND FIRST INIT

Locator: 8b - Patient Name
Scenario: The above edit appears if a claim only includes the patient's last name.
To Correct: Verify the patient's name in the Patient tab on the Registration and ADT screen. The claim must have, at a minimum, a last name and first initial. The claim will need to be regenerated.

EDIT 335 - ATTENDING PHYSICIAN'S UPIN NBR MISSING

Locator: 76 - Attending Physician ID
Scenario: The above edit appears if a claim has an Attending Physician loaded in the Stay Information screen with field 19 "UPIN#" blank in the Physician Table.
To Correct: Verify Physician is correct. Verify the UPIN of the attending physician and load in the Business Office Tables (Hospital Base Menu > Master Selection > Business Office Tables > Maintenance Menu > Physician) in field 19. There is no need to regenerate the claim.

EDIT 336 - MISSING SURGERY PROC CODE FOR REV CODE 71X

Locator: 74 - Procedure Codes
Scenario: The above edit appears if a claim has charges for Revenue Code 71X and is missing a procedure code in the Stay Information screen.
To Correct: Verify charges are correct. If incorrect, have Data Processing correct through patient Charging. If charges are correct, have Medical Records enter a procedure code in the Medical Records Grouper screen. The claim will need to be regenerated.

EDIT 337 - REVENUE CODE 405 NEEDS PRECERTIFICATION

Locator: 42 - Revenue Codes
Scenario: The above edit appears if a claim has charges for Revenue Code 405 and does not have a pre-certification number loaded in the Stay Information screen.
To Correct: Verify the pre-certification number and load in the Stay Information screen. The claim will not need to be regenerated.

EDIT 338 - MISSING CPT CODE FOR REVENUE CODE 300 TO 369

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a Medicare claim has charges for Revenue Codes 300 - 369 and is missing CPT codes.
To Correct: Verify the correct CPT that is required and load in the Item Master for items in Revenue Codes 300 - 369. Regenerate the claim.

EDIT 339 - ACCIDENT HOUR BUT NO ACCIDENT DIAGNOSIS

Locator: 67A - Q - Diagnosis Codes
Scenario: The above edit appears if a claim has an accident hour in the Stay Information screen but does not have an accident diagnosis.
To Correct: Verify the accident hour is correct. If incorrect, then delete from the Stay tab on the Registration and ADT screen. If correct, then the patient has to have an accident diagnosis. Have Medical Records enter diagnosis in Grouper screen and regenerate the claim.

EDIT 340 - MEDICAID WITHOUT 13 DIGIT POLICY NUMBER

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if a Louisiana Medicaid claim does not have a 13-digit policy number.
To Correct: Verify the correct policy number and load in the Policy Information screen for the claim. The claim will not need to be regenerated.

EDIT 341 - AMBULANCE CLAIM - NO REMARKS

Locator: 80 - Remarks
Scenario: The above edit appears if a claim for the state of Georgia has charges for Revenue Code 54X and has no remarks in the Policy Information screen.
To Correct: Verify the remarks that are needed and load in the Policy Information screen in the Ben. Desc field, preceded with "XMIT". The claim will not need to be regenerated.

EDIT 342 - PHYSICIAN NUMBER 888888 NOT ON FILE

Locator: 76 - Attending Physician ID
Scenario: The above edit appears if a claim has an Attending Physician in the Stay Information screen with the number 888888, which is an unknown physician.
To Correct: Verify the correct physician and load the number in the Stay Information screen of the claim. The claim will not need to be regenerated.

EDIT 343 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes:
92504, 92511, 925411-92548, 92551-92553, 32555-92557, 92561-92569, 92571-92578, 92580-92585, 92589 or 92596 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges can not have the listed CPT codes on the UB. Verify the Summary Code Table, field 10, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 344 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes:
91000, 91010-91012, 91020, 91030, 91032, 91033, 91052, 91055, 91060,
91065 or 91122 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges can not have the listed CPT codes on the UB. Verify the Summary Code Table, field 10, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 345 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes:
93000, 93005, 93024, 93040, 93041, 93201, 93202, 93205, 93208, 93210, 93220, 93221, Q0019, Q0023, Q0027 or Q0030 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges can not have the listed CPT codes on the UB. Verify the Summary Code Table, field 10, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 346 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 93501, 93505, 93510, 93511, 93514, 93524, 93526-93529, 93555, 93556, 93561, 93562 or Q0035 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges can not have the listed CPT codes on the UB. Verify the Summary Code Table, field 10, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 347 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 93225, 93226, 93231, 93232 or 93236 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges can not have the listed CPT codes on the UB. Verify the Summary Code Table, field 10, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 348 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 93300, 93305, 93307-93309, 93312, 93314, 93320, 93321, 93325, 93350, 93600, 93602, 93603, 93607, 93609, 93610, 93612, 93603, 93607, 93610, 93612, 93615, 93616, 93618-93620, 93624, 93631 or 93640-93641 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges can not have the listed CPT codes on the UB. Verify the Summary Code Table, field 10, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 349 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 54240, 93720, 93721, 93731-93738, 93740, 93770, 93875-93882, 93886, 93888, 93920-93931, 93965-93971, 93975, 93976 or 93978-93981 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges can not have the listed CPT codes on the UB. Verify the Summary Code Table, field 10, for the particular Financial Class, is set to summarizer; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 350 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with CPT codes 93255, 93268 or 93278 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges can not have the listed CPT codes on the UB. Verify the Summary Code Table, field 10, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 351 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 95816, 95817, 95819, 95821-95824, 95826, 95827, 95829, 95920, 95933, 95950, 95951, 95953-95956, 95958, 95961 or 95962 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges can not have the listed CPT codes on the UB. Verify the Summary Code Table, field 10, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 352 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 95842, 95858, 95860, 95861, 95863, 95864, 95867-95869, 95872, 95875, 95900, 95904, 95925, 95935 or 95937 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges can not have the listed CPT codes on the UB. Verify the Summary Code Table, field 10, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 353 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 958052, 95807, 95808 or 95810, and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges can not have the listed CPT codes on the UB. Verify the Summary Code Table, field 10, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 354 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 51736, 51741, 51792, 51795, 51797, 54250, 59020, 59025, 93060, 92065, 92081-92083, 92235, 92250, 92265, 92270, 92275, 92280 or 92283-92286 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges can not have the listed CPT codes on the UB. Verify the Summary Code Table, field 10, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 355 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 95004, 95024, 95027, 95028, 95044, 95052, 95056, 95060, 95065, 95070, 95071 or 95078 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges can not have the listed CPT codes on the UB. Verify the Summary Code Table, field 10, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 356 - GA BETTER HEALTHCARE AUTHORIZATION # MISSING

Locator: 78 - Other Physician ID
Scenario: This edit will appear if the Georgia Better Health Care number is not loaded in Policy Information in the GBHC# field or on the second page of the Physician Table.
To Correct: Verify that the number is missing in Policy Information and load in the GBHC# field. Once this has been done, there is no need to regenerate the claim.

EDIT 357 - GROUP NAME/NUMBER CONTAINS EXTRA DASH

Locator: 61-62 Group Name/Insurance Group No.
Scenario: The above edit will appear if there is more than one slash "/" in the Group Info field of Policy Information. There should only be one slash.
To Correct: Verify that there is more than one slash and correct in the Group Info field of Policy Information. The claim does not need to be regenerated.

EDIT 358 - INVALID EMPLOYER NAME

Locator: 65 - Employer Name
Scenario: This edit will appear if the Employer Name field in the Patient tab on the Registration and ADT screen Maintenance contains the words "Unemployed", "Disabled", "None", or "Retired."
To Correct: Verify that the above Employer name is loaded in the Patient tab on the Registration and ADT screen and correct it accordingly. If the above person is not employed, then leave the field blank. The claim will then have to be regenerated.

EDIT 359 - VERIFY DIAGNOSIS CD; CPT = XXXXX

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear if the claim contains the following CPT codes: 82728, 86316, 84153 or 93005.
To Correct: Verify that the Diagnosis Code and the CPT are pulling correctly. If not, the diagnosis or the CPT will need to be corrected. The CPT may be corrected on the Detail Charges screen and on the actual item in the Item Master. The Diagnosis Code may be corrected on the Stay Information screen or through Medical Records.

EDIT 360 - EXP PAY NOT = SUM OF DETAIL LINES

Locator: 55 - Est. Amount Due
Scenario: This edit will appear if the Expected Pay does not equal the Detail Charges total.
To Correct: Verify that the totals do not match, then research. The Detail Charges screen will only print 7 digits of a dollar figure. If the dollar amount is over $99,999.99, the edit will appear because the dollar amount will not match total charges in the Insurance screen. The Total Charges field can print up to 8 digits.

EDIT 361 - REV CODE 54X NEEDS A MODIFIER

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear if a Medicare claim exists with a Revenue Code of 54X that does not have a modifier.
To Correct: Verify that the above criteria applies. Then, load the modifier in the Item Master. Once loaded, regenerate the claim.

EDIT 362 - ATTENDING PHYSICIAN LICENSE NBR MISSING

Locator: 76 - 78 - Attending/Other Physician IDs
Scenario: This edit will appear for Alabama Medicaid claims when the License/Tax number is missing from field 11 of the Physician's table.
To Correct: Verify that the field is blank. Load the number in the Physician's Table field 11. The claim will not need to be regenerated.

EDIT 363 - KENTUCKY BLUE CROSS LAB CHARGES ON FILE-REVIEW

Scenario: The above edit appears if Kentucky Blue Cross lab charges are present.
To Correct: Verify that the above criteria has been met. Make sure charges are pulling to a physician claim.

EDIT 364 - CLAIM CONTAINS REV CODE 253

Locator: 42 - Revenue Code
Scenario: This edit will appear for Texas Medicaid claims with a Revenue Code of 253.
To Correct: Verify that the charges are "take home drugs". If so, they must be billed as non-covered. Detail Charges will need to be manipulated if charges are not pulling as non-covered. For future claims, the Summary Charge Code can be loaded in page 4 field 14 of the Insurance Company tables to force those charges to pull as non-covered.

EDIT 365 - ADMIT TYPE=1; CHECK FOR ER CERT.

Locator: 14 - Admission Type
Scenario: This edit will appear if the claim is an Alabama Medicaid claim with an emergency visit admit type of "1".
To Correct: Verify the above criteria. Once this is done, check to see if "Certified Emergency" or "E" is pulling to the UB04 in the correct locator.

EDIT 366 - ADMIT YR AND DISCHARGE YR MUST BE THE SAME

Locator: 12 - Admit Date
Scenario: This edit will appear if the admit and discharge year are not the same on a Medicare claim.
To Correct: Verify that the dates fall in different years. If so, those charges must be billed separately. Create another claim and manipulate the Detail Charges screen.

EDIT 367 - BILL TYPE 13X, 14X, OR 83X-ADMT DT NOT=DIS D

Locator: 4 - Type of Bill
Scenario: This edit will appear for Alabama Medicaid claims with a Bill Type of 13X, 14X or 83X and the admit/discharge dates are different.
To Correct: Verify the Bill Types and admit/discharge dates. If dates differ, then the charges must be billed separately for each service date. A new claim will need to be created and Detail Charges manipulated.

EDIT 368 - MISSING INSURED'S NAME IN FIELD 58

Locator: 58 - Insured's Name
Scenario: This edit will appear when a claim exists with the Patient Relation to Subscriber as "01" or "18" if using new relationship codes and the patient and subscriber names do not match.
To Correct: Verify the names of the patient and subscriber. If they do not match, either the relationship or subscriber name needs to be corrected. Enter the correct information in Policy Information. Do not regenerate the claim.

EDIT 369 - BILL TYPE 14X WITH REV CD 25X, 27X, OR 450

Locator: 42 - Revenue Code
Scenario: This edit will appear when a Revenue Code of 25X, 27X or 450 is present with a Bill Type of 14X. The Bill Type should be 13X.
To Correct: Verify Bill Type and Revenue Codes. Change Bill Type to 13X on the Detail Charges screen. Do not regenerate the claim.

EDIT 370 - E-CODE WITH NO ACCIDENT DATE

Locator: 31-36 Occurrence Codes
Scenario: This edit will appear when an E-Code is present without an accident date.
To Correct: Verify that the accident date is missing and that the E-Code is correct. Enter the accident date in Stay Information, Accident Information date or re-code in the Medical Records Grouper screen, depending on which is correct. Do not regenerate the claim.

EDIT 371 - MISSING KENPAC PHY

Locator: 77 - Other Physician ID
Scenario: This edit will appear when a referring physician is not loaded in Referring Data from the Patient Functions screen for a Kentucky Medicaid patient.
To Correct: Verify that the physician is not loaded in Referring Data on the Patient Functions screen and then load the correct physician. Regenerate the claim.

EDIT 372 - DIAGNOSIS 520.0 - 529.9 ON MCARE CLAIM

Locator: 67A - Q - Diagnosis Codes
Scenario: This edit will appear when Diagnosis Codes of 5200 to 5299 are placed on a Medicare account. These are invalid Diagnosis Codes for Medicare and should not be billed.
To Correct: Verify that the Diagnosis Code or codes are present and remove the codes from the Medical Records Grouper screen. Also, remove the codes from the Stay Information screen. Do not regenerate the claim.

EDIT 373 - REVENUE CODE OF 54X PRESENT

Locator: 42 - Revenue Code
Scenario: This edit will appear if a Revenue Code of 54X is present.
To Correct: This is simply a notice for the presence of the 54X Revenue Codes. If the 54X Revenue Codes are present then the claim should be an ambulance claim.

EDIT 374 - REV CODE 253 ON MEDICAID UB92

Locator: 42 - Revenue Code
Scenario: This edit will appear when a Revenue Code of 253 is present on an Iowa Medicaid UB04.
To Correct: Verify that the Revenue Code is present. If so, check the Detail Charges screen for the item that is pulling the above Revenue Code and correct it. Also, check the appropriate Summary Code and remove the Revenue Code. Do not regenerate the claim.

EDIT 375 - TYPE OF BILL INVALID – REV CODE 450

Locator: 42 - Revenue Code
Scenario: This edit will appear if a Revenue Code of 450 exists on a claim with a Bill Type of 111.
To Correct: Verify that the Revenue Code of 450 and the 111 Bill Type are present. If so, then either the Revenue Code or the Bill Type are incorrect. To change the Bill Type, access the Detail Charges screen and change the UB92 Type Bill field. If the Revenue Code is incorrect, then a summary code may need to be changed on the Detail Charges screen. Do not regenerate the claim.

EDIT 376 - MISSING PCP CODE

Locator: 31
Scenario: This edit will appear when there is a referring physician loaded for Indiana Medicaid claims with a missing 2-digit Precert#. This number should be loaded in the Percer#/Type field of Policy Information and pull to locator 31 of the UB04.
To Correct: Verify that the 2-digit code is missing and load it in Policy Information. Do not regenerate the claim.

EDIT 377 - INPATIENT CHARGE AMOUNT IS LESS THAN 0

Locator: 47 - Total Charges
Scenario: This edit will appear when an I/P claim contains a negative revenue amount even if the claim has a positive balance.
To Correct: Verify that the negative charge is present and remove it from the Detail Charges screen. Do not regenerate the claim.

EDIT 378 - MISSING VALUE CODE 81 OR COND CODE 80

Locator: 18 - 28 Condition Codes, 39-41 Value Codes
Scenario: This edit will appear if a Value Code of 81 and/or a Condition Code of 80 are missing for Georgia Medicaid Outpatient claims.
To Correct: Verify that the code is missing and load it in the UB92 Coding screen. Do not regenerate the claim.

EDIT 379 - NEEDS A1, X2, OR X3 CONDITION CODE

Locator: 18 - 28 Condition Codes
Scenario: This edit will appear if a 1, 2, 3 or 4 is not loaded in the Misc#3 field of Policy Information for Alabama Medicaid 1500 claims.
To Correct: Verify that the above numbers are not loaded. Load the correct number in the Misc#3 field. Do not regenerate the claim.

EDIT 380 - OR PROCEDURE WITHOUT HCPC

Locator: 74 - Procedure Codes, 44 – HCPCS/Rates/HIPPS Code
Scenario: This edit will appear when a HCPC is not present on a Medicare claim containing an OR procedure.
To Correct: Verify that the HCPC is not present, then load the HCPC on the Detail Charges screen. Do not regenerate the claim.

EDIT 381 - ADMITTING DIAGNOSIS IS NOT VALID ICD9 CODE

Locator: 69 - Admitting Diagnosis
Scenario: This edit will appear when there is an invalid Admitting Diagnosis Code on the claim.
To Correct: Verify that the invalid code is present and correct the code on the Stay Information screen and in the Medical Records Grouper screen. Also, if needed, load the code in the Diagnosis Table. Do not regenerate the claim.

EDIT 382 - PENDING CPT NOT COVERED

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear when a CPT code is present that is not going to be covered. This edit was added to help with Medical Necessity.
To Correct: Verify that the CPT code is present and remove it from the Detail Charges screen. Also, the Medical Necessity Table may need to be updated. Do not regenerate the claim.

EDIT 383 - SCREENING CPT NOT COVERED

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear when a screening CPT is present that will not be covered. This edit was added to help with Medical Necessity.
To Correct: Verify that the CPT is present and remove it from the Detail Charges screen. The Medical Necessity Table may need to be updated. Do not regenerate the claim.

EDIT 384 - CPT NOT SUPPORTED BY DIAGNOSIS

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear if there is a CPT code that does not have a supporting diagnosis loaded in the Medical Necessity Table. This edit was added to help with Medical Necessity.
To Correct: Verify that the CPT code does not have a supporting diagnosis and correct. Load the diagnosis in the Medical Necessity Table or remove the CPT from the table and the Detail Charges screen. Do not regenerate the claim.

EDIT 385 - HOME HEALTH BILL TYPE REQUIRES MSA NUMBER

Locator: 4 - Type of Bill
Scenario: This edit will appear when a Home Health Bill Type is present without an MSA number. The MSA number is a 4-digit number that signifies the area of the agency.
To Correct: Verify that the Bill Type is for Home Health. Also, verify that the MSA number is missing and load it in the appropriate field. The MSA number must pull with a Value Code of 61. The dollar amount must end with a period and 2 zeroes. If the Value Code and the correct dollar amount are not pulling, load them in the UB92 Coding screen. Do not regenerate the claim.

EDIT 386 - DIAGNOSIS CODE EXPIRED

Locator: 67A - Q - Diagnosis Codes
Scenario: This edit will appear when a Diagnosis Code is present that has expired.
To Correct: Verify that the Diagnosis Code has expired by checking the Diagnosis Code Table in the Business Office Tables. If so, decide whether the Diagnosis Code should be expired and correct. If it should be expired, then use another Diagnosis Code. Load the correct code in Stay Information. If it should not be expired, remove the date and call CPSI to verify this. Do not regenerate the claim.

EDIT 387 - EXPIRED CPT CODE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear when one or more of the following problems exist: if an invalid CPT code is loaded in the Item Master, if the CPT code in the Item Master has expired, if a CPT on the Detail Charges screen is invalid, and/or if a CPT code on the Detail Charges screen has expired.
To Correct: Verify the location of the CPT code problem and correct it appropriately. If the problem exists in the Item Master, enter a valid CPT or remove the problem CPT code. Or, if the CPT on the Detail Charges screen is the problem, then remove it or enter a valid one. Do not regenerate the claim.

EDIT 388 - INS. SPECIFIC NON-COVERED CHARGE ON CLAIM

Locator: 48 - Non-Covered Charges
Scenario: This edit will pull if a Summary Charge Code has been entered in the Insurance Company Table page 4, field 14 to cause those charges to pull to the Non-Covered column and they are instead pulling as Covered.
To Correct: Access the Detail Charges screen of the claim and enter the charges into the Non-Covered column for the appropriate Summary Charge Code. The claim will not need to be regenerated.

EDIT 389 – DUP CPT CODE – SAME DAY

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will pull if a CPT code is pulling multiple times for the same Service Date on a claim.
To Correct: Verify that the item with the CPT code was posted duplicate times to the patient's Account Detail. If they were posted in error, have Data Processing remove the charges and regenerate the claim. If a single CPT code was entered into multiple Item Masters incorrectly, then replace with the correct CPT code and regenerate the claim.

EDIT 390 - E OR M DIAGNOSIS CODES PRESENT

Locator: 67A - Q - Diagnosis Codes
Scenario: This edit will print if the state is Louisiana, the Financial Class of the claim is Medicaid, and the claim has any Diagnosis Codes that begin with "E" or "M".
To Correct: The Diagnosis Code should be removed so that it will not print to the claim. The claim will not need to be regenerated.

EDIT 391 - REFUND CHARGE PRESENT

Scenario: The above edit will pull if a Refund Charge (Summary Charge Code "RF") exists on the claim.
To Correct: Verify the reason the charge was posted to the patient's account. If posted in error, have Data Processing back the charge off the patient's account and regenerate the claim.

EDIT 392 - OBSERVATION REV CODE 762 QUANTITY > 48

Locator: 42 - Revenue Code, 46 - Units of Service
Scenario: This edit will pull if a Medicare claim has a Revenue Code of 762 with a quantity greater than 48.
To Correct: Verify if the charge was placed in error on the patient's account. If so, have Data Processing reverse and enter the correct charge. The claim will then need to be regenerated. If the charge was not posted in error, then the Detail Charges screen will need to be manipulated so that the quantity of the Observation Charge is not greater than 48. The claim will not need to be regenerated.

EDIT 393 - NO PRIMARY CLAIM WITH SECONDARY CLAIM PRESENT

Scenario: This edit will pull to a secondary claim if there is no primary claim present on the account.
To Correct: Research should be conducted to determine why no primary claim exists on the account. Create the primary claim and move it to the same status as the secondary claim.

EDIT 395 - CPT FREQUENCY LIMIT PRESENT FOR CPT XXXXX

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: If a Frequency Interval has been loaded in the Medical Necessity Table (Path: Hospital Base Menu > Master Selection > Business Office Tables > Maintenance Menu > Med-Nec > "U"pdate Medical Necessity File > Select seq# > Frequency of Test) for the CPT specified (if supported by a Diagnosis), then this edit will appear. It indicates that a frequency limit exists for this CPT.
To Correct: Steps should be taken to determine if this test has been ordered more frequently than the limit specified for the time frame (Month, Day, Year) indicated in the Medical Necessity Table, which may cause the test to be denied if billed.

EDIT 397 - REVENUE CODES 250, 270 & 483 ALL PRESENT

Locator: 42 - Revenue Code
Scenario: This edit will appear if a Medicaid claim for the state of Michigan with a Bill Type of 13X contains all three Revenue Codes and has HCPC codes of 92XXX and 93XXX.
To Correct: The edit will be removed once the claim no longer contains all three Revenue Codes 250, 270 and 483.

EDIT 398 - QUANTITY >1 FOR TOB 711 AND REV CODE 521

Locator: 46 - Service Units
Scenario: This edit will appear if a claim with a Bill Type of 711 and contains a Revenue Code 521 with a quantity greater than 1.
To Correct: The edit will no longer appear if the quantity of the Revenue Code 521 is 1 or removed.

EDIT 399 - CONDITION CODE 20 OR 21 NEEDED FOR PROCEDURE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear if an MB* claim contains a CPT with a Status Indicator of "A" but no Condition Code 20 or 21 are present.
To Correct: This edit will no longer appear once a Condition Code of 20 or 21 is present on the claim.

EDIT 400 - CONDITION CODE G0 NEEDED FOR PROCEDURE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear on an MB* claim if multiple CPT's with Status Indicator "V" are present for the same date of service without a Condition Code of G0.
To Correct: This edit will no longer appear once a Condition Code of G0 is present on the claim.

Edits 401 - 500

EDIT 401 - MODIFIER 25 NEEDED FOR PROC AND DATE COMBO

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear on an MB* claim if a CPT with Status Indicator "V" is present along with CPT's with Status Indicators "S" or "T" on the same date of service with no Modifier 25 on the "V" CPT.
To Correct: The edit will no longer appear once a Modifier 25 has been added to the "V" CPT.

EDIT 402 - MODIFIER 73 OR 74 WITH UNITS > 1

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear on an MB* claim if a CPT/HCPC has a Modifier of 73 or 74 and the units of service are greater than 1.
To Correct: This edit will no longer appear once the units of service are 1 or removed.

EDIT 403 - ONLY INCIDENTAL SVCS – REIMB MAY BE $0.00

Locator: 44 – HCPCS/Rates/HIPPS Code
Scenario: This edit will appear on an MB* claim if a CPT with Status Indicator "N" is present on the claim, indicating an Incidental Procedure and reimbursement may be $0.00.
To Correct: This edit will no longer appear once an "N" CPT no longer exists on the claim.

EDIT 404 - INPATIENT PROCEDURE PRESENT ON CLAIM

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear if an MB* claim contains a CPT code with a Status Indicator of "C", indicating an Inpatient Procedure.
To Correct: This edit will no longer appear once the Inpatient Procedure has been removed from the claim.

EDIT 405 - MISSOURI MEDICAID: ADDITIONAL INFORMATION REQUIRED

Scenario: Missouri Medicaid has several surgical procedures that require additional information to be submitted with the claim. This edit will appear if a Missouri X** claim has one of the following CPT codes:
28290, 28292, 28293, 28296, 28297, 28306, 28308, 47600, 47605, 47610, 47612, 47620, 49495, 49500, 49500-50, 49505, 49505-50, 49520, 49525, 49550, 49550-50, 49555, 49560, 49565, 49570, 49580, 49585, 56308, 56316, 56317, 56340, 56341, 56342, 57240, 57250, 57260, 57265, 58120, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 59525, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63020-50, 63030, 63030-50, 63035, 63040, 63042, 63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63086, 63088, 63090, 63091, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 66840, 66850, 66852, 66920, 66983, 66984, 55250, 55250W1, 56301, 56302, 58600, 58605, 58611, 58615.
To Correct: This is a notice for the presence of one of the CPT codes listed. Additional Information is required and the claim must also be filed paper.

EDIT 406 - ABN SIGNATURE ON FILE; ABN REQUIRES SIGNATURE

Scenario: This edit will pull a message depending upon whether the patient's Advanced Beneficiary Notice has been signed.

EDIT 407 - PATIENT STATUS CODE 30 INVALID FOR BILL TYPE 131

Scenario: This edit will pull for the state of Kansas if the Bill Type is 131 and a Discharge Code of 30 is present.
To Correct: Once the Discharge Code of 30 has been changed, the edit will no longer pull.

EDIT 408 - CPT (82985 OR 83036) NOT SUPPORTED BY DIAGNOSIS

Scenario: This edit will pull if CPT Codes 82985 or 83036 are present but are not linked to any of the following Diagnosis Codes: 25000–25093, 3548–3549, 3558-3559, 3582, 36201-36229, 34800–64804, 7902, 7906, 9623, V122 and V5869.
To Correct: The edit will no longer pull once CPT Code 82985 or 83036 are supported by one of the Diagnosis Codes listed above.

EDIT 410 - MISSING OR INVALID OASIS MATCHING KEY

Scenario: This edit will pull if there is no Precert# for claims with Financial Class MH* and Bill Types 322, 332, 329 and 339.
To Correct: The edit will no longer pull once there is a Precert# loaded in Policy Information.

EDIT 411 - INVALID HIPPS CODE

Scenario: This edit will pull if there is an invalid HIPPS code on claims with Financial Class MH* and Bill Types 322, 332, 329 and 339.
To Correct: The edit will no longer pull once there is a valid HIPPS Code loaded in Stay Information, HH HIPPS Codes/Dates field. The code should have 4 Alpha characters followed by a 1 only.

EDIT 412 - TX MEDICAID O/P MUST HAVE HCPC-CPT CODE

Scenario: For the state of Texas, this edit will pull if a Medicaid O/P claim does not have an associated CPT code loaded.
To Correct: The edit will no longer pull once a CPT code is loaded in the item master and the claim is regenerated.

EDIT 413 - CHARGE LINE AMOUNT MUST BE > 0

Scenario: For the state of Arkansas, this edit will pull if a Blue Cross claim has a line in the Detail Charges screen with a zero dollar amount.
To Correct: The edit will no longer pull once the zero dollar charge line has been removed.

EDIT 414 - CONTRACT NUMBER IN WRONG FORMAT

Locator: 60 - Insured's Unique ID
Scenario: For the state of Washington, this edit will pull if a Medicaid claim has a Contract number that is not in the following format: AANNNNNNAAAAAX, where A = Alpha, N = Numeric and X=Alpha or Numeric.
To Correct: The edit will no longer pull once the Contract number meets the above requirement.

EDIT 415 - TOO MANY LINES OF DETAIL (>20)

Scenario: For the state of Texas, this edit will pull if a Blue Cross claim has more than 20 lines of detail.
To Correct: The edit will no longer pull once there are 20 lines or less of detail in the Detail Charges screen.

EDIT 416 - CLAIM MUST BE BILLED THRU BHO

Scenario: For the state of Tennessee, this edit will pull if a Medicaid claim with one of the following diagnoses is billed through Tenncare (X**):
290.0-290.4, 290.8-290.13, 290.20-290.21, 290.40-290.43, 291-291.9, 292.0-292.1, 292.8-292.9, 292.11-292.12, 292.81-292.84, 292.89, 292.0-293.1, 293.8-293.9, 293.81-293.84, 293.89, 294.0-294.1, 294.8-294.11, 295.0-295.9, 296.0- 296.9, 296.80-296.82, 296.89-296.90, 296.99 297, 297.0-297.3, 297.8-297.9, 298, 298.0-298.4, 298.8-298.9, 299-299.91, 300, 300.00-300.02, 300.7-300.9, 300.09-300.16, 300.19-300.23, 300.29, 300.81-300.82, 300.89, 301.0-301.5, 301.6-301.9, 301.10-301.13, 301.20-301.22, 301.50-301.51, 301.81-301.84, 301.89, 302, 302.0-302.9, 302.50-302.53, 302.70-302.76, 302.79, 302.81-302.85, 302.89, 303.00-303.93, 304.0-304.9, 305, 305.0, 305.2-305.9, 306-306.99, 307-307.9, 307.20-307.23, 307.40-307.49, 307.50-307.54, 307.59, 307.80, 308, 308.1-308.4, 308.9, 309.0-309.4, 309.8, 309.9, 309.21-309.24, 309.28, 309.81-309.83, 309.89, 310.0-310.1, 310.9, 311, 312, 312.0-312.4, 312.8-312.9, 312.39, 312.81-312.82, 312.89, 312.30-312.35, 313.00-313.99, 314.0-314.2, 314.8-314.9, 314.00-314.01, 316.
To Correct: The edit will no longer pull once the claim is changed to bill through "BHO" instead of Tenncare (X**).

EDIT 417 - CLAIM SPANS MORE THAN ONE MONTH

Scenario: For the state of Alabama, this edit will pull if a Medicaid claim has service dates that are in two different months.
To Correct: The Medicaid claim may need to be split billed.

EDIT 418 - INPATIENT REHAB PPS

Scenario: This edit will pull for claims whose Insurance Company Table has "Inpatient Rehab PPS?" answered "Y" and there is a 2 digit CMG Summary Code on the Detail Charges screen.

EDIT 420 - LINES OF DETAIL >MAX IN INS CO TABLE

Scenario: This edit will pull for Blue Cross claims (except APC claims) when "??" or "ZZ" summary code appears on the Detail Charges screen of the claim. When either of these pull to UB04, the claim has exceeded the number of detailed lines specified in Insurance Company Table page 4 field 9.
To Correct: Edit will no longer pull when the correct numbers of lines pull to the UB04.

EDIT 421 - ER OR OP STAY WITH ROOM CHARGES (REV CD 10X-21X)

Scenario: Edit will appear if there are room charges on an outpatient or ER account, stay type 2 or 3. The revenue codes for room charges would fall in the 10X to 21X range.
To Correct: Room charges should be taken off account through Review and Delete screen.

EDIT 422 - MEDICARE OBSERVATION (GO244)

Scenario: Edit appears if a Medicare Outpatient claim has a revenue category 762 and one of the following diagnosis codes: 4110, 4111, 41181, 41189, 4130, 4131, 4139, 78605, 78650, 78651, 78652, 78659, 49301, 49302, 49311, 49312, 49321, 49322, 49391, 49392, 3918, 39891, 40201, 40211, 40291, 40401, 40403, 40411, 40413, 40491, 40493, 4280, 4281, 4289, 42820-42823, 42830-42833 or 42840-42843.
To Correct: Determine if the HCPC code GO244 can be used to bill the claim. This edit is a warning, it will continue printing as long as the claim meets the criteria.

EDIT 423 - NEED VALUE CODE A0 FOR AMBULANCE CLAIMS

Scenario: Edit will appear if a *BA or *CA claim for ambulance charges does not have Value Code A0 in front of the 5 digit zip code in the UB92 Coding screen. (I.e., A0XXXXX where A0= the Value Code and X = zip code.
To Correct: Value code and zip code (A0XXXXX) need to be on UB92 Coding screen.

EDIT 424 - REVENUE CODES 250 & 637 PRESENT

Scenario: This edit pulls for Medicare Outpatient claims that have revenue codes of 250 and 637.
To Correct: The revenue codes should be combined on the Detail Charges screen if the drug (637) that is administered is considered part of the procedure.

EDIT 426 - ACCIDENT OCCURANCE CODE – VAL CD 45 MISSING

Scenario: This edit pulls for New York Blue Cross claims when occurrence codes 01-06 & 11 appear in the UB92 Coding screen, but no "45" value code is present.
To Correct: Accident date and time should be loaded in the Stay tab on the Registration and ADT screen.

EDIT 427 - CLAIM GENERATION DATE >90 DAYS FOR X** CLAIM – NO REASON CODE

Scenario: This edit pulls if New York sites submit a claim to NY Medicaid 90 days after discharge. If so, they are required to supply a reason code on Form A or B.
To Correct: Reason code must be loaded in the Medigap # field in Policy Information.

EDIT 436 - MISSING TPL CODE

Scenario: This edit pulls if the claim has Medicaid as a secondary insurance to an insurance other than Medicare. A 6-digit TPL code is required.
To Correct: Verify that a TPL code is loaded. This pulls from Policy Information, Group Info field (before the /) for a UB04 and the same location for a 1500. The TPL is the "group name". If unavailable the billers should consult the manual with TPL codes provided by Medicaid.

EDIT 441 - DIAGNOSIS CODES DOESN'T SUPPORT MEDICAL NECESSITY

Scenario: This edit will appear if the claim reflects one of the following blood count CPT codes: 85007, 85008, 85013, 85014, 85018, 85025, 85027 or 85048
and reflects only one of the following diagnosis codes which do not support Medical Necessity for a blood count on a Medicare outpatient. The diagnosis codes that do not support Medical Necessity are as follows: 07810-07819, 2100-2109, 2140, 2160-2169, 217, 2220-2229, 2240, 2300, 2320-2329, 2240, 2300, 2320-2329, 30000-30009, 3010-3019, 3020-3029, 3070, 30720-30723, 3073, 30780-89, 31200-3129, 3130-39, 31400-3149, 36330-36335, 36340-43, 36350-57, 36370-3639,
36600-3669, 3670-3679, 37100-3719, 37300-3739, 37500-3759, 37100-3719, 37300-3739, 37500-3759, 37621-3769, 37710-37716, 37721-37724, 38420-25, 38481-82, 83500-3859, 3870-79, 38800-3885, 38900-3899, 440-4401, 44381-4439, 4481, 4570, 470, 4710-19, 4780, 4784, 5200-5209,52100-5219, 52400-5249, 5250-5263, 5276-79,
5756, 6000-6009, 6030, 6038-39, 605, 6060-61, 6081, 6083, 6100-6109, 6111-16,
6119, 6162, 6180-6189, 6200-03, 6216-17, 6272-79, 6280-89, 67600-67694, 6910-18,
6920-29, 700, 7010-19, 7020-28, 7039, 7060-69, 70900-7094, 71500-71598, 71600-71699, 71800-71899, 7260 -72691, 72700-7279, 72810-72885, 7320-7329, 73300-73309, 734, 7350-7359, 73600-7369, 7370-7379, 7380-89, 7390-99, 8300-8399, 8400-8489, 9050-9099, 9100-9199, 9300-932, 9550-9579, V030-V069, V110-V119, V140-V148, V160, V163, V210-V219, V2501-V259, V260-V269, V400-V409, V410-V419, V430-V431, V440-V449, V450-V4589, V480-V489, V490-V499,V51, V520-V529, V5301-V5309, V531, V5331-V5339, V534-V539, V540-49, V550-59, V570-V579, V585, V5901-V599, V610-V619, V622-29, V652-53, V6540-49, V655, V658-59, V660-69, V673-74, V693, V7101-09, V720-22, V724-27, V729, V7610-19 and V762.
To Correct: Verify that the correct diagnosis is on the claim.

EDIT 442 - NCD Denied Diagnosis Codes

Scenario: This edit will appear if there is a CPT code that has a "denied" ICD-9-CM diagnosis code as the reason the test is being performed. This edit has been added to assist in compliance with the National Coverage Decisions. The list of CPT codes are 87086, 87088,87539, 86689, 86701, 86702, 86703, 87390, 87391, 87534, 87535, 87537, 87538, 85007, 85008, 85013, 85014, 85018, 85025, 85027, 85048, 85730, 85610, 82728, 83540, 83550, 84466, 82523, 82947, 82948, 82962, 82985, 83036, 84436, 84439, 84443, 84479, 80061, 82465, 83715, 83716, 83718, 83721, 84478, 80162, 82105, 82378, 84702, 86304, 86300, 86301, 84153, 82977, 80074 and 82270. The denied ICD-9 codes are 7980-7989, V161-V162, V1640, V1651-V1659, V166, V167, V168, V169, V170-V178, V180-V188, V190-V198, V200-V202, V280-V289, V500-V509, V532, V600-V609, V620, V621, V650, V651, V680-V689, V700-V709, V730-V7399, V700-V709, V730-V7399, V740-V749, V750-V759, V760, V763, V642-V769, V770-V779, V790-V789, V790-V799, V800-V803, V810-V816, V820-V829.
To Correct: Verify that the CPT code does not have a supporting diagnosis. If the patient has requested that this noncovered/denied service be billed to Medicare the GZ modifier must be added to the CPT prior to submission of the UB04.

EDIT 443 - MISSING SUBSCRIBER DOB

Scenario: This edit pulls if EBOS claims are lacking the subscriber date of Birth.
To Correct: Verify that subscriber DOB is loaded in policy information.

EDIT 444 - MISSING AUTHORIZATION PHY

Scenario: This edit flags all X** claims when the state code is "ME" in the physician 999999 table and there is no physician loaded in the Referring Data screen on the patient's account.
To Correct: Verify that referring physician is loaded on account.

EDIT 445 - MISSING REFERRING AUTH NUMBER

Scenario: This edit flags all X** claims when the state code is "ME" in the physician 999999 and there is a referring physician setup on the claim but no referring physician authorization number loaded in the Referring Physician Table (Hospital Base Menu > Master Selection > Business Office tables > Maintenance Menu > Referring Physician).
To Correct: Verify that referring physician authorization number is loaded in Referring Physician table.

EDIT 446 - MISSING REFERRAL NUMBER

Scenario: This edit pulls if a referring physician is loaded on the claim for State code "LA" and no provider number is loaded.
To Correct: Verify that referring physician is loaded on the claim, if so make sure provider number is loaded. If not, one should be loaded.

EDIT 447 - REVENUE CODE 490 REQUIRES CHARGES BILLED UNDER ONE LINE

Scenario: This edit pulls when an O/P hospital claim includes an ICD-9 procedure in which the first two digits fall within the range of 01-86.
To correct: Verify that the ICD-9 procedure is correct. The claim must be built under one line using revenue code 490.

EDIT 448 - INCIDENTAL CHARGES BILLED ALONE

Scenario: This edit flags claims that only have incidental charges on them or one of the following revenue codes; 250, 251, 252, 253, 254, 255, 256, 271, 272 or 278.
To Correct: Verify charges are correct. Some charges may need to be placed on a separate claim. Incidental charges cannot be billed alone.

EDIT 451 - REV CODE 360 HAS ZERO CHARGE

Scenario: This edit appears if Rev Code 360 is present on an account multiple times as well as a line(s) with $0.00 charge amount.
To Correct: Verify charges on account.

EDIT 452 - MISSING OCCURRENCE CODE 11 FOR ONSET OF ILLNESS

Scenario: This edit appears on all commercial claims that do not have an 11 Occurrence code for onset of illness. B
To Correct: Verify onset of illness and load occurrence code 11 in UB92 Coding screen.

EDIT 453 - POSSIBLE 3rd PARTY LIAB – PROVIDE DOCUMENTATION

Scenario: This edit appears when any accident diagnosis code is present on an account. These accident diagnosis codes will begin with either an "E", "8" or "9".
To Correct: Supplemental documentation is needed for accident patients. Documentation will vary per financial class and each individual situation.

EDIT 454 - MISSING REFERRING PHYSICIAN

Scenario: This edit appears on Medicaid claims in the State of Louisiana when a referring physician is not loaded on the patient's account. A referring physician is required on the claim.
To Correct: Lock on the patients account, select Referring Data and load the referring physician. The claim has to be regenned.

EDIT 456 - REPETITIVE AND NONREPETITIVE SERVICES EXIST

Scenario: This edit appears on Medicare claims when a non repetitive revenue code appears on a claim with a repetitive revenue code. A repetitive revenue code would consist of the following: 290-299, 333, 410-419, 420-429, 430-439, 440-449, 550-559, 820-859, 482, 943, 900-901 and 911-919.This only applies to claims that have a bill type of 13x.
To Correct: Verify the revenue codes. If repetitive and non repetitive revenue codes exist on the account they should be separated. This can be accomplished through the Insurance Company Table page 4, field 11-13.

EDIT 457 - NEED OCC CODE 74 - ADDITIONAL MEDICARE CLAIM

Scenario: This edit appears on Medicare claims when the dates of service for a repetitive service and non repetitive service are billed on the same day.
To Correct: Occurrence code 74 should be added to the recurring Medicare claim in the UB92 Coding screen. This will allow Medicare to identify that it is not duplicated billing.

EDIT 459 - MISSING DEVICE CODE FOR CPT/HCPC 92995 OR 92996
C-Code: C1721

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper.

EDIT 460 - MISSING DEVICE CODE FOR CPT/HCPC G0298 OR G0300
C-Code: C1721

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 461 - MISSING DEVICE CODE FOR CPT/HCPC G0297 OR G0299
C-Code: C1722

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 462 - MISSING DEVICE CODE FOR CPT/HCPC 35458, 35459, 35460, 35470, 35471, 35472-35476, 92997-92998, 92282 OR 92984.
C-Code: C1725, C1885

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 463 - MISSING DEVICE CODE FOR CPT/HCPC 93600, 93602, 93603, 93609, 93610, 93612, 93615, 93616, 93618, 93623 OR 93631.
C-Code: C1730, C1731, C1732, C1733, C2629, C2630

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 464 - MISSING DEVICE CODE FOR CPT/HCPC 36557, 36558, 36570, 36571, 36581 36585 OR 36640
C-Code: C1751

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 465 - MISSING DEVICE CODE FOR CPT/HCPC 36557, 36558 or 36581
C-Code: C1750, C1752

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 466 - MISSING DEVICE CODE FOR CPT/HCPC 61885, 63685, 64590 OR 61886
C-Code: C1767

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 467 - MISSING DEVICE CODE FOR CPT/HCPC 36260, 36563 OR 36583
C-Code: C1772, C1891

Scenario: This edit appears on MB* claims that have the Insurance Company Table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 468 - MISSING DEVICE CODE FOR CPT/HCPC 33211, 33216 OR 33217
C-Code: C1779, C1898

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 469 - MISSING DEVICE CODE FOR CPT/HCPC 33212
C-Code: C1786, C2620

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 470 - MISSING DEVICE CODE FOR CPT/HCPC 36570, 36571 or 36585
C-Code: C1788

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 471 - MISSING DEVICE CODE FOR CPT/HCPC 43256, 44370, 44379, 44383, 44397 45327, 45345 OR 45387
C-Code: C1874, C1875, C1876, C1877

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 472 - MISSING DEVICE CODE FOR CPT/HCPC G0297, G0298, G0299 OR G0300
C-Code: C1882

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 473 - MISSING DEVICE CODE FOR CPT/HCPC 61626
C-Code: C1887, C2628

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 474 - MISSING DEVICE CODE FOR CPT/HCPC 93600, 93602, 93603, 93610, 93612, 93615,
93616, 93618, 93623 OR 93631
C-Code: C1766, C1892, C1893, C1894

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 476 - MISSING DEVICE CODE FOR CPT/HCPC 33224 OR 33225
C-Code: C1900

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 477 - MISSING DEVICE CODE FOR CPT/HCPC 43256, 44370, 44379, 44383, 44397
45327 45345 or 45387
C-Code: C2617

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 478 - MISSING DEVICE CODE FOR CPT/HCPC 55873
C-Code: C2618

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 479 - MISSING DEVICE CODE FOR CPT/HCPC 43256, 44370, 44379, 44383,
44397, 45327, 45345, 45387, 36260, 36563 OR 36583
C-Code: C2625

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, field 10 "APC REIMBURSE?" set to "Y". If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

Edit 487 - REVENUE CODE 0343 NEEDS A VALID RADIOLOGY HCPC

Scenario: The above edit appears if a claim has a Bill Type of 13X or 83X and a Revenue Code of 343.The claim must have one of the CPT codes in the Item Master listed in Appendix A (attached).
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with the above Revenue Codes and the items have valid CPT codes in the Item Master. If the items are missing CPT codes, load the CPT code in the Item Master and regenerate the Claim.

Edit 488 - ER REVENUE CODE 450 NEEDS MODIFIER 25 FOR MEDICARE PATIENTS WITH EKG OR XRAY SERVICES

Scenario: The above edit appears anytime a Medicare patient (M**) is in the E/R and has a rev code of 450 and CPT of 99281-99285 and another service like X-ray or EKG with revenue code 32X or 720 is performed on that account. The CPT for the E/R procedure must be appended with a modifier 25.
To Correct: Verify the insurance is correct. If the account has a revenue code of 450 with a CPT of 99281-99285 and a X-ray or EKG service with revenue code 32X or 720, the CPT for the ER procedure must have a modifier of 25. The modifier may be added in the Detail Charges screen.

EDIT 490 - NEW YORK BLUE CROSS CLAIM NEEDS BIRTHWEIGHT

Scenario: The above edit appears if financial class B** has state code of NY in the Insurance Company table and the claim does not show the birth weight for a patient less than 29 days old with a bill type of 11X.
To Correct: Verify the insurance and date of birth for the patient. If this is correct, add the weight in the patient's account in the Clinical tab on the Registration and ADT screen.

EDIT 491 - CPT/HCPC CODES THAT SUPPORT MEDICAL NECESSITY

Scenario: The above edit appears for M**claims if CPT/HCPC codes J0882 or J0886 are present in the Detail Charges screen, and ICD9s 28521 and 5856 are not loaded in the Grouper screen (pulling to Stay Information screen).
To Correct: Verify the Insurance company. If CPT/HCPC codes J0882 or J0886 are pulling to the Detail Charges screen, verify if ICD9 28521 and 5856 should be coded on the Grouper screen. The claim will need to be regenerated if any codes are changed.

EDIT 493 - PREAUTHORIZATION REQUIRED FOR RADIOLOGY PROCEDURES

Scenario: The above edit appears for BB* claims with IA as the state code in the Insurance Company table, page 1 field 5. A pre authorization number must be entered in the Policy Information screen or in the Guarantor/Ins tab on the Registration and ADT screen for accounts with non-emergency radiology procedures.
To Correct: Verify the insurance company code. If the account has one of the following CPT codes, a pre certification number must be entered in the Policy Information screen. CPT's: 74150, 74160, 74170, 71250, 71260, 71270, 73200-73202, 73700-7302, 70450, 70460, 70470, 70480-70482, 70486-70488, 70490-70492, 72192-72194, 72125-72133, 74175, 75635, 71275, 73206, 70496, 70498, 72191, 74181-74186, 76400, 76093, 76094, 71550-71552, 75552-75556, 73218-73223, 73718-73723, 70336, 70540, 70542, 70543, 70551-70553, 72195-72197, 72141, 72142, 72156, 72146, 72147, 72157, 72148, 72149, 72158, 74185, 71555, 73225, 73725, 70544-70549, 72198, 72159, 76390, 78460, 78461, 78464, 78465, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78494, 78608, 78609, 78491, 78492, 78811-78816

EDIT 494 - ICD9 NEEDED FOR ANEMIA AND INDICATION

Scenario: The above edit appears for M** claims with CPT/HCPC codes J0885 or J0881 in Detail Charges screen (loaded on item or in the MR grouper screen), but do not have an ICD-9 code from the following two list. Each claim needs at least one from each category.
Each claim must contain an ICD-9 from the following anemia list:
2850, 28521, 28522, 28529.
Each claim must also contain an ICD-9 code from the appropriate indication as follows:
1400-20891, 2300-2399, 40311, 40391, 40413, 40491, 40493, 5853, 5854, 5855, E9317, V078, V5811.
To Correct: Verify the Insurance. If the account has a CPT/HCPC code of J0885 or J0881, it must have one of the following ICD9 codes from the anemia list: 2850, 28521, 28522, 28529 and also one of the following ICD9 codes from the appropriate indication list: 1400-20891, 2300-2399, 40311, 40391, 40413, 40491, 40493, 5853, 5854, 5855, E9317, V078, V5811. The claim will need to be regenerated to pull any additional codes that have been added.

EDIT 496 - HALTER MONITOR NEEDS DIAGNOSIS CODE

Scenario: The above edit appears if a claim is M**, has one of the following CPT/HCPC codes on the detail charges screen: 93224 93225 93226 93227 93230 93231 93232 93233 or 93235 and does not have an appropriate principle diagnosis.
To Correct: Verify the CPT/HCPC is correct. If correct add a principle diagnosis code of 41000-41092, 4110-4118, 41100-41189, 412, 4130, 4131, 4139, 4148, 4240, 4241, 4254, 4260, 42610, 42612, 42613, 4262, 4263, 4264, 42651, 42652, 42653, 4266, 4267, 42681, 42682, 42689, 4269, 4270, 4271, 4272, 42731, 42732, 42742, 42760, 42761, 42769, 42781, 42789, 4279, 4280-4289, 4358, 4359, 78002, 7802, 7804, 7850, 7851, 78602, 78609, 78650, 78651, 78659, 99601, V4500, V4501, V5863, V5864, V5865, V5869, V5883, or V6751 on page 1 of the MR Grouper screen.

EDIT 497 - VACCINE CHARGE ON INPATIENT

Scenario: This edit will appear if the account is an Inpatient, with a 771 revenue code present and the Type of Bill does not equal 12X .
To Correct: Check the bill type on the account. If incorrect, change the bill type on the Detail Charges screen.

EDIT 499 - BLOOD PRODUCT CHARGE BUT NO BLOOD ADMINISTRATION CHARGE

Scenario: This edit will appear if there is a blood product charge with a 038X or 0390 revenue code, but no 0391 revenue code is present.
To Correct : Verify charges and revenue codes on the account. If a charge needs to be added, contact data processing.

EDIT 500 - DUPLICATE BLOOD ADMINISTRATION CHARGES ON THE SAME DAY

Scenario: This edit will appear if CPT Code range 36430 through 36460 is duplicated on the same day.
To Correct: Verify charges and CPT codes on the account. If a charge needs to be added or credited on the account, contact data processing.

Edit 501

EDIT 501 - Need CPT PANEL CODE 80050

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a F/C of XB*, state code of MO (Insurance Company Table, p1 f5) and CPT codes 84443, 85025 and 80053 appear on the claim with the same service dates. The edit will also appear if a claim has a F/C of XB*, state code of MO (Insurance Company Table, p1 f5) and CPT codes 80053, 84443 and 85027 appear on the claim with the same service dates.
To Correct: Claims with the CPT codes listed above with the same service dates need to bill under CPT code 80050.

Appendix A

Edits 177 and 487 appear if a claim does not have a valid CPT code loaded in the Item Master. This section lists the valid CPT codes for each edit.

Valid CPT for Edit Number 177

J0290
J0340
J0380
J0510
J0530
J0610
J0630
J0635
J0690
J0694
J0695
J0696
J0697
J0698
J0700
J0710
J0743
J0745
J0780
J0895
J0970
J1050
J1070
J1080
J1160
J1165
J1170
J1200
J1240
J1380
J1390
J1410
J1580
J1630
J1631
J1720
J1760
J1780
J1790
J1840
J1885
J1890
J1940
J2060

J2175
J2270
J2320
J2321
J2322
J2540
J2550
J2560
J2680
J2700
J2720
J2765
J2920
J2930
J2970
J3010
J3070
J3120
J3130
J3230
J3250
J3260
J3280
J3301
J3364
J3365
J3370
J3410
J3420
J3430
Z9930
Z9935
Z9939
Z9941
Z9943
Z9944
Z9945
Z9949
Z9955
Z9959
Z9963
Z9969
Z9970
Z9971
Z9972
Z9974
Z9975
Z9976
Z9977
Z9996
Z9997
Z9998
90724

90731
90732

Valid CPT for Edit Number 487

70000-79999
A4641
A4642
A9500
A9502
A9503
A9505
A9507
A9508
A9510
A9511
A9512
A9513
A9514
A9515
A9516
A9519
A9520
A9521
A9524
A9526
A9528
A9529
A9531
A9600
C1079
C1080
C1081
C1082
C1091
C1092
C1093
C1122
C1200
C1201
C1775
C9013
C9102
C9103
C9400
C9401
C9403
C9404
Q3000
Q3002
Q3003
Q3004

Q3005
Q3006
Q3007
Q3008
Q3009
Q3010
Q3011
Q3012

Appendix B

Edit 297 appears if a claim has a Diagnosis Code listed in this section as the Principal Diagnosis.

Principal Diagnosis Codes; Manifestation Code Edit Number 297

3207
3210
3211
3212
3213
3214
3218
3230
3231
3232
3234
3236
3237
3302
3303
3317
3344
3362
3363
3371
3571
3572
3573
3574
3581
3595
3596
36201
36202
36271
36272
36411
36541
36542
36543

36544
36641
36642
36643
36644
37044
37105
37215
37231
37233
3734
3735
3736
37451
37613
37621
37622
38013
38015
38202
4200
4211
4220
42491
4257
4258
44381
45620
45621
4841
4843
4845
4846
4847
4848
5161
5171
5172
5178
5670
5731
5732
58081
58181
58281
58381
59081
5954
59801
6014
60491
60881
61611

61651
6281
7130
7131
7132
7133
7134
7135
7136
7137
7138
72081
72701
7311
7318
73740
73741
73742
73743
7740
77431
7745

1500 Insurance Claim Edits

Overview

Within the billing procedures are 1500 claim edits. These edits help the Business Office to determine what additional information should be included on the insurance claims prior to billing.

Insurance 1500 Claim Edits

EDIT 1 - PATIENT NAME IS BLANK

Locator: 2 - Patient's Name
Scenario: The patient's name is missing from the Patient tab on the Registration and ADT screen.
To Correct: Load the patient name in the Patient tab on the Registration and ADT screen.

EDIT 2 - NAME ‘BABY’ IS INVALID

Locator: 2 - Patient’s Name
Scenario: The patient’s name is "BABY"
To Correct: Change the patient name from "BABY" to the appropriate name.

EDIT 3 - INVALID PATIENT SEX

Locator: 3 - Patient’s Birth Date/Sex
Scenario: The patient’s sex is not loaded in the Patient tab on the Registration and ADT screen.
To Correct: Load this information in the Patient tab on the Registration and ADT screen.

EDIT 4 - PATIENT BIRTHDAY INVALID

Locator: 3 - Patient’s Birth Date/Sex
Scenario: The patient’s birth date is missing.
To Correct: Load the information in the Patient tab on the Registration and ADT screen.

EDIT 5 - PATIENT ADDRESS IS BLANK

Locator: 5 - Address/Phone
Scenario: The patient’s address is missing.
To Correct: Load the information in the Patient tab on the Registration and ADT screen.

EDIT 6 - PATIENT ADDRESS1 CONTAINS SPECIAL CHARACTERS

Locator: 5 - Address/Phone
Scenario: Unusual characters appear in address field.
To Correct: Load the correct information in the Patient tab on the Registration and ADT screen.

EDIT 7 - PATIENT ADDRESS2 CONTAINS SPECIAL CHARACTERS

Locator: 5 - Address/Phone
Scenario: Unusual characters appear in address field.
To Correct: Load the correct information in the Patient tab on the Registration and ADT screen.

EDIT 8 - PATIENT CITY IS NOT ALPHABETIC

Locator: 5 - Address/Phone
Scenario: For the state of Texas, this edit occurs if non-alpha characters appear in the city field.
To Correct: Load the correct city in the Patient tab on the Registration and ADT screen.

EDIT 9 - PATIENT STATE IS NOT ALPHABETIC

Locator: 5 - Address/Phone
Scenario: For the state of Texas, this edit occurs if non-alpha characters appear in the state field.
To Correct: Load the correct state in the Patient tab on the Registration and ADT screen.

EDIT 10 - PATIENT ZIP CODE IS MISSING

Locator: 5 - Address/Phone
Scenario: The patient Zip code is missing.
To Correct: Load the information in the Patient tab on the Registration and ADT screen.

EDIT 11 - ADMISSION DATE IS INVALID

Locator: 18 - Hospitalization Dates Related to Current Services
Scenario: Admission date is missing.
To Correct: Load the correct Admission Date in the Stay Information screen.

EDIT 12 - PATIENT AGE > 65 & THIS CLAIM IS NOT MEDICARE

Scenario: Patient is over the age of 65, and does not have the Financial Class of Medicare. This edit will pull for Blue Cross claims in the state of Texas that meet this scenario.
To Correct: If the Patient does have Medicare, set up a Medicare claim.

EDIT 13 - BLUE CROSS WITHOUT BANK PLAN NUMBER

Scenario: If the Financial class is Blue Cross and the Provider state is North Carolina, and the Bank Plan Number is missing, then this edit will appear.
To Correct: Go to the Insurance Company table page 2 field 23 and load the information.

EDIT 14 - PATIENT AND SUBSCRIBER NAME MUST BE DIFFERENT

Locators: 2 - Patient's Name and 4 - Insured's Name
Scenario: If relation code in Policy Information screen is a number other than 1, then patient name and subscriber name must be different.
To Correct: Either change the relation code, or correct the Subscriber in the Guarantor/Ins tab on the Registration and ADT screen.

EDIT 15 - PATIENT AND SUBSCRIBER NAME MUST MATCH

Locators: 2 - Patient's Name and 4 - Insured's Name
Scenario: If relation code in Registration Policy Information screen of registration is 1, then patient name and subscriber name must be the same.
To Correct: Either change the relation code, or correct the Subscriber in the Guarantor/Ins tab on the Registration and ADT screen.

EDIT 16 - CONTRACT/CERTIFICATE NUMBER BLANK

Locator: 11 - Insured's Policy Group or FECA Number
Scenario: The contract and group number is blank in the patient's Insurance Policy Information screen.
To Correct: Load the information in the Guarantor/Ins tab on the Registration and ADT screen.

EDIT 17 - CONTRACT NUMBER IS BLANK OR ALL ZEROS

Locator: 1a - Insured's I.D. Number
Scenario: Contract Number field is blank.
To Correct: Load the Contract Number in the Policy information screen.

EDIT 18 - FIRST CHARACTER OF CONTRACT NUMBER NOT NUMERIC

Locator: 1a - Insured's I.D. Number
Scenario: For Medicare claims in the state of New Hampshire, if the Contract number begins with a character other than numeric, this edit will appear.
To Correct: Enter the correct number in the Policy information screen.

EDIT 19 - MEDICARE CERTIFICATE NOT NUMERIC

Locator: 1a - Insured's I.D. Number
Scenario: This edit will pull if the numeric portion of the certificate number is not numeric.
To Correct: Correct the number in the Policy Information screen.
Example: Certificate number would be XXA422058081A.

EDIT 20 - FIRST 3 DIGITS OF MEDICARE CERTIFICATE INVALID

Locator: 1a - Insured's I.D. Number
Scenario: This edit will pull if the first three characters are not XXA.
To Correct: Correct the number in the Policy Information screen.
Example: Certificate number would be XXA422058081A.

EDIT 21 - MEDICARE SUFFIX IS MISSING OR INVALID

Locator: 1a - Insured's I.D. Number
Scenario: This edit pulls if the fourteenth character of the Certificate number is not A, B, C, D, E, G or H.
To Correct: Correct the number in the Policy Information screen.
Example: Certificate number would be XXA422058081A.

EDIT 22 - MEDICARE SUFFIX OF H MUST BE FOLLOWED BY A, B OR C

Locator: 1a - Insured's I.D. Number
Scenario: This edit checks the fourteenth character of the Certificate number. When a suffix of "H" follows the certificate number, the system also checks to ensure another suffix code of A, B or C follows to further explain the plan the patient has.
To Correct: Correct the number in the Policy Information screen.

EDIT 23 - CONTRACT NUMBER HAS EMBEDDED SPACES/SPECIAL CHARACTERS

Locator: 1a - Insured's I.D. Number
Scenario: This edit checks the Policy Information screen to see if any character other then alpha or numeric exist.
To Correct: Remove spaces and/or punctuation from the contract number in the Policy Information screen from this field.

EDIT 24 - SUBSCRIBER IS BLANK

Locator: 4 - Insured's Name
Scenario: Subscribers name is missing from the Policy Information screen.
To Correct: Enter the guarantor name in the Policy Information screen.

EDIT 25 - SUBSCRIBER ADDRESS OR CITY IS BLANK

Locator: 7 - Insured's Address
Scenario: Subscribers address is missing from the Policy Information screen.
To Correct: Enter the Guarantors address in the Policy Information screen.

EDIT 26 - INSURED ADDRESS1 CONTAINS SPECIAL CHARACTERS

Locator: 7 - Insured's Address
Scenario: Non-alpha and/or non-numeric characters appear in the Subscribers address.
To Correct: Correct the address and remove any punctuation in the Policy Information screen.

EDIT 27 - INSURED ADDRESS2 CONTAINS SPECIAL CHARACTERS

Locator: 7 - Insured's Address
Scenario: Non-alpha and/or non-numeric characters appear in the Subscribers address.
To Correct: Correct the address and remove any punctuation in the Policy Information screens.

EDIT 28 - SUBSCRIBER STATE BLANK

Locator: 7 - Insured's Address
Scenario: The state is not loaded in the Policy Information screen for the address.
To Correct: Enter the Guarantors address state in the Policy Information screen.

EDIT 29 - SUBSCRIBER ZIP CODE MISSING

Locator: 7 - Insured's Address
Scenario: The Zip Code is not loaded in the Policy Information screen.
To Correct: Enter the Guarantors Zip Code in the Policy Information screen.

EDIT 30 - PRE-CERT NUMBER IS BLANK

Locator: 23 - Prior Authorization Number
Scenario: The pre certification number is missing from the Policy Information screen.
To Correct: Enter the precert number in the Policy Information screen.

EDIT 31 - INCORRECT CLAIM TYPE – NOT OUTPATIENT

Scenario: This edit will appear after a claim is generated then the form code is changed in the Insurance Company table.
To Correct: Check the patient type and also verify the form code in the Insurance Company table.

EDIT 32 - DETAIL CHARGE DATE INVALID

Locator: 24A - Date(s) of service
Scenario: For the state of Arkansas, this edit pulls if the Service date is missing.
To Correct: Verify dates of charges via patient account detail.

EDIT 33 - DETAIL CHARGE DATE INVALID

Locator: 24A - Date(s) of service
Scenario: This will occur if the charges on the patient account are not within the admit and discharge dates.
To Correct: Verify dates of charges via patient account detail.

EDIT 34 - OUTPATIENT CHARGE IS LESS THAN 0

Locator: 24F - $ Charges
Scenario: No charges appear on the patient account detail.
To Correct: Verify charges have been entered and posted to the patient account detail.

EDIT 35 - MORE THAN 5 DETAIL CHARGE ITEMS

Scenario: For Medicaid claims in the state of Georgia, this edit will pull if the patient claim has more then five lines of detail.
To Correct: Manually create another claim for this patient account.

EDIT 36 - TOO MANY SUMMARY CHARGE CODES

Scenario: When the detail has exceeded the number of lines allowed, it displays a Charge Summary code of "??"
To Correct: Increase the Max chg Lines on Claim in the Insurance Company table, page 4 field 9.

EDIT 37 - CLAIM CONTAINS MORE THAN 6 DETAIL LINES

Scenario: For "MP" and "BP" claims in the state of Kansas, this edit pulls if more then 6 lines of detail appear on the claim.
To Correct: Manually create another claim for this patient account.

EDIT 38 - CLAIM CONTAINS MORE THAN 6 DETAIL LINES

Scenario: For "BP" claims in the state of Vermont, this edit pulls if more then 6 lines of detail appear on the claim.
To Correct: Manually create another claim for this patient account.

EDIT 39 - MULTIPLE REV CODE 960-969 FOR SAME STAY

Scenario: For "MP" claims in the state of South Carolina, this edit pulls if there is more then one charge for Anesthesia.
To Correct: This edit is strictly a flag to warn of this occurrence. In this instance, verify the validity of multiple revenues codes for anesthesia.

EDIT 40 - CLAIM CONTAINS MORE THAN 12 DETAIL LINES

Scenario: For "XP" claims in the state of Mississippi, the above edit appears if the claim has more than 12 lines of detail on the account.
To Correct: Create another claim for this patient account.

EDIT 41 - CRNA CHARGES MUST NOT BE BILLED ON PAPER CLAIMS

Scenario: For the state of Alabama, the system looks for CPT codes between 00100 and 01999.
To Correct: If the above CPT codes appear on the claim, it cannot be billed electronically. A paper 1500 must be submitted.

EDIT 42 - BLUE CROSS ANESTHESIA CLAIM MINUTES MUST BE ENTERED

Scenario: For Blue Cross claims in the state of Idaho, if Revenue codes 963, 964 or 370 appear on the claim, this edit will appear, regardless of whether minutes are loaded or not. This is strictly a flag for the Insurance Biller.
To Correct: Verify the Anesthesia minutes are on the patient account.

EDIT 43 - REPEAT PROCEDURE BY SAME PHYSICIAN

Scenario: This edit will pull if there is a duplicate procedure listed for the same physician.
To Correct: Verify the Medical Records coding for this patient account.

EDIT 44 - REPEAT PROCEDURE BE ANOTHER PHYSICIAN

Scenario: This edit will pull if there is a duplicate procedure listed for another physician.
To Correct: Verify the Medical Records coding for this patient.

EDIT 45 - MISSING CPT CODE

Scenario: This edit will pull if there is not a CPT code on the claim.
To Correct: All charges on a 1500 should have a CPT code. Verify the coding is appropriate as well as charges.

EDIT 46 - TOTAL CHARGES EXCEED $99,999.99

Scenario: This edit will pull if the total charges exceed $99,999.99.
To Correct: Verify the charges to appear on the claim. This is done via the Detail Charges screen. If necessary, manually create another claim.

EDIT 47 - NO DIAGNOSIS CODE PRESENT

Locator: 21 - Diagnosis Code
Scenario: This edit will pull if the Diagnosis Code is missing.
To Correct: Verify the information is loaded in the Medical Records coding screen.

EDIT 48 - CLAIM CONTAINS AN E-CODE

Locator: 21 - Diagnosis or Nature of Illness or Injury
Scenario: This edit will pull for Medicare claims for the state of Kansas if an E-CODE is listed as a diagnosis code.
To Correct: Confirm the diagnosis in the Medical Records Grouper screens.

EDIT 49 - E-CODE DIAGNOSIS INVALID

Locator: 21 - Diagnosis or Nature of Illness or Injury
Scenario: For Blue Cross claims, this edit will pull if an E-Code is listed as a diagnosis.
To Correct: Medical Records will have to verify the coding for this claim.

EDIT 50 - ADMITTING DIAGNOSIS BLANK

Locator: 21 - Diagnosis or Nature of Illness or Injury
Scenario: For Medicare claims in the states of Arkansas, Louisiana, New Hampshire and Vermont, this edit will pull if the Admitting diagnosis is missing.
To Correct: Medical Records will need to correct this or the information can be entered into the Stay Information screen.

EDIT 51 - SURGERY DATE MISSING

Scenario: This edit will pull if the Surgery date is missing.
To Correct: In the Medical Records screen page 2 fields 31 through 40, first column, enter the procedure date.

EDIT 52 - SURGERY PROCEDURE CODE MISSING

Scenario: If surgical procedure code is missing the system will flag for this error.
To Correct: The procedure codes will need to be loaded in the patient Medical Records Grouper screen page 2, the second column of fields 31 through 40.

EDIT 53 - NO VALID DIAGNOSIS CODE PRESENT FOR EKG

Scenario: If an account has a CPT of 93010 and does not have one of the following Diagnosis codes or fall within the given ranges, then this edit will appear.
The diagnosis codes are as follows:

V7281	4140 – 4149	7804
0930 – 0934	4150 – 4151	7807
1640 – 1649	4160 – 4169	7820
2127	4170 – 4179	7823
3062	4200 – 42099	7825
391	4210 – 4219	7850 - 7859
393	4220 – 42299	78600 - 78609
3940 – 3949	4230 – 4239	778650 - 8659
3950 – 3959	4240 – 42499	7870
3960 – 3969	4250 – 4259	7871
3970 – 3979	4260 - 4269	7890
3980 – 39899	270 – 4279	7891
4010 – 4019	4280 – 4289	7932
40291 – 40300	4290 – 4299	79430 - 79431
40300 – 40391	4410 – 4419	99600 - 99609
4040 – 4049	4440 - 44489	7991
40500 – 40599	4460 - 4467	V450
41000 – 41092	4580 - 4589	V472
4110 – 41189	7800	V717
412	7802	
4130 – 4139	7803	

To Correct: Load the correct diagnosis on the patient Medical Records Grouper screen.

EDIT 54 - ACCIDENT HOUR BUT NO ACCIDENT DIAGNOSIS

Scenario: Accident hour is loaded in the Stay tab on the Registration and ADT screen., but no Accident diagnosis is present (except for Occurrence Code 11 – ILLNESS).
To Correct: Verify the Medical Records coding to ensure this was truly an accident.

EDIT 55 - ACCIDENT DATE BUT NO ACCIDENT DIAGNOSIS

Scenario: Accident date is loaded in the Stay tab on the Registration and ADT screen., but no Accident diagnosis is present (except for Occurrence Code 11 – ILLNESS).
To Correct: Verify the Medical Records coding to ensure this was truly an accident.

EDIT 56 - ACCIDENT DIAGNOSIS BUT NO ACCIDENT TIME

Scenario: There is an accident diagnosis but there is not an accident time.
To Correct: Verify this was the result of an accident; load the accident time in the Stay Information screen.

EDIT 57 - ACCIDENT DIAGNOSIS BUT NO ACCIDENT DATE

Scenario: There is an accident diagnosis but there is not an accident time.
To Correct: Verify this was the result of an accident; load the accident date in the Stay Information screen.

EDIT 58 - EXPIRED DIAGNOSIS CODE

Locator: 21 - Diagnosis or Nature of Illness or Injury
Scenario: This edit pulls if an expired diagnosis code appears on a patient claim. The system reads the expiration date loaded in the Diagnosis Table.
To Correct: Verify the diagnosis code is valid, and expiration date on the Diagnosis Code Table.

EDIT 59 - MISSING TIMES OF ANESTHESIA

Scenario: For the state of Arizona and for Medicaid claims in the state of Arkansas, this edit pulls if a CPT for Anesthesia (00100-01999) appears on the patient claim and no value code of "BA". For the state of Iowa, this edit pulls for Blue Cross claims if a CPT for Anesthesia appears on the patient claim and no value code of "AT".
To Correct: Need to verify the Anesthesia times are on the patient account.

EDIT 60 - PHYSICIAN PROVIDER NUMBER MISSING

Locator: 33 - Billing Provider Info & Ph #
Scenario: For the state of Arizona, this edit pulls if the physician provider number is missing from the physician table.
To Correct: Physician table or Insurance Company table.

EDIT 61 - POLICY INFORMATION – FIELD 25 NO 1, 3 OR 4

Scenario: For Medicaid claims for the state of Alabama, this edit pulls if the Subscriber's DOB in the Policy Information screen is blank.
To Correct: The Subscriber's DOB in the Policy Information screen should have a 1, 3 or 4.

EDIT 62 - ATTENDING PHYSICIAN NAME MISSING

Scenario: This edit pulls if the Attending Physician is not entered.
To Correct: In the Medical Records screen the Attending Physician needs to be loaded.

EDIT 63 - PHYSICIAN NUMBER 888888 - NOT ON FILE

Scenario: This edit will pull if this physician number pulls to the claim. This Physician is sometimes set up for additional information to pull to the electronic file for billing.
To Correct: Remove this physician from the patient Medical Records screen.

EDIT 64 - SURGEON NUMBER MISSING OR INVALID

Scenario: Surgeon is not listed in Medical Records coding for the patient.
To Correct: Enter the Surgeon for the procedure associated with this claim.

EDIT 65 - SURGEON NUMBER, PRINCIPLE PROCEDURE CODE OR PROCEDURE DATE MISSING

Scenario: A surgeon is listed, but no surgical procedure appears on the Medical Records Coding screen.
To Correct: Verify the Medical Records Coding for the patient account, and add the necessary codes.

EDIT 66 - CLAIM TOTAL IS NOT GREATER THAN ZERO

Locator: 28 - Total Charge
Scenario: This edit pulls if the total charges on the claim are not greater than zero dollars.
To Correct: Verify the account charges via Account Detail.

EDIT 67 - EXPECTED PAY IS NOT GREATER THAN ZERO

Locator: 30 - Balance Due
Scenario: This edit pulls if the expected pay on the claim is not greater than zero.
To Correct: Verify the charges on the Account Detail screen.

EDIT 68 - BENEFIT DESCRIPTION MUST BE COMPLETED!!

Scenario: For Medicare claims for the states of Massachusetts, Maine, New Hampshire or Vermont, this edit will appear if the Benefit Description is not completed.
To Correct: Go to the Policy Information screen and populate the field with then necessary information.

EDIT 69 - NO PRIOR PAYMENT INFO ON CLAIM

Scenario: For the state of Michigan, if a Medicaid secondary claim does not have prior payment information in the Prior Payment and Prior Payment Code fields in the Detail Benefits screen, this edit will pull.
To Correct: Enter prior payment information in both fields in the Detail Benefits screen. This information will pull to locators 24K and 24J, respectively, of the 1500.

EDIT 70 - CLAIM SPANS MORE THAN ONE CALENDAR MONTH

Scenario: For the state of Alabama, this edit will pull if a Medicaid claim has service dates that are in two different months.
To Correct: The Medicaid claim may need to be split billed.

EDIT 71 - INVALID PRINCIPAL DIAGNOSIS; E-CODE

Scenario: This edit will pull for Medicaid claims in the state of Louisiana if the Principal Diagnosis Code begins with an "E".
To Correct: If the Principal Diagnosis is an E-code, have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

EDIT 75 - CPT NOT SUPPORTED BY DIAGNOSIS

Locator: 24D - Procedures, Services, or Supplies
Scenario: This edit will appear if there is a CPT code that does not have a supporting diagnosis loaded in the Medical Necessity table. This edit was added to help with Medical Necessity.
To Correct: Verify that the CPT code does not have a supporting diagnosis and correct. Load the diagnosis in the Medical Necessity table or remove the CPT from the table and the Detail Charges screen. Do not regenerate the claim.

EDIT 78 - MISSING AUTHORIZATION PHY

Locator: 17 - Referring Physician
Scenario: This edit flags all X** claims when the state code is "ME" in the physician table 999999 and there is no physician loaded in the Referring Data screen on the patient’s account.
To Correct: Verify that referring physician is loaded on the account.

EDIT 79 - MISSING REFERRING AUTH NUMBER

Locator: 17a - ID Number of Referring Physician
Scenario: This edit flags all X** claims when the state code is "ME" in the physician table 999999 and there is a referring physician setup on the claim but no referring physician authorization loaded in the referring physician table.
To Correct: Verify that referring physician authorization number is loaded in
Referring Physician table.

EDIT 81 - POSSIBLE 3rd PARTY LIAB – PROVIDE DOCUMENTATION

Scenario: This edit appears when any accident diagnosis code is present on an account. These accident diagnosis codes will begin with either an "E", "8", or "9".
To Correct: Supplemental documentation is needed for accident patients. Documentation will vary per financial class and each individual situation.

EDIT 82 - EXPIRED CPT CODE

Scenario: This edit appears if a CPT code in the Detail Charges screen is either invalid or has expired.
To Correct: Verify and update the Detail Charges screen with the correct or current CPT code. Update the CPT code in the Item Master of the charge item to prevent this edit from pulling on future claims.

Secondary Billing Procedures

Overview

Secondary Billing of insurance claims is done on a daily basis as the primary claim on the account is paid or rejected by the insurance company. As seen in the section on Daily Procedures, the secondary claims on an account are worked and kept at the same status as the primary claim. There are two different methods for Secondary Billing. Automated Secondary Billing consists of running a report, reviewing UB and 1500 edits on the secondary claims that have been set to Ready to Bill and moving these claims. Manual Secondary Billing is more time consuming and involves a series of steps. Both methods are discussed in this section.

Secondary Billing

Secondary billing has been automated to speed up the process and has proven to be more accurate. When using the **Automated Secondary Billing**, Insurance Company Table, page 4, field 19 should be set to **Y**. The **Secondary Billing Auto Reverse** report should be printed. When printing the report, the system searches through all paid claims with a payment type of **F**, Paid in Full, or **A**, Applied to Deductible, in the selected date range. If the account has a secondary claim, the secondary claim will be reversed to the Ready to Bill status with an expected pay equal to the sum of the Non-covered, Deductible, Co-pay, and Coinsurance amounts from the claim that was paid. The Print Form will be selected or left blank depending on how the Print Form field on page 4, field 19 of the Insurance Company Table is set. The Elect Bill will be selected or blank depending on how the Elect Bill field on page 4, field 19 of the Insurance Company Table is set.

NOTE: *Non-Primary claims should be reviewed to ensure that the amounts are appropriately reflected on the claims.*

If using the manual Secondary Billing method, and the intermediary requires a copy of the primary remit along with the secondary form, during the receipting process, receipting personnel should highlight claims on the remittance being paid or rejected that have a secondary claim. The remittance is then given to the Insurance personnel in charge of secondary billing. This allows the Insurance personnel to determine which claims need to have a secondary claim worked. The **Secondary Billing Report** should also be printed. This report lists the claims that have been paid or rejected in the past two days that have other claims on the account. The remittance and the Secondary Billing report are the first steps in the process of manually billing secondary claims.

When the remittance is received, the highlighted accounts should be accessed by entering the patient number on the Hospital Base Menu and selecting Insurance from the Patient Functions screen. All claims for this account will be listed on the Insurance Claims by Patient screen.

If electronically billing these secondary claims via EBOS, please refer to the EBOS User Guide.

Select **Hospital Base Menu** > **Patient Account #** > **Insurance** > **<u>Claims By Patient</u>**

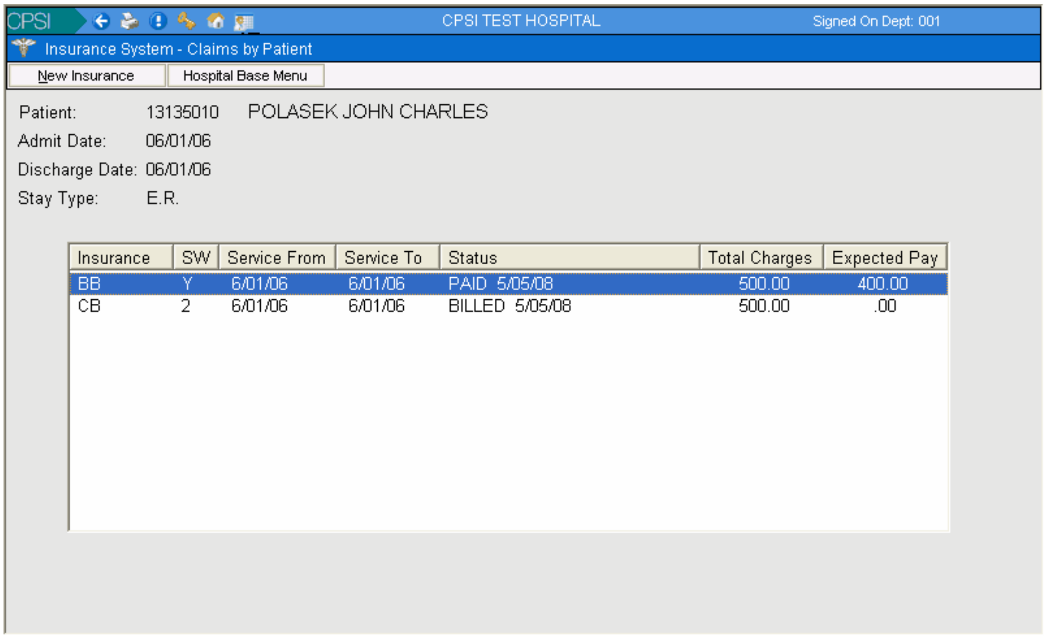


Figure 6.1 Claims By Patient

Select the sequence number associated with the primary claim. Once the primary claim is chosen, select Detail Charges.

On the Detail Charges screen verify the Expected Pay amount. It should reflect the Non-covered, Deductible, Co-pay, and Coinsurance amounts entered during receipting. It may be necessary to adjust the Denied Charges, Deductible, Blood Deductible, Co-pay or Coinsurance fields.

Select **Hospital Base Menu** > **Patient Account #** > **Insurance** > **Detail Charges**

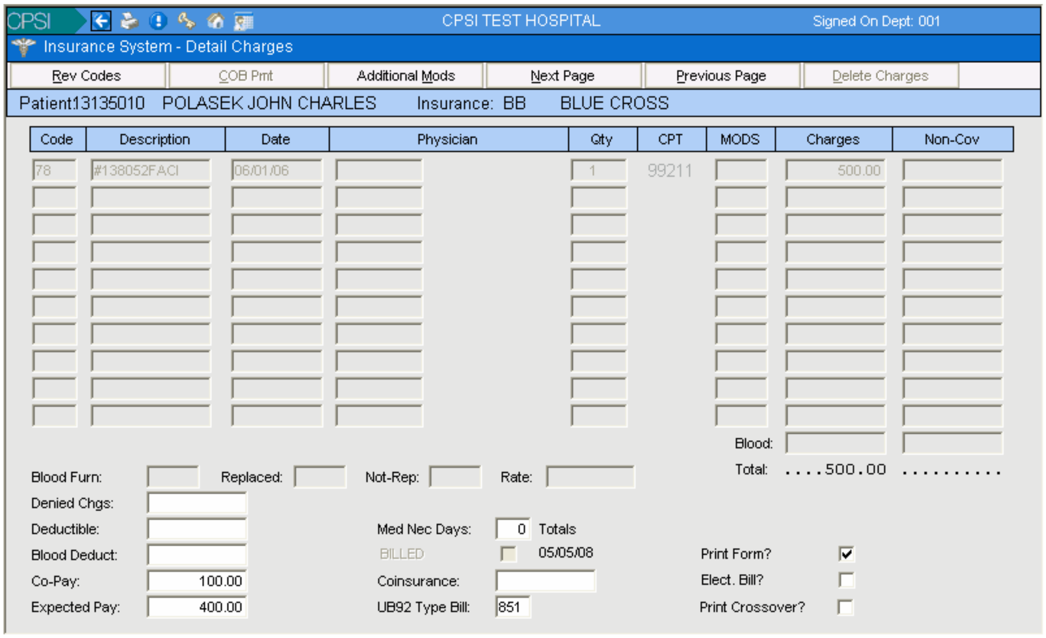


Figure 6.2 Detail Charges

Exit the primary claim. The Expected Pay should reflect the amount receipted against the claim as shown below.

Select **Hospital Base Menu** > **Patient Account #** > **Insurance** > **Claims By Patient**

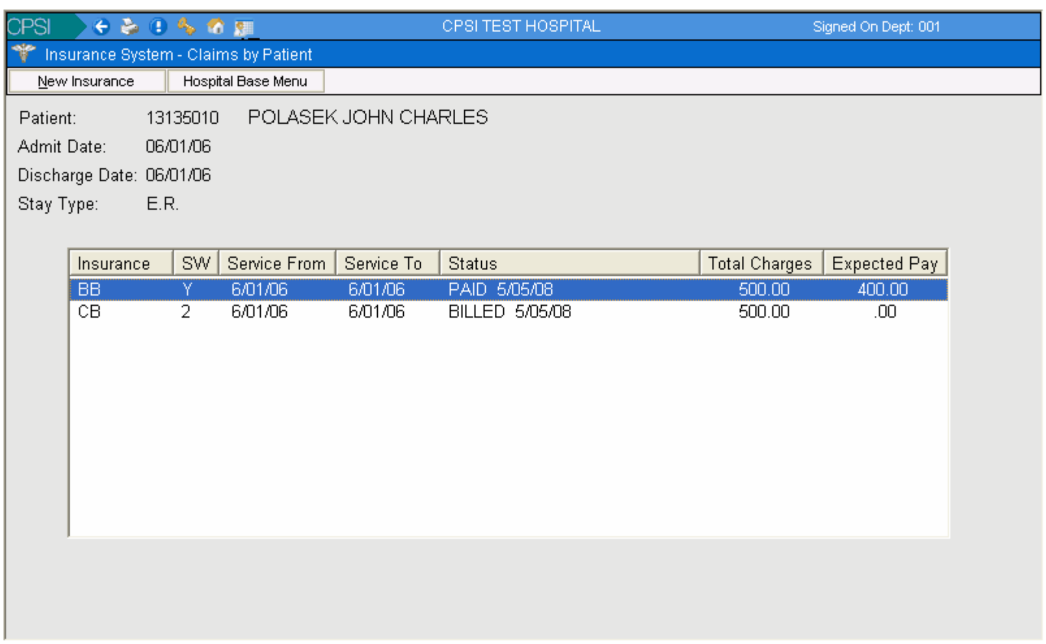


Figure 6.3 Claims By Patient

On the secondary claim, the Billed Date should be reversed. This is done by locking onto the secondary claim and selecting **Reverse** at the top of the screen. Reversing the Billed Date will cause the secondary insurance to age properly on the Billed but Unpaid report, and the Expected Pay will be correct. As seen below, after selecting **Reverse**, the Billed Date will be removed, but will display the original date directly to the right.

Select **Hospital Base Menu** > **Patient Account #** > **Insurance** > **<u>Claim Status</u>**

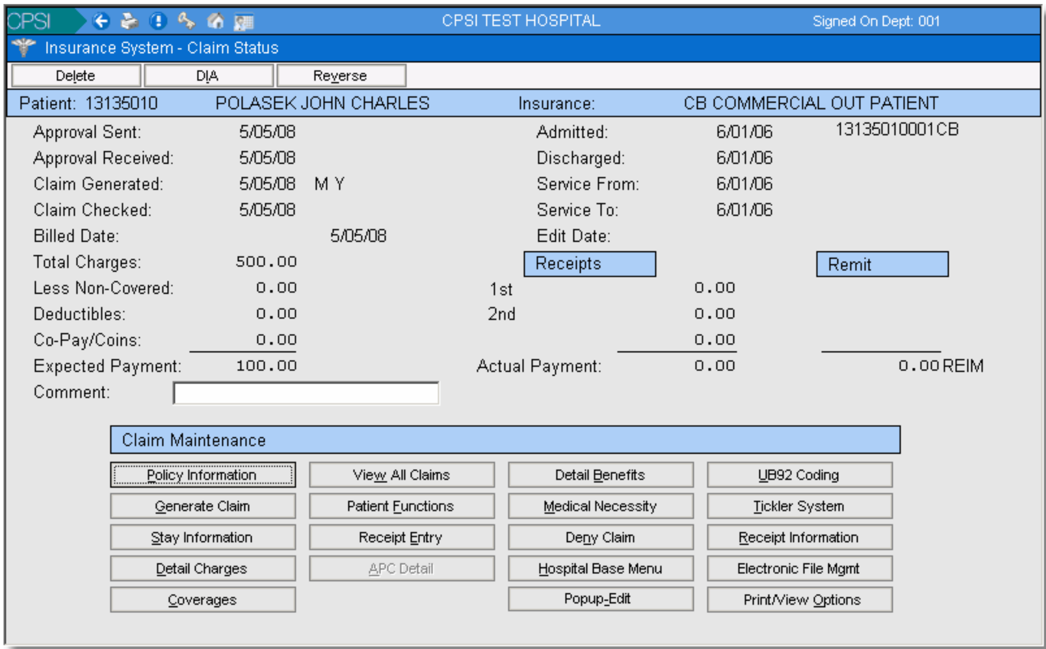


Figure 6.4 Claim Status

Select **Detail Charges** then **Expected Pay**. Enter the difference between the total charges and the actual payment of the primary claim. The claim should be set to the Ready to Bill status. From the Detail Charges screen, the **Ready to Bill** option should be selected, and Print Form option should not be selected. Selecting Ready to Bill will allow the claim to advance to the Billed status the next time UB04s are updated. Not selecting the Print Form field will prevent a UB04 from printing. Copies of the remittance advice with the claim's payment are usually sent to the secondary Financial Class carrier; therefore, a form does not need to be printed for submission. If the secondary claims are not sent in the electronic file, Elect Bill should not be selected.

Select **Hospital Base Menu** > **Patient Account #** > **Insurance** > **<u>Detail Charges</u>**

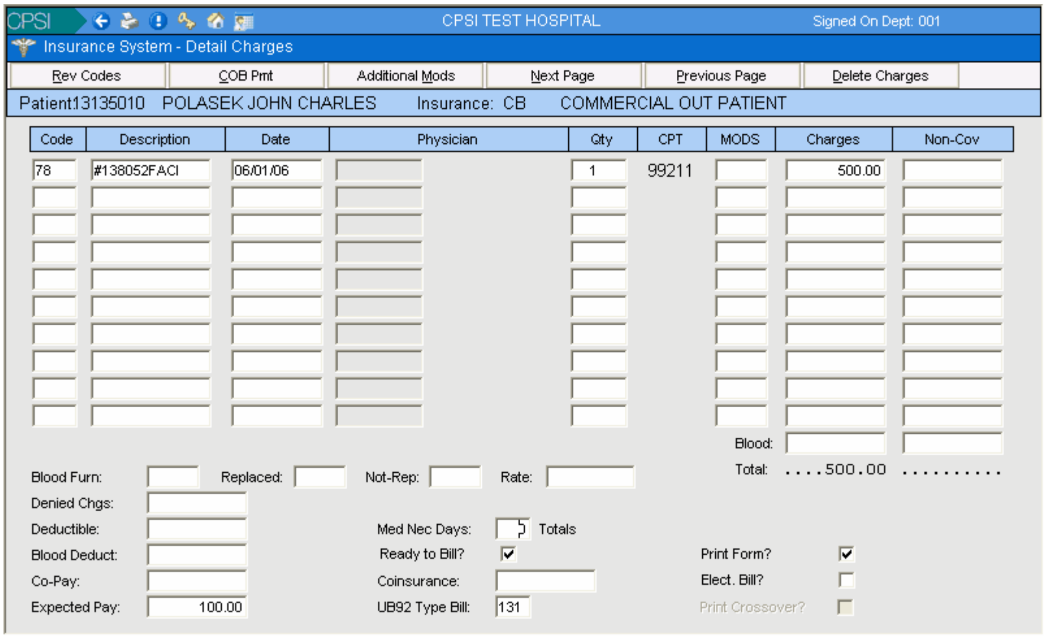


Figure 6.5 Detail Charges

The Expected Pay column on the Claims by Patient screen should now reflect the amount the claims expect to receive from the Insurance companies. The sum of the Expected Pay column should be equal to the total charges. An example of this is shown below:

Select **Hospital Base Menu** > **Patient Account #** > **Insurance** > **<u>Claims by Patient</u>**

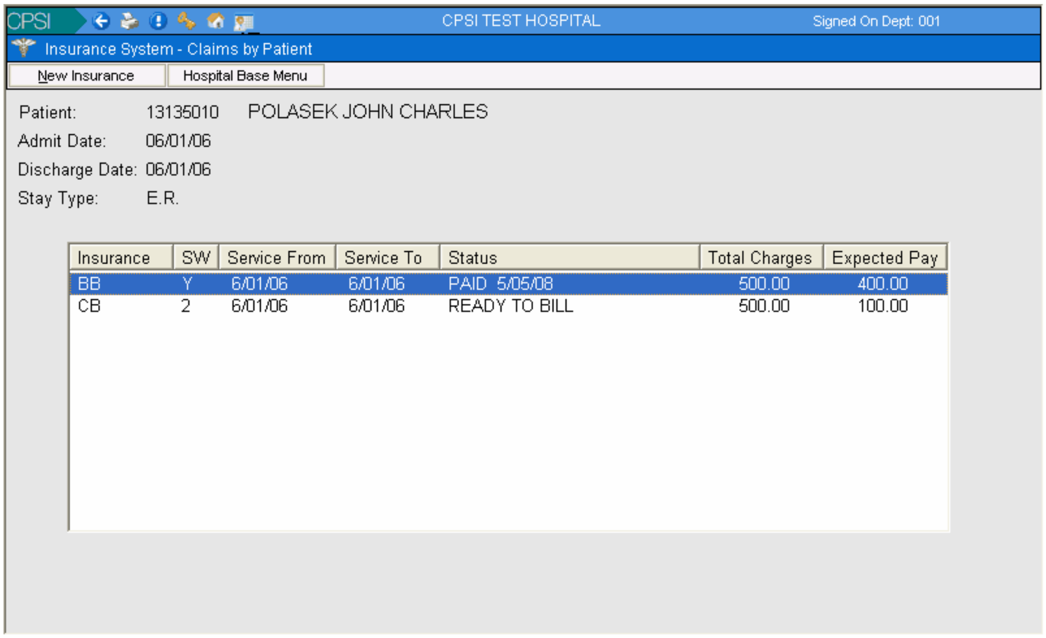


Figure 6.6 Claims By Patient

Staying current with the billing of secondary claims is important in the management of patient accounts. Once the primary claim is paid or rejected, the secondary claim should be billed as soon as possible to allow the flow of the billing cycle to continue. Once all claims are satisfied, the system will allow the remainder of the amount due to become the patient's responsibility, in accordance with billing policies and procedures.