



Insurance Procedures and Edit Codes User Guide

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TruBridge
54 St. Emanuel Street
Mobile, AL 36602
T(877) 424-1777
trubridge.com



Table of Contents

Chapter 1 Introduction

Attestation Disclaimer	1
What's New	1

Chapter 2 Overview

Chapter 3 Insurance Procedures

Overview	3
Daily Procedures	3
Insurance Verification/Pre-Authorization	4
Follow-up Procedures	5
Secondary Billing	6
Adjustment Claims/Re-Billing	6
Weekly Procedures	7

Chapter 4 Secondary Billing Procedures

Overview	8
Secondary Billing	8

Chapter 5 Form Locators

Overview	14
UB04 Locators	14
1500 Locators	21

Chapter 6 UB04 Insurance Claim Edits

Overview	28
Edits 1 - 100	28
Edits 101 - 200	48
Edits 201 - 300	70
Edits 301 - 400	88
Edits 401 - 500	109
Edit 501 - 513	123
Appendix A	125
Valid CPT for Edit Number 177	125
Valid CPT for Edit Number 487	127
Appendix B	129
Appendix C	133
Appendix D	137

Chapter 7 1500 Insurance Claim Edits

Overview	141
Insurance 1500 Claim Edits	141

Chapter 1 Introduction

1.1 Attestation Disclaimer

Promoting Interoperability Program attestation confirms the use of a certified Electronic Health Record (EHR) to regulatory standards over a specified period of time. TruBridge's Promoting Interoperability Program certified products, recommended processes and supporting documentation are based on TruBridge's interpretation of the Promoting Interoperability Program regulations, technical specifications and vendor specifications provided by CMS, ONC and NIST. Each client is solely responsible for its attestation being a complete and accurate reflection of its EHR use during the attestation period and that any records needed to defend the attestation in an audit are maintained. With the exception of vendor documentation that may be required in support of a client's attestation, TruBridge bears no responsibility for attestation information submitted by the client.

1.2 What's New

This section introduces the new features and improvements for the **Insurance and Procedures application** for release Version 22.01. A brief summary of each enhancement is given referencing its particular location if applicable. As new branches of Version 22.01 are made available, the original enhancements will be moved to the Previous Work Requests section. The enhancements related to the most current branch available will be listed under the main What's New section.

Each enhancement includes the Work Request (WR) Number and the description. If further information is needed, please contact **Client Services** Support.

NOTE: *Version 22.01 does not include any new enhancements.*

Chapter 2 Overview

The TruBridge EHR 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 TruBridge EHR Billing System recommends using daily and weekly procedures to assist personnel in the billing activities. Within the billing procedures are UB 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.

Chapter 3 Insurance Procedures

3.1 Overview

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

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

Print the Insurance Reports:

1. AutoGen Insurance Claims
2. APC Claims to Ready-To-Bill
3. Late Charge/Credit Report: This 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.
4. UB Edit List and 1500 Edit List: Correct all errors from the **UB 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.
5. Print UB and Print 1500. This step will advance the claims to the Billed status and allow the claims to be picked up in the Electronic Billing process.
6. 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.

NOTE: If utilizing EBS, please refer to the EBS User Guide.

Insurance Verification/Pre-Authorization

This section of billing procedures will move claims to the correct status in order to fall into the Primary Billing process for the following day.

Unapproved Claims Report

Run this report and work all claims on the report. This report indicates claims that require some form of verification (ex: precertification or data verification). If this type of verification is not required, the claim should not start at this status. If there are additional insurance claims on the account, approve them also. Two asterisks will appear next to claims when the admit date is older than 20 days.

1. Enter the **Patient Account #** from the Hospital Base Menu or the Master Selection screen. Next, select **Insurance** and the appropriate insurance **claim** from the Insurance Claims by Patient screen. Claims will be displayed in primary order. Work your primary claims first. Verify insurance claim and Stay Type. Create a new claim if necessary.
2. Select **Policy Information** from the Insurance Claim Status screen. Enter the Approved date. Verify and add any other pertinent information.
3. Enter **Detail Benefits**. For primary claims complete the following fields:
 - Enter Deductible amount.
 - Enter Coverage % if not filing insurance at 100%. System will default to 100% if field is blank.
4. For secondary claims, complete steps A and B from above. If the primary insurance is not filed at 100%, enter the coverage percent in the Policy Detail Benefits screen. If the Expected Pay on the secondary claim is the deductible from the primary claim, enter the deductible amount as a negative in the Detail Charges screen of the secondary claim.

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.

Claims with Missing Information

Run this report and process claims with a **Y** below M/R complete.

If a claim appears on this report, it should be for one of three reasons:

- First, it may be an APC claim, which will automatically generate to the Unchecked status if the Auto Gen Ready-to-Bill field on page 4 of the Insurance Company table is set to **N** and will contain the message "(APC Claim)" in the Comment field.
- Second, if the claim is not an APC claim, it was manually set back from the Ready to Bill status, and the reason should be placed in the Comment field. The APC claims will move to the Ready to Bill status once a M/R Verified Date has been placed on the claim and the APC Claims to Ready to Bill report has been printed. The non-APC claims will not automatically move from the Unchecked status to the Ready to Bill status, and will need to be manually reset to Ready to Bill when ready.
- Third, if the facility utilizes EBS, 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.

When working claims at the Unchecked status, the following should be done:

1. Select **Generate Claim** to pick up any late charges which may have occurred after initial generation.
2. Select **Stay Information** and verify the information on this screen. Select option **Medical Records Diags/Proc** to view all diagnosis and procedure codes. If changes need to be made to the codes, contact Medical Records. If there are discrepancies, enter these in the Comment field of the Claim Status screen.
3. 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.
4. Repeat steps 1 and 3 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.
5. Select the **Coding Screen** and verify all Condition, Occurrence and Value codes. All necessary codes must be present in order to print on the UB.

NOTE: If utilizing EBS, please refer to the EBS User Guide.

72 Hour Re-admissions

Run this report to allow accounts to be reviewed that may need certain charges combined with inpatient accounts to comply with the 72 Hour Rule.

Secondary Billing

Process all Secondary claims

- 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 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 Automated Sec Billing fields on page 4 of the Insurance Company table.
- 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

Process all Rejected claims and rebill

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

3.3 Weekly Procedures

Print the Insurance Reports:

1. **Approved Claims:** Review claims on this report weekly. Claims that are flagged with two asterisks means the account has been discharged for four days. 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 once the account has been coded and lag days have been met should be researched further.
2. **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.
3. **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.

Chapter 4 Secondary Billing Procedures

4.1 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 chapter 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 chapter.

4.2 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**, the Automated Sec Billing field on page 4 of the Insurance Company table 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 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 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 Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > **Claims By Patient**

TruBridge Community Hospital
Signed On Emp: SJ Dept: 058

Insurance System - Claims by Patient

New Insurance Hospital Base Menu Pay Source

Patient: 358611 CLARK JAMES E

Admit Date: 11/25/23

Discharge Date: 11/25/23

Stay Type: E.R.

Insurance	SW	Service From	Service To	Status	Total Charges	Expected Pay
BB	Y	11/25/23	11/25/23	PAID 11/30/23	1204.00	1204.00
CB5	2	11/25/23	11/25/23	PENDING AS OF 2/07/25	1649.30	.00

Insurance System - 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 **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Detail Charges**

TruBridge Community Hospital						Signed On Emp: SJ Dept: 058			
Insurance System - Detail Charges									
Rev Codes		COB Pmt		Additional Mods		Next Page		Previous Page	
								Delete Charges	
Patient:	358611 CLARK JAMES E			Insurance:	CB5		BENEFIT MANAGEMENT		
Code	Description	Date		Physician	Qty	CPT	MODS	Charges	Non-Cov
73	#92150ORADI	11/25/23			1.00	70010		400.00	
78	TYLENOL325M	11/25/23			1.00			4.00	
36	#1900510ER	11/25/23			1.00	99282		975.00	
71	#501506MRI	11/25/23			1.00	72158		269.10	
78	APAP325MG/1	11/25/23			2.00			1.20	
Blood Furn:		Replaced:		Not-Rep:		Rate:		Total:1649.30
Denied Chgs:						Totals			
Deductible:				Med Nec Days:					
Blood Deduct:				Ready to Bill?	<input type="checkbox"/>			Print Form?	<input type="checkbox"/>
Co-Pay:				Coinurance:				Elect. Bill?	<input type="checkbox"/>
Expected Pay:	241.30			UB Bill Type :	131			Print Crossover?	<input type="checkbox"/>

Insurance System - Detail Charges

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

Select Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claims By Patient

TruBridge Community Hospital
Signed On Emp: SJ Dept: 058

Insurance System - Claim Status

Delete DIA **Reverse**

Patient: 358611 CLARK JAMES E Insurance: CB5 BENEFIT MANAGEMENT

Approval Sent: 2/07/25 Admitted: 11/25/23 358611XX001CB5

Approval Received: 2/07/25 Discharged: 11/25/23

Claim Generated: 2/07/25 M Y Service From: 11/25/23

Claim Checked: 2/07/25 Service To: 11/25/23

Billed Date: 2/07/25 Edit Date:

Total Charges: 1649.30 Receipts Remit

Less Non-Covered: 0.00 1st 0.00

Deductibles: 0.00 2nd 0.00

Co-Pay/Coins: 0.00 0.00

Expected Payment: 0.00 Actual Payment: 0.00 0.00 REIM

Comment:

Claim Maintenance

Policy Information View All Claims Detail Benefits Coding Screen

Generate Claim Patient Functions Medical Necessity Tickler System

Stay Information Receipt Entry Deny Claim Receipt Information

Detail Charges Line Item Receipt Detail Hospital Base Menu Electronic File Mgmt

Coverages Popup-Edit Print/View Options

Insurance System - 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. After selecting **Reverse**, the Billed Date will be removed but will display the original date directly to the right.

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 the **Print Form** option should also be selected. Selecting Ready to Bill will allow the claim to advance to the Billed status the next time UBs are updated. Selecting Print Form will allow a UB to print. If the secondary claims are not sent in the electronic file **Elect Bill** should not be selected.

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

[illegible]

Insurance System - 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 Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > **Claims by Patient**

The screenshot shows the 'Insurance System - Claims by Patient' interface. At the top, there are tabs for 'New Insurance', 'Hospital Base Menu', and 'Pay Source'. The 'Hospital Base Menu' tab is selected. Below the tabs, patient information is displayed: Patient: 358611, CLARK JAMES E; Admit Date: 11/25/23; Discharge Date: 11/25/23; Stay Type: E.R. Below this information is a table with columns: Insurance, SW, Service From, Service To, Status, Total Charges, and Expected Pay. The table contains two rows of data.

Insurance	SW	Service From	Service To	Status	Total Charges	Expected Pay
BB	Y	11/25/23	11/25/23	PAID 11/30/23	1204.00	1204.00
CB5	2	11/25/23	11/25/23	READY TO BILL	1649.30	241.30

Insurance System - 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.

Chapter 5 Form Locators

5.1 Overview

Form Locators are used to show where billing information is located on the UB and 1500. TruBridge 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.

5.2 UB04 Locators

UB Locators

LOC	DESCRIPTION	PULLED FROM/DETERMINED BY TRUBRIDGE EHR
1	PROVIDER NAME, ADDRESS, TELEPHONE, FAX & COUNTY CODE	CLINIC CODE TABLE PHYSICIAN TABLE #999999 - Physician Group Information
2	PAY-TO NAME, ADDRESS	CLINIC TABLE - Name and address fields, Pull Address to locator 2 on UB field & UB Locator 2 Desc (Used for Maine Medicaid only, at this time). INSURANCE CO. TABLE - page 2
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 UB Type Bill field
5	FED TAX NUMBER	INSURANCE COMPANY TABLE - page 2 Fedtax# field PHYSICIAN TABLE #999999 - page 1 Lic# or Tax# field
6	STMT COVERS PERIOD	INSURANCE CLAIMS STATUS SCREEN Service From/To Dates NOTE: <i>If the Type of Bill is an Inpatient 111, 121, 181, 211, or 411 and there are charges on the account prior to the admit date, when the claim is generated, the first service date on the account will pull as the statement begin date.</i>
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 fields
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 (FIRST NUMBER)
15	SOURCE OF ADMISSION	REGISTRATION - STAY TAB - ADMISSION CODE field (SECOND NUMBER)
16	DISCHARGE HOUR	REGISTRATION - STAY TAB - DISCHARGE HOUR field
17	PATIENT/STATUS DISCHARGE CODE	REGISTRATION - STAY TAB - DISCHARGE CODE field
18-28	CONDITION CODES	CODING SCREEN
29	ACCIDENT STATE	REGISTRATION - STAY TAB - ACCIDENT/THERAPY STATE field
30	UNLABELED	
31-34	OCCURRENCE CODE/DATE	CODING SCREEN
35-36	OCCURRENCE SPAN CODE	PRIOR STAY INFORMATION
37	UNLABELED	
38	RESPONSIBLE PARTY - NAME/ADDRESS	INSURANCE ADDRESS - If INSURANCE COMPANY TABLE - page 4 Print Ins Addr Loc 38 field is set to Y GUARANTOR ADDRESS - If INSURANCE COMPANY TABLE - page 4 Print Ins Addr Loc 38 field is set to N

39-41	VALUE CODE/AMOUNT	CODING SCREEN
42	REVENUE CODE	SUMMARY CODE TABLE - UB Revenue Code; DETAIL CHARGES
43	REVENUE CODE DESCRIPTION	SUMM CD TABLE - Description field; ITEM MASTER - Description field; DETAIL CHARGES; ICT, Pg 9 Pull AUC - the Ordering Provider's NPI with the DK qualifier before it.
43-44	PAGE OF PAGE; CREATION DATE	NUMBER OF PAGES OF UB; DATE CLAIM WAS PRINTED
44	HCPCS/RATES/HIPPS RATE CODES	ITEM MASTER - (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 Name field
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 - NPI field if a clinic code is associated with the claim; otherwise, will pull from

		PHYSICIAN TABLE #999999 - page 1 NPI field or page 2, field code = N
57	OTHER PROVIDER - PRIMARY, SECONDARY & TERTIARY	INSURANCE COMPANY TABLE - page 1 Provider Number field
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 Shaded area - Pulls a Y if ICT p7 f21 is set to Y.
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 DRG field

71	PPS CODES	STAY INFORMATION - PPS field
72	ECI (EXTERNAL CAUSE OF INJURY CD)	PULLS CODES V00*-Y99* FROM DIAG LIST ON GROUPER if ICT page 7 POA field is set to Yes
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, page 1 NPI field, QUAL/ID - page 1 Lic# or Tax# & UPIN fields, QUAL may be overwritten from page 2 fld code U with phy type as the QUAL
77	OPERATING – NPI/QUAL/ID & LAST/FIRST	Primary Physician on the Primary Procedure in the Grouper (Physician Type must be Surgeon or this field will display blank) PHYSICIAN TABLE, page 1 NPI field QUAL/ID - page 1 Lic# or Tax# & UPIN fields, QUAL may be overwritten from page 2 fld code U with phy type as the QUAL
78-79	OTHER – NPI/QUAL/ID & LAST/FIRST	Locator 78: When determining which physician's information to display in this locator, TruBridge EHR will use the following hierarchy: 1. Referring Physician loaded in Referring Data 2. Primary Procedure's Secondary Physician in the Grouper (Physician Type must be Surgeon or Assisting Surgeon) 3. Secondary Procedure's Primary Physician in the Grouper (Physician Type must be Surgeon or Assisting Surgeon. This Physician will not pull if this is the same Physician as the Operating Physician in Locator 77) 4. Secondary Procedure's Secondary Physician (Physician Type must be Surgeon or Assisting Surgeon) The Physician's information will pull from the following tables. REFERRING PHYSICIAN TABLE - NPI REFERRING PHYSICIAN TABLE - Provider Number PHYSICIAN TABLE - page 2, field code N (NPI)

		<p>NOTE: If there is not a field code N loaded, ZZ will pull to the box in front of the NPI field.</p> <p>PHYSICIAN TABLE - page 2, field code U (QUAL)</p> <p>PHYSICIAN TABLE - NPI</p> <p>PHYSICIAN TABLE - Lic# or Tax# (QUAL)</p> <p>PHYSICIAN TABLE - UPIN (QUAL)</p> <p>Blank field if INSURANCE COMPANY TABLE - page 6 NPI field is selected.</p> <p>Locator 79:</p> <p>When determining which physician's information to display in this locator, TruBridge EHR will use the following hierarchy:</p> <ol style="list-style-type: none"> 1. If Locator 78 is displaying a Referring Physician, the Primary Procedure's Secondary Physician in the Grouper (Physician Type must be Surgeon or Assisting Surgeon. This Physician will not pull if this is the same Physician as the Operating Physician in Locator 77) 2. If Locator 78 is NOT displaying a Referring Physician, TruBridge EHR looks to the additional procedures in ranking order to find a Primary or Secondary Physician that is not listed as the Operating Physician in Locator 77 or the Other Physician in Locator 78 (Physician Type must be Surgeon or Assisting Surgeon) <p>The Physician's information will pull from the following tables.</p> <p>PHYSICIAN TABLE - page 2, field code N (NPI)</p> <p>NOTE: If there is not a field code N loaded, ZZ will pull to the box in front of the NPI field.</p> <p>PHYSICIAN TABLE - page 2, field code U (QUAL)</p> <p>PHYSICIAN TABLE - NPI</p> <p>PHYSICIAN TABLE - Lic# or Tax# (QUAL)</p> <p>PHYSICIAN TABLE - UPIN (QUAL)</p> <p>Blank field if INSURANCE COMPANY TABLE - page 6 NPI field is selected.</p> <p>QUAL:</p> <p>REFERRING PHYSICIAN TABLE - NPI Type</p>
80	REMARKS	POLICY INFORMATION - BENEFIT DESC, INS COMPANY TABLE - page 4 Print Ins Addr Loc 80 field
81CC a-d	CODE - CODE - QUAL/CODE/VALUE	TAXONOMY CODE 208D00000X pulls unless a different code is loaded in the PHYSICIAN #9999999 TABLE - page 2 using a field code T; OVERFLOW pulls from CODING SCREEN

UB Example Form

1										2										3a PAT CNTL # b MED REC # 5 FED. TAX NO										4 TYPE OF BILL																																																																																																																																																																																																							
8 PATIENT NAME										9 PATIENT ADDRESS										6 STATEMENT COVERS PERIOD FROM THROUGH										7																																																																																																																																																																																																							
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42 REV CD										43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE										45 SERV DATE										46 SERV UNITS										47 TOTAL CHARGES										48 NON-COVERED CHARGES										49																																																																																																																																																															
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UB-04 CMS-1450 APPROVED OMB NO. NUBC[®] national uniform billing convention LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

5.3 1500 Locators

1500 Locators

LOC	DESCRIPTION	PULLED FROM/DETERMINED BY TRUBRIDGE EHR
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	RESERVED FOR NUCC USE	RESERVED FOR NUCC USE
9	OTHER INSURED'S NAME	POLICY INFORMATION (Additional insurance claim)
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	POLICY INFORMATION (Additional insurance claim)
9b	RESERVED FOR NUCC USE	RESERVED FOR NUCC USE
9c	RESERVED FOR NUCC USE	RESERVED FOR NUCC USE
9d	INSURANCE PLAN	POLICY INFORMATION (Additional insurance claim)
10	IS PATIENT'S CONDITION RELATED TO:	REGISTRATION - STAY TAB - ACCIDENT/THERAPY SECTION; STAY INFORMATION

10a	EMPLOYMENT? (Current or Previous) YES NO	INSURANCE - CLAIM STATUS - STAY INFORMATION - ACCIDENT/THERAPY SECTION (If "Emp Related?"=Y, then YES will be checked.)
10b	AUTO ACCIDENT? PLACE (State) YES NO	INSURANCE - CLAIM STATUS - STAY INFORMATION - ACCIDENT/THERAPY SECTION (If "Auto?"=Y, then YES will be checked. If a State code is loaded, then it will pull, but will only pull with "Auto?"=Y)
10c	OTHER ACCIDENT? YES NO	INSURANCE - CLAIM STATUS - STAY INFORMATION - ACCIDENT/THERAPY SECTION; (If Occurance Code 01, 02, 03, or 05 is present and "Emp Related?" and "Auto?" = N or blank, YES will be checked)
10d	CLAIMS CODES (Designated by NUCC)	CODING SCREEN - CONDITION CODES
11	INSURED'S POLICY	POLICY INFORMATION - GROUP
11a	INSURED'S BIRTHDAY & SEX	POLICY INFORMATION
11b	OTHER CLAIM ID (Designated by NUCC)	DETAIL BENEFITS - OTHER CLAIM ID/QUAL
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, INJURY, OR PREGNANCY (LMP)	REGISTRATION - STAY TAB - ACCIDENT/THERAPY/TREATMENT - DATE AND QUAL
15	OTHER DATE	REGISTRATION - STAY TAB - ACCIDENT/THERAPY/TREATMENT - OTHER DATE/QUAL

NOTE: Locator 14 only allows treatment qualifier codes of 431 and 484; if any other qualifier is loaded in the QUAL field then it will pull to Locator 15. Locator 15 will not allow qualifier codes 431 or 484; if either of these codes is loaded in the OTHER DATE/QUAL field then it will pull to Locator 14. If 431 and 484 are both loaded in the QUAL fields, the system will pull the one that is loaded in the first QUAL field.

16	DATES UNABLE TO WORK	NOT CURRENTLY USED
17	REFERRING PROVIDER OR OTHER SOURCE	REFERRING PHYSICIAN TABLE, pulls DN qualifier CHARGING PHYSICIAN TABLE, pulls DK qualifier ADMITTING PHYSICIAN TABLE, pulls DQ qualifier
17a	OTHER ID# AND QUALIFIER	REFERRING PHYSICIAN TABLE - field code 1 CHARGING PHYSICIAN TABLE - field code 1 BILLING PHYSICIAN TABLE - page 4 Billing Physician field ADMITTING PHYSICIAN TABLE - field code 1 ADMITTING PHYSICIAN TABLE - page 1 UPIN# field
17b	NPI	REFERRING PHYSICIAN TABLE - NPI populated with field code 1, or PHYSICIAN TABLE - page 1 NPI# field
18	HOSPITALIZATION DATES	STAY INFORMATION (for I/P's only)
19	ADDITIONAL CLAIM INFO (Designated by NUCC)	POLICY INFORMATION - BENEFIT DESC field - enter XMIT then information to pull to this locator; only the first 45 characters following XMIT will display on the locator. POLICY INFORMATION - BENEFIT DESC field - enter 1500 then information to pull to this locator; the first 71 characters following 1500 will display on the locator. Line 1 on the locator may accommodate 23 characters and line 2 on the locator may accommodate 48 characters.
20	OUTSIDE LAB	NOT CURRENTLY USED
21	DIAGNOSIS OR NATURE OF INJURY - IDC IND.	INSURANCE COMPANY TABLE, PAGE 1 - TYPE PROC CD'S USED
21 A-L	DIAGNOSIS OR NATURE OF INJURY	STAY INFORMATION - INS DIAG/PROC, GROUPER SCREEN
22	RESUBMISSION	STATE SPECIFIC
23	PRIOR AUTHORIZATION NUM	CLIA NUMBER - page 5 of Order Entry Information POLICY INFORMATION - PERCERT #

24A	DATES OF SERVICE	DETAIL CHARGES SCREEN
24B	PLACE OF SERVICE	SUMMARY CODE TABLE - Place of Service field 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. #	<p>(shaded portion) All states except KY and NM CHARGING PHYSICIAN TABLE - field code 3 CHARGING PHYSICIAN TABLE - page 1, Lic# or Tax# (Commercial) field, Provider # (All other Financial Classes) fields STAY INFO PHYSICIAN TABLE - field code 3 STAY INFO PHYSICIAN TABLE - page 1, Lic# or Tax# (Commercial) field, Provider # (All other Financial Classes) fields</p> <p>(shaded portion) for states KY and NM CHARGING PHYSICIAN TABLE - field code T CHARGING PHYSICIAN TABLE - field code 3 CHARGING PHYSICIAN TABLE - page 1 Lic# or Tax# (Commercial) field, Provider # (All other Financial Classes) fields STAY INFO PHYSICIAN TABLE - field code T STAY INFO PHYSICIAN TABLE - field code 3 STAY INFO PHYSICIAN TABLE - page 1 page 1 Lic# or Tax# (Commercial) field, Provider # (All other Financial Classes) fields</p> <p>(unshaded portion) CHARGING PHYSICIAN TABLE - field code 4</p>

		CHARGING PHYSICIAN TABLE - field code N CHARGING PHYSICIAN TABLE - page 1 NPI# field STAY INFO PHYSICIAN TABLE - field code 4 STAY INFO PHYSICIAN TABLE - field code N STAY INFO PHYSICIAN TABLE - page 1 NPI# field PHYSICIAN 999999 TABLE - page 1 NPI# field
25	FEDERAL TAX ID NUMBER	INSURANCE COMPANY TABLE - page 2 Fedtax# field; PHYSICIAN TABLE #999999 - page 1 Lic# or Tax# field; if blank will pull from PHYSICIAN TABLE - page 1 Social Security# field
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	RESERVED FOR NUCC USE	RESERVED FOR NUCC USE
31	SIGNATURE OF PHY	HARD CODED to pull BILLED date, INSURANCE COMPANY TABLE - page 4 Phy Signature 1500 ... 31 field

32	SERVICE FACILITY LOCATION INFO	PHYSICIAN TABLE #999999 - Physician Group Information fields or CLINIC CODE TABLE
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NOTE: The Clinic Code may be linked to a Financial Class on Insurance Company Table, Page 7 or to a Department on Department Table, Page 5.

32a	NPI NUMBER	CLINIC CODE TABLE - NPI & Pull NPI to Locator 32a on 1500 = Y CLINIC CODE TABLE - NPI & Pull NPI to Locator 32a on 1500 = N - pull NPI from Physician Table #999999 PHYSICIAN TABLE #999999 - page 1 NPI field
32b	OTHER ID NUMBER	INSURANCE COMPANY TABLE - page 6 NPI Only field, this locator will pull blank CLINIC CODE TABLE - Provider Number & Pull Provider Number to locator 32b on 1500 = Y CLINIC CODE TABLE - Provider Number & Pull Provider Number to locator 32b on 1500 = N - pull from Physician Table #999999 PHYSICIAN TABLE #999999 - page 1 Mcare EKG#/Rad# - Blue Cross# fields
33	PHYSICIAN NAME and ADDRESS	CLINIC CODE TABLE; PHYSICIAN TABLE and/or INSURANCE COMPANY TABLE - page 2
33a	NPI NUMBER	CHARGING PHYSICIAN TABLE - field code n ADMITTING PHYSICIAN TABLE - field code n PHYSICIAN TABLE #999999 - field code N PHYSICIAN TABLE #999999 - page 1 NPI field
33b	OTHER ID NUMBER	CHARGING PHYSICIAN TABLE - field code 5 CHARGING PHYSICIAN TABLE - field code 6 ADMITTING PHYSICIAN TABLE - field code 5 ADMITTING PHYSICIAN TABLE - field code 6 PHYSICIAN 999999 TABLE - field code 5 PHYSICIAN 999999 TABLE - field code 6 INSURANCE COMPANY TABLE - page 1 Provider Number field

1500 Example Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA				PICA			
1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (DoD/DoD) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>				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		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
CITY		STATE		CITY		STATE	
ZIP CODE		TELEPHONE (Include Area Code)		ZIP CODE		TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:			
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)			
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
d. INSURANCE PLAN NAME OR PROGRAM NAME				10g. CLAIM CODES (Designated by NUCC)			
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 other than 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 _____ DATE _____			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (IMP) MM DD YY QUAL				15. OTHER DATE MM DD YY QUAL			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24e) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				22. REFERENCE CODE ORIGINAL REF. NO.			
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				23. PRIOR AUTHORIZATION NUMBER			
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.			
27. ACCEPT ASSIGNMENT? (For g/f, depts, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$			
29. AMOUNT PAID \$				30. Revt for NUCC Use			
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			
33. BILLING PROVIDER INFO & PH # ()							

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Chapter 6 UB04 Insurance Claim Edits

6.1 Overview

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

Please note that the following documentation includes diagnosis and procedure codes that are wildcarded. When wildcarding ICD-10 codes, a single * following a code (ex. 0UP34*) indicates that the remaining characters may include any alpha or numeric character, the code may be up to seven characters in length but does not have to be seven characters long. Multiple * after a code indicates that the remaining characters may include any alpha or numeric character, but the code length must match the number of characters that are specified by the *. For example, 0UP8*** would mean that the code must be seven characters long, but the last three characters may include any alpha or numeric character.

6.2 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 the Physician Group Information fields 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Insurance Company table, page 2, that is not numeric or is blank.

To Correct: Verify the Federal Tax Number is correct and load it in the Insurance Company 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 Lic# or Tax# field in the Physician table 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 = ADMIT THROUGH DISCHARGE 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 Coding Screen 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 than 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen screen and the age is not greater than 65.

To Correct: Verify the Value Code is correct. If incorrect, delete the code from the Coding Screen 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 Coding Screen screen and the age is not less than 65.

To Correct: Verify the Value Code is correct. If incorrect, delete the code from the Coding Screen 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 and the Bill Type is not 111, 121, 181, 211, or 411.

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 1-6, 8-9, A or D-F, and the type of bill is not 1XX, 3XX or 8XX.

To Correct: Verify the admission source and type of bill, are correct and enter in the correct admission source in the Stay tab on the Registration and ADT screen, and/or enter in the correct type of bill in the Detail Charges 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 - ADMIT SOURCE NOT VALID WITH ADMIT TYPE

Locator: 15 - Admission Source

Scenario: The above edits appear if a Tricare claim has an admit type of 1 and does not have an admit source of 1 or 4 - 6.

To Correct: Verify the admission type is correct. If incorrect, change the admission type on the Stay tab on the Registration and ADT screen. If admission type is correct, the source can only be 1 or 4 - 6. 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 or 70.

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 or 70.

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 Coding Screen screen.

To Correct: Check to see if the claim needs a Condition Code and load the correct code in the Coding Screen 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 Coding Screen screen and does not have a Condition Code 02.

To Correct: Verify Value Code. If incorrect, change the code on the Coding Screen screen. If correct, the claim must have an 02 Condition Code loaded on the Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen screen.

To Correct: Verify the correct Condition Code and load in the Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen screen. The claim does not need to be regenerated.

EDIT 83 - NEEDS A6 CONDITION CODE; PRIN DIAG = Z23

Locator: 18 - 28 Condition Codes

Scenario: The above edit appears if a claim with service dates after 09/30/15 has a diagnosis "Z23" and does not have a Condition Code of "A6" in the Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 N186.

To Correct: Verify the Condition Code is correct. If incorrect, delete code from the Coding Screen screen of the claim. If correct, the Principal Diagnosis Code must be N186. 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 N186 and does not have a Condition Code of 70, 71, 73, 74 or 76 on the Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen screen of the claim. If correct, the claim needs a Condition Code of 02 loaded in the Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen screen and is missing an Occurrence Date.

To Correct: If Occurrence Code is not needed, delete from the Coding Screen screen. If Occurrence Code is correct, then verify the date and load in the Coding Screen 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 Coding Screen 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 Coding Screen screen. If Occurrence Code is correct, verify the code and load in the Coding Screen 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 UB9 Coding screen that is greater than the current date.

To Correct: Verify the Occurrence Date and change in the Coding Screen 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 one of the trauma Diagnosis Codes listed below and does not have an Occurrence Code of 01-05 in the Coding Screen screen of the claim.

Diagnosis Codes: S00* to S99* including codes with a seventh character of A, B, C, or S but excluding codes with a seventh character of D, E, F, G, H, J, K, M, or N; T07*; T14*-T79* including codes with a seventh character of A, B, C, or S but excluding codes with a seventh character of D, E, F, G, H, J, K, M, N, P, Q, or R; L79*; M1A1*; M84*S (where S is the seventh character); M966*; M968*; R65*; G970; G972; G9731; G9732; G9748; G9749; G9751; G9752; G9781; G9782; J954; J955; J9561; J9562; J9571; J9572; J95830; J95831; J95851; J95859; J9588; J9589; K6811; K913; K9161; K9162; K9171; K9172; K9181; K9182; K9183; K9184*; K9186; N9952*; N99953*; N996*; N997*; N998*; E898*; H590*; H591*; H592*; H593*; H598*; H9521; H9522; H9531; H9532; H9541; H9542; D78*; E36*

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 Coding Screen screen and does not have an Occurrence Code of 04.

To Correct: Verify the Value Code is correct. If incorrect, delete code from Coding Screen screen. If correct, the claim must have an Occurrence Code of 04 in the Coding Screen 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 J60, J61, J6238, J63*, J64, J66*, J68*, J700, J701, J705, J708, or J709 and does not have an Occurrence Code of 05 or 24 in the Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen screen. The claim will not need to be regenerated.

6.3 Edits 101 - 200

EDIT 101 - NEED OCCUR CODE 01 - 06

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 V00*-Y99*, and does not have an Occurrence Code of 01-06 in the Coding Screen 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 Coding Screen 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 Coding Screen screen.

To Correct: Verify the Value Code is correct. If incorrect, delete the code from the Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen screen.

To Correct: Verify the Condition Code is correct. If incorrect, it can be changed in the Coding Screen screen. If Condition Code is correct, enter an Occurrence Code of 33 in the Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen screen of the claim.

To Correct: Verify a Value Code is needed. If the code is not needed, delete code from the Coding Screen 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 Coding Screen screen and has no amount loaded.

To Correct: Verify the Value Code is needed. If not needed, remove the code from Coding Screen 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 Coding Screen screen and has no code loaded.

To Correct: Verify the Value Code is needed. If not needed, remove the amount from Coding Screen 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 Coding Screen screen of the claim.

To Correct: Verify the correct Value Code and delete the codes that are not needed from the Coding Screen 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 Coding Screen screen.

To Correct: Verify the Value Code amount. Enter Value Code 23 and the amount in the Coding Screen 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 Coding Screen screen.

To Correct: Verify the correct value amount and load Value Code 05 and the amount in the Coding Screen 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 Coding Screen 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 Coding Screen screen: 12, 13, 14, 15, 16, 41, 42 or 43.

To Correct: Verify which Value Code is needed and enter in the Coding Screen 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 Coding Screen screen: 12, 13, 14, 15, 16, 41, 42 or 43.

To Correct: Verify which Value Code is needed and enter in the Coding Screen 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 Coding Screen screen and has Value Codes 12, 13 or 43.

To Correct: Verify the Condition Code is correct. If incorrect, delete the code from the Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen screen.

To Correct: Verify the value amount. Load Value Code 37 and 38 and the value amount in the Coding Screen 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 Coding Screen screen.

To Correct: Verify Value Code 06 is required. If it's not required, delete code from the Coding Screen 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 Coding Screen screen.

To Correct: Verify the correct value amount for Value Codes 38 and 39. Enter the correct amount in the Coding Screen 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 Coding Screen screen.

To Correct: Verify the correct value amount for Value Codes 38 and 37. Enter the correct amounts in the Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen screen.

To Correct: Verify the correct Value Code and amount and enter in the Coding Screen 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 Coding Screen screen.

To Correct: Verify the correct Value Code and amount and enter in the Coding Screen 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 Coding Screen screen.

To Correct: Verify which Value Code is required (either 43 or 11). Delete the Value Code that is not needed in the Coding Screen 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 Coding Screen screen.

To Correct: Verify that Value Code 68 is entered in the Coding Screen 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 Coding Screen screen.

To Correct: Verify the Value Code is correct and enter in the Coding Screen 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 Coding Screen screen.

To Correct: Verify the Condition Code is correct. If incorrect, then delete Condition Code from the Coding Screen screen of the claim. If Condition Code is correct, then one of the Value Codes listed needs to be entered in the Coding Screen 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 Coding Screen screen.

To Correct: Verify the Condition Code is correct. If incorrect, delete the Condition Code from the Coding Screen 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 Coding Screen screen.

To Correct: Verify the Condition Code is correct. If incorrect, delete code from the Coding Screen screen. If code is correct, the Value Code listed is invalid with this Condition Code. Delete Value Code from Coding Screen 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 Coding Screen screen.

To Correct: Verify the Value Code amount. Enter Value Code 06 and the amount in the Coding Screen 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 Coding Screen screen.

To Correct: Verify which Value Code is the correct code (01 or 02.) Delete the invalid code from the Coding Screen 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 Coding Screen screen for a claim, the Principal Diagnosis "Z23" must be present in the Grouper screen, and a charge with Revenue Code 636 or 771 must be entered.

To Correct: Verify which of the above is missing. Then load in Stay Information, claim's Detail Charges screen or Coding Screen screen.

EDIT 155 - PRIN DIAG NOT = N186; 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 N186.

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 N186. 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 = N186; 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 N186 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen screen and no charges with Revenue Code 38X.

To Correct: Verify Value Code is correct. If not, delete the Value Code in the Coding Screen 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 ICD10 Z53* 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 ICD10 Diagnosis Code Z5309, Z5329, Z538, Z5301, Z5309, Z531, Z5320, Z5321, Z539.

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 ICD10 Diagnosis Codes. If the item is missing a CPT code, load it in the Item Master and regenerate the claim. If the ICD10 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 procedure codes listed below is in the Medical Records Grouper screen and a valid ASC Revenue Code without a valid ASC CPT code is in the Item Master.

Procedure Codes: 01N5*, 059Y30Z, 059Y3ZZ, 059Y40Z, 059Y4ZZ, 069Y30Z, 069Y3ZZ, 069Y40Z, 069Y4ZZ, 079T0ZX, 079T3ZX, 079T4ZX, 07DQ0ZX, 07DQ3ZX, 07DR0ZX, 07DR3ZX, 07DS0ZX, 07DS3ZX, 085E3ZZ, 085F3ZZ, 085J3ZZ, 085K3ZZ, 08BJ3ZZ, 08BK3ZZ, 08DJ3ZZ, 08DK3ZZ, 08Q0XZZ, 08Q1XZZ, 08Q23ZZ, 08Q33ZZ, 08QE3ZZ, 08QF3ZZ, 08RJ3JZ, 08RK3JZ, 095K0ZZ, 095K3ZZ, 095K4ZZ, 0B9*3ZX, 0B9*4ZX, 0B9*7ZX, 0B9*8ZX, 0BB3ZX, 0BB34ZX, 0BB37ZX, 0BB38ZX, 0BB43ZX, 0BB44ZX, 0BB47ZX, 0BB48ZX, 0BB53ZX, 0BB54ZX, 0BB57ZX, 0BB58ZX, 0BB63ZX, 0BB64ZX, 0BB67ZX, 0BB68ZX, 0BB73ZX, 0BB74ZX, 0BB78ZX, 0BB83ZX, 0BB84ZX, 0BB87ZX, 0BB88ZX, 0BB93ZX, 0BB94ZX, 0BB97ZX, 0BB98ZX, 0BBB3ZX, 0BBB7ZX, 0BBB8ZX, 0BJ08ZZ, 0BJK8ZZ, 0BJL8ZZ, 0D717*, 0D718*, 0D72*, 0D727*, 0D728*, 0D737*, 0D738*, 0D747*, 0D748*, 0D757*, 0D758*, 0D963ZX, 0D964ZX, 0D967ZX, 0D968ZX, 0D9E3ZX, 0D9E4ZX,

0D9E7ZX, 0D9E8ZX, 0D9H3ZX, 0D9H4ZX, 0D9H7ZX, 0D9H8ZX, 0D9N3ZX, 0D9N4ZX, 0D9N8ZX, 0DBE3ZX, 0DBE4ZX, 0DBE7ZX, 0DBE8ZX, 0DBE0ZZ, 0DBE3ZZ, 0DBE7ZZ 0DBH3ZX, 0DBH4ZX, 0DBH7ZX, 0DBH8ZX, 0DBN3ZX, 0DBN4ZX, 0DBN7ZX, 0DBN8ZX, 0DB63ZX, 0DB64ZX, 0DB67ZX, 0DJ08ZZ, 0DJ68ZZ, 0DJD8ZZ, 0T7D0DZ, 0T7D3DZ, 0T7D4DZ, 0T7D7DZ, 0T7D8DZ, 0T7D8ZZ, 0T9B70Z, 0T9B80Z, 07JB8ZZ, 0H50*, 0H51*, 0H54*, 0H55*, 0H56*, 0H57*, 0H58*, 0H59XZD, 0H59*, 0H5A*, 0H5B*, 0H5C*, 0H5D*, 0H5E*, 0H5F*, 0H5G*, 0H5H*, 0H5J*, 0H5K*, 0H5L*, 0H5M*, 0H5N*, 0H5Q*, 0H5R*, 0H9*XZX (excluding 2,3), 0HB*XZX (excluding 2,3), 0HB*XZZ (excluding 2,3), 0H9T0ZX, 0H9U0ZX, 0H9V0ZX, 0H9W0ZX, 0H9X0ZX, 0HBT0ZX, 0HBU0ZX, 0HBV0ZX, 0HBW0ZX, 0HBY0ZX, 0HBT*ZZ, 0HBU*ZZ, 0HBV*ZZ, 0HQ**ZZ (excluding Q,R,W,X,Y), 0J5*, 0J9*3ZX (excluding 2,3), 0JB*3ZX (excluding 2,3), 0JB*0ZZ (excluding 2,3), 0PSH3ZZ, 0PSH4ZZ, 0PSHXZZ, 0PSJ3ZZ, 0PSJ4ZZ, 0PSJXZZ, 0PSK3ZZ, 0PSK4ZZ, 0PSKXZZ, 0PSL3ZZ, 0PSL4ZZ, 0PSLXZZ, 0UDB7ZX, 0UBD7ZZ, 0UBD8ZX, 0UBD8ZZ, 0V903ZX, 0V904ZX, 0V907ZX, 0V908ZX, 0VB03ZX, 0VB04ZX, 0VB07ZX, 0VB08ZX, 0W993ZZ, 0W9B3ZZ, 0YQ50ZZ, 0YQ53ZZ, 0YQ54ZZ, 0YQ5XZZ 0YQ60ZZ, 0YQ63ZZ, 0YQ64ZZ, 2Y41X5Z, 3E09XGC, 3E0R0*, 3E0R33Z, 3E0R36Z, 3E0R37Z, 3E0R3AZ 3E0R3BZ, 3E0R3CZ, 3E0R3E*, 3E0R3GC, 3E0R3HZ, 3E0R3KZ, 3E0R3NZ, 3E0R3SF, 3E0R7SF, 3E0S3BZ, 3E0S3CZ, 3E0S33Z, 3E0S36Z, 3E0S37Z, 3E0S3BZ, 3E0S3CZ, 3E0S3GC, 3E0S3HZ, 3E0S3KZ, 3E0S3NZ, 3E0S7SF, 3E0S33Z, 3E0S36Z, 3E0S37Z, 3E0S3BZ, 3E0S3CZ, 3E0S3GC, 3E0S3HZ, 3E0S3KZ, 3E0S3NZ, 3E0S3SF, 3E0S7SF.

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.

EDIT 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, 83X, or 85X and 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.

6.4 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, 90669 & 90732 WITH REV CD 636

Locator: 44 - HCPCS/Rates/HIPPS Code

Scenario: The above edit appears if a claim with service dates after 09/30/15 has a Condition Code of "A6" or a diagnosis "Z23," a charge item with Revenue Code 636, and does not have a CPT Code of 90655, 90657-58, 90660, 90669 & 90732 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 Coding Screen 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, 90669 & 90732 in the Item Master. If the CPT is missing, load in Item Master and regenerate the claim.

EDIT 223 - NEED CPT G0008 & G0009 WITH REV CD 771

Locator: 44 - HCPCS/Rates/HIPPS Code

Scenario: The above edit appears if a claim with service dates after 09/30/15 has a Condition Code of "A6" or a diagnosis "Z23," a charge item with Revenue Code 771, and does not have a CPT Code of G0008 or G0009 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 Coding Screen screen in the claim. If both are correct, verify the item charged with 771 Revenue Code has a CPT Code of G0008 or G0009 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 01, 18, 19, 20, 21, 39, 40, 53 and G8.

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 Coding Screen 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 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 ICD10 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 ICD10 Diagnosis Code and it is not in the TruBridge EHR ICD10 Diagnosis table, call TruBridge Software Support in order to correct the table.

EDIT 294 - PRINCIPAL DIAGNOSIS SHOULD BE Z23

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 Z23.

To Correct: Verify Condition Code is correct. If not, delete code from Coding Screen 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 Z23 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 one of the Principal Diagnosis Code listed below and does not have an Occurrence Code/Span Code of 01 - 06.

Diagnosis Codes: S00*-S99* including codes with a seventh character of A, B, C or S but excluding codes with a seventh character of D, E, F, G, H, J, K, M, N, P, Q, or R; T07*; T14*-T79* including codes with a seventh character of A, B, C or S but excluding codes with a seventh character of D, E, F, G, H, J, K, M, N, P, Q, or R; L76*; M1A1*; M84*S (where S is the seventh character); M966*; M968*; R65*; G970; G972; G9731; G9732; G9748; G9749; G9751; G9752; G9781; G9782; J954; J955; J9561; J9562; J9571; J9572; J95830; J95831; J95851; J95859; J9588; J9589; K6811; K913; K9161; K9162; K9171; K9172; K9181; K9182; K9183; K9184*; K9186; N9952*; N99953*; N996*; N997*; N998*; E898*; H590*; H591*; H592*; H593*; H598*; H9521; H9522; H9531; H9532; H9541; H9542; D78*; E36*; T8****A.

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 Coding Screen 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 - V-Y CODES

Locator: 67 - Prin Diag Cd

Scenario: The above edit appears if a claim has a Principal Diagnosis Code of V00*-Y99*; excluding Y6551, Y6552, and Y6553.

To Correct: Verify Principal Diagnosis. If a V00*-Y99* diagnosis is principal and is not Y6551, Y6552, or Y6553 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](#) ¹²⁹ 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 ICD10 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 ICD10 Diagnosis Code and it is not in the TruBridge EHR ICD10 Diagnosis table, call TruBridge 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 - EXTERNAL CAUSE OF MORBIDITY INVALID FOR CHAMPUS CLAIMS

Locator: 67A-Q - Other Diagnosis Codes

Scenario: The above edit appears if a Champus/Tricare claim has Diagnosis Codes V00*-Y99* 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.

6.5 Edits 301 - 400

EDIT 302 - NEED DIAGNOSIS CODE OF D66, D67, OR D680

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 D66, D67 or D680.

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 Z5189, 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 69

Locator: 69 - Admitting Diagnosis Code

Scenario: The above edit appears if a claim has a Bill Type of 11X, 12X or 22X and there is not an Admitting Diagnosis Code in locator 69.

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.

EDIT 305 - ADMIT DIAG ARE INVALID FOR TRICARE CLAIMS

Locator: 69 – Admitting Diagnosis Code

Scenario: The above edit appears if a Tricare Claim has an Admitting Diagnosis Code of V00*-Y99* in locator 69.

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 ICD10 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 ICD10 Procedure code and it is not in the TruBridge EHR table, call TruBridge Software Support in order to correct the table.

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/Tricare Claim has one of the Diagnosis Codes listed below, but does not have one of the Principal Procedure Codes listed below.

Diagnosis Codes: O000*-O089*, O094*, O095*, O1*, O200, O208, O209, O210, O2110, O212, O218, O219, O23*, O24*, O25*, O261*, O262*, O263*, O264*, O266*, O267*, O268*, O269*, O29*, O30*(excluding O30021, O30022, O30023, O30029), O31*, O32*, O33*, O34*, O351*, O352*, O353*, O354*, O355*, O356*, O358*, O359*, O361*, O362*, O363*, O364*, O365*, O366*, O367*, O3681*, O3689*, O369*, O4*, O6*, O71*, O72*, O73*, O74*, O752, O753, O755, O7582, O7589, O76, O77*, O80, O8611, O8613, O8619, O862*, O89*, O905, O906, O9081, O94, O98*, O990*, O991*, O992*, O993*, O995*, O996*, O997*, O998*, O9A*, Z332, A34

Procedure Codes: 0U1*, 0U5*, 0U75*, 0U76*, 0U77*, 0U79*, 0U7C*, 0U7G0*, 0U7G3*, 0U7G4*, 0U7K*, 0U8*, 0U9*, 0UB*, 0UC1*, 0UC2*, 0UC3*, 0UC4*, 0UC5*, 0UC6*, 0UC7*, 0UC8*, 0UC90ZZ, 0UC93ZZ, 0UC94ZZ, 0UCB*, 0UCC*, 0UCF*, 0UCG0ZZ, 0UCG3ZZ, 0UCJ*, 0UCK*, 0UCL*, 0UCM0ZZ, 0UDB*, 0UDN*, 0UF* (excluding 0UF6XZZ), 0UH9*HZ, 0UHC*HZ, 0UHD*, 0UHH*, 0UJ**ZZ (excluding X in fifth character), 0UL*, 0UM*, 0UN*, 0UP30*, 0UP33*, 0UP34*, 0UP8*** (excluding X in fifth character), 0UPD0*, 0UPD3*, 0UPD4*, 0UPD7** (excluding H in sixth character), 0UPD8* (excluding H in sixth character), 0UPDH*** (excluding X in fifth character), 0UPM0*, 0UQ*, 0US*, 0UT*, 0UU*, 0UV*, 0UW**** (excluding X in fifth character), 0UY*, 109*, 10A* (excluding X in seventh character), 10D*, 10E*, 10H*, 10J*, 10P*, 10Q*, 10S*, 10T*, 10Y*, 3027*, 3E0DXGC, 3E0E305, 3E0E337, 3E0E3*Z, 3E0E705, 3E0E729, 3E0E7*Z, 3E0E805, 3E0E829, 3E0E8*Z, 3E0E7SF, 3E0E8SF, 3E0P3LZ, 3E0P3Q*, 3E0P73Z, 3E0P76Z, 3E0P77Z, 3E0P7GC, 3E0P7LZ, 3E0P7Q0, 3E0P7Q1, 3E0P83Z, 3E0P86Z, 3E0P87Z, 3E0P8GC, 04LE**T, 04LF**U, 4A0H7*, 4A0H8, 4A0HX*, 4A0J7*, 4A0J8*, 4A0JX*, 4A1H7*, 4A1H8*, 4A1HX*, 4A1J7*, 4A1J8*, 4A1JX*, 0WBN*, 0WQN*, 0W8NXZZ, 0W9N**Z, 0H99X0Z, 0H99XZX, 0H99XZZ, 0H89XZZ, 0H59XZZ, 0HB9XZZ, 0JCB0ZZ, 0JCB3ZZ

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/Tricare Claim has one of the Diagnosis Codes listed below, but does not have one of the Other Procedure Codes listed below.

Diagnosis Codes: O000*-O089*, O094*, O095*, O1*, O200, O208, O209, 0210, 02110, 0212, 0218, 0219, 023*, 024*, 025*, 0261*, 0262*, 0263*, 0264*, 0266*, 0267*, 0268*, 0269*, 029*, 030* (excluding 030021, 030022, 030023, 030029), 031*, 032*, 033*, 034*, 0351*, 0352*, 0353*, 0354*, 0355*, 0356*, 0358*, 0359*, 0361*, 0362*, 0363*, 0364*, 0365*, 0366*, 0367*, 03681*, 03689*, 0369* O4*, O6*, O71*, O72*, O73*, O74*, O752, O753, O755, O7582, O7589, O76, O77, O80, O8611, O8613, O8619, O862*, O89*, O905, O906, O9081, O94, O98*, O990*, O991*, O992*, O993*, O995*, O996*, O997*, O998*, O9A*, Z332, A34

Procedure Codes: 0U1*, 0U5*, 0U75*, 0U76*, 0U77*, 0U79*, 0U7C*, 0U7G0*, 0U7G3*, 0U7G4*, 0U7K*, 0U8*, 0U9*, 0UB* 0UC1*, 0UC2*, 0UC3*, 0UC4*, 0UC5*, 0UC6*, 0UC7*, 0UC8*, 0UC90ZZ, 0UC93ZZ, 0UC94ZZ, 0UCB*, 0UCC*, 0UCF*, 0UCG0ZZ, 0UCG3ZZ, 0UCJ*, 0UCK*, 0UCL*, 0UCM0ZZ, 0UDB*, 0UDN*, 0UF* (excluding 0UF6XZZ), 0UH9*HZ, 0UHC*HZ, 0UHD*, 0UHH*, 0UJ**ZZ (excluding X in fifth character), 0UL*, 0UM*, 0UN*, 0UP30*, 0UP33*, 0UP34*, 0UP8*** (excluding X in fifth character), 0UPD0*, 0UPD3*, 0UPD4*, 0UPD7** (excluding H in sixth character), 0UPD8* (excluding H in sixth character), 0UPDH*** (excluding X in fifth character), 0UPM0*, 0UQ*, 0US*, 0UT*, 0UU*, 0UV*, 0UY*, 0UW**** (excluding X in fifth character), 10A*(excluding X in seventh character), 109*, 10D*, 10E*, 10H*, 10J*, 10P*, 10Q*, 10S*, 10T*, 10Y*, 3027*, 3E0DXGC, 3E0E305, 3E0E337, 3E0E3*Z, 3E0E705, 3E0E729, 3E0E7*Z, 3E0E805, 3E0E829, 3E0E8*Z, 3E0E7SF, 3E0E8SF, 3E0P3LZ, 3E0P3Q*, 3E0P73Z, 3E0P76Z, 3E0P77Z, 3E0P7GC, 3E0P7LZ, 3E0P7Q0, 3E0P7Q1, 3E0P83Z, 3E0P86Z, 3E0P87Z, 3E0P8GC, 04LE**T, 04LF**U, 4A0H7*, 4A0H8, 4A0HX*, 4A0J7*, 4A0J8*, 4A0JX*, 4A1H7*, 4A1H8*, 4A1HX*, 4A1J7*, 4A1J8*, 4A1JX*, 0WBN*, 0WQN*, 0W8NXZZ, 0W9N**Z, 0H99X0Z, 0H99XZX, 0H99XZZ, 0H89XZZ, 0H59XZZ, 0HB9XZZ, 0JCB0ZZ, 0JCB3ZZ

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/Tricare Claim has a Principal Procedure Code of 10D00*, 10A00ZZ, 10A03ZZ, 10A04ZZ, 10T20ZZ, 10T23ZZZ, or 10T24ZZ, but does not have a Diagnosis Code of O01*, O02*, O03*, O04*, O05*, O06*, O07*, O08*, O094*, O095*, O1*, O20*, O21*, O22*, O23*, O24*, O25*, O26*, O29*, O30*, O31*, O32*, O33*, O34*, O35*, O360*, O361*, O362*, O363*, O364*, O365*, O366*, O367*, O3681*, O3689*, O369*, O4*, O6*, O7*, O8*, O90*, O91*, O92*, O98*, O99*, O9A*, Z332, or A34.

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 it 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 Z5301, Z5309, Z531, Z5320, Z5321, Z5329, Z538, or Z539, but does not have a Procedure Code. The second is if a Champus/Tricare 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 - PRINCIPAL PROCEDURE IS NOT VALID

Locator: 74 - Principal Procedure Code/Date

Scenario: The above edit appears if a claim has a Principal Procedure Code of 08Q8XZZ, 08Q9XZZ, 09HD*4Z, 09HE*4Z, 0NH5*SZ, 0NH6*SZ, 02YA*, 02HA*QZ, 02RK*JZ, 02RL*JZ, 02WA*QZ, 02PA*QZ, or 0FY0*.

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

Locator: 74a-e - Other Procedure Code/Date

Scenario: The above edit appears if a claim has a Secondary Procedure Code and no Secondary Procedure date.

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 ICD10 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 74a-e.

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 ICD10 Procedure code and it is not in the TruBridge EHR ICD10 Procedure table, call TruBridge 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 Coding Screen screen but no remarks in locator 80.

To Correct: Verify Occurrence Code is correct. If incorrect, delete code from the Coding Screen 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 76 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 UPIN# field blank in the Physician table.

To Correct: Verify Physician is correct. Verify the UPIN of the surgeon and load in Table Maintenance > Control Tab > Physicians > UPIN# field. 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 duplicate Revenue Codes and CPT codes from the 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 be summarized, then set the Summarize O/P Ins field in the Summary Code table to summarize for 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 the UPIN# field 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 > Business Office Tables Maintenance > Physician). 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.

Procedure Codes: 01N5*, 059Y30Z, 059Y3ZZ, 059Y40Z, 059Y4ZZ, 069Y30Z, 069Y3ZZ, 069Y40Z, 069Y4ZZ, 079T0ZX, 079T3ZX, 079T4ZX, 07DQ0ZX, 07DQ3ZX, 07DR0ZX, 07DR3ZX, 07DS0ZX, 07DS3ZX, 085E3ZZ, 085F3ZZ, 085J3ZZ, 085K3ZZ, 08BJ3ZZ, 08BK3ZZ, 08DJ3ZZ, 08DK3ZZ, 08Q0XZZ, 08Q1XZZ, 08Q23ZZ, 08Q33ZZ, 08QE3ZZ, 08QF3ZZ, 08RJ3JZ, 08RK3JZ, 095K0ZZ, 095K3ZZ, 095K4ZZ, 0B9*3ZX, 0B9*4ZX, 0B9*7ZX, 0B9*8ZX, 0BB3ZX, 0BB34ZX, 0BB37ZX, 0BB38ZX, 0BB43ZX, 0BB44ZX, 0BB47ZX, 0BB48ZX, 0BB53ZX, 0BB54ZX, 0BB57ZX, 0BB58ZX, 0BB63ZX, 0BB64ZX, 0BB67ZX, 0BB68ZX, 0BB73ZX, 0BB74ZX, 0BB78ZX, 0BB83ZX, 0BB84ZX, 0BB87ZX, 0BB88ZX, 0BB93ZX, 0BB94ZX, 0BB97ZX, 0BB98ZX, 0BBB3ZX, 0BBB7ZX, 0BBB8ZX, 0BJ08ZZ, 0BJK8ZZ, 0BJL8ZZ, 0D717*, 0D718*, 0D72*, 0D727*, 0D728*, 0D737*, 0D738*, 0D747*, 0D748*, 0D757*, 0D758*, 0D963ZX, 0D964ZX, 0D967ZX, 0D968ZX, 0D9E3ZX, 0D9E4ZX, 0D9E7ZX, 0D9E8ZX, 0D9H3ZX, 0D9H4ZX, 0D9H7ZX, 0D9H8ZX, 0D9N3ZX, 0D9N4ZX, 0D9N8ZX, 0DBE3ZX, 0DBE4ZX, 0DBE7ZX, 0DBE8ZX, 0DBE0ZZ, 0DBE3ZZ, 0DBE7ZZ, 0DBH3ZX, 0DBH4ZX, 0DBH7ZX, 0DBH8ZX, 0DBN3ZX, 0DBN4ZX, 0DBN7ZX, 0DBN8ZX, 0DB63ZX, 0DB64ZX, 0DB67ZX, 0DJ08ZZ, 0DJ68ZZ, 0DJD8ZZ, 0T7D0DZ, 0T7D3DZ, 0T7D4DZ, 0T7D7DZ, 0T7D8DZ, 0T7D8ZZ, 0T9B70Z, 0T9B80Z, 07JB8ZZ, 0H50*, 0H51*, 0H54*, 0H55*, 0H56*, 0H57*, 0H58*, 0H59XZD, 0H59*, 0H5A*, 0H5B*, 0H5C*, 0H5D*, 0H5E*, 0H5F*, 0H5G*, 0H5H*, 0H5J*, 0H5K*, 0H5L*, 0H5M*, 0H5N*, 0H5Q*, 0H5R*, 0H9*XZX (excluding 2,3), 0HB*XZX (excluding 2,3), 0HB*XZZ (excluding 2,3), 0H9T0ZX, 0H9U0ZX, 0H9V0ZX, 0H9W0ZX, 0H9X0ZX, 0HBT0ZX, 0HBU0ZX, 0HBV0ZX, 0HBW0ZX, 0HBY0ZX, 0HBT*ZZ, 0HBU*ZZ, 0HBV*ZZ, 0HQ**ZZ (excluding Q,R,W,X,Y), 0J5*, 0J9*3ZX (excluding 2,3), 0JB*3ZX (excluding 2,3), 0JB*0ZZ (excluding 2,3), 0PSH3ZZ, 0PSH4ZZ, 0PSHXZZ, 0PSJ3ZZ, 0PSJ4ZZ, 0PSJXZZ, 0PSK3ZZ, 0PSK4ZZ, 0PSKXZZ, 0PSL3ZZ, 0PSL4ZZ, 0PSLXZZ, 0UDB7ZX, 0UBD7ZZ, 0UBD8ZX, 0UBD8ZZ, 0V903ZX, 0V904ZX, 0V907ZX, 0V908ZX, 0VB03ZX, 0VB04ZX, 0VB07ZX, 0VB08ZX, 0W993ZZ, 0W9B3ZZ, 0YQ50ZZ, 0YQ53ZZ, 0YQ54ZZ, 0YQ5XZZ, 0YQ60ZZ, 0YQ63ZZ, 0YQ64ZZ, 2Y41X5Z, 3E09XGC, 3E0R0*, 3E0R33Z, 3E0R36Z, 3E0R37Z, 3E0R3AZ, 3E0R3BZ, 3E0R3CZ, 3E0R3E*, 3E0R3GC, 3E0R3HZ, 3E0R3KZ, 3E0R3NZ, 3E0R3SF, 3E0R7SF, 3E0S3BZ, 3E0S3CZ, 3E0S33Z, 3E0S36Z, 3E0S37Z, 3E0S3BZ, 3E0S3CZ, 3E0S3GC, 3E0S3HZ, 3E0S3KZ, 3E0S3NZ, 3E0S7SF, 3E0S33Z, 3E0S36Z, 3E0S37Z, 3E0S3BZ, 3E0S3CZ, 3E0S3GC, 3E0S3HZ, 3E0S3KZ, 3E0S3NZ, 3E0S3SF, 3E0S7SF.

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 V00* - Y99*

Scenario: The above edit appears if a claim has an accident hour in the Stay Information screen but does not have an accident diagnosis of V00* - Y99*.

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 Summarize O/P Ins field in the Summary Code table 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 Summarize O/P ins field in the Summary Code table 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 Summarize O/P Ins field in the Summary Code table 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.

EDT 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 Summarize O/P Ins field in the Summary Code table 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 Summarize O/P Ins field in the Summary Code table, 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 Summarize O/P Ins field in the Summary Code table, 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 Summarize O/P Ins field in the Summary Code table, 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 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 Summarize O/P Ins field in the Summary Code table, 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 Summarize O/P Ins field in the Summary Code table, 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 Summarize O/P Ins field in the Summary Code table, 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 Summarize O/P Ins field in the Summary Code table, 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 Summarize O/P Ins field in the Summary Code table, 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 Summarize O/P Ins field in the Summary Code table, 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 the Physician's table.

To Correct: Verify that the field is blank. Load the number in the Lic# or Tax# field in the Physician's table field. 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 claims have Revenue Codes 030* - 031* with Type of Bill 13X. This edit will not flag if Revenue Codes 025*, 036*, 045*, 063*, and 076* are also on the claim.

To Correct: Verify that the above criteria has been met. Charges should be billed on a 1500.

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 may be loaded in the Non-Covered Sum-CD field on page 4 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 UB 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 - ACCIDENT DIAGNOSIS WITH NO ACCIDENT DATE

Locator: 31-36 Occurrence Codes

Scenario: This edit will appear when Diagnosis V00* - Y99* is present without an accident date.

To Correct: Verify that the accident date is missing and that the accident diagnosis 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 K0*, K1*, M26*, AND M27* ON MCARE CLAIM

Locator: 67A - Q - Diagnosis Codes

Scenario: This edit will appear when Diagnosis Codes of K0*, K1*, M26*, and M27* 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 UB

Locator: 42 - Revenue Code

Scenario: This edit will appear when a Revenue Code of 253 is present on an Iowa Medicaid UB.

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 UB Bill Type 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 UB.

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 Coding Screen 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 ICD10 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 Ins Diag/Proc 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 Coding Screen 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 Table Maintenance. 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 TruBridge 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 Non-Covered Sum CD field on page 4 of the Insurance Company table 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 - V00* - Y99* 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 of V00* - Y99*.

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 is included in the Medical Necessity Policy then this edit will appear. It indicates that a frequency limit exists for this CPT. Path: Table Maintenance > Business Office > Medical Necessity Policies.

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 Policy, 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.

6.6 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 HCPC or Procedure Codes:

HCPC Codes:

51925, 55250, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58548, 58550, 58552, 58553, 58554, 58565, 58570, 58571, 58572, 58573, 58600, 58605, 58611, 58615, 58670, 58671, 58951, 58953, 58954, 58956, 59525.

ICD10 Procedure Codes:

0U550ZZ - 0U578ZZ, 0UL50CZ - 0UL78ZZ, 0V5N0ZZ - 0V5Q4ZZ, 0VBN0ZZ - 0VBQ4ZZ, 0VTN0ZZ - 0VTQ4ZZ.

To Correct: This is a notice for the presence of one of the HCPC or Procedure 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 Diagnosis Codes listed below.

Diagnosis Codes: D137, E08*, E09*, E10*, E11*, E13*, E15, E31*, E160-E163, E31*, E748, E790, E831*, E891, K860-K861, K912, O2401*, O2403, O2411*, O2413, O2431*, O2433, O2441*, O2443*, O2481*, O2483, O2491*, O2493, O99810, O99815, R730*, R739, R7871, R7879, R7889, R790, R7989, R799, T383X1A, T383X2A, T383X3A, T383X4A, Z793, Z794, Z79891, Z79899, Z862, Z863*

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: AANNNNNNNAAAAAX, 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 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 UB, the claim has exceeded the number of detailed lines specified in the Max chg Lines on Claim field on page 4 of the Insurance Company table.

To Correct: Edit will no longer pull when the correct numbers of lines pull to the UB.

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 (GO378)

Scenario: Edit appears if a Medicare Outpatient claim has a revenue category 762 and one of the following diagnosis codes: I018, I0981, I110, I130, I132, I200, I201, I208, I209, I240, I241, I248, I50**, J440, J441, J45**, R0602, R071, R072, R078*, or R079.

To Correct: Determine if the HCPC code GO378 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 Coding Screen 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 Coding Screen 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 Coding Screen 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 UB 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: 85004, 85007, 85008, 85013, 85014, 85018, 85025, 85027, 85032, 85048, or 85049 and reflects only one of the 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 listed in [Appendix C](#)¹³³.

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-10-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.

CPT Codes: 8006, 80074, 80162, 82105, 82378, 82465, 82523, 82728, 82947, 82948, 82962, 82977, 82985, 83036, 83540, 83550, 83700, 83701, 83704, 83718, 83721, 84153, 84436, 84439, 84443, 84466, 84479, 84702, 85004, 85007, 85008, 85013, 85014, 85018, 85025, 85027, 85032, 85048, 85049, 85610, 85730, 86300, 86301, 86304, 86689, 86701, 86702, 86703, 87066, 87088, 87390, 87391, 87534, 87535, 87536, 87537, 87538, 87539, G0328

Diagnosis Codes: R99, Z000*, Z0011*, Z0012*, Z005, Z006, Z007*, Z008, Z020-Z026, Z027*, Z028*, Z029, Z046, Z048, Z049, Z11*, Z120, Z1210, Z1213, Z122, Z126, Z127*, Z128*, Z129, Z130, Z1321, Z1322*, Z1329, Z134, Z135, Z137*, Z1381*, Z1382*, Z1383, Z1384, Z1385*, Z1388, Z1389, Z139, Z36, Z400*, Z408, Z409, Z41*, Z461, Z560, Z562-Z566, Z568*, Z569, Z57*, Z59*, Z602, Z6221, Z710, Z741-Z749, Z755, Z760-Z764, Z7681, Z801, Z802, Z805*, Z806-Z809, Z81*, Z82*, Z83*, Z84*

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 claim.

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 > Business Office Tables Maintenance > 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 a HCPCS codes range 10021-69979 with revenue code 490

To correct: Verify that the HCPC 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 Coding Screen 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 are V00-X58

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 Separate Claims For fields on page 4 of the Insurance Company table.

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 Coding Screen 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 APC Reimburse field on page 4 of the Insurance Company table set to Yes. 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 APC Reimburse field on page 4 of the Insurance Company table set to Yes. 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 APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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 APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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 APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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 36570, 36571, 36585 or 36640
C-Code: C1751

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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, APC REIMBURSE? is set to Yes. 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, C1820

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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 APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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 APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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 APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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 APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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 APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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 APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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 APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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 APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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 APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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 APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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 APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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 APC Reimbursement field on page 4 of the Insurance Company table set to Yes. 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 - CLAIM REQUIRES MODIFIER 25

Scenario: The above edit appears anytime a Medicare patient (M**) has a revenue code of 450 and CPT of 99281-99285, without a modifier of 25, and any other 450 revenue code is present.

To Correct: Verify the insurance is correct. If the account has a revenue code of 450 with a CPT of 99281-99285 and any other lines of detail with a revenue code of 450 and CPT of 99281-99285, the CPT must have a modifier of 25. The modifier may be added in the Detail Charges screen.

EDIT 490 - CLAIMS REQUIRES BIRTHWEIGHT

Scenario: The above edit appears if 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, J0886, J0887, J0890 or Q4081 are present in the Detail Charges screen, and ICD10s D631 and N186 are not loaded in the Grouper screen (pulling to Stay Information screen).

To Correct: If the account has a CPT/HCPC code of J0882, J0886, J0887, J0890 or Q4081 pulling to the detail charges screen, then verify ICD10 D631 and N186 are both coded on the Grouper screen. The claim will need to be regenerated if any codes have been added to the Grouper.

EDIT 492 - INVALID MEDICARE PRINCIPAL DIAG

Locator: 66 DX

Scenario: This edit will appear when one of the Diagnosis Codes listed in [Appendix D](#)¹³⁷ is 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 493 - PREAUTHORIZATION REQUIRED FOR RADIOLOGY PROCEDURES

Scenario: The above edit appears for BB* claims with IA as the state code on page 1 of the Insurance Company table. 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 - ICD10 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 the ICD10 code(s) from one of the six groups listed below.

Group 1: Patients with chronic kidney disease (not yet on dialysis) and anemia ICD10 D631 is required with one of the following: I120, I1311, I132, N183, N184 or N185

Group 2: Patients with anemia related to treatment with zidovudine (AZT) and/or other Nucleoside Reverse Transcriptase Inhibitor (NRTI) for HIV disease. ICD10 D611, D612, D613 or D6189 is required with either B20 or B9735.

Group 3: Patients with anemia related to chemotherapy. ICD10 D6481.

Group 4: Patients with anemia related to myelodysplastic syndrome. ICD10 D460, D461, D4621, D46A, D46B, D46C, D469 or D471 is required.

Group 5: Preoperative used in specified patients. ICD10 D638 or D649 is required with Z418.

Group 6: Patients with anemia of chronic disease. ICD10 D638 is required with one of the following: B171*, B182, D658, K5000, K50011-K50018, K5010, K0111-K50118, K5080, K50811-K50818, K5100, K51011-K51018, K5120, K51211-K51218, K5130, K51311-K51318, K5140, K51411-K51418, K5150, K51511-K51518, K5180, K51811-K51818, M069, M32.19, M32.8, T375X5A, T375X5S.

To Correct: If the account has a CPT/HCPC code of J0885 or J0881 on the detail charges screen, then the claim must meet the criteria of one of the six ICD10 groups listed above. The claim will need to be regenerated to pull any additional codes that have been added to the Medical Record Grouper.

EDIT 496 - HOLTER 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 93228 93229 93268 93270 93271 93272 0295T 0296T 0297T or 0298T and does not have an appropriate principle diagnosis.

To Correct: Verify the CPT/HCPC is correct. If correct add a principle diagnosis code of I20*, I210*, I211*, IS12*, IS14, I220, I221, I222, I228, I240, I241, I248, I25110, I25111, I25118, I252, I25700, I25701, I25708, I25710, I25711, I25718, I25720, I25721, I25728, I25730, I25731, I25738, I25750, I25751, I25758, I25760, I25761, I25768, I25790, I25791, I25798, I440, I441, I442, I4439, I444, I445, I4469, I447, I450, I4519, I452, I453, I454, I455, I456, I4581, I4589, I470, I471, I472, I479, I480, I481, I482, I483, I484, I4901, I4902, I491, I492, I493, I495, I498, R001, R002, R0601, R0602, R0609, R062, R063, R064, R0681, R0682, R0683, R0689, R072, R0782, R0789, R295, R404, R42, R55, Z79891, Z79899 in the Medical Record Grouper.

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 498 - NEED VALUE CODE 54

Scenario: This edit appears if the patient is less than 29 days old, with a type of bill 11X and value code 54 is not present for the newborn birth weight.

To Correct: Verify the insurance, date of birth and admit weight for the patient. If this is correct, add value code 54 to the Coding Screen 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.

6.7 Edit 501 - 513

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) 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) 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.

EDIT 502 - CPT CODES XXXXX AND XXXXX CANNOT BE BILLED ON THE SAME DOS

Scenario: The above edit appears when one of the following conditions exist: The financial class matches one set up in the CCI Edit Code Maintenance table. The claim type is equal to a UB. The procedure code pair matches one set up in CCI Edit Code Maintenance table. Or the claim falls within the effective/expiration date for the procedure pair in the CCI Edit Code Maintenance Table.

To Correct: The edit will be cleared when the following has been completed: The modifier is attached to the second CPT for the procedure pair and modifier is equal to 1 in the CCI Edit Code Maintenance table. Or the modifier for the procedure pair is listed as 9 in the CCI Edit Code Maintenance table (This would be considered Not Applicable).

EDIT 503 - CPT REQUIRES NDC CPT#

Scenario: The above edit appears if a claim has a F/C of X**, Bill Type 13x or 85X, a Revenue Code of 636, and there is not a NDC number attached to the item.

To Correct: An NDC number will need to be entered in the item.

EDIT 505 - MISSING OR INVALID ATTENDING PHYSICIAN'S NPI

Scenario: The above edit appears if a claim has an Attending Physician loaded in the Stay Information screen with the NPI field blank or is not 10 characters in the Physician table.

To Correct: Verify Physician is correct. Verify the NPI of the attending physician and load in the Business Office Tables (Hospital Base Menu > Master Selection > Business Office Tables > Business Office Tables Maintenance > Physician). There is no need to regenerate the claim.

EDIT 506 - MISSING OR INVALID SURGEON'S NPI

Scenario: The above edit appears if a claim has a Surgeon loaded in the Stay Information screen with the NPI field blank or is not 10 characters in the Physician table.

To Correct: Verify Physician is correct. Verify the NPI of the surgeon and load in the Business Office Tables (Hospital Base Menu > Master Selection > Business Office Tables > Business Office Tables Maintenance > Physician). There is no need to regenerate the claim.

EDIT 507 - BLUE CROSS OF NORTH DAKOTA REQUIRES 86X BILLTYPE

Scenario: The above edit appears if a claim has a F/C of B**, the Insurance Company table has a state code of ND and the UB Bill Type is not 86X.

To Correct: Verify the UB Bill Type in the Detail Charges screen. There is no need to regenerate the claim if the Bill Type is changed.

EDIT 509 - HCPC REQUIRED FOR REVENUE CODE 964

Scenario: The above edit appears if a claim has a Bill Type of 85X, a Revenue Code of 936 and there is no HCPC code present.

To Correct: Verify that the Revenue Code of 964 is correct, and if so, add the corresponding HCPC code to page 2 of the Medical Records Grouper or load the CPT in the Item Master. The claim will need to be regenerated if any changes are made.

EDIT 510 - MODIFIER EA, EB OR EC IS NOT PRESENT ON ACCOUNT

Scenario: The above edit appears if CPT J0881 and/or J0885 is present on a Medicare account without Modifier EA, EB or EC.

To Correct: Verify the Modifier is needed, if so add to the detail charges screen.

EDIT 511 - VALUE CODE 48 OR 49 IS NOT PRESENT ON ACCOUNT

Scenario: The above edit appears if CPT J0881, J0882, J0885 and/or Q4081 are present on a Medicare account and must have value code 48 - for Hemoglobin reading or 49 - for Hematocrit reading.

To Correct: Verify the Value Code is needed, if so add it to the Coding Screen Screen.

EDIT 513 - MORE THAN 10 THERAPY VISITS

Scenario: The above edit appears if a claim has a F/C of M** and is pulling a Therapy value code of 50, 51 or 52 with a quantity greater than 10 in the Coding Screen screen.

To Correct: The edit will be cleared when the claim is regenerated for a smaller service date range that includes 10 therapy visits or less.

NOTE: Edit 513 was created for Functional Therapy Reporting.

6.8 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

A4641
A4642
A9270
A9500
A9501
A9502
A9503
A9504
A9505
A9507
A9508
A9509
A9510
A9511
A9512
A9513
A9514
A9515
A9516
A9521
A9524
A9525
A9526
A9528
A9529
A9531
A9532
A9536
A9537
A9538
A9539
A9540
A9541
A9542
A9544
A9546
A9547
A9548
A9550
A9551
A9552
A9553
A9554
A9555

A9556
A9557
A9558
A9559
A9560
A9561
A9562
A9566
A9567
A9568
A9569
A9570
A9571
A9572
C9399
C9898

6.9 Appendix B

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

D63*

D641

D7581

D77

E080*

E081*

E082*

E0831*

E0832*

E0833*

E0834*

E0835*

E0836

E0839

E084*

E085*

E0861*

E0862*

E0863*

E0864*

E0865

E0865

E0869

E088

E089

E35

F028*

F54

G01

G02

G053

G054

G07

G13

G26

G320

G328*

G4727

G4736

G4737

G4742*

G4754

G53

G55

G59
G63
G7081
G73*
G914
G94
G99*

H22
H28
H32
H36
H42
H624*
H628X*
H67*
H750*
H758*
H82*
H940*
H948*

I32
I39
I41
I43
I52
I68*
I79*

J17
J8403
J8417
J91*
J99

K23
K67
K77
K87

L14
L45
L54
L62
L86
L99

M01X0
M01X1*
M01X2*
M01X3*

M01X4*
M01X5*
M01X6*
M01X7*
M01X8
M01X9
M0288
M0289
M029
M1480
M1481*
M1482*
M1483*
M1484*
M1485*
M1486*
M1487
M1488
M1499
M36*
M498*
M6380
M6381*
M6382*
M6383*
M6384*
M6385*
M6386*
M6387*
M6388
M6389
M9050
M9051*
M9052*
M9053*
M9054*
M9055*
M9056*
M9057*
M9058
M5059
M9060
M9061*
M9062*
M9063*
M9064*
M9065*
M9066*
M9067*
M9068
M9069
M9080

M9081*
M9082*
M9083*
M9084*
M9085*
M9086*
M9087*
M9088
M9089

N08
N16
N22
N29
N33
N37
N4832
N51
N521
N74
N77*

R4782
N5081

Z9183

6.10 Appendix C

A1859	I700-I701	N477-N478	S46***S	S97***S	Z726- Z72811
A630	I738*	N500	S46*1*A	S98***S	Z734-Z736
	I739	N60**	S47***S	S99***S	Z7382
B07*	I781	N62	S48***S		Z7401- Z7409
	I791	N640-N643	S490**D	T07	Z765
D000*	I798	N6489-N649	S490**G	T1490	Z7682- Z7689
D04*	I972	N750	S490**S	T15***A	Z780-Z789
D04**		N758	S491**D	T15***S	Z800
D10*	J33*	N810-N819	S491**G	T16***A	Z803
D11*	J34*	N830-N8333	S491**S	T16***S	Z8651- Z8659
D170	J34**	N854-N855	S498**S	T17***S	Z87890
D22*	J381	N951-N959	S499**S	T170**A	Z880-Z888
D23*		N970-N979	S50***S	T171**A	Z89011- Z89519
D24*	K00*	N993	S503**A	T180***S	Z89611- Z903
D29*	K01*		S508**A	T190***S	Z9049- Z906
D314*	K02*	O92011-O9279	S509**A	T2****S	Z90721- Z9089
D481	K02**		S51***S	T33***S	Z9115
	K030-K035	P0701-P0718	S51009A	T34***S	Z9183
E0*36	K037		S52***D	T36***S	Z930-Z939
E0*51	K038*	R0981	S52***G	T36*X6A	Z950-Z951
E0*52	K039	R1310	S52***S	T36*X6D	Z955- Z95810
E0*618	K08**	R37	S52***E (EXCLUDE S52*1*E, S5252*E, S5262*E) (INCLUDE S5251*E, S5261*E)	T37***S	Z95818
E1*36	K08***	R4183	S52***F (EXCLUDE S52*1*F, S5252*F, S5262*F) (INCLUDE S5251*F, S5261*F)	T37*X6A	Z959
E1*51	K090-K091	R439	S52***H (EXCLUDE S52*1*H, S5252*H, S5262*H) (INCLUDE S5251*H, S5261*H)	T37*X6D	Z961
E1*52	K116-K119	R45850-R45851	S52***J (EXCLUDE S52*1*J, S5252*J, S5262*J) (INCLUDE S5251*J, S5261*J)	T3796XA	Z9621- Z9622
E1*618	K824	R4681-R4689	S53***A	T3796XD	Z9641
E230		R4789	S53***S	T38***S	Z970
	L0889	R52	S54***A	T38*X6A	Z972- Z98818
F21	L11*	R682	S54***S	T38*X6D	Z9883- Z9884
F340- F3341	L200-L2082	R6882	S55***S	T388*6A	Z9886

F41*	L2084-L209	R6889	S56***S	T388*6D Z9889
F454*	L22-L259	R69	S56*1*A	T389*6A Z992
F489	L300		S57***S	T389*6D
F520- F521	L302	S00***A (EXCLUDE S00*3*A)	S58***S	T39***S
F522*	L308-L309	S00***X	S59***D (EXCLUDE S598**D, S599**D)	T39**6A
F523*	L550-L599	S01***S	S59***G (EXCLUDE S598**G, S599**G)	T39**6D
F524	L609	S02***D	S59***S	T40***S
F526- F529	L664	S02***G	S60***A (EXCLUDE S600**A, S601**A, S602**A)	T40**6A
F60*	L70*	S02***S	S60***S	T40**6D
F60**	L720	S03*XXA (EXCLUDE S032XXA)	S61***S	T41***S
F63*	L739	S03*XXS	S61009A	T41**6A
F63**	L80-L879	S04***S	S61209A	T41**6D
F64*	L900-L919	S05***S	S61409A	T42***S
F65*	L921-L923	S0500XA	S61509A	T42**6A
F65**	L929	S0501XA	S62***D	T42**6D
F66	L940-L943	S0502XA	S62***G	T42*6XA
F6810	L948-L950	S0590XA	S62***S	T42*6XD
F6812- F6813	L958-L959	S06***S	S63***A	T43***S
F69	L985-L988	S07***S	S63***S	T43***S
F819	L99	S08***S	S64***A	T43**6A
F90*		S09***S	S64***S	T43**6D
F91*	M0760- M0769	S510***A (EXCLUDE 5100XXA, 510*3XA)	S65***5	T4396XA
F938- F939	M121*	S510***S	S66***S	T4396XD
F94*	M121**	S11***S	S66*1*A	T44***S
F95*	M1250- M1389	S1190XA	S67***S	T44**6A
F984- F989	M150-M2212	S12***D	S68***S	T44**6D
	M2350	S12***G (EXCLUDE S128XXG, S129XXG)	S69***S	T45***S
G89*	M238X9	S12***S	S70***A (EXCLUDE S700*XA, S701*XA)	T45**6A
G89**	M2400-M249	S13***A	S71***S	T45**6D
	M2520- M25376	S13***S	S71009A	T4596XA
H00***	M2570- M25776	S14***S	S72***D	T4596XD
H01***	M26*	S144XXA	S72***E	T46***S
H04*	M26**	S148XXA	S72***F	T46**6A
H04**	M271	S149XXA	S72***G	T46**6D
H04***	M2740- M2763	S15***S	S72***H	T47***S
H053*	M357	S16***S	S72***J	T47**6A

H053**	M4000- M4319	S161XXA	S72***S	T47**6D
H17*	M433- M438X9	S17***S	S73***A	T4796XA
H17**	M439	S19***5	S73***S	T4796XD
H17***	M484*XD	S20***A (EXCLUDE S2000XA, S2001XA, S2002XA, S2020XA, S20211A, S20212A, S20219A, S20221A, S20222A, S20229A)	S74***A	T48***S
H18*	M484*XG	S20***S	S74***S	T48**6A
H18**	M484*XS	S21***S	S75***S	T48**6D
H18***	M485*XD	S21109A	S76***S	T49***S
H25*	M485*XG	S21209A	S76*1*A	T49**6A
H25**	M485*XS	S22***D	S77***S	T49**6D
H25***	M532X1- M532X6	S22***G	S78***S	T4996XA
H26*	M532X9	S22***S	S79***D (EXCLUDE S798**D, S799**D)	T4996XD
H26**	M6010- M6028	S23***A	S79***G (EXCLUDE S798**G, S799**G)	T5****S
H26***	M6100- M6218	S23***S	S79***S	T50**6A
H28	M623-M6259	S24***S	S80***A (EXCLUDE S800*XA)	T50**6D
H310**	M62831- M6289	S249XXA	S80***S	T6****S
H311**	M6500- M7072	S25***S	S81***S	T7****S
H321**	M7100-M724	S26***S	S82***D	T80***S
H310**	M729-M779	S27***S	S82***E (EXCLUDE S8231*E, S8281*E, S8282*E)	T81***S
H311**	M80***D	S28***S	S82***F (EXCLUDE S8231*F, S8281*F, S8282*F)	T82***S
H312**	M80***G	S29***S	S82***G	T83***S
H314*	M80***S	S2901*A	S82***H (EXCLUDE S8231*H, S8281*H, S8282*H)	T84***S
H314**	M810	S30***S	S82***J (EXCLUDE S8231*J, S8281*J, S8282*J)	T8404*D
H32	M816	S308**A	S82***S	T85***S
H3533	M818	S309**A	S83***A	T88***S
H472*	M843**D	S31000A	S83***S	
H472**	M843**G	S31***S	S84***A	Z002- Z003
H473**	M843**S	S32***D	S84***S	Z010- Z0121
H52*	M844**D	S32***G	S85***S	Z01812
H52**	M844**G	S32***S	S86***S	Z0182
H52***	M844**S	S33***A	S86*1*A	Z0184- Z0189
H547	M845**D	S33***S	S87***S	Z0389

H579	M845**G	S34***S	S88***S	Z09
H71**	M845**S	S35***S	S89***D (EXCLUDE S898*XD, S899*XD)	Z1211
H72**	M846**D	S36***S	S89***G (EXCLUDE S898*XG, S899*XG)	Z1231- Z125
H72***	M846**G	S38***S	S89***S	Z131
H7381*	M846**S	S38***S	S90***A (EXCLUDE S900**A, S901**A, S902**A, S903**A)	Z136
H7382*	M8938	S39***S	S90***S	Z23
H74**	M898X8	S3901*A	S91***S	Z30011- Z323
H74***	M910-M9399	S40***A (EXCLUDE S400**A)	S91009A	Z3A00- Z3A49
H80**	M950-M960	S40***S	S91109A	Z421- Z4509
H833**	M962-M965	S41***S	S91309A	Z4531- Z460
H90*	M9900- M9919	S41009A	S92***D	Z462- Z4681
H90**	M9980-M999	S41109A	S92***G	Z4689- Z4789
H91*		S42***D	S92***S	Z5189- Z529
H91**	N400-N403	S42***G	S93***A	Z531
H930**	N4283	S42***S	S93***S	Z550- Z559
H931**	N430	S43***A	S94***A	Z561
H932**	N432-N4404	S43***S	S94***S	Z600
H933**	N4601- N46025	S44***A	S95***S	Z603- Z6791
H939**	N4611- N46129	S44***S	S96***S	Z69010- Z709
H940**	N470-N475	S45***S	S96*1*A	Z711- Z719

NOTE: A single * following a code (ex. 0UP34*) indicates that the remaining characters may include any alpha or numeric character, the code may be up to seven characters in length but does not have to be seven characters long. Multiple * after a code indicates that the remaining characters may include any alpha or numeric character, but the code length must match the number of characters that are specified by the *. For example, 0UP8*** would mean that the code must be seven characters long, but the last three characters may include any alpha or numeric character.

6.11 Appendix D

B6013	Z000*	Z201	Z4689	Z7289	Z8553	Z944
	Z0011*	Z202	Z469	Z729	Z8554	Z945
C802	Z0012*	Z203	Z4800	Z730	Z8559	Z946
	Z002	Z204	Z4801	Z731	Z856	Z947
D8981*	Z003	Z207	Z4802	Z732	Z857*	Z948*
	Z005	Z20810	Z4902	Z733	Z858**	Z949
F17200	Z007*	Z20818	Z493*	Z734	Z8589	Z950
F17201	Z008	Z2089	Z5189	Z735	Z859	Z951
F17210	Z0110	Z209	Z5200*	Z736	Z860**	Z952
F17211	Z0111*	Z220	Z5201*	Z7381*	Z8603	Z953
F17220	Z0112	Z221	Z5209*	Z739	Z861*	Z954
F17221	Z012*	Z222	Z5281*	Z740*	Z862	Z955
F17290	Z013*	Z2232*	Z530*	Z74*	Z863*	Z958**
F17291	Z0181*	Z2233*	Z531	Z75*	Z865*	Z959
	Z0182	Z2239	Z532*	Z760	Z866*	Z960
G543	Z0183	Z224	Z538	Z762	Z8671*	Z961
G731	Z0184	Z225*	Z539	Z768*	Z8672	Z962*
	Z0189	Z226	Z55*	Z7701*	Z8673	Z963
H168	Z020	Z228	Z560	Z7702*	Z8674	Z964*
H4012**	Z022	Z229	Z561	Z7709*	Z8679	Z965
H4013**	Z024	Z23	Z562	Z7711*	Z870*	Z9660
H4015*	Z025	Z280*	Z563	Z7712*	Z871*	Z966**
H547	Z026	Z281	Z564	Z772*	Z872	Z967
H579	Z027*	Z282*	Z565	Z779	Z8731*	Z968*
H939*	Z0282	Z283	Z566	Z78*	Z8739	Z969
	Z0289	Z288*	Z568*	Z7902	Z8741*	Z970
I2582	Z029	Z289	Z569	Z791	Z8742	Z971*
I2583	Z037*	Z3001*	Z570	Z792	Z8743*	Z972
I2584	Z048	Z3002	Z571	Z795*	Z8744*	Z973
I2601	Z08	Z3009	Z572	Z7981*	Z875*	Z974
I2690	Z09	Z3040	Z573*	Z7983	Z8771*	Z975
I314	Z11*	Z3041	Z574	Z79890	Z8772*	Z978
I7092	Z115*	Z3042	Z575	Z800	Z8773*	Z980
I76	Z116	Z3043*	Z576	Z801	Z8774	Z981
	Z118	Z3049	Z577	Z802	Z8775	Z982
J9312	Z119	Z308	Z578	Z803	Z8776	Z983
	Z120	Z309	Z579	Z804*	Z8779*	Z98**
K7681	Z121*	Z3141	Z59*	Z805*	Z8781	Z988**
	Z122	Z3142	Z60*	Z806	Z8782*	Z990
L49*	Z123*	Z3143*	Z620	Z807	Z8789*	Z992
	Z124	Z314*	Z621	Z808	Z88*	Z993
N641	Z126	Z315	Z622*	Z809	Z89***	Z998*
	Z127*	Z316*	Z623	Z81*	Z899	

O090*	Z128*	Z318*	Z626	Z820	Z900*
O091*	Z129	Z319	Z6281*	Z821	Z902
O0921*	Z130	Z322	Z6282*	Z822	Z903
O0929*	Z131	Z323	Z6289*	Z823	Z9041*
O093*	Z1321	Z331	Z629	Z824*	Z9049
O094*	Z1322*	Z340*	Z630	Z825	Z905
O0951*	Z1329	Z348*	Z631	Z826*	Z906
O0952*	Z134	Z349*	Z633*	Z827*	Z907**
O0961*	Z135	Z36	Z634	Z828	Z9079
O0962*	Z136	Z370	Z635	Z830	Z908*
O097*	Z137*	Z371	Z636	Z831	Z910**
O0981*	Z1381*	Z372	Z637*	Z832	Z9102
O0982*	Z1382*	Z373	Z638	Z834*	Z9109
O0989*	Z1383	Z374	Z639	Z8251*	Z9111
O099*	Z1834	Z375*	Z64*	Z8352	Z911**
O3000*	Z1385*	Z376*	Z65*	Z836	Z9114
O3001*	Z1388	Z377	Z66	Z837*	Z9115
O3003*	Z1389	Z379	Z67**	Z840	Z914**
O3004*	Z139	Z381	Z681	Z841	Z9149
O3009*	Z140*	Z384	Z682*	Z842	Z915
O3010*	Z141	Z387	Z683*	Z843	Z918*
O3011*	Z148	Z391	Z684*	Z848*	Z920
O3012*	Z150*	Z392	Z685*	Z8500	Z922*
O3019*	Z158*	Z3A0*	Z69011	Z8501	Z9224*
O3020*	Z161*	Z3A1*	Z69021	Z8502*	Z9225
O3021*	Z162*	Z3A2*	Z691*	Z8503*	Z9229
O3022*	Z1630	Z3A3*	Z698*	Z8504*	Z923
O3029*	Z1631	Z3A4*	Z70*	Z8505	Z9281
O3080*	Z1632	Z408	Z710	Z8506*	Z9282
O3081*	Z1633	Z409	Z711	Z8507	Z9283
O3082*	Z16341	Z413	Z712	Z8509	Z9289
O3089*	Z16342	Z419	Z713	Z8511*	Z931
O3680X*	Z1635	Z439	Z714*	Z8512	Z932
O99820	Z1639	Z449	Z715*	Z8520	Z933
O99825	Z170	Z4582	Z716	Z8521	Z934
	Z171	Z4589	Z717	Z8522	Z935*
R180	Z180*	Z459	Z718*	Z8523*	Z936
R4183	Z181*	Z460	Z719	Z8529	Z938
R45850	Z182	Z461	Z720	Z853	Z939
R4681	Z183*	Z464	Z723	Z854*	Z940
R4689	Z188*	Z465*	Z724	Z8550	Z941
	Z189	Z466	Z725*	Z8551	Z942
T8112XA	Z2009	Z4681	Z726	Z8552*	Z943
			Z72821		

NOTE: A single * following a code (ex. 0UP34*) indicates that the remaining characters may include any alpha or numeric character, the code may be up to seven characters in length but does not have to be seven characters long. Multiple * after a code indicates that the remaining characters may include any alpha or numeric character, but the code length must match the number of characters that are specified by the *. For example, 0UP8*** would mean that the code must be seven characters long, but the last three characters may include any alpha or numeric character.

Chapter 7 1500 Insurance Claim Edits

7.1 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.

7.2 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 Bank Plan field on page 2 of the Insurance Company table 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 than 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 than 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 on page 4 of the Insurance Company table.

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 than 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 than 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 than 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 - KANSAS MEDICARE - INVALID DIAGNOSIS - V-Y CODES

Locator: 21 - Diagnosis or Nature of Illness or Injury

Scenario: This edit will pull for Medicare claims for the state of Kansas if V00-Y99* is listed as a diagnosis code.

To Correct: Confirm the diagnosis in the Medical Records Grouper screens.

EDIT 49 - BLUE CROSS INVALID DIAGNOSIS V-Y CODES

Locator: 21 - Diagnosis or Nature of Illness or Injury

Scenario: For Blue Cross claims, this edit will pull if V00-Y99* is listed as a diagnosis code.

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: Enter the procedure date in the first column on page 2 of the Medical Records screen.

EDIT 52 - SURGERY PROCEDURE CODE MISSING

Scenario: If surgical procedure code is missing the system will flag for this error.

To Correct: Enter the procedure codes in the second column on page 2 of the Medical Records Grouper screen.

EDIT 53 - This edit is no longer valid and has been removed.

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. TruBridge EHR reads the expiration date loaded in the ICD-10 Diagnosis table.

To Correct: Verify the 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 ICD-10 Diagnosis code and has an expiration date in the ICD10 Diagnosis table, please call TruBridge Software Support in order to correct the 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 LISTED, NO PRINCIPLE PROCEDURE CODE OR PROCEDURE DATE

Scenario: This edit appears if the surgeon, procedure, or procedure date is missing when any of the others are present.

To Correct: Verify the Medical Records Coding for the patient account, and add the necessary missing information.

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 - STATE OF LOUISIANA MEDICAID

Scenario: This edit will pull for Medicaid claims in the state of Louisiana if the Principal Diagnosis Code is V00-Y99*.

To Correct: If the Principal Diagnosis is V00-Y99*, 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 be in the range of V00-Y99*.

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.

EDIT 83 - CPT CODES XXXXX AND XXXXX CANNOT BE BILLED ON THE SAME DOS

Scenario: The above edit appears when one of the following conditions exist: The financial class matches one set up in the CCI Edit Code Maintenance table. The claim type is equal to 1500. The procedure code pair matches one set up in CCI Edit Code Maintenance table. Or the claim falls within the effective/expiration date for the procedure pair in the CCI Edit Code Maintenance Table.

To Correct: The edit will be cleared when the following has been completed: The modifier is attached to the second CPT for the procedure pair and modifier is equal to 1 in the CCI Edit Code Maintenance table. Or the modifier for the procedure pair is listed as 9 in the CCI Edit Code Maintenance table (This would be considered Not Applicable).

EDIT 85 - CPT REQUIRES NDC CPT#

Scenario: The above edit appears if a claim has a F/C of X**, Bill Type 13x or 85X, a Revenue Code of 636 and there is not a NDC number attached to the item.

To Correct: An NDC number will need to be entered in the item.

EDIT 86 - ATTENDING PHYSICIAN NPI NUMBER MISSING

Scenario: The above edit appears if the NPI number is missing from the NPI field in the attending physician table.

To Correct: Load the NPI number in the physician table.

EDIT 87 - PERFORMING PHYSICIAN NPI NUMBER MISSING

Scenario: The above edit appears if the NPI number is missing from the NPI field in the performing physician table.

To Correct: Load the NPI number in the physician table.

EDIT 89 - BLOOD RESULTS MISSING ON MEDICARE CLAIM

Scenario: The above edit appears if CPT J0881, J0882, J0885, J0886, J0890 and/or Q4081 are present on a Medicare account and is missing a test result loaded in the Misc 6 field on the Detail Benefits tab.

To Correct: Verify the Blood Test Result is loaded, if not, load it in the Misc 6 field on the Detail Benefits tab.