

**EDIT 0001 - GENERIC ELIGIBILITY RECORD USED.**

This edit posts when the first two digits of the beneficiary's id number starts with a 58, 59, or 50. This edit does not deny the claim. Below are the form locators that apply:

ADA	15
1500	1A
UB-04	60
MC-6	1 & 2
MC-9	3
MC-12	3 & 4
MC-19	8
TAD	5

**EDIT 0002 - BILLING PROVIDER NUMBER MISSING/INVALID**

This edit posts when the billing provider number is invalid or missing. Below are the form locators that apply:

ADA	52A
1500	33B
UB-04	57
MC-6	10
MC-9	10
MC-12	9
MC-19	24
TAD	Top left corner

**EDIT 0004 - INV/MISS PRESCRIBER'S MEDICAID ID NUMBER**

This edit posts to a claim when the prescribing Medicaid ID Number is missing or invalid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	23
MC-9	17
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0005 - INV/MISS ATTENDING PHYSICIAN MEDICAID ID NUMBER**

This edit posts to a claim when the attending physician Medicaid ID Number reported is either missing or invalid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	76
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	7

**EDIT 0006 - INVALID REFERRING/OTHER INDIVIDUAL MEDICAID ID NUMBER**

This edit will post when the referring or other physician field on the submitted claim is invalid or not numeric. Below are the form locators that relate to this edit:

ADA	N/A
1500	17A
UB-04	78 & 79
MC-6	N/A
MC-9	17
MC-12	N/A
MC-19	11
TAD	N/A

**EDIT 0007 - BILLING PROVIDER CHECK DIGIT INVALID**

This edit posts if the provider's check digit, calculated by the system, is not consistent with the billing provider number on the claim. Below are the form locators that relate to this edit:

ADA	52A
1500	33B
UB-04	57
MC-6	10
MC-9	10
MC-12	9
MC-19	24
TAD	Top left corner

**EDIT 0009 - SERVICES NOT COVERED FOR THIS RECIPIENT.**

The beneficiary is not entitled to the service billed. This edit does not apply to any specific form locator.

**EDIT 0010 - INVALID SERVICING PROVIDER MEDICAID ID NUMBER**

The Medicaid provider number of the servicing provider must have seven numeric digits and must be valid. If a servicing provider number is not required, that corresponding field must be blank. Below are the form locators that apply:

ADA	58
1500	24J
UB-04	N/A
MC-6	N/A
MC-9	27
MC-12	N/A
MC-19	14J
TAD	N/A

**EDIT 0011 - RECIPIENT NUMBER MISSING OR INVALID**

This edit posts when the claim has a Medicaid ID Number that is missing or invalid. Medicaid ID Number must be 12 digits. Below are the form locators that apply:

ADA	15
1500	1A
UB-04	60
MC-6	1 & 2
MC-9	3 & 4
MC-12	3 & 4
MC-19	8
TAD	5

**EDIT 0012 - MISSING RECIPIENT NAME**

This edit posts to a claim when the first five digits of the Beneficiary's last name are missing, and/or if the first character of the first name is missing. Below are the form locators that apply:

ADA	12
1500	2
UB-04	8B
MC-6	3 & 5
MC-9	1
MC-12	1
MC-19	1
TAD	3 & 4

**EDIT 0013 - INVALID BIRTHDATE**

This edit posts to a claim when the Beneficiary's date of birth reported on the Claim is not numeric or is equal to zeroes. Below are the form locators that apply:

ADA	13
1500	3
UB-04	10
MC-6	4
MC-9	5
MC-12	5
MC-19	2
TAD	N/A

**EDIT 0014 - STATEMENT THRU DATE < OCCURRENCE DATE**

This edit posts to a claim if the occurrence date is greater than the statement thru date. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	6 & 31 - 36
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0015 - STATEMENT THRU DATE < STATEMENT FROM DATE**

This edit posts to a claim if the span statement date is invalid. For example 10/01/2012 - 10/31/2011. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	6
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0016 - INV/MISS SERVICE FROM DATE**

This edit will post to a claim when the "from" date of service is invalid. Below are the form locators that apply:

ADA	form locator 24
1500	form locator 24A
UB-04	form locator 6 and 45 6
MC-6	form locator 12
MC-9	form locator 25A
MC-12	N/A
MC-19	form locator 14
TAD	form locator 10

**EDIT 0017 - INV/MISS SERVICE THRU DATE**

This edit will post to a claim when the date of service is invalid. Below are the form locators that apply:

ADA	form locator 24
1500	form locator 24A
UB-04	form locator 6
MC-6	form locator 12
MC-9	form locator 25
MC-12	N/A
MC-19	form locator 14
TAD	form locator 11

**EDIT 0018 - SERVICE THRU DATE < SERVICE FROM DATE**

This edit will post to a claim when the service thru date is less than the service from date. Below are the form locators that apply:

ADA	form locator 24
1500	form locator 24A
UB-04	form locator 6 and 45 6
MC-6	form locator 12
MC-9	form locator 25
MC-12	N/A
MC-19	form locator 14
TAD	form locator 10

**EDIT 0020 - SERVICE THRU DATE > DATE RECEIVED - VERIFY SERVICE THRU DATE**

This edit will post to a claim when the claim is received by the Fiscal Agent with a future date of service. Please note you cannot bill for a service before it is rendered. If you are billing with a spanned date of service, you cannot send in the claim before the end of the span date. Below are the form locators that apply:

ADA	form locator 24
1500	form locator 24A
UB-04	form locator 6
MC-6	form locator 12
MC-9	form locator 25A
MC-12	N/A
MC-19	form locator 14
TAD	form locator 11

**EDIT 0021 - BILLED DATE LESS THAN THRU DATE**

This edit will post to a claim when the signature date on the claim is before the date(s) of service. Below are the form locators that apply:

ADA	form locator 24 and 53
1500	form locator 24A and 31
UB-04	form locator 6 and 45 (creation date)
MC-6	form locator 12 and 8
MC-9	form locator 27
MC-12	N/A
MC-19	form locator 14 and 25
TAD	DO NOT SEND IN CLAIMS BEFORE THE END OF THE MONTH

**EDIT 0022 - INV/MISS BILLED DATE**

This edit posts to a claim when the signature date is missing or invalid. Below are the form locators that apply:

ADA	53
1500	31
UB-04	Creation date
MC-6	8
MC-9	27
MC-12	23
MC-19	25
TAD	N/A

**EDIT 0023 - BILLED DATE < STATEMENT THRU DATE**

This edit posts to a claim when the bill date is less than the statement through date. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	6 & Creation date
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0024 - POS REVERSAL REJECTED-RESUBMIT USING FD 999 FORM**

This edit posts only to pharmacy void requests that are submitted via POS and the information does not match any paid claim on the system. The Provider must use the FD-999 form for the adjustment. This edit does not apply to any specific form locator.

**EDIT 0025 - INVALID OR MISSING DISPENSING DATE**

This edit posts to a vision claim when the dispensed date is missing. Below are the form locators that apply.

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	20C
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0026 - CLAIM WITHOUT ATTACHMENT EXCEEDS TIMELY FILING**

This edit posts when the claim received is more than one year from the date of service and there is no attachment to prove that the claim was previously submitted within timely filing guidelines. Medicaid claims must be received within one year of the "from" date of service.

Claims submitted for processing more than one year from the date of service require proof that the fiscal agent originally received the claim within the year. An example for proof of timely filing is a copy of a Remittance Advice page listing the control number of the original submission. Remittance Advice(s) showing claim(s) denied for timely filing edits (026,076,080) may not be used to prove timely filing. This edit does not apply to any specific form locator.

**EDIT 0027 - INPATIENT CLAIM WITHOUT ATTACHMENT EXCEEDS TIMELY FILING**

This edit posts when the Fiscal Agent receives an inpatient claim more than one year from the "from" date of service and there is no attachment to prove that claim was previously submitted within timely filing guidelines. Inpatient claims must be received within one year of the "from" date of service.

Claims submitted for processing more than one year from the "from" date of service require proof that the fiscal agent originally received the claim within the year. An example for proof of timely filing would be a copy of a Remittance Advice page listing the control number of the original submission. Remittance Advice(s) showing claim(s) denied for timely filing edits (027,077,080) may not be used to prove timely filing.

Resubmit the claim and attach a copy of the RA showing that the claim was submitted timely.

**EDIT 0028 - EPSDT FILING LIMIT**

This edit posts when the date of service on the claim is 45 days old. This edit does not deny the claim.

**EDIT 0029 - MEDICARE CROSSOVER CLAIM EXCEEDS TIMELY FILING LIMIT**

This edit is posted if the claim receipt exceeds Medicaid's timely filing rule of 1 year from the date of service. Medicaid requires that the claim be received by Medicare within the year which is determined by a review of the ICN on the Medicare EOB. The only exception is when Medicare receives the claim within the year but processed the claim after the year expired. In that case only, the provider has 90 days from Medicare's payment date to submit the claim to Medicaid. This edit does not apply to any specific form locator.

**EDIT 0030 - CONDITION CODE LIABILITY**

This edit posts if the condition code is 01 - 05, 08, or 10 which would indicate that the claim is possible involved in a liability case. This edit does not deny the claim.

**EDIT 0031 - CONDITION CODE 85/C3 PRESENT, REQUIRES REVENUE CODE 912**

This edit will post to a claim when condition code C3 is present and there is no revenue code 912 on the claim. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locator 42
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0033 - SUBMITTER ID IS NOT NUMERIC OR = "0"**

This edit posts to pharmacy claims submitted via POS. The required seven-digit submitter number was either invalid or missing. The software vendor can provide the appropriate field for this data element. This edit does not apply to any specific form locator.

**EDIT 0034 - MISSING LABORATORY SERVICE REVENUE CODE**

This edit posts to outpatient hospital claims when the claim contains a laboratory procedure, but a corresponding Revenue Code in the 300 through 319 or 634 through 635 ranges is missing. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	42 & 44
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0035 - HOSPICE CLAIM - NUMBER OF UNITS NOT EQUAL TO NUMBER OF DAYS**

This edit posts to a Hospice claim when the number of units do not equal the number of days within the spanned dates being billed.

ADA	N/A
1500	24A and 24G
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0036 - INVALID ACUTE DAYS**

This edit will post to a Hospital claim when the acute days calculated are invalid. The acute days are calculated from the span date reported and any occurrence span codes listed on the claim. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locator 6 and 35 thru 36
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0037 - INVALID SNF DAYS**

This edit will post to a Hospital claim when the SNF days reported are invalid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locator 35 thru 36, and 42
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0038 - INVALID ICF DAYS**

This edit will post to a Hospital claim when the ICF days reported are invalid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locator 35 thru 36, and 42
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0039 - INVALID RESIDENTIAL DAYS**

This edit will post to a Hospital claim when the Residential days reported are invalid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locator 35 thru 36, and 42
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

Note: Social Necessity Days are days when a hospital keeps DYFS children longer than needed until a placement can be found. These days are billed as residential days and as “non-covered” days. The provider must submit the claim with an explanatory cover letter to Hospital Reimbursement Unit, PO Box 712, Trenton, NJ 08625

**EDIT 0040 - INV/MISS ADMISSION DATE**

This edit will post to a Hospital claim when the admission date is missing or invalid. The date of admission must be entered in the MMDDYY format. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locator 12
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0041 - ADMISSION DATE > SERVICE COVERS FROM DATE**

This edit will post to a Hospital claim when the admission date is greater than the “from” date of service on the claim. The date of admission must be entered in the MMDDYY format. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locator 6 and 12
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0042 - INVALID OR MISSING TYPE BILL CODE**

This edit posts to a claim when the three digit bill type is missing or invalid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	4
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0043 - INVALID OR MISSING BIRTH WEIGHT**

This edit will post to a claim when the admit date is equal to the date of birth listed on the claim and the birth weight has not been provided.

ADA	N/A
1500	N/A
UB-04	FL39-41
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0044 - INV/MISS TYPE OF ADMISSION**

This edit posts to a claim when the type of admission code on the claim is missing or invalid. The type of admission must be one of the following: 1 = emergency, 2 = urgent, 3 = elective, 4 = newborn, 5 = trauma, 9 = information not available. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	14
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0045 - INV/MISS PATIENT STATUS CODE**

This edit will post to a claim when the 2-digit code, denoting the patient status, on the claim is missing or invalid. Refer to the Billing Supplement for valid codes. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locator 17
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0046 - TOTAL DAYS NOT EQUAL TO DATES OF SERVICE**

This edit will post to a Hospital claim when the total days billed (Acute+ SNF+ ICF+ Residential) entered are missing or invalid. Medicaid does not count the discharge date in the total number of days. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locator 6, 42 and 46
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0047 - DATES OF SERVICE NOT ELIGIBLE FOR POS PROCESSING**

This edit posts to a claim when the date of service on the claim is prior to the submitter agreement date on file with the Fiscal Agent; the pharmacy must submit a hard copy claim. This edit does not apply to any specific form locator.

**EDIT 0048 - MISSING/INV SURGICAL PROCEDURE CODE**

This edit will post to a claim when the information in Form Locators 74 & 77 of the UB-04 indicates a surgery, but no surgical procedure code is present. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locator 42, 44 and 74
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0049 - INVALID OR MISSING SURGICAL DATE**

This edit posts to a claim when the information in Form Locators 74 & 77 of the UB-04 indicates a surgery, but no surgical procedure date is present. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	74
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0050 - BLOOD NOT REPLACED AMOUNT MUST BE NUMERIC**

This edit posts to a claim when the Blood Units not replaced is not numeric. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	39 A, B, C, & D - 41 A, B, C & D
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0051 - RENAL REVENUE CODE IS PRESENT - RENAL BILL TYPE IS MISSING**

This edit posts to a claim when the Bill Type conflicts with the revenue codes on the claim submitted. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	4 & 42
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0052 - TOTAL BLOOD PINTS FURNISHED INCORRECT**

This edit posts to a claim when the total blood pints indicated on the claim form is incorrect. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	46
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0053 - INV/MISS ACCOMMODATION DAYS**

This edit will post to a claim when the number of units, to indicate the accommodation days that correspond to the revenue codes submitted on the claim are missing or invalid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locator 42
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0055 -1 IS NOT PRESENT IN THE PA IND FIELD AND A PA # IS PRESENT**

This edit posts to pharmacy claims submitted via POS. The pharmacy must enter 1 in the PA INDICATOR field preceding the prior authorization number issued by First Health.

**EDIT 0056 - INV/MISS REVENUE UNITS**

This edit posts when the number of units for one or more claim lines is missing, invalid, or equal to zero. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	46
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0057 - CONDITION CODE 40 - FROM/THROUGH NOT EQUAL**

Condition code 40 reflects a same day transfer. When using this condition code, the "from" date of service and the "through" date must be the same. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	6
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0058 - INV/MISS PROCEDURE CODE/REVENUE CODE/CHARGE**

This edit will post to a claim if one or more Revenue Codes entered on the claim form reflects a charge that is invalid or missing. The dollar and cents amount must be numeric. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locator 42, 44 and 47
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0059 - MISSING CHARITY CARE CLAIM WRITEOFF DATE**

This edit posts to Charity Care claims when the write off date is not entered in loop 2300 field NTE02 positions 29-36. Format is CCYYMMDD. (eg.20050501 is May 1, 2005)

**EDIT 0060 - INV/MISS OCCURENCE CODE - SUPPLY VALID CODE OR REMOVE DATE**

This edit will post to a claim when the occurrence code is invalid or the occurrence code date is missing. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	31-34
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0061 - WRITEOFF DATE LESS THAN SERVICE DATE THRU**

This edit posts to Charity Care claims if the write off date is before 01-01-95. Claims written off prior to this date were not processed through Gainwell Technologies.

**EDIT 0062 - INVALID CONDITION CODE**

This edit posts if one or more condition codes entered on the claim form is invalid. Condition Codes must be two-digits. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	18-28
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0063 - INVALID OR MISSING ADMISSION HOUR**

This edit posts if the admission hour indicated on the claim form is invalid. The hour the patient was admitted must be indicated by two-digits. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	13
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0064 - SERVICE THROUGH DATE > STATEMENT THRU DATE**

This edit posts if the service date is greater than the statement date. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	6 & 45
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0065 - PINTS OF BLOOD FURNISHED MUST BE NUMERIC**

This edit posts if the number of pints of blood furnished to the patient are invalid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	39 A, B, C, & D - 41 A, B, C & D
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0066 - INVALID SPECIAL PROGRAM INDICATOR**

This edit posts to a Hospital claim when the Hospital file does not reflect the correct Special Program for the service being billed. This edit does not apply to any specific form locator.

**EDIT 0067 - INVALID OR MISSING NON-COVERED HOSPITAL DAYS**

This edit post to a claim when the number of Days Not Covered is not numeric. The number of residential days (Occurrence = M4) must equal the number of Non-Covered Days. Below are the form locators that apply:

1500	N/A
UB-04	form locators 33 thru 36, and 42
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
ADA	N/A
TAD	N/A

**EDIT 0068 - INVALID SOURCE OF ADMISSION**

This edit posts when the source of admission entered is not valid. It must be a valid one-digit numeric code. Check the billing supplement for valid codes. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	15
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0069 - INVALID OCCURRENCE DATE**

This edit posts to a claim when the date entered for an occurrence is invalid. The date must be in the MMDDYY format; e.g., September 15, 2001 would be 091501. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	31-36
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0070 - CHARITY CARE WRITEOFF DATE > CLAIM SUBMISSION DATE**

This edit posts to Charity Care claims if the write-off date is after the month following the ICN date; e.g. if the ICN date is 09/17/00, then the write-off date cannot exceed 10/31/00.

**EDIT 0071 - INVALID STATEMENT COVERS FROM DATE**

This edit post to a claim when the Statement Covers "From" Date is invalid. The date must be entered in MMDDYY format; e.g., September 15, 2001 would be 091501. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	6
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0072 - INVALID STATEMENT COVERS "THROUGH" DATE**

This edit posts to a claim when the Statement Covers "Through" Date is invalid. This must be entered in MMDDYY format; e.g., September 30, 2001 would be 093001.

ADA	N/A
1500	N/A
UB-04	6
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0073 - SERVICE COVERS FROM DATE IS LESS THAN STATEMENT FROM DATE**

This edit posts to a claim when the Claim Service Date is less than the Statement "From" Date. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locator 6 and 45
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0074 - STATEMENT COVERS FROM DATE IS GREATER THAN "THROUGH" DATE**

This edit posts to a claim when the Statement Covers "From" Date is greater than "Through" date. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locator 6 and 45
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0075 - PINTS OF BLOOD REPLACED NOT NUMERIC**

This edit posts to hospital claims when the blood units that are replaced are not numeric. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locator 39 thru 41
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0076 - CLAIM W/ATTACH EXCEEDS TIMELY FILING**

This edit posts when a claim is received more than one year from the date of service with an attachment that does not prove timely filing. The provider must resubmit the claim with proof of timely filing. Claims submitted for processing more than one year from the date of service require proof that the Fiscal Agent originally received the claim within the year. An example for proof of timely filing is a copy of a Remittance Advice page listing the control number of the original submission. Remittance Advice(s) showing claim(s) denied for timely filing edits (026,076,080) may not be used to prove timely filing. This edit does not apply to any specific form locator.

**EDIT 0077 - INPATIENT CLAIM EXCEEDS TIMELY FILING LIMIT**

This edit posts when an inpatient claim is received more than one year from the discharge date with an attachment that does not prove timely filing. The provider must resubmit the claim with an attachment that proves that the original submission was within a year. This edit does not apply to any specific form locator.

**EDIT 0078 - SUBMISSION TIME ELAPSED-RECEIVED > 2YRS AFTER SERV DATE THRU**

This edit is for Charity Care claims. It posts when the claim entry code is July 1 or later and the date associated with the J3 Occurrence Code is for the prior year (or earlier).

**EDIT 0079 - INPATIENT CLAIM-REQUIRES AT LEAST ONE ACCOMMODATION REV CODE**

This edit posts when an accommodation Revenue Code does not appear on the claim. Inpatient claims require at least one accommodation Revenue Code. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	42
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0080 - ICN DATE IS GREATER THAN TWO YEARS FROM DATE OF SERVICE**

This edit posts when the claim received is beyond 2 years from the date of service. The Fiscal Agent cannot process any claim over 2 years from the date of service. The only option would be to apply for a Fair Hearing. Within 20 days from the Medicaid denial complete the FD-387 (Administrative Hearing Information Form), attach any supporting documentation, and submit to the Fiscal Agent to the address at the bottom of the form. The Fiscal Agent will start a preliminary hearing and forward their decision to the State, If the State still refuses to pay your claim you will be notified that you have the right to be seen by an Administrative Law Judge who will then make that decision. This edit does not apply to any specific form locators.

**EDIT 0081 - INVALID/MISSING CLINIC CODE**

This edit post when the clinic code that is required is missing or invalid. For Emergency Room charges (Revenue Codes 450 or 459) and Clinic charges (Revenue Codes 510, 511, 512, 513, 514, 515 or 519) a two-digit numeric clinic code must be entered to the right of the "through" service date entered in Form Locator 43 on the UB-92 claim form. **THIS EDIT DOES NOT APPLY TO THE UB-04 FORM.**

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0082 - EMERGENCY ROOM REVENUE CODE PRESENT - CLINIC CODE "00" IS MISSING**

This edit will post to a claim when the Revenue Code entered on the claim form is 450 or 459, the Clinic Code "00" must be entered to the right of the "through" service date in Form Locator 43 on the UB-92 claim form. **THIS EDIT DOES NOT APPLY TO THE UB-04 FORM.**

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0083 - REV CODE 099, 36X, 37X, 49X OR 71X REQ VALID SURGICAL PROC**

This edit will post to a claim when one or more revenue codes indicate that surgery was performed, and a valid HCPCS surgical procedure code was not on the claim. If more than one surgery was performed then you need to indicate more than one surgical procedure code. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locators 42 and 44 (on Outpatient Claims); 74, 74A-E (on Inpatient Claims)
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0084 - BABY & MOTHER - ADMIT SOURCE INVALID FOR ADMIT TYPE (NEWBORN)**

This edit will post to a claim when the claim is an inpatient hospital or an institutional crossover claim and the type of admission code is equal to "4" (newborn) and the source of admission is not equal to 5 or 6. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	14 & 15
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0085 - INV/MISS DAYS/UNITS/VISITS**

This edit is posted to claims when the days/units/visits are not numeric or equal to zeroes. In addition, this edit can post when the number of units billed does not equal the number of days indicated. Below are the form locators that apply:

ADA	N/A
1500	24G
UB-04	46
MC-6	17
MC-9	25D
MC-12	17F
MC-19	14G
TAD	N/A

**EDIT 0086 - NUMBER OF UNITS EXCEEDS MONTHS/DAYS OF SERVICE**

This edit is posted when the number of units exceeds the maximum allowable units for the procedure code on the claim. Below are the form locators that apply:

ADA	N/A
1500	24G
UB-04	46
MC-6	17
MC-9	25D
MC-12	17F
MC-19	24G
TAD	N/A

**EDIT 0087 - CLAIM INDICATES SURGERY - SURGEON NUMBER MISSING**

This edit will post to a claim if the claim contains a surgical procedure code in the range of 8700-9999. The surgeon's Medicaid provider ID is required. This only applies to Hospital claims. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	form locator 74 and 77
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0088 - DATE OF SURGERY IS LESS THAN STATEMENT FROM DATE**

This edit posts to a claim when the Surgery Date is less than the Statement From Date. Below are the specific form locators that apply:

ADA	N/A
1500	N/A
UB-04	6 and 74 A-E
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0089 - DATE OF SURGERY > SERVICE/STATEMENT THRU DATE**

This edit posts to a claim when the Surgery Date is greater than the Service Statement Through Date. Below are the specific form locators that apply:

ADA	N/A
1500	N/A
UB-04	6 & 74 A-E
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0090 - SUBMISSION TIME ELAPSED - ADJUSTMENT AMOUNT > 0**

This edit is for Charity Care. It posts to adjustments when the claim entry code is July 1 or later and the date associated with the J3 Occurrence Code is for the prior year (or earlier).

**EDIT 0091 - INVALID/MISSING EPSDT LABORATORY INDICATOR**

This edit will post to a claim when one or more laboratory indicators are invalid or missing. Below are the specific form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	19
TAD	N/A

**EDIT 0092 - INV/MISS EPSDT IMMUNIZATION STATUS CODE(S)**

This edit posts when one or more immunization status codes entered in Item 20 on the MC-19 claim form reflect an entry other than numeric digits 1-4, or are blank. This is a required field.

Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	20A-D
TAD	N/A

**EDIT 0093 - INV/MISS EPSDT SCREENING INFORMATION INDICATORS**

This edit posts when one or more screening codes entered in Item 15B-H on the MC-19 claim form reflects an entry other than numeric digits 1-6, or is blank. This is a required field. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	15B-H
TAD	N/A

**EDIT 0094 - INV/MISS OR CONFLICTING EPSDT PHYSICAL DATA INDICATOR**

This edit posts when one or more physical codes entered in Item 15A on the MC-19 claim form reflect an entry other than numeric digits 1-6 or are blank. This is a required field. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	15A
TAD	N/A

**EDIT 0095 - INV/MISS EPSDT RACE CODE**

This edit posts when one of the blocks in Item 10 on the MC-19 claim form is not checked to indicate the beneficiary's race. This item must be complete.

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	10
TAD	N/A

**EDIT 0096 - EPSDT ANTICIPATORY GUIDANCE MISSING OR INVALID**

This edit posts to a claim when the Anticipatory Guidance/Health Education Indicator is not equal to 'y' or 'n'. This edit does not deny the claim.

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	21
TAD	N/A

**EDIT 0097 - INVALID EPSDT PHYSICAL SCREEN INDICATOR**

This edit posts to a claim when the EPSDT - SCRNDATA-IND is equal to 'y' and the fields below have a value of something other than 1-4. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	15
TAD	N/A

**EDIT 0098 - INVALID OR MISSING EPSDT CONTINUED CARE**

This edit post to a claim when the EPSDT-SCRNDATA-IND is equal to 'y' and the Continued Care IND is not equal to 'y' or 'n'. Below are the Form Locators that apply

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	22
TAD	N/A

**EDIT 0099 - EPSDT WIC INDICATOR INVALID OR MISSING**

This edit posts when the WIC IND is not equal to 'y' or 'n'. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	23
TAD	N/A

**EDIT 0100 - ORIGINAL RECIPIENT ID HAS BEEN CHANGED DUE TO LINK/UNLINK**

This edit posts when the original recipient identification number has been updated. This edit does not deny the claim. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	8
TAD	N/A

**EDIT 0101 - ABNOR INDIC IN THE PHYS/SCR IND NEW/PRIOR COND INVAL/MISS**

This edit posts when the EPSDT-SCRN-DATA-IND is equal to 'y' and the fields below do not have the appropriate value. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	15
TAD	N/A

**EDIT 0102 - INV/MISS TOOTH SURFACE**

This edit posts to a dental claim with a missing or invalid tooth surface code. Valid Tooth Surface Codes are: M - Mesial, I - Incisal, D - Distal, B - Buccal, O - Occlusal, L - Lingual

Below are the Form Locators that apply:

ADA	28
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0104 - SUBMISSION TIME ELAPSED: NEGATIVE ADJ/VOID ALLOWED**

This edit is for Charity Care. It posts to adjustments or voids when the date of service is greater than 2 years and a void or negative adjustment is submitted. This is an EOB message.

**EDIT 0105 - FOR TPL/HMO CLAIMS HAVING AN ATTACHMENT CODE 15**

This edit posts to all claims (except capitation claims) having an HMO co-payment EOB. These claims will be pended for manual pricing. This is an EOB message and will not deny the claim. This edit does not apply to any specific form locator.

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0106 - CONSECUTIVE LEAVE TYPES - OVERLAPPING DATES OF SERVICES**

This edit posts to a Long Term Care claim when the Hospital Leave “Through” date is exactly the same as the second Hospital Leave “From” date. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	24 and 26

**EDIT 0109 - ALLOWABLE AMOUNT IS LESS THAN CO-PAY AMOUNT**

This edit posts to co-pay claims when the Medicaid allowable amount is less than the co-pay amount entered in the manual-pricing field. This edit does not deny the claim. There are no specific Form Locators that apply.

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0110 - DATE OF SERVICE < ADMISSION DATE**

This edit posts to a Long Term Care claim when the From or To Date of Service is less than the Date of Admission. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	8, 10, 11

**EDIT 0111 - LIVERY CLAIM FILED > 90 DAYS AFTER SERVICE**

This edit posts for selected Transportation Providers and selected Procedure Codes if the claim receipt date is more than 90 days after the service through date. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	17A
MC-19	N/A
TAD	N/A

**EDIT 0113 - LTC/HOSPICE CLAIM SPANS MONTHS'**

This edit posts to a claim when a Long Term Care or a Hospice Provider spans their dates of service into another month. Providers may only bill for one month of service per claim line. Below are the Form Locators that apply:

ADA	N/A
1500	24A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	11

**EDIT 0114 - INV/MISS ADMIT CODE**

This edit posts to a Long Term Care claim when the Admit Date is missing or invalid. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	9

**EDIT 0115 - INVALID GENERAL STATUS / DISCHARGE CODE**

This edit posts to a Long Term Care claim when the Discharge Code is missing or invalid. Please see the Billing Supplement for acceptable values. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	12

**EDIT 0116 - INVALID LEAVE OF ABSENCE DATE**

This edit posts to a Long Term Care claim when the Leave Of Absence Date is missing or invalid. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	24, 26, 28, 30, and 32

**EDIT 0117 - LEAVE OF ABSENCE DATE (S) OUTSIDE DATES OF SERVICE**

This edit posts to a Long Term Care claim when the Leave Of Absence Date(s) are outside the Dates of Service. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	24, 26, 28, 30, and 32

**EDIT 0118 - LEAVE OF ABSENCE FROM/THRU DATE CONFLICT**

This edit posts to a Long Term Care claim when the Leave Of Absence From Date is less than The Through Date for the same leave. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	24, 26, 28, 30, and 32

**EDIT 0119 - INV/MISS LEAVE OF ABSENCE CODE**

This edit posts for a Long Term Care claim when there is a Leave Of Absence Date and no Leave of Absence Code. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	23, 25, 27, 29, and 31

**EDIT 0120 - INVALID LTC TAD ADDITIONAL SERVICES/THERAPIES**

Each block for additional nursing services (Item 17) and therapies (Item 18) on the TAD must reflect an entry of Y for yes, or N for no. The fields for additional nursing services are: TRA - Tracheotomy, RES - Respiratory Therapy, IVT - IV Therapy, HTR - Head Trauma, OXY -Oxygen, NGT - Tube Feed and WOU - Wound Care. The fields for Therapies are PHY - Physical Therapy, SPE Speech Therapy and OCC - Occupational Therapy

**EDIT 0121 - MCARE BED HOLD BEGIN DATE OUTSIDE DATES OF SERVICE**

This edit posts to a Long Term Care claim when the Medicare Bed Hold Begin Date is outside of the Dates Of Service. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	10, 11, 24, 26, 28, 30, and 32

**EDIT 0122 - MCARE BED HOLD END DATE OUTSIDE DATES OF SERVICE**

This edit posts to a Long Term Care claim when the Medicare Bed Hold End Date is outside the Dates of Service. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	10, 11, 24, 26, 28, 30, and 32

**EDIT 0123 - EMC CLM NOT ALLOWED FOR SR GOLD CLM SUBMIT BY POS**

This edit post to a Pharmacy claim when the Beneficiary's ID Number starts with "7" and the claim was submitted through EDI. Pharmacy claims can only be submitted POS. This edit does not deny the claim.

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0124- INCORRECT CUSTOMER LOCATION CODE REPORTED**

The customer location code submitted on the POS claim is not in the range of 00-11.

**EDIT 0125 - THIS PROVIDER INVALID WITH MODIFIER UE OR U6 OR WI OR WR**

This edit posts to a DME claim when modifiers US, U6, WI, or WR are used.

Only a provider designated by DMAHS as a "recycled DME" provider may use the modifiers UE, U6, WI and WR.

ADA	N/A
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0126 - COMPOUND DRUG INDICATOR INVALID**

This edit posts to a Pharmacy claim when the Compound Drug Indicator is invalid.

The compound drug indicator must indicate Y for yes or N for no when submitted POS . Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	24
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0127 - NDC CODE MISSING OR INVALID**

This edit posts to a Pharmacy claim when the NDC is missing or invalid. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	15
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0128 - CLAIM > \$400: VERIFY METRIC QUANTITY REPORTED**

This edit posts when, after review, it was determined that the metric quantity entered on the MC-6 claim form was not correct. This is an EOB message.

**EDIT 0129 - INVALID ATTACHMENT CODE > 15**

This edit posts when the attachment code indicated on the HIPAA attachment cover sheet is not within the range of 03 through 15.

**EDIT 0130 - INV/MISS DAYS SUPPLY**

This edit posts to a Pharmacy claim when the Days Supply is missing or invalid. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	17
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0131 - INV/MISS PRESCRIPTION NUMBER**

This edit posts to a Pharmacy claim when the Prescription Number is missing or invalid. Below are the Form Locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	13
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0132 - INVALID/MISSING FACILITY (LTC) INDICATOR**

The LTC indicator is a required field. One block must be checked to indicate whether or not the beneficiary resides in a Long-Term Care facility.

**EDIT 0133 - RECIPIENT PARTICIPATES IN PERSONAL PREFERENCE PROGRAM (PPP)**

This recipient participates in the PPP Program and receives a monthly grant to pay for home care services. The provider must collect payment from the beneficiary.

**EDIT 0134 - USE PROPER PROCEDURE CODE**

This edit posts when the claim submitted has an invalid procedure code.

**EDIT 0135 - INVALID/MISSING CURRENT EXAM DATE**

The current exam date entered in Item 20B on the MC-9 Claim Form (Vision Care) must appear in MMDDYY format; e.g., September 15, 2001 would be 091501.

**EDIT 0136 - COPAY CLAIM DENIED- NO BENEFICIARY OR PROGRAM LIABILITY**

This edit posts to outpatient claims submitted for HMO co-payment will be satisfied on the 1st service line of the claim. The remaining lines deny with this message.

**EDIT 0137 - CURRENT EXAM GREATER THAN DATE DISPENSED**

The current exam date entered in Item 20B on the MC-9 Claim Form must not be greater than the date dispensed entered in Item 20C; e.g., if the exam date is 091501 the date of dispense cannot be 090101.

**EDIT 0138 - ACCIDENT INDICATOR MUST BE Y, N, OR SPACE**

This edit posts when the accident indicator fields reflect an entry other than Y, N, or space. Below are the form locators that apply:

ADA	N/A
1500	10 A-C
UB-04	N/A
MC-6	N/A
MC-9	8
MC-12	8
MC-19	N/A
TAD	N/A

**EDIT 0139 - EPSDT INDICATOR NOT Y, N, OR SPACE**

This edit posts to a claim when the EPSDT indicator is not equal to space, Y, or N. Below are the form locators that apply:

ADA	1
1500	24H
UB-04	N/A
MC-6	N/A
MC-9	9
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0140 - LABORATORY INDICATOR MUST BE Y OR N**

This edit posts to a claim when the Lab Indicator is not equal to Y or N. There are no form locators that apply.

**EDIT 0141 - INVALID/MISSING PLACE OF SERVICE**

This edit posts when the claim submitted does not have a place of service listed on the claim form or the place of service is not a valid code (valid codes are 0 through 9). Below are the form locators that apply:

ADA	N/A
1500	24B
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	14B
TAD	N/A

**EDIT 0142 - INV/MISS ORIGIN CODE**

This edit posts to a Transportation Claim when the Origin Code is missing or invalid (valid origin codes are 0 through 9). Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	17H
MC-19	N/A
TAD	N/A

**EDIT 0143 - INV/MISS DESTINATION CODE**

This edit posts to a Transportation Claim when the Destination Code is missing or invalid (valid destination codes are 0 through 9). Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	17H
MC-19	N/A
TAD	N/A

**EDIT 0147 - FAMILY PLANNING INDICATOR MUST BE 'Y' OR 'N'**

This edit posts to a claim when the Family Planning Indicator is not = to Y or N. Below are the form locators that apply.

ADA	N/A
1500	24H
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	14I
TAD	N/A

**EDIT 0148 - RESPITE CARE EXCEEDS MAXIMUM OF 5 DAYS**

This edit posts for a Respite claim that exceeds 5 days. There are no form locators that apply.

**EDIT 0149 - CONTINUOUS HOME CARE BILLED LESS THAN 8 HOURS**

This edit posts for a Continuous Home Care Claim submitted for less than 8 hours. Claims for this service must be at least 8 hours. Below are the form locators that apply:

ADA	N/A
1500	24G
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0150 - INVALID PROCEDURE CODE FOR EPSDT FORM - REBILL ON CMS 1500**

This edit will post to all services submitted on the MC-19 claim form, if the 1st service line field is not the EPSDT visit, or the EPSDT visit is not approved by Gainwell Technologies. If this was not an EPSDT visit, services must be billed on the 1500. If this service was a valid EPSDT visit, resubmit the valid visit and the incentive code on the MC-19 claim form and make sure all fields are completed correctly. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	14D
TAD	N/A

**EDIT 0151 - INV/MISS CLAIM LINE CHARGE(S)**

This edit posts to a claim when the line charge is missing or invalid. Below are the form locators that apply:

ADA	31
1500	24F
UB-04	47
MC-6	25
MC-9	25I
MC-12	17I
MC-19	14H
TAD	N/A

**EDIT 0152 - INV/MISS TOTAL CHARGE**

This edit will post to a claim if the total claim charge submitted is missing or invalid. Below are the form locators that apply:

ADA	33
1500	28
UB-04	42 and 47 REV Code 001
MC-6	25
MC-9	28
MC-12	20
MC-19	16
TAD	N/A

**EDIT 0153 - INCORRECT TOTAL CHARGES**

This edit posts when the total claim charge submitted by the provider does not equal the sum of the total claim lines. Below are the claim forms and form locators that apply:

ADA	33
1500	28
UB-04	N/A
MC-6	25
MC-9	28
MC-12	20
MC-19	16
TAD	N/A

**EDIT 0154 - CO-INSURANCE AND/OR LIFETIME RESERVE DAYS CONFLICT DATE OF SERVICE**

This edit posts on institutional crossover claims when the beneficiary is not eligible on the date of admission. The total number of days entered in Form Locators 9 and 10 on the UB-92 Claim Form cannot be greater than the total number of service dates recorded in Form Locator 6.

**EDIT 0155 - COINSURANCE DAYS, LIFETIME RESERVE DAYS AND/OR BLOOD DEDUCTIBLE MISSING**

Institutional crossover claims require an entry in at least one of these three UB-92 fields:

Form Locator 9: Numeric digit reflecting the number of co-insurance days.

Form Locator 10: Numeric digit reflecting the number of lifetime reserve days.

Form Locators 39-41: Value Code 06 and the blood deductible amount. (Only if applicable)

**EDIT 0156 - COINSURANCE DAYS AND/OR LIFETIME RESERVE DAYS NOT NUMERIC**

This edit posts when the coinsurance and/or lifetime reserve days are not numeric on the claim.

**EDIT 0157 - ACUTE DAYS > 150 - RESUBMIT AS INPATIENT TPL CLAIM**

This edit will post to a claim when the acute days are greater than 150 and the condition code “80” is not present. This will apply only to Medicare Crossover claims. Below are the claim forms and form locators that apply.

ADA	N/A
1500	N/A
UB-04	6, 42, and 46
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0158 - ACUTE DAYS > 90 - RESUBMIT AS INPATIENT TPL CLAIM**

This edit will post to a claim when lifetime reserved days are equal to 0 and the acute days are greater than 90. This will apply only Medicare Crossover claims. Below are the specific form locators that apply:

ADA	N/A
1500	N/A
UB-04	6, 42, and 46
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0159 - NO MEDICAID LIABILITY - MEDICARE REIMBURSES AT 100 %**

Medicare pays this procedure at 100 percent. Therefore, there is no Medicaid liability.

**EDIT 0160 - INVALID ANESTHESIA CLAIM - CORRECT PROCEDURE AND UNITS**

This edit posts when a claim crosses over from Medicare with a procedure code that Medicaid does not recognize. The provider should resubmit the claim with a Medicaid procedure code and the Medicare EOMB. These codes can be found on the njmmis.com website. Modifier AA denotes services performed by an anesthesiologist or a certified nurse-anesthetist supervised by an anesthesiologist.

The procedure code will usually be the surgeon's primary surgical HCPCS procedure code. The provider must convert the time to units. Each fifteen-minute increment is equal to one (1) unit and fractions should not be billed. The base units are automatically added to the time units on the claim form. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0161 - INV/MISS HCPCS PROCEDURE CODE**

This edit will post to a claim when the procedure code entered on the claim form is missing or invalid for NJ Medicaid. Below are the form locators that apply:

ADA	29
1500	24D
UB-04	44
MC-6	N/A
MC-9	25B
MC-12	17B
MC-19	14D
TAD	N/A

**EDIT 0162 - INVALID OR MISSING PROCEDURE CODE MODIFIER**

This edit posts when the procedure code entered on the claim form requires a modifier, but a modifier is not present on the claim. It will also post if Medicaid does not recognize a modifier submitted on a claim form. Below are the form locators that apply:

ADA	29
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	25B
MC-12	17B
MC-19	14D
TAD	N/A

**EDIT 0163 - PROCEDURE - SPANNING DATES OF SERVICE**

This edit is posted if the procedure code billed does not allow for spanned dates of service. One date per line must be billed. Below are the form locators that apply:

ADA	24
1500	24A
UB-04	6, 45
MC-6	N/A
MC-9	25A
MC-12	17A
MC-19	14A
TAD	N/A

**EDIT 0165 - EMC - INVALID HCPCS PROCEDURE PREFIX**

This edit posts to EDI crossover claims when the first position of the procedure code is W, X, Y or Z. There are no form locators that apply.

**EDIT 0166 - INVALID/MISSING DIAGNOSIS CODE**

This edit posts if the diagnosis code entered on the claim form is either missing or invalid. Below are the form locators that apply:

ADA	N/A
1500	21, 24E
UB-04	66 A-C, 67A-Q, 69,70A-C, 72
MC-6	N/A
MC-9	12
MC-12	N/A
MC-19	14F
TAD	14-16

**EDIT 0167 - MISSING PRIMARY DIAGNOSIS CODE**

This edit posts to a claim when the Primary Diagnosis is missing. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04 - I/P	67, 69
UB-04 - O/P	67, 70
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	14

**EDIT 0170 - EXCESSIVE ANESTHESIA UNITS - PEND FOR MEDICAL REVIEW**

This edit posts to a claim when the anesthesia units reported exceed the number of allowed units on the Procedure Code file. Below are the form locators that apply:

ADA	N/A
1500	24G
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0171 - INVALID/MISSING CARRIER CODE**

This edit posts to a claim when the 3 digit carrier code is submitted is zeros. Below are the form locators that apply:

ADA	11
1500	10D
UB-04	N/A
MC-6	28
MC-9	7
MC-12	8
MC-19	9
TAD	33 and 34

**EDIT 0172 - INVALID PAYER CODE**

This edit posts to a claim when the Payer code is missing or invalid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	50 A-C
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0173 - INVALID COINSURANCE DAYS**

This edit only posts to LTC claims when Medicare is the primary payer and the coinsurance days are greater than the dates of service billed. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	10 & 11

**EDIT 0174 - IMP XOVER - RESUBMIT CAID CLM**

This edit posts when the claim is processed as a Medicare crossover and it is not. The provider should resubmit the claim.

**EDIT 0175 - BLOOD DEDUCTIBLE CHARGES MUST BE NUMERIC**

This edit posts to a claim when the Blood Deductible reported is not numeric. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	39-41
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0176 - MEDICARE DEDUCTIBLE AMOUNT MUST BE NUMERIC**

This edit posts to a claim when the deductible amount reported is not numeric. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	39-41
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0177 - MEDICARE CO-INSURANCE AMOUNT MUST BE NUMERIC**

This edit posts to a claim when the co-insurance is missing or not numeric. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	39-41
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0178 - BLOOD DEDUCTIBLE (PINTS) MUST BE NUMERIC**

This edit posts to hospital claims when the blood units deductible is not numeric. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	39-41
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0179 - MISSING / INVALID COINSURANCE DAYS**

This edit posts to institutional LTC crossover claims that do not contain coinsurance days. There are no form locators that apply.

**EDIT 0180 - OTHER INSURANCE INDICATOR MUST BE Y OR N**

This edit posts to a claim if the "Other Insurance Indicator" is not "Y" or "N". Below are the form locators that apply:

ADA	4
1500	11D
UB-04	N/A
MC-6	N/A
MC-9	7
MC-12	8
MC-19	9
TAD	N/A

**EDIT 0181 - TOTAL TPL AMOUNT MUST BE NUMERIC**

This edit posts to a claim if the total TPL payment amount reported is not numeric. Below are the form locators that apply:

ADA	32
1500	29
UB-04	54
MC-6	26
MC-9	29
MC-12	20
MC-19	17
TAD	36

**EDIT 0183 - MEDICARE PAYMENT DATE IS MISSING OR INVALID**

This edit posts to a Medicare Crossover Claim if the Medicare payment date is missing or invalid. This edit does not apply to any specific form locator.

**EDIT 0184 - INVALID OR MISSING ADJUSTMENT REASON**

This edit posts to adjustment transactions when the adjustment reason field is blank or does not contain a valid code.

**EDIT 0185 - FORMER ICN NUMBER INVALID OR MISSING**

This edit posts to adjustment transactions when the ICN number of the claim to be adjusted is missing or invalid. This applies to item 6 on the FD-999 Form.

**EDIT 0186 - MEDICARE ALLOWED NOT NUMERIC OR NOT > ZERO**

This edit posts when the Medicare allowed field on the claim is not numeric or the Medicare allowed field on the claim is not greater than zero.

**EDIT 0187 - DEDUCTIBLE, BLOOD DEDUCTIBLE, AND/OR CO-INSURANCE AMOUNT MISSING**

This edit posts to a claim when it is a Medicare crossover and there is no deductible, blood deductible, and/or co-insurance are zero or blank. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	39-41
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0188 - CASH DEDUCTIBLE AMOUNT EXCEEDS THE YEARLY MAXIMUM**

This edit posts to a Medicare Crossover Claim when the deductible amount reported on the claim exceeds the amount determined by Medicare for that year. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	39-41A-D
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0189 - EXPIRATION OF CCF TIME LIMIT OR NO CHANGE INDICATED ON CCF**

This edit posts to a claim for the following reason:

Provider submits a claim with a correctable error, that claim pends and a CCF (claim correction form) is placed on the njmmis.com website (Provider must be logged in). If no correction to the CCF is made, then the claim will deny with this edit. The Provider must correct the claim and resubmit. This edit does not apply to any specific form locator.

**EDIT 0190 - FIRST TWO POSITIONS OF BILL TYPE CONFLICTS WITH PAYER ID**

This edit posts to a claim when the first two digits of the Type of Bill is 11 and the payor code is 015. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	4 and 50A-C
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0192 - MEDICAID NOT PRIMARY PAYER SINCE TPL AMOUNT IS GREATER THAN ZERO**

This edit posts to an Inpatient Hospital claim when there is another insurance payment reported, but there is no other insurance reported on the claim. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	54
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0195 - CORRECT UNITS-15 MINUTES ANESTHESIA TIME = 1 UNIT OF SERVICE**

This edit posts to a claim for anesthesia when the units exceed 40. Below are the form locators that apply:

ADA	N/A
1500	19 and 24G
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0196 - TIMELY FILING EDIT BYPASSED DUE TO CONSENT ORDER**

This edit posts when the timely filing edits are bypassed due to a consent order from the State. This edit does not deny the claim. This edit does not apply to any specific form locator.

**EDIT 0197 - MISSING/INVALID NCPDP MAND**

This edit is posted to Pharmacy claims when the NCPDP field with usage starting with NCPDP 5.1 is not populated correctly. This also applies to NCPDP D.O. This edit does not apply to any specific form locator

**EDIT 0201 - SERVICING PROVIDER NOT ELIGIBLE ON DATE OF SERVICE**

This edit posts to a claim when the servicing provider reported on the claim is not active with NJ Medicaid for the date of service reported. Below are the form locators that apply:

ADA	24 and 58
1500	24A, 24J and 33B
UB-04	6 and 57
MC-6	N/A
MC-9	25A and 27
MC-12	17A and 9
MC-19	14A and 14J
TAD	7

**EDIT 0202 - PROVIDER CANNOT SUBMIT THIS CLAIM TYPE**

This edit is posted when a billing provider is not authorized to bill using the claim form submitted or has billed a procedure code that can not be specified on the submitted claim. This edit does not apply to any specific form locator.

**EDIT 0203 - PROVIDER ON REVIEW - STATE PEND**

This edit posts when the provider is under state review. This is an EOB message.

**EDIT 0204 - SERVICING AND BILL/ING PROVIDER NOT LINKED ON DATE OF SERVICE**

This edit posts when the Medicaid billing provider number and Medicaid servicing provider number are not linked on the claim's date of service. Check the accuracy of provider numbers reported on the claim. If this does not resolve the problem, contact Provider Enrollment to verify provider status. Below are the form locators that apply:

ADA	58A and 58
1500	24J and 33B
UB-04	6 and 57
MC-6	N/A
MC-9	25A and 27
MC-12	17A and 9
MC-19	14A and 14J
TAD	Top left corner of TAD

**EDIT 0205 - SERVICING PROVIDER IS GROUP PROVIDER**

This edit posts when the Servicing Provider Number on the claim is the provider number assigned to a Group Practice. Below are the form locators that apply

ADA	58
1500	24J
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	14J
TAD	N/A

**EDIT 0206 - BILLING PROVIDER NOT ON FILE**

This edit posts when the billing provider number reported on the claim is not on file. Below are the form locators that apply:

ADA	52A
1500	33B
UB-04	57
MC-6	10
MC-9	27
MC-12	9
MC-19	24
TAD	Top left corner of Form

**0207 - BILLING PROVIDER INELIGIBLE ON DATE OF SERVICE**

This edit posts when the Medicaid billing provider number is not eligible on the claim's date of service. Below are the form locators that apply:

ADA	52A
1500	33B
UB-04	57
MC-6	10
MC-9	27
MC-12	9
MC-19	24
TAD	Top left corner of Form

**EDIT 0209 - GROUP MUST BILL FOR MEMBER OF GROUP**

This edit posts when a servicing provider number appears in the field reserved for the billing provider.

ADA	52A
1500	33B
UB-04	N/A
MC-6	N/A
MC-9	27
MC-12	N/A
MC-19	24
TAD	Top left corner of form

**EDIT 0210- PROVIDER NOT CERTIFIED FOR THIS PROCEDURE**

The procedure code on the claim requires an appropriate certification on the provider's Medicaid file.(for example: if the Provider is billing for mammography services they would need specific certification on file with the State). Contact Provider Enrollment to update this information.

This edit does not apply to any specific form locator.

**EDIT 0211 - SERVICING PROVIDER IS GROUP-GROUP HAS NO MEMBERS**

This edit posts to a claim when the servicing provider reported on the claim is for a group that has no members assigned to it. Below are the form locators that apply:

ADA	58
1500	33B
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	14J
TAD	N/A

**EDIT 0212 - SERV PROV NOF/ LTC COTTAGE NUMBER INVALID**

This edit posts to a claim when the servicing Provider Number reported is not on file. Below are the form locators that apply:

ADA	58
1500	24J
UB-04	76
MC-6	N/A
MC-9	27
MC-12	N/A
MC-19	14J
TAD	Top left corner

**EDIT 0214 - PROVIDER NOT ELIGIBLE FOR HEALTHSTART PROCEDURES**

The provider is not eligible to render HealthStart services identified by procedure codes appearing on the claim form.

**EDIT 0216 - SERVICING (INDIVIDUAL) PROVIDER NUMBER REQUIRED**

This edit posts when the Servicing Provider Number does not appear on the claim. It only posts when the billing (or group) provider file indicates that a servicing provider is also required, or if invalid date is entered in the servicing provider number fields on the claim form. Check the billing supplement for specific instructions.

**EDIT 0217 - LTC PROVIDER NOT ELIGIBLE FOR ENTIRE PERIOD - CUTBACK**

This edit posts when the provider is not eligible for the entire claim period, or when the PAS file shows a different LTC provider for some or all of the service period reported on the TAD.

**EDIT 0218 - REFERRING/OTHER PHYSICIAN NOT ON FILE**

This edit posts when Item 17A (referring physician) on the 1500 Claim Form reflects an entry that is not a valid 7-digit Medicaid number.

**EDIT 0219 - PROVIDER NOT AUTHORIZED PARTIAL CARE/PARTIAL HOSPITALIZATION**

The provider master file indicates that this provider is not authorized for partial care or partial hospitalization services for the claim date(s).

**EDIT 0220 - CLAIM SPANS FISCAL YEAR**

Providers who are paid per diem cannot submit claims that span the provider's fiscal year. Two separate claims are required. The "through" service date recorded in Form Locator 6 on the first claim must be the last day of the first fiscal year. The "from" service date recorded in Form Locator 6 on the second claim is the first day of the following fiscal year. When Medicare is primary, the Medicare claims must reflect the same service periods.

**EDIT 0221- PROVIDER NOT CERTIFIED/BONDED AT TIME OF SERVICE**

The procedure code entered on the claim requires a specific certification on file at Gainwell Technologies. Contact Provider Enrollment for instructions on how to submit the form or bond.

**EDIT 0224 - PRESCRIBING PHYSICIAN/PRACTITIONER NUMBER NOT ON FILE**

The seven-digit number provider number entered in the field designed for referring or prescribing physician is not on the Medicaid file. Check the number for accuracy.

**EDIT 0225 - BILLING PROVIDER IS NOT A GROUP**

This edit posts when different provider numbers appear in the servicing and billing provider fields, and the billing number does not reflect a group.

**EDIT 0226 - BILL PROVIDER DEACTIVATED DUE TO INACTIVITY 18 MO. OR MORE**

This edit posts when a claim is received for a billing provider listed as inactive in the system. The claim will suspend indefinitely until the provider's status is reactivated. When a provider has had no claim activity for more than 18 consecutive months, the provider's status will automatically be deactivated in the system. In order for services to be reimbursed after this period, the provider must contact provider enrollment to initiate reactivation.

**EDIT 0227 - PROVIDER NOT APPROVED FOR EMC**

This edit posts for EDI, POS or Medicare crossover claims if the provider is not eligible to submit EMC. The provider must submit hard copy claims.

**EDIT 0229 - SERVICE PROVIDER DEACTIVATED DUE TO INACTIVITY 18 MO. OR MORE**

This edit posts when a claim is received for a servicing provider within the group listed as inactive in the system. The claim will suspend indefinitely until the provider's status is reactivated. When a servicing provider has had no claim activity for more than 18 consecutive months, that provider's status will automatically be deactivated in the system. In order for any services provided by this provider to be reimbursed after this period, provider enrollment must be contacted to initiate reactivation.

**EDIT 0230 - BILLING OR SERVICING PROVIDER NOT ALLOWED**

This edit posts when the Billing or Servicing Provider is not allowed to bill on their own.

**EDIT 0232 - YD MODIFIER NOT ALLOWED**

The YD modifier is not allowed for the procedure code billed.

**EDIT 0233 - PROVIDER NOT CERTIFIED FOR MAMMOGRAPHY**

Gainwell Technologies has not yet received the provider's Mammogram Certification Form, or the certification date has expired. Contact Provider Enrollment to resolve this issue.

**EDIT 0236 - PROCEDURE /PLACE OF SERVICE RESTRICTION**

This edit posts when the Place of Service conflicts with the Procedure code billed. Below are the claim forms and Form Locators that apply:

ADA	38
1500	24B
UB-04	N/A
MC-6	N/A
MC-9	25K
MC-12	N/A
MC-19	14B
TAD	N/A

**EDIT 0237 - PROCEDURE/PROVIDER SPECIALTY RESTRICTION**

This edit post to a claim when the provider's specialty does not allow the procedure code billed. For example an internal medicine physician cannot bill for anesthesia services. Below are the claim forms and Form Locators that apply:

ADA	form locator 29
1500	form locator 24D
UB-04	N/A
MC-6	N/A
MC-9	form locator 25B
MC-12	form locator 17B
MC-19	form locator 14D
TAD	N/A

**EDIT 0238 - PROCEDURE CODE NOT SUBSTANTIATED BY DOCUMENT**

The procedure code billed requires either an operative report and/or pathology report attached to the claim. These documents were either not attached or did not substantiate the procedure code.

**EDIT 0239 - ALTERED DOCUMENTATION-ORIGINAL PRICE LIST OR INVOICE NEEDED**

The document(s) attached to the claim was (were) altered. The provider should resubmit with an original price list or invoice.

**EDIT 0241 - 22 MODIFIER NOT JUSTIFIED/PAID AT UNMODIFIED RATE**

Using the 22 modifier was not justified. The provider may submit an adjustment form (FD-999), along with documentation, to support the request for unusual services.

**EDIT 0242 - SPECIAL PROGRAM/PROCEDURE CODE RESTRICTION**

This edit posts when the beneficiary is in a special program and the procedure code billed is not consistent with the special program.

**EDIT 0243 - PROVIDER NOT AUTHORIZED - TARGETED CASE MANAGEMENT**

The servicing provider is not authorized to bill for Adult Clinical Case Management or Adult Liaison Services.

**EDIT 0245 - ATTACHMENT REQUIRED OR INCORRECT ATTACHMENT FOR PROCEDURE**

The procedure code on the claim requires specific documentation.

**EDIT 0246 - PROLONGED DETENTION BILL**

This edit posts when the claim is pending for a medical review.

**EDIT 0247 - REVENUE CODE/PROCEDURE CODE ON CLAIM CONFLICTS WITH CLAIM TYPE**

The revenue code or procedure code billed on the claim is not allowed for this claim type.

**EDIT 0248 - ICD9 PROCEDURE CODE NOT ON FILE**

Medicaid does not recognize the surgical procedure code billed on the UB-92 Claim Form in Form Locator 80 or 81.

**EDIT 0251 - DENY FOR DIAGNOSIS**

This edit posts when the diagnosis code reported does not support the procedure code billed.

**EDIT 0252 - PROCEDURE, REVENUE, NDC, OR DIAGNOSIS CODE REQUIRES REVIEW**

The procedure code, revenue code, NDC code or diagnosis code entered on the claim requires review. The provider should submit the claim hardcopy, not EMC.

**EDIT 0253 - REVENUE/PROCEDURE NOT ACTIVE ON DATE OF SERVICE**

The revenue code or procedure code entered on the claim is not valid on the date of service.

**EDIT 0254 - PROCEDURE CODE/AGE RESTRICTION**

The procedure code, revenue code, NDC code or diagnosis code is restricted to a specific age group. This edit posts when the beneficiary's age is not consistent with the code(s) billed.

**EDIT 0255 - PROCEDURE SEX RESTRICTION**

The procedure code, revenue code, NDC code or diagnosis code is restricted to one sex. This edit posts when the beneficiary's sex is not consistent with the code(s) billed.

**EDIT 0256 - PROCEDURE MODIFIER REQUIRED**

The procedure code entered on the claim requires an appropriate modifier.

**EDIT 0257 - PROC/NDC/REV/ICD9 NOT COVERED BY MEDICAID**

Medicaid does not cover the procedure code, revenue code, NDC code or diagnosis code entered on the claim.

**EDIT 0258 - AMBULATORY SURGICAL CENTER - DAYS/DATES INCONSISTENT**

The "from" service date and the "to" date entered in item 24A on the 1500 form must be identical. Moreover, the number of units entered in item 24G must be 1.

**EDIT 0259 - HCPC PROCEDURE CODE NOT ON FILE**

Medicaid does not recognize the procedure code entered on the claim form.

**EDIT 0260 - DIAGNOSTIC REPORT (X-RAYS, LAB, ETC) REQUIRED**

Medical review determined that a diagnostic report, e.g., X-ray report, lab reports etc. is required. The provider should resubmit the claim with the clarifying report(s).

**EDIT 0261 - OPERATIVE, HISTORY AND/OR PATHOLOGY REPORT REQUESTED**

Medical review determined that an operative report, a pathology report or the medical history report is required. The provider should resubmit the claim with the clarifying report(s).

**EDIT 0262 - REFERRING/OTHER PHYSICIAN REQUIRED - CONSULT 2ND OPINION**

This edit posts when the procedure code denotes a consultation or second opinion visit. These services require a referring physician. The doctor's name and seven-digit Medicaid Provider number must appear in Items 17 and 17A respectively on the 1500 Claim Form. If the doctor does not participate with New Jersey Medicaid, the default is 6666666 for an in state doctor or 5555555 for an out-of-state provider.

**EDIT 0263- NON-COVERED SERVICE FOR SPECIAL PROGRAM CODE**

This edit posts when the beneficiary has alien status and the service billed is not an emergency. Services for aliens are limited to emergency care, labor and delivery. The provider may resubmit with a completed FD-80 form attached to explain and document the emergency condition.

This edit will also post for premium support beneficiaries. It indicates that the billed service is not covered by the beneficiary's Family Care program.

**EDIT 0264 - SPECIAL PROGRAM CODE - REVIEW ATTACHMENT**

This edit will post when a service for an alien is determined to be a non-emergency. However, there is an attachment to the claim that will be reviewed. If it is not the required FD-80 form, the claim will deny for edit 263.

This edit will also post for claims involving premium support beneficiaries. It indicates that the claim is in process pending review of the other insurance EOB.

**EDIT 0265 - MISSING ASC LEVEL DATA**

This edit posts if the claim is for an ambulatory surgical center and the code is not valid.

**EDIT 0266 - NOT AN SAI COVERED SERVICE**

The billing provider is a Workfirst NJ/SAI provider. This special program does not cover the procedure code entered on the claim form.

**EDIT 0267 - PROCEDURE CODE DOES NOT WARRANT ANESTHESIA SERVICES**

Modifier AA, indicating anesthesia services, cannot be billed with this procedure code.

**EDIT 0268 - ANESTHESIA UNITS NOT ON PROCEDURE FILE FOR DATES OF SERVICE**

This edit posts when the anesthesia procedure code was not active on the claim service date. Base units cannot be calculated.

**EDIT 0270 - HEPATITIS 'A' NON-COVERED SERVICE**

This edit posts after a State review, if the procedure is 90730 and is used for routine immunization this claim will deny.

**EDIT 0271- SUBMITTER NOT APPROVED FOR PROVIDER**

The provider is not authorized to submit claims electronically on the claim's date of service.

**EDIT 0272 - USE PROPER PROCEDURE CODE**

This edit post when the procedure code used is invalid.

**EDIT 0273 - PROCEDURE DOES NOT WARRANT SURGICAL ASSISTANT**

The procedure code billed does not permit reimbursement to a surgical assistant. Make sure that the modifier is correctly codes.

**EDIT 0275 - RADIOLOGY SERVICES REQUIRE REFERRING PHYSICIAN**

This edit posts when a specific radiology service requires that a referring physician be indicated on the claim on the appropriate field. This edit only applies to the forms indicated below:

1500            17A&B

**EDIT 0276 - UTILIZATION EXCEEDS ESTABLISHED PARAMETERS**

This Medicaid maximum limit is exceeded. This edit posts to pharmacy claims for condoms.

**EDIT 0277 - REFERRING PROVIDER NUMBER REQUIRED**

The referring physician's seven-digit Medicaid number must be entered on the claim form. If the doctor does not participate with New Jersey Medicaid, 6666666 is the default for in-state doctors and 5555555 for out-of-state doctors.

**EDIT 0278 - PROVIDER NOT AUTHORIZED FOR THIS PROCEDURE**

This edit posts for procedure codes 59855 or 59856 with modifiers WZ and 22 when the provider number is not 2979802.

**EDIT 0279 - DENIED AS A RESULT OF PREPAYMENT REVIEW BY DMAHS**

This edit posts when a state reviewer denies payment for a claim previously in process for edit 203. For POS, it indicates that the state reviewer denied payment for this previously approved claim. This is an EOB message.

**EDIT 0281 - POS VOID PROVIDER-ON-REVIEW**

This edit posts when the claim being voided is for a provider on review.

**EDIT 0283 - PROVIDER LIMITED TO NON DYFS BENEFICIARIES**

This edit posts to a Long Term Care claim and the 3rd and 4th digits of the Medicaid ID number are '60'.

**EDIT 0284 - PRIVATE DUTY NURSING - SPANNING DATES OF SERVICE**

The "from" date of service date and the "to" date entered in item 24A on the 1500 Claim Form must be the same.

**EDIT 0285 - HOSPICE RECIPIENT IS NOT MEDICARE ELIGIBLE**

Hospice Procedure codes Y6339 and Y6343 can only be billed if beneficiary is eligible for Medicare.

**EDIT 0287 - HOSPICE RELATED CLAIM**

This edit posts to a claim when the beneficiary is enrolled in the Hospice Waiver.

**EDIT 0288 - VETERANS HOME RESIDENT, NON-COVERED SERVICE**

Beneficiaries who reside in a New Jersey Veterans Home are only eligible to receive pharmaceutical services. No other Medicaid services are available.

**EDIT 0289 - PAYMENT BASED ON PLACE OF SERVICE**

This edit posts when the claim is a professional claim without a '26' modifier and the procedure codes is within the range of 91000 - 97799, and a place of service of '0', '3', '7'. The system will automatically plug in a '26' modifier and price the claim accordingly.

**EDIT 0290 - INVALID SECONDARY DIAGNOSIS**

Medicaid does not recognize the secondary diagnosis code entered on the claim form.

**EDIT 0293 - DIAGNOSIS NOT ALLOWED FOR SEX**

This edit will post to a claim when the diagnosis code shown on the claim is not allowed for the recipient sex.

ADA	N/A
1500	3, 21 A-L
UB-04	11, 67 A-Q
MC-6	N/A
MC-9	6, 12
MC-12	N/A
MC-19	5, 14 F
TAD	N/A

**EDIT 0294 - DIAGNOSIS NOT VALID AS PRIMARY DIAGNOSIS**

A diagnosis code beginning with E cannot be used as the primary diagnosis code.

**EDIT 0295 - INVALID THIRD, FOURTH, OR FIFTH DIAGNOSIS**

Medicaid does not recognize one or more diagnosis codes entered on the claim form.

**EDIT 0296 - DIAGNOSIS CODE IS NOT ON FILE**

Medicaid does not recognize the primary diagnosis code entered on the claim form.

**EDIT 0297 - PROVIDER NOT ENROLLED IN CLIA**

The billed services are payable only to providers whose Medicaid provider file includes a CLIA certificate. The provider's profile does not reflect this data element.

**EDIT 0298 - PROVIDER NOT CLIA ELIGIBLE ON DATE OF SERVICE**

The eligibility dates on the CLIA certificate recorded on the Medicaid Provider file do not include the claim date(s) of service.

**EDIT 0299 - SERVICE PROVIDER NOT ELIGIBLE TO PERFORM THIS PROCEDURE**

The provider's CLIA certificate is on file, but the certification level does not cover the procedure code billed.

**EDIT 0300 - HMO COVERED SERVICE**

This beneficiary is enrolled in an HMO on the claim date of service, and this is an in-plan service. It must be billed to the beneficiary's HMO. If the provider has received a denial from a HMO already; check the eligibility hotline 1-800-676-6562 to verify the correct HMO for this beneficiary. If the correct HMO denied the claim, appeal to the HMO. If this still does not resolve the issue, contact DMAHS Managed Care Unit at 1-800-356-1561 for assistance.

**EDIT 0301 - RECIPIENT INELIG ON DATES OF SERVICE**

This edit posts when the Beneficiary is not eligible for the date(s) of service listed on the claim. A provider may verify eligibility by calling REVS at 1-800-676-6562, or logging onto E-MEVS. This edit does not apply to any specific form locator.

**EDIT 0302 - NAME MISMATCH**

This edit posts when the beneficiary's last name entered on the claim form does not match the recipient eligibility file. Below are the claim forms and form locators that apply:

ADA	12
1500	2
UB-04	58
MC-6	5
MC-9	1
MC-12	1
MC-19	1
TAD	3

**EDIT 0303 - RECIPIENT IS SERVICE OR PROVIDER RESTRICTED**

This edit posts to pharmacy claims when the recipient is restricted to another pharmacy. The pharmacist can call the lock-in department at the state to get an override letter if necessary. This edit does not apply to any specific form locator.

**EDIT 0304 - CLAIM TYPE IS NOT COVERED FOR PRESUMPTIVELY ELIGIBLE RECIPIENT**

This recipient is not eligible for inpatient hospital services, chiropractor, or Long Term Care. This edit does not apply to any specific form locator.

**EDIT 0305 - CCPED OR HCEP NON-COVERED SERVICE**

The beneficiary is enrolled in the CCPED or HCEP program, and these special programs do not cover the billed service. This edit does not apply to any specific form locator.

**EDIT 0306 - MEDICAID RECIPIENT ID CORRECTED**

This edit posts when the beneficiary's Medicaid number submitted on the claim has been automatically updated by the system to reflect the most correct Medicaid Identification Number. Below are the claim forms and form locators that apply:

ADA	15
1500	1A
UB-04	60
MC-6	1 & 2
MC-9	3 & 4
MC-12	3 & 4
MC-19	8
TAD	5

**EDIT 0308 - INELIGIBLE SERVICES UNDER MEDICALLY NEEDY PROGRAM**

The billed service is not payable when rendered to a beneficiary enrolled in the Medically Needy program. This edit does not apply to any specific form locator.

**EDIT 0309 - GSHP OUT-OF-PLAN SERVICE- RECIPIENT INELIGIBLE FOR MEDICAID**

This edit posts when the beneficiary has GSHP and the provider has billed for one of the following services; Long Term Care, Medical Day Care, Prosthetic and Orthotic, Transportation, or Dental. This edit does not apply to any specific form locator.

**EDIT 0310 - GSHP RECIPIENT - NOT ELIGIBLE FOR LTC SERVICES**

This edit posts when the beneficiary is GSHP and not eligible for Long Term Care services. This edit does not apply to any specific form locator.

**EDIT 0311 - CORRECT D.O.B. OR RESUBMIT CLAIM UNDER BABY'S NUMBER**

According to the Newborn Plus 60 Program, service to newborns may be billed using the qualified mother's beneficiary number through the end of the month in which the baby becomes 60 days old. This edit may post when:

1. The date of birth on the claim does not match the date of birth on the eligibility file.
2. The mother's date of birth is entered on the baby's claim. You must enter the baby's date of birth.
3. The procedure code entered on the claim form is restricted to newborns, but the beneficiary is not a newborn.
4. The date of service is more than 60 days from the date of birth entered on the claim. The provider must resubmit with baby's beneficiary number entered accordingly. Below are the claim forms and form locators that apply:

ADA	13 & 15
1500	1A & 3
UB-04	10 & 60
MC-6	1, 2 and 4
MC-9	3, 4, & 5
MC-12	3, 4, & 5
MC-19	2 & 8
TAD	N/A

**EDIT 0312 - CORRECT RECIPIENT NUMBER AND RESUBMIT**

This edit posts when the beneficiary number being used is not valid and the provider must rebill using the correct identification number.

**EDIT 0314 - CLAIM SERV. DATES OVERLAP SPEC. PROG. ELIG. BEGIN/END DATES.**

This edit posts when the beneficiary is eligible for a special program after the first date of service on the claim. The provider must resubmit two separate claims. One claim should have the date(s) of service prior to the date that the special program began and the other(s) should have the date(s) of service on and/or after the date that the special program began. Below are the claim forms and form locators that apply:

ADA	24
1500	24A
UB-04	6 & 45
MC-6	12
MC-9	25A
MC-12	17A
MC-19	14A
TAD	10 & 11

**EDIT 0315 - HOSPICE ELECTION REVIEW**

This edit will post to a claim when the claim is for a hospice service (T2042, T2043, T2044, T2045, T2046) and the State is aware that the recipient is receiving hospice services, but have not verified the Hospice Election Package.

The claim is for a non-hospice service and the State is either in the process of verifying the Election Package or has already verified it.

This edit does not apply to any specific form locator.

**EDIT 0316 - LOCK-IN AUTHORIZATION FORM INCORRECT OR INCOMPLETE**

Under the Medicaid lock-in policy this beneficiary is restricted to another pharmacy. The attached State form (SSP-14) authorizing Gainwell Technologies to override Edit 303 does not meet established guidelines. This edit does not apply to any specific form locator.

**EDIT 0318 - MED NEEDY SPENDDOWN RECIP - ATTACHMENT REVIEW**

This edit posts when the dates of service on a claim are within the spend down period for a medically needy beneficiary, and the claim attachment requires review. This edit does not apply to any specific form locator.

**EDIT 0319 - INCORRECT/MISSING MEDICALLY NEEDY TRANSMITTAL FORM**

This edit posts when the data on the Medically Needy Transmittal Form (FD-311) does not match the data on the claim form, or if the form is completed incorrectly. This edit does not deny the claim. This edit does not apply to any specific form locator.

**EDIT 0320 - MED NEEDY SPENDDOWN - INVALID/MISSING ATTACHMENT**

This is a Medically Needy beneficiary with a spend down dollar amount. The Medically Needy Transmittal Form (FD-311) must be attached to the claim and submitted hardcopy. This edit does not apply to any specific form locator.

**EDIT 0321 - RECIPIENT NOT ON FILE**

This edit is posted if the Medicaid ID Number submitted on the claim could not be located. The correct ID number should be located by utilizing REVS, e-MEVs or MEVS and then reported on the claim form. Below are the claim forms and form locators that apply:

ADA	15
1500	1A
UB-04	60
MC-6	1 & 2
MC-9	3 & 4
MC-12	3 & 4
MC-19	8
TAD	5

**EDIT 0322 - HMO COVERED SERVICE - REVIEW REQUIRED**

This edit posts when the claim shows an HMO covered service and the State needs to review.

**EDIT 0323 - SERVICE COVERED BY HMO - NO MEDICAID PAYMENT DUE**

This beneficiary is enrolled in an HMO, and the service is covered by the HMO capitation payment.

**EDIT 0324 - HMO COVERED SERVICE - PAYMENT NOT JUSTIFIED BY ATTACHMENT**

This edit posts after someone reviews the claim and determines that the service is covered by the HMO and no Medicaid payment is due. This edit does not apply to any specific form locator.

**EDIT 0325 - RECIPIENT INELIGIBLE**

This edit posts when the service is not covered by the HMO and the provider send it to Medicaid. If the beneficiary's plan either has limits to a benefit or not covered under that plan then, the beneficiary is not covered by the HMO or Medicaid for that service.

**EDIT 0326 - LTC RECIPIENT NOT ON FILE**

This edit posts to a long term care claim when the Beneficiary's Medicaid ID Number is not on file. The provider may verify the number by calling REVS at 1-800-676-6562, logging onto EMEVS, or MEVS. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	5

**EDIT 0327 - HMO BENEFITS EXHAUSTION UNDOCUMENTED**

This edit posts when the recipient is enrolled in managed care and the service billed is considered in-plan. However, an Exhaustion of Benefits letter does not document HMO benefits exhaustion.

**EDIT 0328 - MHC RECIPIENT-NO M'CAID ELIG SEGMENT FOR THIS PERIOD**

This edit posts when the eligibility file indicates that the beneficiary has no Medicaid eligibility for this recipient for this time period/date of service. This edit does not apply to any specific form locator.

**EDIT 0330 - HYSTERECTOMY DID NOT MEET PROGRAM REQUIREMENTS**

This edit posts when a review of the hysterectomy form and claim form determined the hysterectomy program requirements were not met. This edit does not apply to any specific form locator.

**EDIT 0331 - SECOND OPINION REQUIRED**

This edit posts when the surgical procedure performed required a second opinion and a second opinion or second opinion waiver was not obtained prior to the surgery date. In addition, an attachment confirming that this was an emergency situation was not included with the claim. This edit does not apply to any specific form locator.

**EDIT 0332 - STERILIZATION IS NOT COVERED FOR RECIPIENT UNDER 21**

This edit posts when a sterilization procedure was performed on a recipient who is less than 21 years old. Medicaid will not pay for a sterilization procedure performed on a minor. This edit does not apply to any specific form locator.

**EDIT 0333 - INVALID/MISSING 2ND OPINION INDICATOR**

This edit post when the claim is missing or has an invalid 2nd opinion indicator.

**EDIT 0334 - DATE OF CONSENT MUST BE AT LEAST 30 BUT NOT GREATER THAN 180 DAYS FROM DATE OF SERVICE**

This edit posts when the date the beneficiary signed the Sterilization Consent form is less than 30 days or more than 180 days from the date of surgery. This edit does not apply to any specific form locator.

**EDIT 0335 - ABORTION CERTIFICATE FORM REQUIRED**

This edit posts when the procedure code represents an abortion, "incomplete" abortion, or "missed" abortion. For abortion procedures, the provider must attach the Physician Certification form (FD-179). If it was not an induced abortion, the operative report and discharge summary must be attached to the claim as confirmation. This edit does not apply to any specific form locator.

**EDIT 0336 - ABORTION REQUIRES REVIEW**

This edit is posted if the ICD-9/ICD-10 or HCPCS procedure code is an abortion related procedure. A review of the certification form is required. This edit does not apply to any specific form locator.

**EDIT 0337 - STERILIZATION FORM REQUIRES REVIEW**

This edit posts when the ICD-9/ICD-10 or HCPCS code on the claim indicates the service performed was sterilization. The Sterilization Consent Form (7473-M) submitted requires review. This edit does not apply to any specific form locator.

**EDIT 0338 - HYSTERECTOMY PROC REQ REVIEW OF HYST RECEIPT OF INFO FORM**

This edit posts when the procedure requires a review of the Hysterectomy Receipt of Information Form (FD-189). This edit does not apply to any specific form locator.

**EDIT 0339 - DENY SECOND OPINION NOT OBTAINED**

This edit posts because the State requires the beneficiary to seek a second opinion before this surgery and the Second Opinion form was not attached to the claim. There are two exceptions to the Second Surgical Opinion requirement:

1. The surgery was an emergency. In this an Operative Report, Discharge Summary and a letter from the attending physician indicating that the emergency surgery was necessary, are required.
2. The surgery was due to cancer. In this case the Pathology Report and History and Physical records are required.

This edit does not apply to any specific form locator.

**EDIT 0340 - ABORTION CERT FORM DATA INCORRECT/MISSING OR ILLEGIBLE**

This edit posts when the data on the Abortion Certification form is incorrect, missing or is not legible. Check the billing supplement for specific instructions. This edit does not apply to any specific form locator.

**EDIT 0341 - INSUFFICIENT MEDICAL DOCUMENTATION FOR ABORTION**

This edit posts if, after the medical documentation has been reviewed, it is determined that the medical documentation submitted does not contain sufficient information that the claim was not a legal abortion. This edit does not apply to any specific form locator.

**EDIT 0342 - RECIPIENT DATES, SIGNATURE MISSING ON HYSTER FORM**

This edit posts if the recipient's signature and/or signature date is not on the Hysterectomy form. Check the billing supplement for instructions. This edit does not apply to any specific form locator.

**EDIT 0343 - INVALID/MISS STERILIZATION CONSENT DATE**

This edit posts if the date that the sterilization consent was signed is either missing or invalid. Check the billing supplement for specific instructions. This edit does not apply to any specific form locator.

**EDIT 0344 - PHYSICIAN SIGN/NUMBER DATES MISSING ON ABORTION FORM**

This edit posts when the physician's signature, the Medicaid provider number, and/or the date are not on the Abortion Certification Form. Check the billing supplement for specific instructions. This edit does not apply to any specific form locator.

**EDIT 0345 - MISSING ABORTION PROCEDURE CODE**

This edit posts when Condition Code A7 (induced abortion, danger to life) or A8 (induced abortion, victim rape/incest) is entered but the claim does not include an abortion surgical procedure code. The provider must either remove the condition code or enter a correct procedure code. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	18, 28 and 74A-E
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0349 - SEC OPINION FORM INCOMPLETE,MISSING DATA OR IS OUT OF DATE**

This edit posts for any of the following reasons:

1. The Second Opinion form has incorrect or missing data.
2. The data on the Second Opinion form is illegible.
3. The surgery date was more than a year after the second opinion referral was issued.  
Check the billing supplement for examples. This edit does not apply to any specific form locator.

**EDIT 0351 - RECIPIENT AGE AT THE TIME OF STERILIZATION CONSENT DTE < 21**

New Jersey Medicaid policy does not cover a sterilization procedure when the consent form is signed before the recipient's twenty-first birthday. The date of birth on the recipient's eligibility file was compared to the date of consent, and it was determined that the recipient was under the age of 21 at the time the form was signed. This edit does not apply to any specific form locator.

**EDIT 0352 - INSUFFICIENT MEDICAL DOCUMENTATION FOR STERILIZATION**

This edit posts if, upon review, it was determined that the attached medical documentation was not sufficient proof that the procedure performed was for the purpose of sterilization. This edit does not apply to any specific form locator.

**EDIT 0353 - STERILIZATION CONSENT FORM DATA INCORRECT/MISSING**

This edit posts if, after a medical review of the Sterilization Consent form, it was determined that required data is either missing, incomplete or not legible. Check the billing supplement for the specific instructions to complete this form. This edit does not apply to any specific form locator.

**EDIT 0354 - HYSTERECTOMY REQUIRES ATTACHMENT**

This edit posts when the billed procedure code denotes a hysterectomy and the Hysterectomy Receipt of Information Services Form (FD-189) is missing. Check the billing supplement for the specific instructions to complete this form. This edit does not apply to any specific form locator.

**EDIT 0355 - STERILIZATION FORM REQUIRED**

This edit posts when the procedure code denotes a sterilization procedure and the Sterilization Consent Form (7473-M) is missing. If the procedure did not leave the beneficiary in a sterile condition, then the operative report and discharge summary must be attached as documentation. This edit does not apply to any specific form locator.

**EDIT 0356 - RECIP/PHYS DATE/SIGN MISSING ON STERILIZATION FORM**

This edit posts when the recipient's signature, the physician's signature, and/or the respective date of signature(s), is missing from the Sterilization Consent Form (7473-M). Check the billing supplement for the specific instructions to complete this form. This edit does not apply to any specific form locator.

**EDIT 0357 - HYSTERECTOMY RECEIPT OF INFO FORM-DATA INCORR/MISS OR ILLEG**

This edit posts when, after review of the documentation, the required data on the Hysterectomy Receipt of Information form is incorrect, missing or not legible. Check the billing supplement for the specific instructions to complete this form. This edit does not apply to any specific form locator.

**EDIT 0358 - SECOND OPINION DATE RESTRICTION**

This edit will post if the procedure requires a second opinion and the second opinion form is not attached to the claim. The second opinion must be prior to the date of service and the provider must attach the completed Second Opinion form to the claim. This edit does not apply to any specific form locator.

**EDIT 0359 - SECOND OPINION DATE AND AGE RESTRICTION**

This edit will post if the procedure requires a second opinion for beneficiary's who are age 19 and older and the second opinion form is not attached to the claim. The second opinion must be prior to the date of service and the provider must attach the completed Second Opinion form to the claim. This edit does not apply to any specific form locator.

**EDIT 0360 - PHYSICIAN SIGNATURE/DATE MISSING ON SECOND OPINION FORM**

This edit posts when the providers signature and/or signature date is missing from the Second Opinion form. This edit does not apply to any specific form locator.

**EDIT 0361 - INSUFFICIENT MEDICAL DOCUMENTATION FOR HYSTERECTOMY**

This edit posts when the documentation submitted with the Hysterectomy Receipt of Information Form (FD-189) is not sufficient. The Hysterectomy Receipt of Information Form may be waived if the beneficiary was sterile prior to the surgery date (post-menopausal or has previously been sterilized) and the provider has attached the history and physical as proof instead of the FD-189. This edit does not apply to any specific form locator.

**EDIT 0362 - CLAIM IS POSSIBLE STERILIZATION**

This edit will post when the procedure code denotes a possible sterilization. If the procedure was voluntary, the provider must resubmit the claim using the CMS 1500 (paper claim form), along with the (7473-M) Sterilization Consent Form. If the procedure was involuntary, the provider must resubmit the claim using the CMS 1500 (paper claim form), along with the Operative and Discharge Summary reports attached. These documents must include the beneficiary's name and surgery date. This edit does not apply to any specific form locator.

**EDIT 0363 - CLAIM IS POSSIBLE ABORTION**

This edit posts when the procedure code denotes a possible abortion. If an abortion was induced, the provider must resubmit the claim along with the (FD-179) Abortion Certification form. If no abortion was performed, the provider must resubmit the claim along with the Operative and Discharge Summary reports attached. These documents must include the beneficiary's name and surgery date.

This edit does not apply to any specific form locator.

**EDIT 0364 - CLAIM SPANS HMO ENROLLMENT - CALL REVS**

The claim dates of service are spanned. During this span the beneficiary enrolled in a Medicaid HMO. The provider should call REVS at 1-800-676-6562 or logon to e-Mevs to determine the HMO effective date. The provider may bill fee -for- service for the dates that the beneficiary was only covered by Medicaid and must bill the HMO for the period of time the beneficiary was covered by the HMO. Below are form locators that apply:

ADA	24
1500	24A
UB-04	6 and 45
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	14A
TAD	10 and 11

**EDIT 0368 - NOT LOCK IN PHARMACY/EMERGENCY SUPPLY DISPENSED**

This edit will post if the following conditions occur:

1. The claim is a pharmacy claim/lock-in recipient.
2. The days supply on the in-coming claim is less than 7.
3. There is an emergency supply dispensed claim within the 90 days of the Date of Service. Note: The claim has the same GCN as the in-coming claim. This edit does not apply to any specific form locator.

**EDIT 0371 - CSOCI - UNABLE TO DETERMINE COVERAGE**

This edit is for CBHS (formerly known as CSOCI) services. The claim is pending for an internal review in order to determine if the service billed is covered by CBHS (CSOCI). This edit does not apply to any specific form locator.

**EDIT 0373 - CSOCI - NON-COVERED SERVICE**

This edit posts when a provider bills under a CBHS (formerly known as CSOCI) number and is seeking reimbursement for a service other than an allowable mental health service. This edit does not apply to any specific form locator.

**EDIT 0374 - REPORTED SERVICE UNITS MUST BE GREATER THAN 1 & LESS THAN 6**

This edit will post if the service units are not greater than 1 and less than 6. Below are the claim forms and form locators that apply:

ADA	N/A
1500	24G
UB-04	46
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0380 - CLAIM SUBMITTED FFS - SERVICE IS IN-PLAN (MANAGED CARE)**

This edit posts when the beneficiary is enrolled in a HMO and the service is in-plan. The provider should not bill Medicaid fee-for-service. The provider should call REVS at 1-800-676-6562 or logon to E-MEVS to determine which HMO the beneficiary is enrolled in; providers must participate with that HMO in order for the claim to be considered for payment. This edit does not apply to any specific form locator.

**EDIT 0383 - DATE OF SERVICE LATER THAN DATE OF DEATH**

This edit will post to a claim when the date of service on the claim is greater than the date of death.

ADA	24
CMS-1500	24A
UB-04	6
MC-6	12
MC-9	25A
MC-12	17A
MC-19	14
TAD	10, 11

**EDIT 0384 - DATE OF SERVICE LATER THAN DATE OF DEATH**

This edit will post to a claim when the eligibility file end date is earlier than the date of service and the recipient is deceased.

ADA	24
CMS-1500	24A
UB-04	6
MC-6	12
MC-9	25A
MC-12	17A
MC-19	14
TAD	10,11

**EDIT 0385 - NON-COVERED SERVICE FOR PROGRAM STATUS CODE**

This service is not payable under the New Jersey Kid-Care/Family-Care programs. Check the website for appropriate Newsletter to determine covered services. This edit does not apply to any specific form locator.

**EDIT 0387 - BILLING PROVIDER NOT ENROLLED IN CLIA**

This edit posts if the procedure code on the claim requires that the provider must have CLIA certification and the provider file does not have this data. Below are the claim forms and form locators that apply:

ADA	48-52A
1500	33
UB-04	56 & 57
MC-6	N/A
MC-9	17 & 27
MC-12	N/A
MC-19	24 & 25
TAD	N/A

**EDIT 0388 - BILLING PROVIDER NOT CLIA ELIGIBLE ON DATE OF SERVICE**

The procedure code on the claim requires CLIA certification. This edit posts when the provider's CLIA certification does not include the claim service date. Below are the claim forms and form locators that apply:

ADA	48-52A
1500	33
UB-04	56 & 57
MC-6	N/A
MC-9	17 & 27
MC-12	N/A
MC-19	24 & 25
TAD	N/A

**EDIT 0389 - BILLING PROVIDER NOT ELIGIBLE TO PERFORM THIS PROCEDURE**

The procedure code on the claim requires CLIA certification. This edit posts when the provider's CLIA certification is not the appropriate level to perform this procedure. Below are the claim forms and form locators that apply:

ADA	48-52A
1500	33
UB-04	56 & 57
MC-6	N/A
MC-9	17 & 27
MC-12	N/A
MC-19	24 & 25
TAD	N/A

**EDIT 0390 - INVALID: REF PROV/ RCP CNTY/REF PROV TYP/PLC OF SVC FOR PROC**

Home based hospice services are only payable for a beneficiary who does not reside in an institution and who is eligible for Medicaid through a county-based Medical Assistance program. The first two digits of the beneficiary's Medical Assistance Identification Number must be 01-21, denoting the county code. Below are the claim forms and form locators that apply:

ADA	N/A
1500	1A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0391 - PREMIUM SUPPORT - BILL OTHER INSURANCE**

This edit posts to pharmacy claims for premium support beneficiaries. It indicates that the pharmacist must bill the other insurance.

**EDIT 0394 - MEDICARE ENROLLMENT REQUIRED TO RECEIVE PAAD / SR GOLD PAYMENT**

This edit posted because the pharmacy provider must be enrolled in Medicare before PAAD (Pharmaceutical Assistance to the Elderly or Disabled) or Senior Gold claims can be paid by these programs.

**EDIT 0395 - INITIAL PRESCRIPTION LIMITED TO A 34-DAY SUPPLY**

The maximum days supply for original prescriptions is 34. For refills only, Medicaid beneficiaries may receive a supply exceeding 34 days or 100 units of a prescribed medication - whichever is greater. This edit applies to Pharmacy claims only and applies to form locator 17 of the M-6 claim form.

**EDIT 0396 - REFILL RX LIMITED TO 34 DAYS / 100 UNITS**

This edit posts on refill pharmacy claims when the days supply exceeds 34 and the number of units exceeds 100. Both parameters cannot be exceeded. This edit applies to Pharmacy claims only and applies to form locator 17 of the M-6 claim form.

**EDIT 0401 - DATE OF SERVICE < DATE OF BIRTH**

This edit posts when the claim date of service is earlier than the beneficiary's date of birth on the Medicaid eligibility file. Below are the claim forms and form locators that apply:

ADA	13 & 24
1500	3 & 24A
UB-04	10 & 45
MC-6	4 & 12
MC-9	5 & 25A
MC-12	5 & 17A
MC-19	2 & 14A
TAD	10 & 11

**EDIT 0402 - NOT COVERED BY GA - BILL ADDP**

This edit posts to a Pharmacy claim for a Beneficiary enrolled in GA. The drug is now covered under the ADDP Program and not covered by GA. This edit does not apply to any specific form locator.

**EDIT 0403 - DURATION AT THIS DOSAGE EXCEEDED**

This edit posts to Point of Sale pharmacy claims only. It establishes DUR standards for the duration of the drug based on the generic code or specific therapeutic class. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	17
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0404 - DURATION STANDARD EXCEEDED- POSSIBLE CUTBACK**

This edit posts to Point of Sale pharmacy claims only. This edit is to notify the Provider that the standard duration of drug therapy was partially exceeded. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	17
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0405 - POSSIBLE THERAPEUTIC CLASS DUPLICATION**

This edit posts to a pharmacy claim when the claim submitted matches a claim in history with the same therapeutic class that does not match by prescription number. This edit does not deny the claim. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	15
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0406 - INAPPROPRIATE UNITS; BULK SOLUTION > 100CC**

This edit posts to pharmacy claims for compound drugs when the compound indicator on the claim is “Y”, the drug form is 2 (liquid) and the package size is greater than 100. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	24
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0407 - THERAPEUTIC DUPE; CLAIM THRESHOLD EXCEEDED**

This edit is usually due to the pharmacist filing a claim for a drug that is in the same therapeutic class or category with an existing medication on the Beneficiary's profile. A review of the other drugs on the profile similar to the one being processed could provide an answer to this edit. In the event the original prescription was filled at a different pharmacy, then there is no way to know this and the pharmacist would have to depend on the MEP representative for guidance. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	15
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0408 - PRIOR AUTHORIZATION NUMBER INVALID**

This edit posts if the prior authorization number entered on the claim is invalid. It must be 10 numeric digits in length and begin with 01 through 15. Below are the claim forms and form locators that apply:

ADA	2
1500	23
UB-04	63
MC-6	21
MC-9	verify top right pre-printed number
MC-12	verify top right pre-printed number
MC-19	N/A
TAD	N/A

**EDIT 0409 - PROSTHETIC AND/OR ORTHOTIC CHARGES REQUIRES PA**

This edit posts when charges exceed the following limits and no prior authorization is on file: Prosthesis with a charge of \$1,000.00 or more; Orthotics with a charge of \$500.00 or more; Replacement part(s) with charge of \$250.00 or more. Below are the claim forms and form locators that apply:

ADA	N/A
1500	23, 24D & 24F
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0410 - SERVICE NOT AUTHORIZED BY GSHP CASE MANAGER**

This edit posts when the Beneficiary is enrolled in GSHP, the service requires prior authorization, and the authorization is missing.

ADA	N/A
1500	23
UB-04	63
MC-6	21
MC-9	Top right corner
MC-12	N/A
MC-19	13A
TAD	N/A

**EDIT 0411 - GSHP PRIOR AUTHORIZATION NOT REQUIRED..**

This edit posts when the service being billed is for a Beneficiary who is enrolled in GSHP, and a prior authorization is not required. This edit does not apply to any specific form locator.

**EDIT 0412 - GSHP QA/QU PRIOR AUTHORIZATION REQUIRED**

This edit posts to a claim when the Beneficiary is enrolled in GSHP and the procedure code is 90731, 90707, 90737, or 90716, and the servicing provider is not the PCM or in the PCM's group. The claim will pend for review by the GSHP QA/AU section who will determine if the servicing provider was/was not authorized to perform the procedure.

**EDIT 0413 - 2 PRESCRIPTIONS REMAIN WITHOUT NEED FOR PRIOR AUTHORIZATION**

This edit posts when only two prescriptions remain before prior authorization for additional prescriptions must be obtained. This edit does not apply to any specific form locator.

**EDIT 0414 - 1 PRESCRIPTION REMAINS WITHOUT NEED FOR PRIOR AUTHORIZATION**

This edit posts when only one prescription remains before prior authorization for additional prescriptions must be obtained. This edit does not apply to any specific form locator.

**EDIT 0415 - NO PRESCRIPTIONS REMAIN WITHOUT NEED FOR PRIOR AUTHORIZATION**

This edit posts when no additional prescriptions may be dispensed without prior authorization. This edit does not apply to any specific form locator.

**EDIT 0416 - PRESCRIPTION VOLUME EXCEEDS THRESHOLD - PA REQUIRED**

This edit posts when the number of prescriptions a beneficiary may have during a one-month period has been reached. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	20
MC-19	N/A
TAD	N/A

**EDIT 0417 - GENERIC SUBSTITUTION REQUIRED OR INAPPROPRIATE DAW**

This edit will post when a pharmacist inputs a brand name claim for a product that has a multisource generic equivalent available. If the prescriber indicates "Brand Medically Necessary" on the prescription, the pharmacist should alert the prescribing provider to contact Gainwell Technologies MEP (1-877-888-2939) to justify the use of the brand medication and obtain a PA if approved. If this was in error (pharmacist not aware of generic availability), a quick review of available generic NDCs for the product should resolve this. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	15
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0418 - FAMILYCARE ADDP ENROLLMENT EDIT**

This edit posts to a Pharmacy claim for an HIV drug when the Beneficiary is enrolled in NJ Family Care Plan "D", and is eligible for ADDP.

**EDIT 0419 - WFNJ/GA OR NJFL CLAIM PROCESSED AS ADDP**

This edit posts to a pharmacy claim for an HIV drug with an incoming WF/GA or NJFC Medicaid Number when the Beneficiary has open eligibility for ADDP. The claim will be processed under the ADDP Number. This edit does not apply to any specific form locator.

**EDIT 0420 - CLAIM PAYABLE UNDER WFNJ/GA OR FC ONLY**

This edit posts when the submitted claim is submitted with an ADDP Medicaid Number and is not for an HIV drug. This edit does not apply to any specific form locator.

**EDIT 0421 - SERVICE UNITS VALUE FACTORED FOR PROCESSING**

This is an Explanation of Benefit (EOB), which posts to indicate that the units reported on the paper Remittance Advice Statement represent the number of the actual units reported on the claim form divided by 10. The approved amount on the RA was calculated from the total units reported on the original claim. This edit does not apply to any specific form locator.

**EDIT 0422 - MANAGED CARE RECIPIENT-PRIOR AUTHORIZATION REQUIRED**

This edit will post for managed care dental claims with procedure codes Y2910 or D8080 that do not have a prior authorization number on the claim. Below are the claim forms and form locators that apply:

ADA	2 & 24
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0423 - PRIOR AUTHORIZATION REQUIRED**

This edit is posted to claims that require a Prior Authorization based on the service billed. The claim did not contain a PA Number In the appropriate field. Below are the form locators that apply:

ADA	2
1500	23
UB-04	63
MC-6	20
MC-9	verify top right pre-printed number
MC-12	verify top right pre-printed number
MC-19	N/A
TAD	N/A

**EDIT 0424 - ELIG ENDED BEFORE CLAIM THRU DATE FOR DME-CUTBACK APPLIED**

This edit posts only to approved DME claims when the beneficiary's Medicaid eligibility ended prior to the last date of service reported on the claim. The payment amount is 'cut back' to pay only the Medicaid eligible days. Below are the claim forms and form locators that apply:

ADA	N/A
1500	24A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0426 - NO FQHC ENCOUNTER WITH DELIVERY HCPCS CLAIM PAID AT NON-ZERO**

This edit posts to a claim for a FQHC Provider when there is no matching encounter claim on file. This edit does not apply to any specific form locator.

**EDIT 0427 - FQHC DELIVERY HCPCS MINUS ENCOUNTER RATE.**

This edit posts to an FQHC claim when the payment made is reduced from the payment of the encounter claim.

**EDIT 0429 - GSHP 30 DAY WAIVER ON PA**

This edit posts to a claim when the Beneficiary is enrolled in GSHP, the service being billed requires Prior Authorization, but the service date is prior to 12/29/1991.

**EDIT 0430 - OTHER COVERAGE CODE VALUE IS INVALID**

This edit posts to a pharmacy claim when the other coverage code value is invalid. This edit does not apply to any specific form locator.

**EDIT 0431 - OTHER PAYOR ID REQUIRED WITH TPL PAYMENT**

This edit posts to a pharmacy claim when there is an amount in any of the "OTHER PAYER AMOUNT PAID" fields and the related "OTHER PAYER ID" field is blank or spaces. This edit does not apply to any specific form locator.

**EDIT 0432 - THIS LEGEND DRUG NOT COVERED BY PAAD/SG**

This edit posts to a PAAD or Senior Gold pharmacy claim only when the drug is not covered by PAAD/Senior Gold. This edit does not apply to any specific form locator.

**EDIT 0433 - "POSSIBLE UNDERUTILIZATION; MEP UNIT TO CONTACT MD"**

This edit monitors pharmacy claims to determine the potential for underutilization of certain drugs. This edit does not apply to any specific form locator.

**EDIT 0434 - "VERIFY DOSAGE BASED ON WEIGHT"**

This edit monitors pharmacy claims to determine the potential for underutilization of certain drugs. This edit does not apply to any specific form locator.

**EDIT 0435 - UNABLE TO DETERMINE HIPAA CLAIM TYPE.**

This edit posts to an electronic claim when the system is unable to determine the claim type. This edit does not apply to any specific form locator.

**EDIT 0436 - SUBMITTER NOT ELIGIBLE FOR CLAIM TYPE ON ACTIVITY DATE**

This edit posts to an electronic claim when the submitter is not eligible to submit this claim type on the claim activity date. This edit does not apply to any specific form locator.

**EDIT 0437 - INVALID SUBMITTED ID**

This edit posts to an electronic claim when the submitted submitter ID is invalid. This edit does not apply to any specific form locator.

**EDIT 0438 - PAYOR ID QUALIFIER DOES NOT EQUAL 99 PBM LIST**

This edit will post to a pharmacy claim if any of the "OTHER PAYOR ID QUALIFIER" fields are entered with anything other than '99'. This edit does not apply to any specific form locator.

**EDIT 0439 - INVALID OTHER PAYOR ID CODE NOT ON PBM LIST**

This edit will post to a pharmacy claim if any "OTHER PAYOR AMOUNT PAID" fields are greater than zero and the related OTHER PAYOR ID field does not contain one of the codes from the PBM list. This edit does not apply to any specific form locator.

**EDIT 0440 - LTC PHARMACY INELIGIBLE FOR UD RECYCLING.**

This edit will post to a pharmacy claim if the provider submits invalid facility ID for a Unit Dose Recycling Transaction. This edit does not apply to any specific form locator.

**EDIT 0441 - NUMBER OF UNITS RESTOCKED EXCEEDS ORIGINAL UNITS PAID**

This edit will post to a pharmacy claim if the service units on a Unit Dose Recycling adjustment claim is equal to or greater than the units on the previously paid claim. This edit does not apply to any specific form locator.

**EDIT 0442 - ORIGINAL CLAIM INELIGIBLE FOR UNIT DOSE RESTOCKING/RECYCLING**

This edit will post to a pharmacy claim if the following is true.

1. The original claim is less than \$12.00.
2. The first eight digits of the NDC on the original claim is different from the one on the adjustment transaction.
3. The original and incoming claims are Sr. Gold or PAAD recipients.
4. The amount payable by Medicaid is less than the cutback plus TPL amount on the adjustment transaction.

This edit does not apply to any specific form locator.

**EDIT 0443 - TPL PAYMENT EXPECTED PAYOR ID ON CLAIM BUT NO TPL AMOUNT**

This edit will post to a pharmacy claim if any of the "OTHER PAYER AMOUNT PAID" fields are zero and the related "OTHER PAYER ID" field does not contain a valid PBM code. See NCPDP 5.1 HIPAA Companion Guide section 3 for a complete list. This edit does not apply to any specific form locator.

**EDIT 0444 - DIAGNOSIS CODE REQUIRED/ MEDICARE COVERED DRUG**

This edit posts to a pharmacy claim when the drug being billed is a Medicare covered drug requires a diagnosis code. Contact First Health for the appropriate code. This edit does not apply to any specific form locator.

**EDIT 0445 - TPL NOT ON RESOURCE FILE BUT TPL AMT ON CLAIM**

This edit posts if any of the "other payer amount paid" fields is greater than zero and the related "other payer ID" field is not on the TPL resource file. This edit does not apply to any specific form locator.

**EDIT 0446- DRUG NOT COVERED BY CF PROGRAM**

This edit code posts to a pharmacy claim for a beneficiary on the CF Drug Distribution Program. The drug submitted is not covered by this program. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	1 & 15
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0447 - DAILY DOSE EXCEEDS REC.LIMITS FOR DRUG FOUND IN COMBO PROD.**

This edit posts to a pharmacy claim when the APAP is greater than 4 grams. This edit does not apply to any specific form locator.

**EDIT 0449 - "INAPPROPRIATE NARCOTIC USE"**

This edit is used to monitor the potential miss-use of narcotics. This edit does not apply to any specific form locator.

**EDIT 0450 - DRUG NOT COVERED FOR ESRD RECIPIENT**

This edit posts when, after review, it is determined that this drug is not covered for recipients who are receiving ESRD services. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	42, 43, 44
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0451 - MEDICAL SUPPLY OR SERVICE(S) NOT COVERED FOR ESRD RECIPIENT**

This edit posts when, after review, it is determined that supplies or services are not covered for recipients who are receiving ESRD services. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	42, 43, 44
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0452 - CERTIFICATION OF EMERGENCY FORM MISSING/INVALID**

This edit is posted when an out-of-state hospital claim for emergency service(s) does not include the required Certification of Emergency Form. This edit only applies to Hospital claims. This edit does not apply to any specific form locator.

**EDIT 0453 - PA/CERT DATES OR RECIPIENT ID# CONFLICT WITH CLAIM**

This edit posts when the Fiscal Agent received an out-of-state hospital claim and one of the following problems exist: On the LD-25 Form either the dates that were authorized on it or the recipient's name does not match the date entered on the claim. On the Emergency Certification Form either the dates that were authorized or the recipient's names does not match the data on the claim. This edit does not apply to any specific form locator.

**EDIT 0455 - RECIPIENT NOT ELIGIBLE ON FROM D.O.S. NO DEDUCTIBLE DUE**

This edit posts to Inpatient Crossover claims because the Medicaid recipient was not eligible for Medicaid on the date of admission. Therefore, Medicaid is not responsible for the Medicare deductible. This edit does not apply to any specific form locator.

**EDIT 0456 - LAB NOT COVERED FOR ESRD RECIPIENT**

This edit posts when, after review, it is determined this lab procedure is not covered for recipients who are receiving ESRD services. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	44
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0457 - LTC FACILITY ID MISSING ON POS REBILL UNIT DOSE RESTOCK**

This edit posts to a pharmacy claim when the submitted claim is for a NCPDP rebill transaction and the Facility ID (8c) is not populated. This edit does not apply to any specific form locator.

**EDIT 0458 - OCCURRENCE CODE INDICATES ACCIDENT REVIEW REQUIRED**

This edit will post when the occurrence code indicates an auto accident and there is an attachment that requires review. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	31-36
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0459 - CLAIM PYMT ADJUSTED DUE TO OTHER INSURANCE.**

This edit posts to a pharmacy claim to inform the Provider that this claim was adjusted as a result of HMS's coordination of benefits with third party insurers. This edit does not apply to any specific form locator.

**EDIT 0460 - INSURANCE ATTACHMENT INVALID/MISSING**

This edit posts to a claim when claim indicates an accident and the attachment is not valid. This edit does not apply to any specific form locator.

**EDIT 0461 - ESRD CLAIM-OCCURRENCE CODE 35 REQUIRED**

This edit posts to ESRD claims when Occurrence Code 35 and the date treatment started are not entered on the claim form. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	31-36
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0462 - RENAL REVENUE CODE PRESENT - RENAL CONDITION CODE REQUIRED**

When an ESRD Revenue code (821, 829, 831, 839, 841, 849, 851 859, or 881) is on the claim form, one of the following ESRD Condition Codes must be reported as well: 71 - Full-care in unit (ESRD), 72 - Self-care in unit (ESRD), 73 - Self-care training (ESRD), 74 - Home (ESRD), 75 - Home 100% Reimbursement (ESRD) and 76 - Back-up facility dialysis (ESRD). This edit posts when the Revenue Code is present, but the condition code is missing. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	18-28 & 31-36
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0463 - UNIT RECAPTURE ADJUSTMENTS**

This edit posts to Pharmacy claims when the metric quantities are improperly reported. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	16
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0464 - HIPAA CLAIM DENIED NO ATTACHMENT SUBMITTED**

This edit posts to a HIPAA EDI claim submission after the 45-day suspend review has expired and Gainwell Technologies has either not received a valid HIPAA Attachment Cover Sheet, or the Cover Sheet did not have the correct attachment present. This edit will also post with one of the following edits: 0026, 0027, 0245, 0252, 0264, 0318, 0320, 0331, 0333, 0337, 0338, 0354, 0355, 0358, 0359, 0362, 0452, 0453, 0458, 0460, 0591, 0608, 0618, 0634, 0643. This edit does not apply to any specific form locator.

**EDIT 0465 - DENTAL SURGERY CODE REQUIRED**

This edit posts to a Hospital claim when the diagnosis code equals 5200-5299, and the rev code does not equal emergency room (rev code 450 or 459). An ICD9 dental surgery procedure code of 230-2799 is required.

**EDIT 0466 - COMPOUND CLAIM WITH ONLY ONE INGREDIENT**

This edit posts to a pharmacy claim for a compound drug with only one ingredient listed. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0471 - FQHC ENCOUNTER WITH NO PD HCPCS ON HIST**

This edit posts for a claim submitted by a Federally Qualified Health Center (FQHC). In order for the Encounter Code to pay, the system needs to see that the procedure done on that day is processed for a zero payment before the encounter will process. This edit does not apply to any specific form locator.

**EDIT 0472 - FQHC ENCOUNNT BILLED UNITS GT PAID HCPCS UNITS ON HIST**

This edit posts to a claim submitted by a Federally Qualified Health Center (FQHC) when the number of visits do not equal the number of units billed for the encounter. For example W9840 was billed with 2 units, but there is only 1 office visit billed for that date of service. This edit does not apply to any specific form locator.

**EDIT 0473 - TOTAL CALCULATED CHARGE NOT EQUAL TO TOTAL BILLED CHARGE**

This edit posts if sum of the charges entered on the claim does not equal the total charge entered. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	47
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0474 - NET CALCULATED CHARGES NOT EQUAL TO NET BILLED CHARGE**

This edit posts when the line item charges on the claim do not equal the total charges. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	47
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0475 - HISTORY RECORD ALREADY ADJUSTED OR VOIDED**

This edit posts to pharmacy adjustment or void requests, when the claim being adjusted has already been adjusted or voided. This edit does not apply to any specific form locator.

**EDIT 0476 - NO CLAIM IN HISTORY FILE MATCHES ADJ/VOID REQUEST**

This edit posts to a pharmacy adjustment/void transaction when the information given cannot be matched to any approved claims on the system. This edit does not apply to any specific form locator.

**EDIT 0477 - ENCOUNTER MC EXTENSION IND IS INVALID**

This edit will post if a pharmacy claim is an encounter-generated claim and the managed care plan code is not zero or spaces. This edit does not apply to any specific form locator.

**EDIT 0478 - NO LONGER ACCEPT PAPER COMPOUND CLAIMS**

This edit posts to a pharmacy claim for a compound drug when it is submitted via paper. As of 01/20/2004 compound drugs can only be submitted electronically to NJ Medicaid. This edit does not apply to any specific form locator.

**EDIT 0479 - PRIV PSYCH HOSP - LTC - PAT AGE > 21 AND < 65**

This edit will post to a claim when Medicaid does not cover the service billed because the provider is a private psychiatric hospital and the LTC patient age is greater than 21 and or less than 65. Below are the claim forms and form locators that apply.

ADA	N/A
1500	N/A
UB-04	10
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0480 - GROUPEE ASSIGNED A NEW DRG CODE**

This edit posts when the system calculates a DRG that is different from the DRG code entered on the claim. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	71
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

NOTE: If a provider disagrees with the DRG assignment they must submit a DRG review request along with the claim and the RA showing Edit 480 to:

DMAHS  
P.O. BOX 712  
TRENTON, NJ 08625  
ATTN: DRG APPEAL

**EDIT 0482 - ESRD CLAIM REQUIRES REVIEW**

This edit posts to an ESRD claim (bill type 72(x)) and the following rev codes are present:

- Pharmacy - 250-259
- Medical Supplies - 270-279
- Lab - 300-319

If one of these rev codes are present a review of the claim attachment is required. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	42
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0483 - LAB TEST INCLUDED IN ESRD COMPOSITE RATE**

This edit posts when a review determines that the claim contains several HCPCS codes for lab test. Charges for lab tests must be included in the ESRD composite rate. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	42 & 44
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0484 - ESRD POSSIBLE ELIGIBLE FOR MEDICARE**

This edit posts for an ESRD claim when the occurrence code equals 35 and the system calculated days from the occurrence code date to the from date of service, is more than 90 days. The claim should be submitted to Medicare for payment. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	31-36
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0486 - PHARMACY {DRUGS} INCLUDED IN ESRD COMPOSITE RATE**

This edit posts when, after review, it is determined that the claim contains separate charges for pharmacy claims which should be included in the ESRD Composite Rate. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	42, 43, & 44
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0487 - MEDICAL SUPPLIES INCLUDED IN THE ESRD COMPOSITE RATE**

This edit posts when, after review it is determined that the claim contains separate charges for medical supplies that should be included in the ESRD Composite Rate. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	42, 43, & 44
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0488 - DRG INTERIM BILL APPROVAL REQUIRED**

This edit posts when a DRG claim is received while the patient is still an inpatient. The State Medicaid office must approve this interim bill. This edit does not apply to any specific form locator.

**EDIT 0489 - BABY AND MOTHER ACCOMMODATION REVENUE CODES ON CLAIM**

This edit posts when hospital services rendered to mother and baby are billed on the same claim. They must be billed on separate claims. This edit does not apply to any specific form locator.

**EDIT 0490 - INPATIENT DATE OF SURGERY < SERVICE FROM DATE**

This edit posts when the surgery date entered on the claim form is less than the "from" statement date entered on the claim form. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	6 & 74
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0491 - INVALID DIAGNOSIS CODE/AP-DRG**

This edit posts to a New Jersey inpatient claim when the diagnosis reported does not exist on the ALL-patient grouper subroutine's processing table. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	67A-Q, 69, 72A-C
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0492 - CLINICAL INACCURACY/ AP-DRG**

This edit will post if codes required by the ALL-patient Grouper subroutine do not, in combination, represent a "sensible" claim. One example would be a "male" sex code for the patient, with a diagnosis and/or procedure code that indicated a "female" claimant. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	11, 42, 44, 67A-Q, 69, 72A-C
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0493 - INVALID AGE CODE / AP-DRG**

This edit posts if the patient age, in years, on a NJ Inpatient hospital claim, is not within the range of 1-124, or if the year calculated is 0, then the age in days is not within a range of 1-366. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	10
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0494 - INVALID SEX CODE/ AP-DRG**

This edit will post if the patient sex on a New Jersey inpatient hospital claim is neither male or female, as determined by the ALL-Patient Grouper Subroutine. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	11
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0495 - INVALID DISCHARGE STATUS/AP-DRG**

This edit posts when the discharge status code on a New Jersey inpatient hospital claim subject to DRG pricing cannot be mapped to a Grouper acceptable code (01-08, 20, 22, 23, 30) prior to calling the ALL-Patient Grouper subroutine. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	17
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0496 - INVALID BIRTH WEIGHT /AP-DRG**

This edit posts when the birth weight entered on the claim form either is less than 100 grams or more than 9000 grams. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	39-41
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0497 - INVALID DISCHARGE AGE /AP-DRG**

This edit will post if the patient age at discharge on a New Jersey inpatient hospital claim, calculated by the ALL-Patient Grouper subroutine, is not greater than or equal to the patient birthdate. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	10
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0498 - INVALID PRINCIPAL DIAGNOSIS /AP-DRG**

This will post if the principal diagnosis code is not considered a principal diagnosis code by the ALL-Patient Grouper subroutine. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	67
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0499 - ACUTE DAYS BILLED EQUAL ZERO**

This edit posts when the number of acute days entered on the claim form is zero. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	6, 42, and 46
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0503 - REVENUE CODE NOT ON FILE**

This edit posts when Medicaid does not recognize one or more Revenue Codes entered on the UB-92 Claim Form.

**EDIT 0505 - LTC CENSUS DATA MISSING FOR SERVICE MONTH**

This edit posts when the Fiscal Agent does not receive the monthly Certification Statement. This data must be received before the month's claims can be processed.

**EDIT 0506 - RECIPIENT INELIGIBLE TO RECEIVE LTC SERVICES**

This edit posts when the recipient is not eligible to receive LTC services.

**EDIT 0508 - PROVIDER NOT MEDICARE CERTIFIED - BED HOLD NOT ALLOWED**

This edit posts when the Medicaid Provider File does not indicate that this provider is Medicare certified.

**EDIT 0509 - MEDICARE BED HOLD INVALID**

This claim has at least two leave of absence periods reported in Items 23-32. A hospital leave while on Medicare (Code M) cannot be used during the same billing period as a therapy leave (Code T) or a hospital leave (Code H). Leave Type M must be billed on a separate TAD line.

**EDIT 0510 - CO-INSURANCE DAYS MUST BE BILLED PRIOR TO LIFETIME RESERVE DAYS**

This edit posts when Lifetime Reserve Days are billed before all 30 coinsurance days have been used.

**EDIT 0512 - DRUG NOT PAYABLE - NO ADDP REBATE AGREEMENT**

This edit posts when a pharmacy bills for an ADDP beneficiary (first four positions of the beneficiary's number are 5901), and the drug file does not reflect a rebate agreement for the NDC billed.

**EDIT 0514 - NURSING FACILITY LEAVE/RETURN RESTRICTED**

This edit posts when the provider file indicates that this facility has terminated its Medicaid agreement or is curtailing Medicaid admissions. The provider should resubmit the claim, entering Code 1 (discharge to hospital) in Item 12, and the "from" leave of absence date recorded in Item 24-32 must be entered as the "to" service date (Item 11).

**EDIT 0515 - NURSING FACILITY ADMIT RESTRICTED**

This edit posts when the provider file indicates that this facility has terminated its Medicaid agreement or is curtailing Medicaid admissions. The code entered in Items 8 and 9 indicates a new admission, but Medicaid cannot cover the service.

**EDIT 0516 - EPSDT FFS INCENTIVE PAYMENT ERROR**

This edit will post to a claim when a procedure code for an incentive payment request (W9828) is in process must meet either of the following two conditions:

A: One of the lines must be for an EPSDT or Healthstart procedure code

B: One of the lines on the claims must be for the HIPAA equivalent of an EPSDT or Healthstart procedure and must contain the modifier of 'EP' or '22'.

ADA N/A  
1500 N/A  
UB-04 N/A  
MC-6 N/A  
MC-9 N/A  
MC-12 N/A  
MC-19 14A, 14D  
TAD N/A

**EDIT 0517 - PASARR RECORD MISSING (DATES INVALID)**

This edit posts when the claim service date is earlier than the LTC assessment date, or the claim service date is after that LTC assessment termination date, or the LTC assessment date is zero.

**EDIT 0518 - INVALID PASARR DATA**

This edit posts when the LTC assessment code or the PASARR code is invalid.

**EDIT 0521 - RECIPIENT NOT ON LTC MASTER FILE**

LTC: This edit posts when there is no PAS record on file at the Fiscal Agent. The Pre-Admission Screening (PAS) record must be on file in order for Gainwell Technologies to approve this claim. You must contact your local Long Term Care Field Office (LTCFO) in order to resolve this condition. HOSPICE: This edit posts when there is no PAS record on file at the Fiscal Agent. This is an Explanation of Benefit (EOB) message only.

**EDIT 0522 - INCORRECT PROVIDER FOR LTC SPECIAL PROGRAM**

This edit is posted when the servicing provider on the LTC (Long Term Care) claim is not authorized.

**EDIT 0524 - INVALID LTC PSYCH RECIPIENT AGE**

This edit posts when the claim is for a recipient between ages 21 and 65. Payment for services in this facility is not allowed.

**EDIT 0526 - PA-3L INCOME GREATER THAN PATIENT PAY AMT PA-3L USED**

This edit posts when the patient payment amount entered in Item 35 of the LTC TAD is less than the PA-3L amount recorded on the beneficiary's eligibility file.

This edit only applies to the LTC TAD form locator 35.

**EDIT 0528 - LTC RECIPIENT NOT ELIGIBLE FOR ENTIRE PERIOD - CUTBACK ASSESSMENT DATE**

This edit posts when the assessment history date indicates that the recipient is not eligible for the entire billing period.

**EDIT 0529 - CLAIM DATES SERVICE BEFORE INITIAL ASSESSMENT DATE**

This edit posts when the claim dates of service are prior to the original assessment date.

**EDIT 0530 - LTC OVERLAPPING LEAVE PERIODS**

This edit posts when the "from" or "to" date on one leave of absence overlaps the "from" or "to" date on another leave for the same billing period.

**EDIT 0531 - LTC/HOSPICE REQUIRES PR-1 OR LTC REQUIRES PATIENT PYT AMOUNT**

LTC: This edit posts when the patient paid amount is blank or zero on the TAD and there is no PR-1 amount with a valid effective date on the beneficiary's eligibility file for this billing period. You must contact your local County Board of Social Services (CBOSS) in order to resolve this condition.

HOSPICE: This edit posts when the patient paid amount is blank or zero on the TAD and there is no PR-1 amount with a valid effective date on the beneficiary's eligibility file for this billing period.. This is an Explanation of Benefit (EOB) message only.

**EDIT 0532 - THIS NON LEGEND DRUG IS NOT COVERED FOR PAAD**

This edit posts when the claim is for an over the counter drug which PAAD does not cover.

**EDIT 0533 - OTC DRUG INCLUDED IN NF PER DIEM**

This edit posts when the claim is for an over the counter drug dispensed to a beneficiary residing in a nursing home. These drugs are already included in the nursing home payment.

**EDIT 0534 - DRUG NOT PAYABLE/IRS DESI**

This edit posts when the claim is for an IRS (Identical, Related, Similar) DESI drug. Medicaid does not cover these products.

**EDIT 0535 - DAILY QUANTITY EXCEEDED - 30 DAY EXTENSION**

This edit posts when a drug quantity exceeds its 30-day limit.

**EDIT 0536 - DAILY QUANTITY POSSIBLY EXCEEDED**

This is an EOB edit that will post when the billed drug's daily dosage exceeds the specified standard daily dosage.

**EDIT 0537 - MAXIMUM DOSE**

This edit posts when the dose or part of the combination drug (e.g. acetaminophen in Percocet) exceeds the daily drug quantity. A quick review of the claim or verification of dose with the prescribing provider would save time. There are of course some exceptions - when the prescribing provider confirms the need to dispense dose as prescribed. The MEP representative would then decide if the request is within clinical reason.

**EDIT 0538 - DAILY METRIC QUANTITY EXCEEDS DUR STANDARD/AGE**

This edit will post to a claim when the billed drug's daily dosage exceeds the standard daily dosage.

ADA N/A  
1500 N/A  
UB-04 N/A  
MC-6 16  
MC-9 N/A  
MC-12 N/A  
MC-19 N/A  
TAD N/A

**EDIT 0539 - THIS LIVERY SERVICE IS ONLY VALID IN COUNTY 07, 09, 90**

This edit posts when Medicaid does not cover the livery service.

**EDIT 0541 - COMPOUND DRUG MANUAL REVIEW REQUIRED**

This edit posted when the compound indicator on the MC-6 claim form was present, and the GSHP indicator was zero, requiring a manual review.

**EDIT 0542 - NON-LEGEND DRUG NOT PAYABLE FOR DATE OF SERVICE**

This edit posts when the claim is for a non-legend drug not payable by Medicaid on the claim date of service.

**EDIT 0544 - DRUG NOT PAYABLE FEDERAL DESI**

This edit posts when the claim is for a DESI drug determined by the Federal government as ineffective. Therefore, Medicaid does not cover it.

**EDIT 0545 - NDC NOT ON FILE**

This edit posts when Medicaid does not recognize the NDC billed.

**EDIT 0546 - PAAD CLAIM SUBMITTED BY OUT-OF-STATE PROVIDER**

The PAAD program does not reimburse out-of-state pharmacies, and the claim is from an out-of-state provider.

**EDIT 0547 - UNIT DOSE PAYABLE FOR NURSING HOME RECIPIENT ONLY**

Medicaid recipients are not eligible to receive unit doses unless they reside in a nursing facility. This edit posts when the claim does not indicate that the recipient is in a nursing facility.

**EDIT 0548 - DAYS SUPPLY EXCEEDS PROGRAM MAXIMUM**

This edit posts when the 34-day maximum supply for new prescriptions is exceeded.

**EDIT 0549 - DRUG NOT PAYABLE - NO REBATE AGREEMENT**

Medicaid reimbursement for legend and non-legend drugs is limited to manufacturers who have entered into a rebate agreement with the Secretary of the U.S. Department of Health and Human Services. This edit posts when there is no rebate agreement with the manufacturer.

**EDIT 0551 - NDC PROBABLY OBSOLETE, CHECK LABEL/COMPUTER**

This edit posts when the NDC on the claim is no longer valid for the date of service.

**EDIT 0552 - ADDP - SERVICE NOT COVERED FOR THIS RECIPIENT**

This edit posts when the patient is in the ADDP program, which does not cover the NDC billed.

**EDIT 0553 - COMPOUND DRUG DID NOT CONTAIN LEGEND DRUG**

This edit posts when the billed compound drug does not contain at least one legend drug.

**EDIT 0555 - PAAD RECIPIENT INELIGIBLE FOR MEDICAID SERVICES**

This edit posts when the claim is for a PAAD beneficiary, but the service is other than a pharmacy service.

**EDIT 0556 - COMPOUND DRUG NOT COVERED**

After review, it was determined that at least one of the NDCS listed on the claim is not covered or is a DESI drug.

**EDIT 0557 - COMPOUND DRUG NOT COVERED FOR PAAD RECIPIENTS**

This edit posts when a review determines that the recipient is a PAAD patient. However, PAAD does not cover compound drugs.

**EDIT 0559 - COMPOUND DRUG/NDC CODE MISSING OR INVALID**

This edit posts when, after review, it was determined that one or more NDC(s) in the compound drug either did not match the description or did not appear in the NDC File.

**EDIT 0560 - COMPOUND DRUG - QUANTITY MISSING OR INVALID**

This edit posts when, after review, it was determined that the quantity of at least one NDC in the compound drug was not written on the back of the claim form.

**EDIT 0561 - COMPOUND DRUG NOT COVERED FOR LTC RECIPIENT**

This edit posts when, after review, it was determined that the compound drug billed contains an OTC drug that is not covered for a Medicaid recipient residing in a LTC facility.

**EDIT 0562 - COMPOUND DRUG WITH INGREDIENT NOT COVERED BY REBATE AGREEMENT**

This edit posts when, after review, it was determined that at least one NDC listed on the claim is not covered by the drug rebate agreement. Medicaid reimbursement for legend and non-legend drugs is limited to manufacturers who have entered into a rebate agreement with the U.S. Department of Health and Human Services.

**EDIT 0565 - OTC DRUG NO UNIT PRICE ON FILE**

This edit posts when the NDC for this OTC drug is not covered on the date of service.

**EDIT 0566 - OTC DRUG NO PACKAGE PRICE ON FILE**

This edit posts when the NDC for this OTC drug is not covered on the date of service.

**EDIT 0567 - TEAMCARE - DRUG NO UNIT PRICE ON FILE**

This edit posts when the NDC is not covered on this date of service.

**EDIT 0568 - TEAMCARE - DRUG NO PACKAGE PRICE ON FILE**

This edit posts when the NDC is not covered on this date of service.

**EDIT 0569 - LEGEND DRUG NO PACKAGE PRICE ON FILE**

This edit posts when this NDC is not covered on this date of service.

**EDIT 0570 - DRUG NOT PAYABLE - NO PAAD REBATE AGREEMENT**

This edit posts when the beneficiary is enrolled in the PAAD Program and there is no manufacturers rebate agreement on file with the PAAD program.

**EDIT 0577 - GENERAL ASSISTANCE**

The State of NJ established this edit as part of clinical monitoring of the GA population. Unless it is associated with another edit (e.g. duplication [405] or ddi [916]), this claim requires the MEP representative to conduct a general profile review.

**EDIT 0578 - CLAIM PRICED UTILIZING CHARITY CARE 30 PERCENT RULE**

This edit posts to Charity Care claims if the Medicaid tentative pay less TPL amount is greater than the PA authorized amount (patient 30 percent threshold amount used in Charity).

**EDIT 0581 - DENTAL SERVICES AFTER ELIGIBILITY TERMINATED**

The edit posts when the claim date of service occurs after the beneficiary's eligibility terminated.

**EDIT 0582 - MISSING/INVALID TOOTH SURFACE CODE**

This edit posts when the entry in Item 17G on the MC-10 Dental Claim form is not a valid Medicaid tooth surface code. The valid codes are: B - Buccal, M - Mesial, O - Occlusal, I - Incisal, D - Distal, L - Lingual.

**EDIT 0583 - PAYMENT DENIED; VACCINE AVAILABLE THROUGH THE VFC PROGRAM**

This edit posts when the procedure code on the claim is for a child vaccine. NJ Medicaid does not pay child vaccines as fee-for-service. The provider must enroll in the Vaccines for Children program since the vaccines are given to the provider free of charge.

**EDIT 0585 - SERVICE UNITS INCONSISTENT WITH PRODUCT PACKAGING**

This edit posts to a pharmacy claim when the units billed do not match the package size of the drug they are billing for.

**EDIT 0586 - MISSING/INVALID TOOTH QUADRANT**

This edit posts when the entry in Item 17F on the MC-10 Claim Form is not a valid tooth quadrant code. This field is used for either tooth number or quadrant. This edit posts when the code entered in Item 17F is a valid tooth surface code, but a valid quadrant code is missing or invalid. The valid tooth quadrant codes are: UL = upper left, UR = upper right, LL = lower left and LR = lower right.

**EDIT 0587 - MISSING/INVALID TOOTH NUMBER**

This edit posts when the tooth number as recorded in Item 17F on the MC-10 Claim Form is either missing or is not a valid Medicaid tooth number. The valid codes are A to T for primary, 1 to 32 for permanent and SN for supernumerary. Item 17F must never have more than one tooth code entered. When billing for a service not specific to a single tooth or quadrant, this field must be blank.

**EDIT 0589 - MODIFIER NOT ALLOWED**

This edit posts if the modifier entered on the claim is not valid for the billed procedure code.

**EDIT 0590 - PROCEDURE CODE BILLED IS ONLY PAYABLE TO A SPECIALIST**

The provider file for the servicing provider indicates a non-specialist. This edit posts when the billed procedure code is only payable to a board certified or board eligible specialist.

**EDIT 0591 - PROVIDER NOT ON PROVIDER RATE FILE**

This edit posts if the billed rate is not on the provider rate file. The Fiscal Agent is unable to price the claim.

**EDIT 0595 - REVENUE CODE/CONDITION CODE CONFLICT FOR COMPOSITE RATE PRICING**

This edit posts when Revenue Code 821, 829, 831, 839, 841, 849, 851, or 859 is entered on the claim, but Condition Code(s) 71-76 is (are) missing. If one of these condition codes is on the claim, one of the above Revenue Codes must also appear.

**EDIT 0597 - VERIFY OR CORRECT PROCEDURE CODE/NDC FOR DATES OF SERVICE**

This edit posts if there is no fee on file for this procedure code or NDC.

**EDIT 0598 - INVALID LEVEL OF CARE CODE**

This edit posts to a claim with an invalid level of care code.

**EDIT 0599 - INVALID LTC COUNTY OF CHARGE**

This edit posts to an ICF.MR claim where the county of charge is invalid.

**EDIT 0600 - LTC RECIPIENT NOT ELIGIBLE ON DATE(S) OF SERVICE**

This edit will post to claim when the LTC recipient is not eligible on the date of service.

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	10 & 11

**EDIT 0601 - PAYMENT REDUCED TO MEDICAID MAXIMUM**

This edit will post to a claim when it is priced at the Medicaid allowance for the laboratory services.

This edit does not apply to any specific form locator.

**EDIT 0602 - MISSING DRG CODE**

This edit will post to a claim when it is subjected to DRG pricing and a valid three-digit DRG code is not entered in Form Locator 71 of the UB-04 claim form, or the claim is not subject to DRG pricing and there is an entry in Form Locator 71.

NOTE: As of October 1, 2018 and after, Inpatient Hospital discharges require a four- digit DRG Code to be entered in Form Locator 71.

ADA	N/A
CMS-1500	N/A
UB-04	71
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0603 - PROVIDER NOT ON DRG RATE FILE**

This edit will post to a claim when it is received from a New Jersey, New York or Pennsylvania hospital, but a record does not exist on the State DRG rate file for the provider billing for the DRG.

This edit does not apply to any specific form locator.

**EDIT 0604 - INVALID PRICING ACTION CODE**

There is no Pricing Action Code (PAC) to coincide with date of service of the claim.

This edit does not apply to any specific form locator.

**EDIT 0605 - OUT OF STATE DRG CLAIM REQUIRES MANUAL PRICING**

This edit will post to a claim when it is submitted by a hospital not located within New Jersey, New York, or Pennsylvania and no rate is on file.

This edit does not apply to any specific form locator.

**EDIT 0607 - LOW VARIANCE ERROR**

This edit will post to a claim when the system detects an inconsistency. There is an error in the number of units billed and/or the charge amount on the claim in incorrect.

ADA	31
1500	24F & 24G
UB-04	Outpatient claims only: 46 & 47
MC-6	N/A
MC-9	25 & 25I
MC-12	17B & 17F
MC-19	14G & 14H
TAD	N/A

**EDIT 0608 - PEND FOR MANUAL PRICING**

This edit will post when the claim submitted requires manual pricing. If this is a DME, Hearing Aid, or Prosthetic and Orthotic claim it will require pricing. Medical claims require Medical Records for pricing.

This edit does not apply to any specific form locator.

**EDIT 0609 - DRG DIRECT COST, LOW TRIM OR HIGH TRIM PER DIEM EQUAL ZERO**

This edit will post to a claim when it is subject to DRG pricing and the DRG is missing.

ADA	N/A
1500	N/A
UB-04	71
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0610 - MANUAL PRICING EXCEEDS BILLED CHARGES**

This edit will post to a claim when the special price amount is greater than the claim charge or if the special price amount is greater than the claim charge and there is no co-payment attachment.

ADA	33
1500	28
UB-04	N/A
MC-6	25
MC-9	28
MC-12	20
MC-19	16
TAD	N/A

**EDIT 0611 - PAYMENT EXCEEDS BILLED CHARGES/PAID CHARGES**

This edit will post to a claim when the claim charge is less than the Medicaid allowed amount.

This edit does not apply to any specific form locator.

**EDIT 0612 - PER DIEM INPATIENT RATE NOT FOUND ON PROVIDER RATE FILE**

This edit will post to a claim when it cannot be priced due to missing per diem rate information on the billing provider's file.

This edit does not apply to any specific form locator.

**EDIT 0613 - DRG CODE SUBMITTED PRIOR TO DRG TRIM EFFECTIVE DATE**

This edit will post to a claim when the reported DRG is submitted prior to its effective date.

ADA	N/A
1500	N/A
UB-04	71
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0614 - NON-COVERED DAYS CONFLICT WITH BILLED DAYS**

This edit will post to a claim when the Residential, SNF and ICF Days billed does not equal to the Non-covered days.

This edit does not apply to any specific form locator.

**EDIT 0615 - DRG NOT EFFECTIVE ON CLAIM SERVICE DATE**

This edit will post to a claim when the reported DRG is not effective on the claim service date.

ADA	N/A
1500	N/A
UB-04	6 & 71
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0616 - DME PAID CHARGES < \$30.00**

This edit will post to a claim when the submitted charges for DME purchases only (does not include rented) is less than \$30.00, there is no fee on file and the procedure code does not require prior authorization to pay the charges.

This edit does not apply to any specific form locator.

**EDIT 0617 - CALCULATED PAYMENT AMOUNT ZERO**

This edit will post to a claim when the system has calculated the payment to be zero.

This edit does not apply to any specific form locator.

**EDIT 0618 - VALID RATE FOR DATES OF SERVICE NOT FOUND ON RATE FILE**

This edit will post to a claim when it cannot be priced because there is no rate information available on the provider file for the date of service submitted. This edit only applies to Hospital and LTC claims. Contact with the State may be required.

This edit does not apply to any specific form locator.

**EDIT 0619 - VALID RATE FOR LEVEL-OF-CARE NOT FOUND ON RATE FILE**

This edit will post to a claim when it cannot be priced because no valid rate was found for this level of care in the provider rate file. The claim service date may be prior to the provider rate effective dates, or the level of care may not be present for the provider.

This edit does not apply to any specific form locator.

**EDIT 0620 - RECIPIENT NOT ELIGIBLE FOR FULL SERVICE PERIOD: CUTBACK**

This edit will post to a claim when the recipient was eligible on some of the submitted dates of service(s) but not all.

ADA	N/A
1500	N/A
UB-04	FL6
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	10 & 11

**EDIT 0621 - DRG CODE NOT ON FILE**

This edit will post to a claim when the DRG entered in Form Locator 71 of the UB-04 claim form is not recognized.

ADA	N/A
1500	N/A
UB-04	71
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**0622 - BILLED CHARGE AMOUNT MORE THAN PRIOR AUTHORIZED AMOUNT**

This edit will post to a claim when the prior authorized amount is less than the billed charge amount. The claim is being paid at the prior authorized amount.

This edit does not apply to any specific form locator.

**EDIT 0623 - MEDICAID ALLOWABLE AMOUNT PAID IN FULL BY MEDICARE**

This edit will post to a claim when Medicare payment exceeds the amount payable by Medicaid.

This edit does not apply to any specific form locator.

**EDIT 0624 - NO VALID PRICE FOR DATE OF SERVICE ON USUAL & CUSTOMARY FILE**

This edit will post to a claim when the HCPCS Procedure Code, the amount, and the date of service billed is compared to the Usual and Customary file and found that there is no price for the billed date of service.

This edit does not apply to any specific form locator.

**EDIT 0625 - MEDICAID ALLOWABLE AMOUNT REDUCED BY OTHER INSURANCE**

This edit will post to a claim when the Medicaid Claim allowed amount is to be reduced by the amount of any Third Party Liability, excluding payment by Medicare.

This edit does not apply to any specific form locator.

**EDIT 0626 - PAYMENT REDUCED TO MAC MAXIMUM**

This edit will post to a pharmacy claim when it is paid from the MAC price instead of charge.

This edit does not apply to any specific form locator.

**EDIT 0627 - PATIENT LIABILITY EXCEEDS ELIG CAP-NEW ADMIT**

This edit will post to a claim when the patient liability amount reported on the LTC claim exceeds the eligibility cap. The LTC Admit Date equals the claim service date.

This edit does not apply to any specific form locator.

**EDIT 0628 - PATIENT LIABILITY EXCEEDS ELIG CAP-CURRENT PATIENT**

This edit will post to a claim when the patient liability amount reported on the LTC claim exceeds the eligibility cap. The LTC Admit Date is less than the claim service date.

This edit does not apply to any specific form locator.

**EDIT 0629 - PATIENT LIABILITY CONFLICT - PAYMENT REDUCED**

This edit will post to a claim when a comparison between patient liability information reported by the facility and information maintained by the State is performed. If the amount maintained by the State is higher, the claim payment is automatically reduced and this edit is posted.

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	35

**EDIT 0630 - LTC LEAVE CUT BACK TO MAXIMUM ALLOWED**

This edit will post to a claim when the provider type is equal to:

**(LTC)** there are up to 24 therapeutic leave days allowed per calendar year and 10 bed hold hospital leave days allowed per leave.

**(RESIDENTIAL CENTER)** there are up to 14 therapeutic leave days per leave allowed and up to 14 bed hold hospital leave days per leave allowed. NOTE: There is no annual leave.

**(ICF-MR)** will not be paid for hospital or Medicare leave days. NOTE: Therapeutic leave days are paid.

**(PSYCHIATRIC HOSPITAL)** will not be paid for leave days.

This edit does not apply to any specific form locator.

**EDIT 0631 - OPTICAL APPLIANCE LENS REVIEW**

This edit will post to a claim when a review of the new lens prescription for lens power changes is required.

This edit does not apply to any specific form locator.

**EDIT 0633 - AMBULANCE/INVALID COACH < 16 MILES**

This edit will post to a claim when the procedure code is for an ambulance, the procedure modifier is "22" and the number of units (miles) is less than 16.

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	17B
MC-19	N/A
TAD	N/A

**EDIT 0634 - DRG CODE SUBMITTED PRIOR TO PROVIDER'S DRG PAYMENT DATE**

This edit will post to a claim when the following applies:

1. The claim is an inpatient hospital claim
2. The claim contains a DRG code
3. The DRG indicator on the Provider's File is equal to "Y"
4. The DRG payment date on the provider file is not equal to zeros and
5. The Date of Admission from the claim for an inpatient hospital claim is less than the DRG Payment Effective Date and greater than the DRG payment Expiration Date.

ADA	N/A
1500	N/A
UB-04	71
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0635 - LTC NEW ADMIT DATE OF SERVICE PRIOR TO ASSESSMENT DATE**

This edit will post to a claim when the admission date on the TAD form is before the initial assessment date.

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	8

**EDIT 0637 - MEDICARE COINSURANCE DAYS USED AS PAYABLE DAYS**

This edit will post to a claim when the Medicare coinsurance days are used as payable days for a LTC claim.

This edit does not apply to any specific form locator.

**EDIT 0638 - LTC PHARMACY PROVIDER NOT FOUND**

This edit will post to a claim when the provider file does not indicate that this LTC facility has selected a pharmacy to provide pharmaceutical services to its residents.

This edit does not apply to any specific form locator.

**EDIT 0639 - REFERRING PROVIDER MUST BE NURSING FACILITY**

This edit will post to a claim when the system determines that the beneficiary transferred from a LTC facility, and that facility's Medicaid provider number was not entered in Item 17A on the 1500 claim form.

ADA	N/A
1500	17A&17B
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0640 - INVOICE/PRICE LIST ATTACHED IS INVALID/INSUFFICIENT**

This edit will post to a claim when the pricing documentation submitted is invalid or insufficient.

This edit does not apply to any specific form locator.

**EDIT 0641 - RX FROM PHYSICIAN REQUIRED**

This edit will post to a claim when a review determined that this claim could not be manually priced without the prescription from the physician.

This edit does not apply to any specific form locator.

**EDIT 0642 - RESUBMIT CLM WITH INVOICE OR MANUFACTURER'S PRICE LIST**

This edit will post to a claim when it must be manually priced and the manufacturer's price list or invoice is not attached.

This edit does not apply to any specific form locator.

**EDIT 0643 - OUT OF REGION NON-DRG HOSPITAL REQ MAN PRICING FOR DOS**

This edit will post to a claim when an out of state hospital submits a claim that must be manually priced. The provider must resubmit attaching either the hospital's Medicaid Per Diem rate or Medicaid percentage of charge for the date(s) of service.

This edit does not apply to any specific form locator.

**EDIT 0644 - OUT OF REG NON-DRG HOSP REQ MAN PRICING-NO PROV RATE RECORD**

This edit will post to a claim when a hospital is out of the tri-state area and does not have a rate on file.

This edit does not apply to any specific form locator.

**EDIT 0645 - MISSING NEW YORK EXEMPT FACILITY RATE DATE**

This edit will post to inpatient claims submitted by New York hospitals that are exempt from DRG pricing and a DRG rate record is present for the billing provider.

This edit does not apply to any specific form locator.

**EDIT 0646 - MISSING NEW YORK REGIONAL BAD DEBT MULTIPLIER**

This edit will post to inpatient claims submitted by New York hospitals who are exempt from DRG pricing and a DRG rate record is present on the Provider File for the Provider Number billed.

This edit does not apply to any specific form locator.

**EDIT 0647 - MISSING PENNSYLVANIA DRG EXEMPT PER DIEM RATE**

This edit will post to inpatient claims submitted by Pennsylvania hospitals who are exempt from DRG pricing and a DRG rate record is present on the Provider File for the Provider Number billed.

**EDIT 0648 - INVALID NEW YORK EXEMPT UNIT RATE CODE**

This edit will post to inpatient claims submitted by New York hospitals when the Provider reports an invalid per diem rate code in fields 39 A,B,C,D - 41 A,B,C,D. For the UB-04 claim form the Provider would type or print 24 and a valid per diem rate code.

\*\*Valid per diem rate codes are 2852, 2853, 2908, 2957, 2959, 2993 and 2994.

ADA	N/A
1500	N/A
UB-04	39A,B,C,D thru 41A,B,C,D
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0649 - MISSING NEW YORK EXEMPT UNIT RATE**

This edit will post to inpatient claims submitted by New York hospitals when the claim is for an exempt unit of a New York DRG facility identified by a New York Rate Code equal to 2852, 2853, 2908, 2957 or 2993.

This edit does not apply to any specific form locator.

**EDIT 0650 - MISSING PENNSYLVANIA HOSPITAL FISCAL YEAR DATA**

This edit will post to a claim submitted by a Pennsylvania hospital subjected to DRG pricing; however, fiscal year data is not available.

This edit does not apply to any specific form locator.

**EDIT 0651 - MISSING PENNSYLVANIA DRG RATE DATA**

This edit will post to a claim when submitted by a Pennsylvania hospital subjected to DRG pricing; however, the Pennsylvania DRG rate data is not available.

This edit does not apply to any specific form locator.

**EDIT 0652 - MISSING NEW YORK DRG RATE DATA**

This edit will post to a claim when submitted by a New York hospital subjected to DRG pricing; however, the New York DRG rate data is not available.

This edit does not apply to any specific form locator.

**EDIT 0653 - MISSING NY DRG SERVICE INTENSITY WEIGHT**

This edit will post to a claim when submitted by a New York hospital subjected to DRG pricing; however, the New York service intensity weight information is not available for the DRG Trim File for the DRG code submitted.

This edit does not apply to any specific form locator.

**EDIT 0654 - MISSING NY DRG OUTLIER PERCENT**

This edit will post to a claim when submitted by a New York hospital subjected to DRG pricing; however, the claim qualifies as a high trim outlier and an entry cannot be located in the NY DRG Outlier Percentages where the claim service date thru is greater than or equal to the outlier percent effective date.

This edit does not apply to any specific form locator.

**EDIT 0655 - MISSING NEW YORK DRG ALC PER DIEM RATE**

This edit will post to a claim when submitted by a New York hospital subjected to DRG pricing and the claim contains charge(s) for ALC days (sum of Days SNF, Days ICF and Residential Days). The ALC Per Diem Rate information has not been provided for the billing provider number.

This edit does not apply to any specific form locator.

**EDIT 0656 - MISSING NJ DRG MARKUP FACTOR**

This edit will post to a claim when submitted by a New Jersey hospital subjected to DRG pricing for the Provider Number Billing and the occurrence of Markup Factor data cannot be found on the hospital record.

This edit does not apply to any specific form locator.

**EDIT 0657 - MISSING NJ DRG PAYOR FACTOR**

This edit will post to a claim when submitted by a New Jersey hospital subjected to DRG pricing for the Provider Number Billing and the DRG Payor Factor data cannot be found on the hospital record.

This edit does not apply to any specific form locator.

**EDIT 0658 - NO PROVIDER RATE RECORD FOR BILLING PROVIDER**

This edit will post to a claim a rate record is not present on the Provider Rate file for the Provider Number billing.

This edit does not apply to any specific form locator.

**EDIT 0659 - NF RATE NOT ON FILE**

This edit will post to a claim when submitted by a New Jersey hospital subjected to DRG pricing and the system has determined that the NF rate is not on file to allow the claim to continue processing.

This edit does not apply to any specific form locator.

**EDIT 0660 - NUMBER OF ACCOMMODATION DAYS NOT EQUAL TO TOTAL DAYS BILLED**

This edit will post to a claim when the total days billed (Acute+SNF+ICF+Residential) entered in Form Locator 6 on the UB-04 claim form does not match the number of room and board days (Revenue codes 100-219)

ADA	N/A
1500	N/A
UB-04	6 & 42
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0661 - INV/MISS DRG CODE**

This edit will post to a claim when the entry in Form Locator 71 on the UB-04 claim form is invalid or missing.

ADA	N/A
1500	N/A
UB-04	71
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0663 - USE PROPER PROCEDURE CODE-SEE NEWSLETTER P669 DATED 08/91**

This edit will post to a claim when the procedure code is 90742 or 90749 and the description on the claim is Acellular DTP, DaPT or DaTP, Acellular pertussis or rhogam.

ADA	N/A
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0664 - ITEM BILLED IS INCLUDED IN ADMINISTRATION/SUPPLY KIT**

This edit will post to a claim when a reviewed determined that this item should not be billed separately because payment is included in the administration or supply kit code.

This edit does not apply to any specific form locator.

**EDIT 0665 - PROCEDURE DESCRIPTION DOES NOT MATCH PRICE LIST**

This edit will post to a claim when, after review, it is determined that the provider used the wrong procedure code, e.g. the pricing documentation reflects gauze pads, but the procedure code reflects a linear yard dressing.

This edit does not apply to any specific form locator.

**EDIT 0667 - COMPUTED DRUG COST ALLOWANCE IS ZERO**

This edit will post to a claim when the calculated payment amount is equal to zero. The calculated payment amount might include: dispensing fee, TPL cutback, claim charge amount, special pricing, MAC pricing and calculating of unit price.

This edit does not apply to any specific form locator.

**EDIT 0668 - USE ASSIGNED PROC CODE/NDC CODE TO MATCH DESCRIPTION GIVEN**

This edit will posts to a claim when a review has determined that the procedure code or NDC does not match the description provided on the claim form.

ADA	29
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	25B
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0669 - DETAILED DESCRIPTION NEEDED FOR PROCEDURE CODE BILLED**

This edit will post to a claim when, after review, it was determined that the claim with attachments did not provide enough information to price it. The description on the component page does not match the corresponding data on the invoice or price list, or the pricing documentation is unacceptable. The description on the component page must include the name of the item (exactly as recorded on the invoice or price list) and the model, serial, or catalog number quantity. The listing on the component page must include:

The procedure code (This code must match the procedure code on the claim form)

The sequential number of the item (This number must be entered next to the circled data on the corresponding page of the invoice or price list)

The name of the item (This must match the invoice or price list)

The model number, the serial number or the catalog number (This number must match the invoice or price list)

The quantity: The component charge, the total item charge (This must match the charge on the component page and on the claim)

**EDIT 0670 - NO PAYMENT DUE - MEDICARE PAYMENT EXCEEDS MEDICAID ALLOWABLE**

This edit will post to a claim when the Medicare paid amount exceeds the Medicaid allowable amount. Medicaid, therefore, does not reimburse for the coinsurance and/or deductible amounts.

ADA	32
1500	29
UB-04	54
MC-6	26
MC-9	29
MC-12	21
MC-19	17
TAD	37

**EDIT 0671 - MEDICARE RATE NOT ON FILE**

This edit will post to a LTC claim when Medicare Rate information is needed in order to process the claim and cannot be found on the Provider Rate file for the claim dates of service.

This edit does not apply to any specific form locator.

**EDIT 0672 - SPLIT CLAIM RECIP ELIG ON DISCHARGE DATE ONLY-NO PMT DUE**

This edit will post to a claim for New Jersey inpatient hospital claims only. This edit is posted to the claim if the only day during the inpatient hospital stay when the recipient was eligible was the date of discharge.

ADA	N/A
1500	N/A
UB-04	6
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0673 - SPLIT CLAIM ALL ELIG DAYS ARE RESIDENTIAL-NO PAYMENT DUE**

This edit will post to a claim for New Jersey inpatient hospital claims only. This edit is posted to the claim if it is determined that the only days during the inpatient hospital stay when the recipient was eligible were residential days.

ADA	N/A
1500	N/A
UB-04	39-41, 42
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0674 - SPLIT CLAIM SNF/ICF DAYS AT/BELOW DRG HIGH TRIM-NO PMT DUE**

This edit will post to a claim for New Jersey inpatient hospital claims only. This edit is posted to the claim if it is determined that the only days during the inpatient hospital stay when the recipient was eligible were SNF and/or ICF days and all SNF and/or ICF days are at or below the DRG HIGH TRIM (Acute Days+SNF Days+ICF Days are less than or equal to DRG high trim).

ADA	N/A
1500	N/A
UB-04	39-41, 42
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0675 - SPLIT CLAIM NJ HIV OUTLIER CLAIM-SNF/ICF DAYS NOT PAYABLE**

This edit will post to a claim for New Jersey DRG HIV inpatient hospital claims only. This edit is posted to the claim if the claim is assigned an HIV outlier and it is determined that the only days during the inpatient hospital stay when the recipient was eligible were SNF and/or ICF days.

ADA	N/A
1500	N/A
UB-04	39-41, 71
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0682 - SERVICE / PRODUCT NOT MEDICAID ELIGIBLE**

This edit will post to a claim when it is a pharmacy claim and Medicaid does not cover the NDC.

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	15
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0690 - PROVIDER NOT PARTICIPATING IN REQUIRED PROGRAM.**

This edit will post to a claim when the provider does not participate with the program they are billing.

This edit does not apply to any specific form locator.

**EDIT 0691 - PROVIDER NOT PARTICIPATING IN REQUIRED PGM ON DATE OF SERVIC**

This edit will post to a claim when the provider does not participate with the program for the procedure code being billed.

This edit does not apply to any specific form locator.

**EDIT 0695 - ADJUSTMENT/VOID ALREADY IN PROCESS**

This edit will post to a claim when the system has determined that there is an adjustment or void for the claim already in process in the system.

This does not apply to any specific form locator.

**EDIT 0696 - CLAIM DENIED PROVIDER NOT RE-ENROLLED**

This edit will post to a claim when the provider's re-enrollment has not been completed.

This edit does not apply to any specific form locator.

**EDIT 0697 - CLAIM DENIED PROVIDER RE-ENROLLMENT NOT COMPLETED**

This edit will post to a claim when the provider's re-enrollment has not been completed.

This edit does not apply to any specific form locator.

**EDIT 0698 - COINSURANCE DAYS EXCEED MEDICARE MAXIMUM OF 30 DAYS**

This edit will post to a claim when the reported Medicare coinsurance days are greater than 30.

This does not apply to any specific form locator.

**EDIT 0699 - LIFETIME RESERVE DAYS EXCEED MEDICARE MAXIMUM OF 60 DAYS**

This edit will post to a claim when the reported Medicare lifetime reserved days are greater than 60.

This does not apply to any specific form locator.

**EDIT 0700 - CONFLICTING SAME DAY LAB SERVICE**

This edit posts when at least one other claim for lab services was paid for the same beneficiary on the same date of service. Below are the form locators that apply:

ADA	N/A
1500	24A
UB-04	45
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0701 - DUPLICATE CONSULTATION**

This edit posts when a claim for a comprehensive or initial consultation has already been paid within a year from the date of service on the current claim. These consultations are limited to one per beneficiary per provider per year. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0702 - SERVICE CONFLICTS WITH SIMILAR SAME DAY PROCEDURE**

The edit posts when the billed procedure code conflicts with a similar paid procedure for the same date of service. Below are the form locators that apply:

ADA	24 & 29
1500	24A & 24D
UB-04	44 & 45
MC-6	N/A
MC-9	25A & 25B
MC-12	17A & 17B
MC-19	14A & 14D
TAD	N/A

**EDIT 0703 - EPISIOTOMY INCLUDED IN DELIVERY CHARGE**

This edit posts when a charge for an episiotomy is billed separately from the delivery charge. The allowable amount for the delivery includes the allowable amount for the episiotomy. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0704 - OUTPATIENT ACUTE-ADULT PARTIAL HOSPITALIZATION - PA REQUIRED**

This edit posts to an outpatient claim with the following conditions:

1. Service date greater than or equal to 02/05/07
2. Outpatient revenue code of 913
3. Recipient is 22 years of age or older
4. A prior authorization number is not present

Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	10, 42, 45, 63
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0705 - CLAIM UNITS/DOLLARS EXCEEDS MAXIMUM - PA REQUIRED**

This edit posts if the number of units or dollars exceeds the program maximum allowed for this beneficiary. Prior authorization is required for further service. Below are the form locators that apply:

ADA	31
1500	24F & 24G
UB-04	46 & 47
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	14G & 14H
TAD	N/A

**EDIT 0706 - 30 DAY NEONATAL CARE LIMIT**

This edit posts when the maximum number of units (30) allowed for this neonatal procedure code has been reached. Below are the form locators that apply:

ADA	N/A
1500	24D & 24G
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0707 - 60 DAY NEONATAL CARE LIMIT**

This edit posts when the maximum number of units (60) allowed for this neonatal procedure code has been reached. Below are the form locators that apply:

ADA	N/A
1500	24D & 24G
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0708 - GLOBAL OB CARE/SERVICE CONFLICT**

This edit posts when individual prenatal, delivery, and postnatal services are billed in conjunction with a global obstetrical care code. Below are the form locators that apply:

ADA	N/A
1500	24D & 24G
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0709 - MULTIPLE SURGERY-PENDED FOR MANUAL REVIEW**

This edit posts to a claim when the system determines that there were multiple surgeries on the same date of service. This edit will pend the claim so that someone can manually review. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0710 - UNABLE TO DETERMINE LEAVE PERIOD-ADJUSTMENT MAY BE REQUIRED**

This edit posts to a long term care claim when the leave dates being reported have been paid on a previous claim. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	23-32

**EDIT 0711 - NF/DME CONFLICT REQUIRES PRIOR AUTHORIZATION**

This edit posts to a DME claim when the system determines that the Beneficiary resided in a Nursing Facility at the time the service was rendered. Prior Authorization is required. Below are the form locators that apply:

ADA	N/A
1500	23
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0712 - CLAIM UNITS/DOLLARS EXCEEDS MAXIMUM-DENY**

This edit posts when the number of units or dollars, on previously paid claims, have met the Medicaid allowable amount. Therefore, the current claim is denied. Below are the form locators that apply.

ADA	N/A
1500	24G
UB-04	46
MC-6	N/A
MC-9	25D
MC-12	17F
MC-19	14G
TAD	N/A

**EDIT 0713 - LAB TEST CONFLICT/LAB PANEL PROCEDURE PREVIOUSLY PAID**

This edit posts when the lab service on the current claim was previously paid as part of a lab panel procedure code. This edit does not apply to any specific form locator.

**EDIT 0714 - LAB TEST CONFLICT, INDIVIDUAL TEST(S) PREVIOUSLY PAID**

This edit posts to a claim when the Provider is billing for a lab panel test and the individual lab test has already been paid for. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	44 & 45
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0715 - MENTAL HEALTH SERVICES OVER \$400-NF/BOARDING HOME**

This edit posts when payment for mental health services provided to a beneficiary residing in a nursing facility or boarding home has exceeded the \$400.00 limit. Prior authorization is required for additional services. Below are the form locators that apply:

ADA	N/A
1500	23
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0716 - PROCEDURE INCLUDED IN THE PHYSICIAN VISIT**

This edit posts when the billed procedure is included in office visit. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0717 - PRIOR AUTHORIZATION UNITS/DOLLARS EXHAUSTED**

This edit posts when the units and or dollars on the prior authorization have all been used. Below are the form locators that apply:

ADA	2 & 31
1500	23, 24F, & 24G
UB-04	N/A
MC-6	16, 21, & 27
MC-9	Top right corner, 25D, & 25I
MC-12	Top right corner, 17F, & 17I
MC-19	N/A
TAD	N/A

**EDIT 0718 - HOSPITAL LEAVE OF ABSENCE EXCEEDS LIMIT**

This edit posts if the maximum payable bed hold days (ten for nursing facilities; fourteen for residential treatment centers) have been exceeded. Psychiatric hospitals and ICF/MR facilities are not paid for bed hold days. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	23-32

**EDIT 0719 - THERAPEUTIC LEAVE OF ABSENCE EXCEEDS LIMIT**

This edit will post to a claim when the therapeutic leave entered on the claim exceeds the allowed limit. Up to 24 therapeutic bed hold days per year are allowed for nursing facilities. 14 consecutive leave days are allowed for residential treatment centers. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	23-32

**EDIT 0720 - TARGETED CASE MANAGEMENT LIMIT EXCEEDED**

This edit posts when the Provider is billing for a range of procedure codes: Z5000-Z5004 and one of them has already been paid for the same month and the same beneficiary, either by the same or a different Provider. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0721 - CONFLICTING TARGETED CASE MANAGEMENT SERVICE**

This edit is posted to a claim if the Provider is billing for Z5004 within 365 (one year) of having been paid for Z5000, Z5001, Z5002, or Z5003. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0722 - SERVICE/VISIT CONFLICT**

This edit is used to prevent a payment of a claim for a visit that occurred within the post-op days limit associated with a paid surgery claim. Below are the form locators that apply:

ADA	24 & 29
1500	24A & 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0723 - LAB PANEL PROCEDURE CODE NOT ON FILE**

This edit posts when the individual procedure code, which corresponds to the lab panel procedure code, is invalid or not on file. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	14D
TAD	N/A

**EDIT 0724 - DATE(S) OF SERVICE DO NOT MATCH LAB PANEL PROCEDURE EFF DATE**

This edit posts when the claim service dates are not within the lab panel procedure from and procedure to dates on the procedure file. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	44 & 45
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0725 - BIOPSY D&C CONFLICT**

This edit posts when claims for both a biopsy and a D & C are submitted for the same date of service. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0726 - INDIVID LAB TESTS EXCEEDS PANEL ALLOWANCE -REDUCED PAYMENT.**

This edit posts when individual lab tests have been paid for this beneficiary, to the same provider on the same date of service. The payment for these tests has exceeded the Medicaid allowable for a lab panel, resulting in a reduced payment. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	44 & 45
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0727 - INDIVIDUAL LAB TESTS ALLOWANCE EXCEEDS PANEL ALLOWANCE**

This edit posts when individual lab tests have been paid for this beneficiary, to the same provider on the same date of service. The payment for these tests has exceeded the Medicaid allowable for a lab panel. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	44 & 45
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0728 - INDIVIDUAL LAB TEST/CBC CONFLICT**

This edit posts when a claim for a complete blood count for the same date of service has previously paid. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	44 & 45
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	14A & 14D
TAD	N/A

**EDIT 0729 - CLAIM PAYMENT REDUCED FOR PREVIOUSLY PAID VISIT**

This edit posts when the current claim reflects surgery and payment for a previously paid post-operative office visit is being recouped via this claim. Medicaid does not pay for post-operative office visits; the payment for surgery is considered inclusive. This edit does not apply to any specific form locator.

**EDIT 0730 - SPECIMEN COLLECTION GREATER THAN ONE**

This edit posts when a claim for specimen collection exceeds the Medicaid maximum of one per day. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	44 & 46
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0731 - THREE YEAR XRAY LIMITATION EXCEEDED**

This edit posts to a Dental claim for a complete mouth x-ray series, limited to once every three years has been submitted, and payment has already been made for this beneficiary within this time frame. Below are the form locators that apply:

ADA	24 & 29
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0732 - ADJUSTMENT TO DENTURES WITHIN 6 MONTHS OF DELIVERY**

This edit posts when a claim for a denture adjustment has been submitted within 6 months of the insertion date. Below are the form locators that apply:

ADA	24 & 29
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0733 - CLAIM EXCEEDS LIMIT OF ONE UNIT OF SERVICE**

This edit posts when the Medicaid limit for the billed service is one, and the number of units billed is greater than one. Below are the form locators that apply:

ADA	N/A
1500	24G
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0734 - SERVICE EXCEEDS PROGRAM FREQUENCY GUIDELINES**

This edit posts when the service billed exceeds the Medicaid frequency guidelines. This edit does not apply to any specific form locator.

**EDIT 0735 - INITIAL VISIT/ANNUAL EXAM/EPSTD EXAM LIMIT**

This edit posts when the service being billed is for an annual visit, and there was already one paid within the rolling year. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	14D
TAD	N/A

**EDIT 0737 - PAAD/SR GOLD RECIP REFILL > 12 MO FROM ORIGINAL PRESCRIPTION**

This edit posts if the recipient is enrolled in either PAAD or senior gold and the prescription number entered on the claim reflects a refill, but the original prescription was not paid within the last year. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	13
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0738 - REFILL EXCEEDS PROGRAM MAXIMUM**

This edit posts when six claims, with same prescription number, were paid within six months. A new prescription is required. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	13
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0739 - TRANSPORT CLAIM MUST PAY FIRST**

This edit posts for a transportation claim when the service being billed is for wait time and nothing else. The provider may resubmit the waiting time claim after the transportation claim is paid. This edit does not apply to any specific form locator.

**EDIT 0740 - OPT APP EXCEEDS PROGRAM LIMITATION**

This edit posts when the program limitation for optical appliances is exceeded. The Medicaid limit is one appliance service per year for beneficiaries younger than 19 or older than 60. For beneficiaries between the ages of 19 and 60, the limitation is every two years. This edit does not apply to any specific form locator.

**EDIT 0741 - PROCEDURE DENIED - COMPONENT PREVIOUSLY PD CLAIM**

After review for manual pricing, it was determined that the procedure is a component of a previously paid claim. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	25B
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0742 - PREVIOUS EXTRACTED TOOTH**

This edit posts when the history record indicates that the tooth number on which the service was provided had been previously extracted. After verifying that the correct tooth number was billed, the Provider must request prior authorization by completing the MC-10(A) form and sending in an X-ray to prove which tooth was extracted. Below are the form locators that apply:

ADA	27
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0743 - DENTAL X-RAYS - AGE LIMIT**

This edit posts when the maximum number of x-rays allowed for this service date is exceeded. The maximum number of units per day for beneficiaries 6 years of age and younger is 7. For ages 7 through 14 it is 11, and for ages 15 and above it is 15 units. This edit does not apply to any specific form locator.

**EDIT 0744 - PANORAMIC/INDIVIDUAL FILMS LIMIT**

The procedure codes for dental x-ray panoramic and individual films have limits by age, as indicated below. The panoramic film procedure equals 10 individual films. This edit posts when the panoramic limit is exceeded. The maximum number of units per day for beneficiaries 6 years of age and younger is 7. For ages 7 through 14 it is 11, and for ages 15 and above it is 15 units. This edit does not apply to any specific form locator.

**EDIT 0745 - HOSPITAL CALL/CONSULTATION CONFLICT**

This edit posts when claims are submitted for a hospital call and a consultation on the same date of service. Medicaid policy does not allow payment for both procedures on the same date. Below are the form locators that apply:

ADA	24 & 29
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0747 - PROPHYLAXIS LIMIT**

This edit posts when a claim for dental prophylaxis exceeds the Medicaid limit. The limit is once every six months for beneficiaries through the age of 17 and once per year for beneficiaries who are 18 years of age and over. Below are the form locators that apply:

ADA	29
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0748 - ORAL EXAMINATION LIMIT**

This edit posts when a claim for an oral examination exceeds the Medicaid limit. The limit is once every six months for beneficiaries through the age of 20, and once per year for beneficiaries who are 21 years of age and over. Below are the form locators that apply:

ADA	24 & 29
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0749 - ANESTHESIA SERVICE ALREADY PAID FOR SAME DATE OF SERVICE**

This edit posts when a claim is submitted for anesthesia service and a payment has been made for a similar service on the same date. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0750 - MULTIPLE ANESTHESIA ON THE SAME DAY**

This edit posts when two claims are submitted for the administration of anesthesia; one for the primary surgery (the code with the AA modifier) and the other for the insertion of the tube. The time for the latter service must be included with the former one. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0751 - PAYMENT REDUCED - SURGERY/VISIT LIMITATION**

This edit posts when it is determined that the procedure on the claim cannot be paid in full because payment for the same day office visit is inclusive. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0752 - VISIT OR SERVICE NOT PAYABLE WITH COMPREHENSIVE EYE EXAM**

This edit posts when a claim has been received for a comprehensive eye exam and an office visit, visual field exam, tonometry, or ophthalmoscopy on the same service date. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0753 - SURGERY/VISIT CONFLICT**

This edit posts when a claim has been received for both surgery and an office or hospital visit on the same date of service. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0755 - EARLY REFILL**

This edit posts to a pharmacy claim when, based on the quantity and day supply, it is too early for a refill. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	16 & 17
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0756 - DRUG SUPPLIED EARLY - REVIEW REQUIRED**

This edit only applies to pharmacy claims prior to 10/01/96, based on the quantity and day supply, it is too early for a refill. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	16 & 17
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0757 - DRUG SUPPLIED EARLY BY DIFFERENT PROVIDERS**

This edit only applies to pharmacy claims prior to 10/01/96, based on the quantity and day supply, it is too early for a refill. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	16 & 17
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0758 - SURGERY/ANESTHESIA CONFLICT - ANESTHESIA DENIED**

This edit posts when a claim has been submitted for anesthesia, and has been considered as being included with payment for the surgical procedure code. This edit does not apply to any specific form locator.

**EDIT 0759 - PAYMENT REDUCED - SURGERY ANESTHESIA CONFLICT**

This edit posts when a provider submits a claim for a nerve block and another for a surgical procedure. New Jersey Medicaid will not reimburse both procedures on the same date of service but will pay the higher of the two allowable amounts. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0760 - NORPLANT EXCEED 2 IN 5 YEARS - SAME PROVIDER**

This edit posts when the maximum number of Norplant implants in a five-year period exceeds two, and the billing provider has already been paid for two. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0761 - NORPLANT EXCEEDS 2 IN 5 YEARS - DIFFERENT PROVIDER**

This edit posts when the maximum number of Norplant implants in a five-year period exceeds two, and another provider has already been paid for two. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0762 - MENTAL HEALTH SERVICES EXCEED \$900**

This edit posts when a claim is submitted for mental health services in a private office setting, and the \$900 limit per rolling year is exceeded. Prior authorization is required for additional services. Below are the form locators that apply:

ADA	N/A
1500	24B & 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0763 - INDEPENDENT CLINIC MENTAL HEALTH SERV EXCEED \$6000**

This edit posts when a claim is submitted for mental health services provided by an independent clinic, and the \$6,000 limit per rolling year is exceeded. Prior authorization is required for additional services. Below are the form locators that apply:

ADA	N/A
1500	24B & 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0764 - PARTIAL CARE AND FULL DAY NOT PAYABLE ON SAME DAY**

This edit posts when a claim is received for both partial care and full day care for the same date of service. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0765 - DELIVERY/ABORTION PROCEDURE LIMITS**

This edit posts when the current claim conflicts with another paid claim. Medicaid allows payment for one abortion procedure, for the same beneficiary, during a 75-day period to the same or a different provider. For delivery procedures, Medicaid will pay one in a 183-day period to the same or a different provider. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0766 - WAIVER SERVICE CONFLICT**

This edit posts when a claim is submitted for two of the same type of waiver services for the same date of service. The Medicaid limit is one. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0767 - PARTIAL CARE/MEDICATION MANAGEMENT CONFLICT**

This edit posts when a claim is submitted for partial care (Z0180 and Z0170) and medication management (90862) for the same beneficiary on the same date of service. Medicaid policy does not allow payment for both services. Below are the form locators that apply:

ADA	N/A
1500	24A & 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0768 - EXCESSIVE PRIVATE DUTY NURSING HOURS-PA REQUIRED**

This edit posts when the Medicaid limit for private duty nursing service is exceeded. The limit is 16 hours per day. Prior authorization is required for hours in excess of 16.

The exceptions to this rule are procedure codes Z1710 WT, Z1730 WT and Z1735 WT. These codes always require prior authorization. Below are the form locators that apply:

ADA	N/A
1500	24D & 24G
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0769 - SECOND MENTAL HEALTH VISIT WITHIN 6 MONTHS**

This edit posts when two mental health visits are billed within 6 months of each other for a GSHP beneficiary. Only one is allowed in a 6 month period of time. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0770 - PROCEDURE CODE/NDC NOT INCLUDED IN PRIOR AUTHORIZATION**

This edit posts when the Medicaid Prior Authorization file does not include the procedure code or NDC entered on the claim. Below are the form locators that apply:

ADA	2 & 29
1500	23 & 24D
UB-04	44 & 63
MC-6	15 & 21
MC-9	25B & upper right hand corner
MC-12	17B & upper right hand corner
MC-19	N/A
TAD	N/A

**EDIT 0771 - DAY SUPPLY INCORRECTLY REPORTED AS ONE DAY.**

This edit posts if the days supply entry equals 1, but the entry for quantity is not 1, or vice versa. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	17
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0772 - PA/PROVIDER NOT AUTHORIZED**

This edit posts if the provider number entered on the claim does not match the provider number on the prior authorization file. Below are the form locators that apply:

ADA	2 & 52
1500	23 & 33B
UB-04	57 & 63
MC-6	21 & 23
MC-9	10 & upper right hand corner
MC-12	9 & upper right hand corner
MC-19	N/A
TAD	N/A

**EDIT 0773 - DATE OF SERVICE CONFLICT WITH PRIOR AUTHORIZATION DATE(S)**

This edit posts when the date of service on the claim is not within the authorized date span on the prior authorization file. Below are the form locators that apply:

ADA	2 & 24
1500	23 & 24A
UB-04	17 & 6
MC-6	12 & 17
MC-9	25A & upper right hand corner
MC-12	17A & upper right hand corner
MC-19	N/A
TAD	N/A

**EDIT 0774 - PRIOR AUTHORIZATION NOT ON FILE**

This edit posts if the prior authorization number entered on the claim is not on the prior authorization file. Below are the form locators that apply:

ADA	2
1500	23
UB-04	63
MC-6	21
MC-9	upper right corner
MC-12	upper right corner
MC-19	N/A
TAD	N/A

**EDIT 0775 - PA RECORD ON FILE IS NOT ACTIVE**

This edit posts if the prior authorization number entered on the claim form reflects a prior authorization that is either suspended or inactive. Below are the form locators that apply:

ADA	2
1500	23
UB-04	63
MC-6	21
MC-9	upper right corner
MC-12	upper right corner
MC-19	N/A
TAD	N/A

**EDIT 0776 - PA DOLLARS/UNITS EXHAUSTED-CUTBACK**

This edit posts if the number of units or dollar amount entered on the claim exceeds the number of available prior authorized units or dollar amounts. Below are the form locators that apply:

ADA	2 & 31
1500	23, 24F, & 24G
UB-04	46, 47, & 63
MC-6	16, 21, & 25
MC-9	25D, 25I, & upper right hand corner
MC-12	17F, 17I, & upper right hand corner
MC-19	N/A
TAD	N/A

**EDIT 0777 - GSHP PA ALREADY PROCESSED**

This edit will post if the prior authorization for a GSHP recipient has already been processed and there are no units available on the prior authorization listed on the claim. Below are the form locators that apply:

ADA	2
1500	23
UB-04	63
MC-6	17
MC-9	upper right corner
MC-12	upper right corner
MC-19	13A
TAD	N/A

**EDIT 0778 - NO IMMUNIZATION CODE PROVIDED ON THE SAME DAY OF SERVICE**

This edit posts if the claim form contains a code or codes for the administration of a vaccine but no vaccines are processed for the same date of service. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	14D
TAD	N/A

**EDIT 0779 - MEDICAID PRIOR AUTHORIZATION NUMBER INVALID**

One of the Prior Authorization numbers reported on the claim does not begin with the appropriate prefix 01-15 or is not numeric. Below are the form locators that apply:

ADA	2
1500	23
UB-04	N/A
MC-6	17
MC-9	upper right corner
MC-12	upper right corner
MC-19	N/A
TAD	N/A

**EDIT 0780 - GSHP PRIOR AUTHORIZATION NOT ON FILE**

This edit is posted to a claim when the recipient is a GSHP and the prior authorization number billed on the claim is not on file for the recipient ID and servicing provider number. Below are the form locators that apply:

ADA	2
1500	23
UB-04	63
MC-6	17
MC-9	upper right corner
MC-12	upper right corner
MC-19	13A
TAD	N/A

**EDIT 0781 - GSHP PRIOR AUTHORIZATION RECORD NOT ACTIVE**

This edit is posted to the claim when the recipient is a GSHP and Prior authorization was required for this procedure/service. The Prior Authorization File indicates that for this procedure/service the prior authorization record status code is not active. Below are the form locators that apply:

ADA	2
1500	23
UB-04	63
MC-6	N/A
MC-9	upper right corner
MC-12	upper right corner
MC-19	13A
TAD	N/A

**EDIT 0782 - GSHP DATE OF SERVICE CONFLICT WITH PRIOR AUTHORIZATION DATE**

This edit is posted to the claim when the recipient is a GSHP and the claim thru date is greater than the PA end date, or the claim from date is less than the PA begin date. Below are the form locators that apply:

ADA	2 & 24
1500	23 & 24A
UB-04	6, 45, & 63
MC-6	12
MC-9	25A & upper right corner
MC-12	17A & upper right corner
MC-19	13A & 14A
TAD	N/A

**EDIT 0783 - GSHP PROCEDURE NOT INCLUDED IN PRIOR AUTHORIZATION**

This edit is posted to the claim when the recipient is a GSHP and the PA File contains an authorization for this recipient, on this date of service and for this provider. The procedure code listed on the claim requires PA. The PA File does not contain the procedure code. Below are the form locators that apply:

ADA	29
1500	24D
UB-04	44
MC-6	N/A
MC-9	25C
MC-12	17B
MC-19	14D
TAD	N/A

**EDIT 0784 - GSHP PRIOR AUTHORIZED UNITS/DOLLARS EXHAUSTED**

This edit posts if the recipient is a GSHP beneficiary and the prior authorized units/visits/services/dollars authorized for the procedure have been exhausted. Below are the form locators that apply:

ADA	29 & 31
1500	24D& 24G
UB-04	44, 46 & 47
MC-6	N/A
MC-9	25C & 25D
MC-12	17B & 17I
MC-19	14D & 14G
TAD	N/A

**EDIT 0785 - MAINFRAME CLAIM NOT PRESENT ON POS HISTORY**

This edit posts if the claim that you're trying to adjust or void cannot be found on the POS history table. This edit does not apply to any specific form locator.

**EDIT 0786 - PREVIOUSLY DENIED CLAIM CANNOT BE ADJUSTED-RESUBMIT CLAIM**

This edit posts when the ICN on the adjustment form (FD-999) reflects a denied claim. Denied claims must be resubmitted, not adjusted. This edit does not apply to any specific form locator.

**EDIT 0787 - ADJUSTMENT CLAIM TYPE NOT MATCHED**

This edit posts to adjustment requests when the claim type of the adjustment does not match the claim on the history file. This edit does not apply to any specific form locator.

**EDIT 0788 - ADJUSTMENT DENIED/ORIG PAID CORRECTLY**

This edit posts when, after review, it is determined that the original claim processed correctly, and this adjustment (FD-999) should not be processed. This edit does not apply to any specific form locator.

**EDIT 0789 - FORMER ICN INVALID OR SPACES**

This edit posts to adjustment requests when the former ICN is invalid. This edit does not apply to any specific form locator.

**EDIT 0790 - INVALID ADJUSTMENT LOCATOR**

This edit posts when the adjustment request contains a field locator value that is invalid or inappropriate for the claim type. This edit does not apply to any specific form locator.

**EDIT 0791 - ADJUSTMENT REQUIRES MANUAL UPDATE**

This edit posts to an adjustment that requires a manual update in the system. This edit does not apply to any specific form locator.

**EDIT 0793- ADJUSTMENT PENDED FOR ARCHIVE CYCLE**

This edit is posted to an adjustment request that is in process. The claim will continue to process when the original claim file is reestablished at Gainwell Technologies. This edit does not apply to any specific form locator.

**EDIT 0794 - FINANCIAL CORRECTION REQUIRED**

This edit posts to an adjustment when the history record is missing for a financial adjustment or void and requires follow up by the Financial unit. This edit does not apply to any specific form locator.

**EDIT 0795 - CLAIM ADJUSTED BY SYSTEM - NEW ICN**

This edit posts when the system automatically updates the ICN to be adjusted (Former ICN) in the adjustment transaction. This edit does not apply to any specific form locator.

**EDIT 0796 - BILLING PROVIDER NOT MATCHED ON HISTORY**

This edit posts if the billing provider number on the original claim does not match the billing provider number entered on the adjustment form (FD-999). Below are the form locators that apply:

ADA	52A
1500	33B
UB-04	57
MC-6	10
MC-9	10
MC-12	9
MC-19	24
TAD	7

**EDIT 0797 - DUPLICATE ADJUSTMENT RECORDS ENTERED**

This edit posts to adjustment requests when the system locates an adjustment transaction with the same recipient ID and former ICN as the transaction previously processed. This edit does not apply to any specific form locator.

**EDIT 0798 - HISTORY RECORD ALREADY ADJUSTED OR VOIDED**

This edit posts when the ICN that was entered on the adjustment form (FD-999) has already been adjusted. This edit does not apply to any specific form locator.

**EDIT 0799 - NO CLAIM IN HISTORY FILE MATCHES ADJ/VOID REQUEST**

This edit posts if the data entered on the adjustment form (FD-999) does not match a paid claim in the history file. This edit does not apply to any specific form locator.

**EDIT 0800 - EXACT DUPLICATE CLAIM**

This edit posts when the current claim conflicts with an identical claim that has already been paid. This edit does not apply to any specific form locator for hardcopy claims.

**EDIT 0801 - POSSIBLE DUPLICATE CONFLICT**

This edit will post if an incoming claim meets the following criteria when matched against a previously paid claim. This edit does not apply to any specific form locator.

**EDIT 0802 - PHYSICIAN AND EPSDT DUPLICATE ERROR**

This edit posts when the current claim has already been paid to the same provider, but as a different claim type.

**EDIT 0803 - INPATIENT AND LTC DUPLICATE ERROR**

This edit posts when there is a paid inpatient or LTC claim for the same date of service or span dates.

**EDIT 0804 - INPATIENT AND OUTPATIENT DUPLICATE ERROR**

This edit posts when the current outpatient claim conflicts with a paid inpatient claim for the same hospital, the same beneficiary and has overlapping dates of service.

**EDIT 0805 - INPATIENT AND HOME HEALTH DUPLICATE ERROR**

This edit posts when the current home health claim conflicts with a paid hospital claim, or vice-versa.

**EDIT 0806 - LTC AND HOME HEALTH DUPLICATE ERROR**

This edit posts when a LTC or home health claim has been paid, and the LTC claim does not include a home leave period.

**EDIT 0807 - INPATIENT AND INSTITUTIONAL CROSSOVER DUPLICATE**

This edit posts when the current inpatient claim conflicts with an institutional crossover claim that has been paid with either the same or overlapping dates of service, or vice versa.

**EDIT 0809 - POSSIBLE DUPLICATE**

This edit posts when the current claim conflicts with a paid claim that has a revenue code with the same first two digits.

**EDIT 0810 - DUPLICATE BILL - OVERLAPPING DATES OF SERVICE**

This edit is posted when an incoming claim matches a previously paid claim. This edit does not apply to any specific form locator.

**EDIT 0812 - TRANSPORTATION AND INPATIENT HOSPITAL DUPLICATE ERROR**

This edit posts when the current transportation claim conflicts with a paid hospital claim. Hospitals are responsible for the cost of transporting patients from one hospital to another. If the hospital requested transportation, the transportation provider must request reimbursement from the facility.

**EDIT 0813 - OUTPATIENT AND INSTITUTIONAL CROSSOVER DUPLICATE ERROR**

This edit posts when the current Medicare institutional crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

**EDIT 0814 - PHYSICIAN AND PHYSICIAN CROSSOVER DUPLICATE ERROR**

This edit posts when the current Medicare physician crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

**EDIT 0815 - AMBULANCE AND AMBULANCE CROSSOVER DUPLICATE**

This edit posts when the current Medicare transportation crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

**EDIT 0816 - CLINIC AND CLINIC CROSSOVER CLAIM**

This edit posts when the current Medicare clinic crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

**EDIT 0817 - P&O AND P&O CROSSOVER DUPLICATE ERROR**

This edit posts when the current Medicare P & O crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

**EDIT 0818 - DME AND DME CROSSOVER DUPLICATE ERROR**

This edit posts when the current Medicare DME crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

**EDIT 0819 - LAB AND LAB CROSSOVER DUPLICATE ERROR**

This edit posts when the current Medicare laboratory crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

**EDIT 0820 - OPTOMETRIST AND OPTOMETRIST DUPLICATE ERROR**

This edit posts when the current Medicare optometrist crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

**EDIT 0821 - MIDWIFE AND MIDWIFE CROSSOVER DUPLICATE ERROR**

This edit posts when the current Medicare midwife crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

**EDIT 0822 - EPSDT AND EPSDT CROSSOVER DUPLICATE ERROR**

This edit posts when the current Medicare EPSDT crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

**EDIT 0823 - LTC AND LTC CROSSOVER DUPLICATE ERROR**

This edit posts when the current Medicare LTC crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

**EDIT 0825 - INPATIENT CLAIM CUTBACK BY PREVIOUSLY PAID OUTPATIENT CLAIM**

This edit posts to inpatient claims because the hospital had already been paid for an outpatient claim with one or more dates of service within the inpatient stay. The inpatient payment is reduced accordingly.

**EDIT 0826 - DUPLICATE OF PREVIOUSLY PAID CLAIM - DENIED AFTER REVIEW**

This edit posts to hardcopy pharmacy claims previously denied for 827. After review, it was determined that the reason for dispensing two prescriptions was not sufficiently explained, or the reason did not substantiate Medicaid reimbursement.

**EDIT 0827 - PHARMACY EXACT DUPLICATE BILL - SAME PROVIDER**

This edit posts when there is a paid claim on file for the same provider, same beneficiary, same date of service and the same NDC generic code.

**EDIT 0828 - PHARMACY EXACT DUPLICATE BILL - DIFFERENT PROVIDER**

This edit posts when the same claim was paid to another pharmacy.

**EDIT 0829 - EARLY REFILL SAME PROVIDER, DENIED AFTER REVIEW**

This edit posts when a pharmacy claim and the attached explanation for an early refill are reviewed and determined to be not payable.

**EDIT 0830 - EARLY REFILL - SAME PROVIDER**

This edit posts when the prescription being filled is not 85% use. If the Beneficiary is General Assistance the prescription can not be filled until 90% is gone.

**EDIT 0831 - EARLY REFILL- DIFFERENT PROVIDER, DENIED AFTER REVIEW**

This edit posts when a pharmacy claim and the attached explanation for an early refill are reviewed and determined to be not payable.

**EDIT 0832 - EARLY REFILL - DIFFERENT PROVIDER**

This edit posts for a early refill done by the same provider. Refills must be at least 85% used unless it is for a General Assistance then it must be 90% used.

**EDIT 0833 - CLAIM FOR CONTINUOUS LEAVE - NO PRIOR SERVICE DATE PAID CLAIM**

This edit posts when a beneficiary who receives Medicare benefits is admitted to a hospital, and the LTC facility entered leave code H instead of M on the TAD.

**EDIT 0837 - TBI BEHAVIOR PROGRAM EXCEED UNITS OF SERVICE**

The maximum number of units payable for Y7564 is four per calendar year. This edit posts because the history file indicates payment for four units.

**EDIT 0838 - PROVIDER PRODUCED EOB IS INCOMPLETE**

This edit posts when a claim is submitted with a computer generated EOMB, but after review, it is determined that the EOMB did not supply all the required data. It must always include 1) the beneficiary's name, 2) the amount billed to Medicare, 3) the Medicare allowed amount, 4) the date of service and 5) the coinsurance amount.

In addition, the following information must be included on the EOMB if applicable:

If Medicare denied the claim, the denial reason must be included.

If the beneficiary's name on the claim does not match the EOMB, the beneficiary's Medicare number must be included.

If the service date is over the timely filing limit, the EOMB must include the Medicare payment date and their Internal Control.

If a deductible amount is involved, it must be included.

**EDIT 0839 - ADJUSTMENT MUST HAVE CORRECTED CLAIM WITH ATTACHMENTS**

This edit posts when, after review of the adjustment request, it is determined that the EOMB or TPL attachment was not included with the FD-999.

**EDIT 0840 - EXACT DUPLICATE WITHIN GROUP PRACTICE**

This edit posts when the current claim conflicts with a paid claim for the same date of service, same beneficiary number, same procedure code, but a different servicing provider.

**EDIT 0841 - PROVIDER CANNOT BE SURGEON AND ASSISTANT SURGEON OR ANESTHESIOLOGIST**

This edit posts when the current claim conflicts with at least one other paid claim for the same servicing provider, and with the modifier 80 or AA or vice versa.

**EDIT 0842 - ADJUSTMENT MUST HAVE CORRECTED CLAIM ATTACHED**

This edit posts when, after review of this adjustment (FD-999), it is determined that the description did not identify the requested change, and a corrected claim was not attached to the FD-999. The provider must resubmit the adjustment with a corrected claim attached to the FD-999, and identify the requested change clearly and concisely in Item 5 on the FD-999.

**EDIT 0843 - ADJUSTMENT REQUEST NEEDS TO BE MORE SPECIFIC**

This edit posts when, after review of this adjustment (FD-999), it is determined that the description entered in Item 5 did not identify the requested change. The provider must resubmit the adjustment, and identify the requested change clearly and concisely in Item 5 on the FD-999.

**EDIT 0845 - ADJUSTMENT DENIED/EOMB REQUIRED**

This edit posts when, after review of this adjustment (FD-999), it is determined that the Explanation of Medicare Benefits (EOMB) must also be reviewed before the adjustment can be processed. The EOMB is required for all Medicare crossover adjustments.

**EDIT 0846 - ADJUSTMENT MUST HAVE RA ATTACHED**

This edit posts when, after review, it is determined that all Remittance Advice (RA) pages relevant to the paid claim were not attached to the FD-999, and those pages are essential for the review. The provider must resubmit the FD-999 with the relevant RA pages.

**EDIT 0847 - INCORRECT ICN ON FD-999**

This edit posts when, after review, it is determined that the beneficiary's name on the paid claim matches the name on the FD-999, but other claim data (diagnosis code, procedure code etc.) does not match the attached claim form.

**EDIT 0848 - ADJUSTMENT CLAIM MISSING PAYER/CARRIER CODE/OR TPL PAYMENT**

This edit posts when, after review, it is determined that the adjustment (FD-999) cannot be processed because the payer, carrier code and/or TPL payment amount was not entered either in Item 5 of the FD-999 or on the attached claim. The provider must resubmit the correct FD-999 with a correct claim form.

**EDIT 0849 - RENTAL DENIED PURCHASE WITHIN 24 MONTHS**

This edit posts to a DME claim when the system shows that there has been a purchase for the same procedure code paid to the same provider for the same beneficiary within a 24 month period. This edit does not apply to any specific form locator.

**EDIT 0851 - RENTAL DENIED 6 WITHIN 24 MONTHS.**

This edit posts to a DME claim when the system shows that there has been a purchase for the same procedure code paid to the same provider for the same beneficiary within a 24 month period. This edit does not apply to any specific form locator.

**EDIT 0852 - RENTAL DENIED 10 WITHIN 24 MONTHS.**

This edit posts to a DME claim when the system shows that there were already 10 months paid for the same procedure, for the same beneficiary and provider within a 24 month period. Any rental over \$100.00 is only eligible to be paid for 10 months after that, it is considered a purchase. This edit does not apply to any specific form locator.

**EDIT - 0853 PURCHASE DENIED 6 RENTALS WITHIN 24 MONTHS.**

This edit posts to a DME claim when the system shows that there were 6 rentals paid for the same procedure, for the same beneficiary and provider within a 24 month period. This edit does not apply to any specific form locator.

**EDIT - 0854 PURCHASE DENIED 10 RENTALS WITHIN 24 MONTHS.**

This edit posts to a DME claim when the system shows that there were 10 rentals paid for the same procedure, for the same beneficiary and provider within a 24 month period. This edit does not apply to any specific form locator.

**EDIT - 0855 PURCHASE DENIED 1 IN 24 MONTHS**

This edit posts to a DME claim when the system shows that there was a payment made for a purchase of the same procedure, for the same beneficiary and provider within a 24 month period. This edit does not apply to any specific form locator.

**EDIT 0857 - WEEKLY PCA/MENTAL HEALTH HRS EXCEED 25 HRS**

This edit posts because the maximum hours for Personal Care Assistant mental health services has been exceeded. It is 25 hours a week per beneficiary.

**EDIT 0858 - WEEKLY PCA HOURS EXCEED 40 HRS**

This edit posts because the maximum hours for Personal Care Assistant services has been exceeded. It is 40 hours a week per beneficiary.

**EDIT 0859 - CLAIM OVERLAPS WEEK**

This edit posts because the service week for Personal Care Assistant services overlaps from one week to the next. The PCA workweek starts at 12:01 am on Sunday and ends at 12:00 Midnight on Saturday.

**EDIT 0860 - PROCEDURE CODE MODIFIERS IN CONFLICT**

This edit posts for a DME claim when there is either a paid purchase or rental already on file.

**EDIT 0861 - LIMIT OF 6 CONSECUTIVE RENTALS EXCEEDED**

This edit posts when the rental period for DME has been exceeded, and the item is considered purchased.

**EDIT 0862 - LIMIT OF 10 CONSECUTIVE RENTALS EXCEEDED**

This edit posts when the rental period for DME has been exceeded, and the item is considered purchased.

**EDIT 0865 - LTC AND HOSPICE DUPLICATE ERROR**

This edit posts when a LTC and Hospice claim have the same or overlapping dates of service for the same beneficiary.

**EDIT 0866 - CUTBACK / PAYMENT REDUCED BY PRIOR RENTALS**

This edit posts to DME claims and indicates consecutive rentals just prior to the purchase. Medicaid reduces the payment by the number of prior consecutive rentals.

**EDIT 0867 - PCA SERVICES > 25 HRS & VALID PA NUMBER IS NOT ON CLAIM**

This edit posts when weekly Personal Care Assistant services for this beneficiary exceed 25 hours. A "week" begins at 12:01 am on Sunday and ends at 12:00 midnight on Saturday.

**EDIT 0868 - PCA UNITS OF SERVICE EXCEEDS WEEKLY ALLOWABLE ON THE PA**

This edit posts when the weekly Personal Care Assistant services for this beneficiary have exceeded the available hours on the prior authorization file.

**EDIT 0869 - POSSIBLE (SEVERE) DD CONFLICT - 30 DAY EXIT**

This is an EOB edit that will determine if the drug billed will cause severe harm to the beneficiary if taken with another drug at the same time. It posts if the generic code is subject to the 30-day supply extension defined by the Medical Exception process.

**EDIT 0870 - POSSIBLE WARFARIN CONFLICT**

This EOB edit will determine if the drug billed will cause severe harm to the beneficiary if taken with another drug at the same time. It will post if there is a claim on history for the beneficiary with a Standard Therapeutic Class that conflicts with the new claim.

**EDIT 0872 - KIDCARE THERAPY SERVICE LIMITS**

This edit posts when benefits to this beneficiary, limited to 60 visits for speech, occupational and physical therapy per HMO contract, have been exceeded within the contract year. The contract year starts on 10/01 and ends on 09/30.

**EDIT 0873 - KIDCARE D MENTAL HEALTH SERVICE EXCEEDED**

This edit posts when benefits to this beneficiary, limited to 35 inpatient days and 40 outpatient services per calendar year, have been exceeded.

**EDIT 0875 - FAMILY CARE PE FUNDS EXHAUSTED**

This edit posts because the available funds to pay for services rendered to Family Care presumptively eligible (PE) patients are limited. Prior Family Care PE claims have exhausted the State's fiscal limit. The fiscal year is from July 1 through June 30.

**EDIT 0876- CO-PAY FOR SERVICE DATE PAID**

This edit posts when there is a previously paid outpatient co-pay claim on file for the same provider, same beneficiary and same or overlapping dates of service.

**EDIT 0878 - NO EMERG CLAIM FOR ALIEN TRANS**

This edit is posted to emergency transportation claims with specific procedure codes for a beneficiary on a special program without an additional emergency claim on file for the same day.

**EDIT 0880 - CUMULATIVE RETRO REVIEW**

This EOB edit posts when the threshold for the drug billed is exceeded by prior claims.

**EDIT 0881 - URO / DRG ADJUST - REQUEST DENIED**

This edit advises providers that the claim they are attempting to void or adjust has already been adjusted based on a Utilization Review audit.

**EDIT 0884 - CLAIM DENIED, SUBMIT DME CLAIM TO MEDICARE**

This edit posts when a beneficiary is eligible for Medicare, and the billed drug is payable by Medicare.

**EDIT 0885 - NON-PARTIC PHARM PROV SVE W/PA**

This EOB edit posts to override edit 893, which denies a claim because the beneficiary's file reflects other coverage.

**EDIT 0886 - OVERRIDE EDIT 893 NOT NECESSARY**

This EOB edit indicates that the beneficiary has no other coverage on file. However, an Other Coverage code of 1 was incorrectly reported on the claim.

**EDIT 887 - POS/MATCHING HISTORY NOT FOUND**

This edit posts to Pharmacy POS claims only when no matching ICN is found for the adjustment/void submitted for processing. This edit does not apply to any specific form locator.

**EDIT 0892 - NO INSURANCE COVERAGE KNOWN, BUT INSURANCE PAYMENT REDUCED**

This edit posts to a pharmacy claim when the beneficiary's eligibility file does not reflect other coverage, but the provider received an insurance payment.

**EDIT 0893 - INSURANCE COVERAGE KNOWN, OTHER COVERAGE CODE = 0**

This edit posts to pharmacy claims when the beneficiary has other coverage, but the other coverage indicator is 0, reflecting no specified coverage.

**EDIT 0894 - OVERRIDE FOR EDIT 893**

This edit will override edit 893 when the pharmacy reports the other coverage indicator of 1.

**EDIT 0895 - TPL PAYMENT CONFLICTS WITH OTHER COVERAGE CODE**

This edit posts to pharmacy claims when the other coverage indicator denotes no coverage, no coverage for the product, or payment not collected.

**EDIT 0896 - NO INSURANCE PAYMENT RECEIVED, BUT OTHER COVERAGE CODE = 2**

This edit posts to pharmacy claims when no other insurance payment is reported on the claim, but the pharmacist reported the other coverage indicator of 2.

**EDIT 0901 - MULTIPLE SURGERY - PAID AS PRIMARY PROCEDURE**

This edit posts when more than one surgery is billed for the same date of service, and only the primary surgery is paid at the Medicaid allowable amount. The primary surgery reflects the one with the highest Medicaid allowable. The other "secondary" surgeries are paid at 50 percent of the Medicaid allowable up to a maximum of 200 percent of the primary surgery payment amount. Surgeries beyond this threshold are paid at zero.

**EDIT 0902 - MULTIPLE SURGERY - PAID AS SECONDARY PROCEDURE**

This edit posts to all secondary surgeries paid at 50 percent of the Medicaid allowable.

**EDIT 0903 - MULTIPLE SURGERY - PRIMARY PROCEDURE REDUCED BY PRIOR PAID CLAIM**

This edit posts when a primary surgery claim is processed after the secondary surgeries. The amount that was previously paid, because it was paid as primary, is recouped and reflected as a cutback on this claim.

**EDIT 0904 - MULTIPLE SURGERY - ZERO PAID, 200 % LIMIT EXCEEDED**

This edit posts to a secondary surgery when the 200 percent threshold has been reached.

**EDIT 0905 - MULTIPLE SURGERY - REDUCED BY INCIDENTAL PROCEDURE**

This edit posts when a primary surgery claim is processed after the secondary surgeries, and 100 percent of the previous payment is recouped and reflected as a cutback on this claim.

**EDIT 0906 - MULTIPLE SURGERY - ZERO PAID, INCIDENTAL PROCEDURE**

This edit posts to a secondary surgery because Medicaid determined that this surgery is incidental to one of the other surgeries and is not payable.

**EDIT 0907 - MULTIPLE SURGERY - FIRST UNIT PRIMARY, ADDITIONAL AS SECONDARY**

This edit posts to a claim reflecting multiple units with a procedure code representing surgery. One of the units on the claim is priced as primary (100 percent of the Medicaid allowable) while the remaining units are priced as secondary (50 percent of the Medicaid allowable) up to 200 percent of the primary payment.

**EDIT 0910 - PAYMENT EXCEEDS THRESHOLD**

This edit posts when a review determines that this claim is not payable because it would exceed the Medicaid threshold.

**EDIT 0914 - NICU PROCEDURES INCLUDED IN GLOBAL FEE**

This edit posts when the current claim is for a general procedure that was already included in the payment for neonatal intensive care.

**EDIT 0915 - MULTIPLE LTC/HOSPICE CLAIMS PROCESSED SAME MONTH AND YEAR**

This edit is posted when multiple LTC/Hospice claims are processed for the same calendar month and year. The patient payment amount of the claim will be set to zero. This edit does not apply to any specific form locator.

**EDIT 0916 - SEVERE DRUG / DRUG INTERACTION**

This edit establishes Drug Utilization Review (DUR) standards for the duration of the drug. It monitors severe interaction between two or more drugs.

**EDIT 0917 - MODERATE DRUG / DRUG INTERACTION**

This edit establishes Drug Utilization Review (DUR) standards for the duration of the drug. It monitors moderate interaction between two or more drugs.

**EDIT 0919 - DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR NJ**

This edit will post to a claim when the second claim submitted to Gainwell Technologies has denied when the first claim is paid in a NJ Hospital readmission occurrence. A readmission occurrence in NJ is when the discharge and readmission dates are at the same hospital for the same beneficiary with the same or similar principle diagnosis codes within seven (7) days.

For these readmissions, hospital stays must be combined for pricing purposes. However, if the hospital does not agree that the two stays should be combined, they can appeal the denied claim as described in the June 1998 Newsletter Volume 8 No. 44 and Newsletter Volume 22 No. 10 for Hospital Readmissions.

**EDIT 0920 - DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR PA**

This edit will post to a claim when the second claim submitted to Gainwell Technologies has denied when the first claim is paid in a PA Hospital readmission occurrence. A readmission occurrence in PA is when the discharge and readmission dates are at the same hospital for the same beneficiary with the same or similar principle diagnosis codes within thirty-one (31) days.

For these readmissions, hospital stays must be combined for pricing purposes. However, if the hospital does not agree that the two stays should be combined, they can appeal the denied claim as described in the June 1998 Newsletter Volume 8 No. 44 and Newsletter Volume 22 No. 10 for Hospital Readmissions.

**EDIT 0921 - MILD DRUG / DRUG INTERACTION**

This edit establishes Drug Utilization Review (DUR) standards for the duration of the drug. It monitors mild interaction between two or more drugs.

**EDIT 0922 - PREGNANCY PRECAUTION -DUR**

This edit establishes Drug Utilization Review (DUR) standards for the duration of the drug. It monitors potential pregnancy drug conflicts.

**EDIT 0924 - DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR NY**

This edit will post to a claim when the second claim submitted to Gainwell Technologies has denied when the first claim is paid in a NY Hospital readmission occurrence. A readmission occurrence in NY is when the discharge and readmission dates are at the same hospital for the same beneficiary with the same or similar principle diagnosis codes within thirty (30) days.

For these readmissions, hospital stays must be combined for pricing purposes. However, if the hospital does not agree that the two stays should be combined, they can appeal the denied claim as described in the June 1998 Newsletter Volume 8 No. 44 and Newsletter Volume 22 No. 10 for Hospital Readmissions.

**EDIT 0925 - UTILIZATION REVIEW APPROVAL MISSING/INCORRECT**

This edit is posted as a denial if the hospital's readmission appeal for two stays instead of one stay is denied by the State and the claims must be combined as described in the June 1998 Newsletter, Volume 8, No. 44 for Hospital Readmissions.

The claim paid if the hospital's readmission appeal for two stays instead of one stay was approved by the State. (Please see edit codes 919, 920 and 924).

**EDIT 0926 - AUTHORIZATION FOR ORTHO SERVICES EXCEEDED PA REQUIRED**

This edit posts to a dental claim for orthodontic services for procedure code D8080 that exceeds 2 years from the date of initial payment. Pa is now required.

**EDIT 0927 - DUR EDIT POSTED - PA REQUIRED AFTER 30 DAYS SUPPLIED**

This edit posts to pharmacy claims to notify the pharmacist that a prescription exceeds the DUR standards and will require prior authorization if the next claim for the drug exceeds the 30 day extension.

**EDIT 0928 - DUR EDIT POSTED, 30 DAY SUPPLY PARTIALLY EXHAUSTED, PA REQUIRED**

This edit posts to notify the pharmacist that the prescription exceeds the DUR standards and the 30-day supply extension. To receive full payment, prior authorization is required.

**EDIT 0929 - DUR EDIT - ALLOWABLE 30 DAY SUPPLY EXHAUSTED - PA REQUIRED**

This edit posts to notify the pharmacist that the prescription exceeds the DUR standards and the 30-day supply extension. To receive payment for the claim, prior authorization is required.

**EDIT 0930 - BED-HOLD EXCEEDS MAXIMUM OF 10 CONSECUTIVE DAYS**

This edit posts when the bed-hold maximum of 10 consecutive days is exceeded.

**EDIT 0931 - OVERLAPPING DATES OF SERVICE FOR PROCEDURE CODE GROUP**

This edit will post to a claim when one of the following procedure codes may be billed for the same day of service:

- S9126 - Hospice In Home Care
- Y6333 or T2042 - Routine Home Care
- Y6334 or T2043 - Continuous Home Care
- Y6335 or T2044 - Inpatient Respite Care
- Y6336 or T2045 - General Inpatient Care
- Y6337 - Therapeutic Leave Days
- Y6338 - Bed Hold Days
- Z2015 - Room and Board

ADA	N/A
1500	FL24A and FL24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 0932 - THERAPEUTIC LEAVE EXCEEDS MAXIMUM TO 24 CONSECUTIVE DAYS**

This edit posts when the therapeutic leave maximum of 24 days within a year is exceeded.

**EDIT 0935 - GENERAL INPATIENT CARE AND INPATIENT CLAIM BILLED SAME DAY**

This edit posts when a current claim with procedure code Y6336 or T2045 conflicts with a paid inpatient claim for the same date of service, or vice versa.

**EDIT 0936 - INPATIENT RESPITE CARE EXCEEDS MAXIMUM OF 5 CONSECUTIVE DAYS**

This edit posts when the maximum, per occurrence, for inpatient respite care (Y6335) of 5 days is exceeded.

**EDIT 0939 - RECIPIENT IS MEDICARE PART A ELIGIBLE**

This edit posts when it is determined that the services on the claim are payable by Medicare. The provider must bill Medicare Part A first.

**EDIT 0941 - SENIOR GOLD CO-PAY APPLIED FROM VOIDED CLAIM**

This EOB edit posts when the cutback dollar amount for a Senior Gold beneficiary is not recalculated because the same prescription was filled and voided.

**EDIT 0944 - PROCEDURE CODE AND/OR CHARGES ON CLAIM DO NOT MATCH EOB**

This edit posts when, after review of the Medicare EOB, it is determined that the TPL payment amount from the EOB is missing from the claim.

**EDIT 0947 - MEDICARE OUTPATIENT PART B EOMB MISSING**

This edit posts when a review determines that Payer Code 015 was on the claim, but the Medicare Part B EOMB was not attached.

**EDIT 0949 - CLAIM VOIDED - BILLING PROVIDER ERROR**

This edit explains an adjustment when a provider billed under the wrong provider number.

**EDIT 0952 - CLAIM VOIDED - RECIPIENT ID ERROR**

This edit explains an adjustment when a provider billed under the wrong beneficiary id number.

This edit explains an adjustment done from a service not provided.

**EDIT 0954 - CLAIM VOIDED - SYSTEM PROCESSING ERROR**

This edit explains an adjustment from a system error.

**EDIT 0955 - CLAIM VOIDED; RESUBMITTED AS ORIGINAL CLAIM**

This edit posts when a claim has been voided and reprocessed.

**EDIT 0956 - CLAIM REPROCESSED TO CORRECT PAYMENT**

This is an informational edit only to advise that the claim has been reprocessed to correct a previous payment.

This edit does not apply to any specific form locator.

**EDIT 0957 - CLAIM CORRECT OR REPROCESSED BY REQUEST**

This edit posts to an adjusted claim to specify that it is a Provider requested adjustment. This edit does not apply to any specific form locator.

**EDIT 0959 - CLAIM UPDATED WITH TPL PAYMENT**

This edit explains an adjustment involving third party insurance.

**EDIT 0960 - CLAIM UPDATED WITH PATIENT PAYMENT**

This EOB edit explains an adjustment involving beneficiary liability.

**EDIT 0961 - SYSTEM UPDATE TO PATIENT INCOME**

This EOB edit explains an adjustment involving system-generated updates to beneficiary income.

**EDIT 0962 - ADJUSTMENT OR VOID CORRESPONDS TO PROVIDER REFUND**

This EOB edit explains an adjustment involving a provider refund.

**EDIT 0965 - MEDICARE INPATIENT PART A EOMB MISSING**

This edit posts when a review determines that Payer Code 011 was on the claim, but the Medicare Part A EOMB was not attached.

**EDIT 0966 - MEDICARE INPATIENT PART B EOMB MISSING**

This edit posts if a review determines that this beneficiary has Medicare Part B. A provider must bill Medicare Part B first.

**EDIT 0970 - BILL THIRD PARTY CARRIER FIRST**

This edit is posted if the TPL file contains coverage data in effect for the beneficiary on the service dates billed on the claim. The TPL EOB must be attached to the claim with the corresponding carrier or payer code indicated in the appropriate field on the claim. Below reflects the form locators related to this edit:

ADA	11
1500	10D and 11D
UB-04	50 & 60
MC-6	28
MC-9	7
MC-12	8
MC-19	N/A
TAD	N/A

**EDIT 0971 - MISSING CARRIER CODE/PAYER CODE**

This edit is posted if the TPL carrier/payor code is not coded on the claim. This code is used to identify the other insurance and the presence of an attached EOB. Below reflects the form locators related to this edit:

ADA	11
1500	10D
UB-04	50
MC-6	28
MC-9	7
MC-12	8
MC-19	N/A
TAD	N/A

**EDIT 0972 - NO EOB ATTACHED; RECIPIENT WITH OTHER RESOURCE INDICATED**

This edit posts when a three-digit carrier code or payer code is present on the claim but the EOB or letter of denial was not submitted with the claim.

**EDIT 0973 - CLAIM REQUIRES REVIEW FOR MULTIPLE TPL RESOURCE**

This edit posts when a claim is received with multiple carrier or payer codes and a payment amount from third party sources. The sum of payments on the EOB attachments, including zero payments must equal the TPL amount on the claim.

**EDIT 0974 -TPL PAYMENT ON EOB MISSING FROM CLAIM**

This edit will post when the claim contains carrier codes and the TPL EOB payment was not billed on the claim.

ADA	32
1500	29
UB-04	54
MC-6	26
MC-9	29
MC-12	21
MC-19	29
TAD	N/A

**EDIT 0975 - RESOURCE FILE INDICATES INSURANCE OTHER THAN THAT BILLED**

This edit is posted when the recipient has private insurance and the carrier code was missing from the claim or the carrier code does not match the resource file. Below are the form locators that relate to this edit:

ADA	11
1500	10D
UB-04	50
MC-6	22
MC-9	7
MC-12	8
MC-19	9
TAD	N/A

**EDIT 0976 - MEDICAID PAYMENT REDUCED BY OTHER INSURANCE**

This edit posts because the claim reflects a TPL amount that has been subtracted from the Medicaid tentative allowable amount. If there has been no prior payment, then the amount paid field must be blank or \$0. Below are the claim forms and the form locators that apply:

ADA	32
1500	29
UB-04	54
MC-6	26
MC-9	29
MC-12	21
MC-19	17
TAD	36

**EDIT 0979 - RECIPIENT IS MEDICARE PART B ELIGIBLE**

This edit posts when the beneficiary is eligible for Medicare/Medicare HMO, and Medicare covers the procedure code entered on the claim. The provider must bill Medicare, or resubmit with the Medicare EOMB attached to the claim. This edit does not apply to any specific form locator.

**EDIT 0980 - EOB ATTACHED FOR CARRIER/PAYER NOT REPORTED ON CLAIM**

This edit posts because, after review, it is determined that either the attached EOB does not match the carrier code or payer code entered on the claim, or an EOB is missing that corresponds to a carrier code or payer code that appears on the claim.

**EDIT 0981 - RECIPIENT/DATES OF SERVICE DO NOT MATCH EOB**

This edit posts when, after review, it is determined that either the date of service or the beneficiary's name does not match the EOB.

**EDIT 0982 - EOB INDICATES BILLING ERROR, REBILL TO CARRIER**

This edit posts when the EOB or EOMB attached to the claim indicates that another insurance company or Medicare denied the claim for a correctable error. Because Medicaid is the payer of last resort, the other carrier must be re-billed.

**EDIT 0983 - RESOURCE FILE INDICATES INSURANCE OTHER THAN PAYER CODE CODED**

This edit posts when the payer code entered on the UB-92 Claim Form is not listed on the Medicaid TPL resource file. The provider must enter payer code that identifies the beneficiary's other carrier.

**EDIT 0984 - CLAIM REQUIRES REVIEW-MEDICARE PART B ATTACHMENT**

This edit will post to a claim when the service billed in covered by Medicare Part B. The claim requires review for validation of services, service dates, beneficiary name and other information on the EOMB against the claim.

This edit does not apply to any specific form locator.

**EDIT 0985 - TPL PAYMENT ON CLAIM DOES NOT EQUAL PROVIDER PAYMENT ON EOBs**

This edit posts when, after review, it is determined that the TPL payment indicated on the EOB does not match the payment amount entered on the claim form.

**EDIT 0986 - INVALID PAYER ID**

This edit posts if a payer code entered on the claim is not listed on the Medicaid TPL Resource file.

**EDIT 0993 - CLAIM DENIED AT PROVIDER REQUEST**

This edit is manually applied when a provider requests that a claim in process be denied for any reason.

**EDIT 0994 - PRIOR PAY AMOUNT MISSING OR DOES NOT MATCH**

This edit posts when, after review, it is determined that the TPL payment on the EOB does not match the payment amount entered on the claim form.

**EDIT 1001 - REVENUE UNITS ( 45 LINES) ARE GREATER THAN 999**

This edit posts when the claim being billed (up to 45 lines) has revenue units greater than 999.

**EDIT 1002 - DAYS ACUTE ARE GREATER THAN 999**

This edit posts when the claim being billed has more than 999 acute days.

**EDIT 1003 - DAYS SNF ARE GREATER THAN 999**

This edit posts when the claim being billed has more than 999 SNF days.

**EDIT 1004 - DAYS ICF ARE GREATER THAN 999**

This edit posts when the claim being billed has more than 999 ICF days.

**EDIT 1005 - DAYS RESIDENTIAL ARE > 999**

This edit posts when the claim being billed has more than 999 Residential days.

**EDIT 1007 - SUD PLACE OF SERVICE RESTRICTION**

This edit will post to substance abuse claims when the place of service on the claim does not include the place of service allowed for the procedure code that is on the claim. This edit will only post if the provider is an independent clinic and the procedure code has an "HF" modifier. Below are the form locators that apply:

ADA	N/A
1500	24B, 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1011 - NOT A FAMILY PLANNING SVC/NOT ATTESTED PLANNING SVC**

This edit will post to a claim when the claim is not a Professional, Professional Crossover, Outpatient, Outpatient crossover and the procedure code billed was not attested as a family planning service. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	44
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1015 - DDD/IME CLAIM MODIFIERS DO NOT MATCH PA MODIFIERS**

This edit will post to a claim when the incoming claim has one or more modifiers that do not match the service code modifiers on the Prior Authorization (PA). In order to process the claim, the service code modifiers must be corrected to match the Prior Authorization that is referenced on the claim and must be resubmitted.

ADA	N/A
1500	23, 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1021 - CAPITATION PAYMENT REDUCED BY FULL PATIENT LIABILITY**

This edit posts only to capitation claims when the non-ABP MLTSS beneficiary's full patient liability amount was used to reduce the capitation payment. There are no form locators that apply.

**EDIT 1023 - NO PATIENT LIABILITY AMOUNT ON FILE FOR NON-ABP MLTSS RECIPIENT**

This edit posts only to capitation claims when no patient liability amount could be found on file for a non-ABP MLTSS recipient. There are no form locators that apply.

**EDIT 1024 - CAPITATION PAYMENT REDUCED BY PARTIAL PATIENT LIABILITY**

This edit posts only to capitation claims when a partial amount of the non-ABP MLTSS beneficiary's patient liability amount was used to reduce the capitation payment. There are no form locators that apply.

**EDIT 1026 - CAPITATION PAYMENT REDUCED FOR ELIGIBILITY LIMITS**

This edit posts when there is a reduction in the capitation amount because the beneficiary currently has restricted benefits. There are no form locators that apply.

**EDIT 1200 - ALC OCC SPAN DAY DOES NOT MATCH THE NUMBER OF REVENUE UNITS**

This edit is posted when claims with lower level of days (SNF, ICF, Residential) are reported and number of days identified by the occurrence span code did not equal the revenue code units on the claim.

M4 RESIDENTIAL= 190  
M3 ICF= 191 THRU 194  
75 SNF= 191 THRU 194  
74 LEAVE OF ABSENCE= 180

ADA N/A  
1500 N/A  
UB-04 Form Locator 35 A,B,C thru 36 A,B,C  
MC-6 N/A  
MC-9 N/A  
MC-12 N/A  
MC-19 N/A  
TAD N/A

**EDIT 1203 - STATE REQUESTED ON LINE HISTORY ONLY DENIAL**

This edit will post as a result of claims that have been in a Pend Status and the State has requested that this denial be a history-only transaction and have no financial impact. Therefore, the denied claim has not appeared on the provider's remittance advice. This EOB is to indicate that the claim is not on an RA.

**EDIT 1204 - ANESTHESIA SERV NOT PAYABLE-SURG PROC WITH AA MOD REQ**

This edit posts when the claim is being billed with a code not valid.

**EDIT 1214 - INVALID NDC OR NDC NOT ON FILE**

This edit is posted to the claim if the claim has a procedure code: J0120 thru J9999; Q0144 thru Q0181; Q4079 thru Q4081; Q9945 thru Q9999, Q3025, Q3026, Q2009, Q2017. These procedure codes require a corresponding NDC in order to price and process the claim. Below are the form locators that relate to this edit:

ADA N/A  
1500 24A shaded area  
UB-04 43  
MC-6 N/A  
MC-9 N/A  
MC-12 N/A  
MC-19 N/A  
TAD N/A

**EDIT 1215 - PROCEDURE/NDC COMBINATION IS INVALID OR NOT ON FILE**

This edit posts when the Procedure code and NDC do not match.

**EDIT 1217 - TAXONOMY CODE IS MISSING FOR THE BILLING PROVIDER**

This edit posts when the taxonomy code is missing for the billing provider.

**EDIT 1218 - TAXONOMY CODE IS INVALID FOR THE BILLING PROVIDER**

This edit posts when the taxonomy code is invalid for the billing provider.

**EDIT 1219 - TAXONOMY CODE IS MISSING FOR THE SERVICING PROVIDER**

This edit posts when the taxonomy code is missing for the servicing provider.

**EDIT 1220 - TAXONOMY CODE IS INVALID FOR THE SERVICING PROVIDER**

This edit posts when the taxonomy code is invalid for the servicing provider.

**EDIT 1221 - NPI IS MISSING FOR SERVICING/RENDERING PROVIDER**

This edit posts to a claim when the servicing/rendering provider's NPI number is missing. Below are the form locators that apply:

ADA	49, 54
1500	24J, 33A
UB-04	N/A
MC-6	N/A
MC-9	Only Applies to DDE
MC-12	N/A
MC-19	Only Applies to DDE
TAD	Only Applies to HIPAA

**EDIT 1222 - NPI IS INVALID FOR SERVICING/RENDERING PROVIDER**

This edit posts to a claim when the servicing/rendering NPI is invalid. Below are the form locators that apply:

ADA	49, 54
1500	24J, 33A
UB-04	56
MC-6	N/A
MC-9	Only Applies to DDE
MC-12	Only Applies to DDE
MC-19	Only Applies to DDE
TAD	Only Applies to HIPAA

**EDIT 1223 - NPI IS MISSING FOR ATTENDING PROVIDER**

This edit posts to a claim when the attending physician's NPI is missing. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	76
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	39

**EDIT 1224 - NPI IS INVALID FOR ATTENDING PROVIDER**

This edit posts to a claim when the NPI reported for the attending physician is invalid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	76
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	39

**EDIT 1225 - NPI IS MISSING FOR REFERRING PROVIDER**

This edit posts when the NPI is missing for the referring provider.

**EDIT 1226 - NPI IS INVALID FOR REFERRING PROVIDER**

This edit posts to a claim when the NPI reported for the referring provider is invalid. Below are the form locators that apply:

ADA	Only Applies to HIPAA
1500	17B
UB-04	78 or 79 with qualifier DN
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	Only Applies to DDE
TAD	N/A

**EDIT 1227 - NPI IS MISSING FOR OPERATING PROVIDER**

This edit posts to a claim when the NPI for the operating provider is missing. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	77
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1228 - NPI INVALID - UB04 OPERATING 1 PROVIDER**

This edit posts to a claim when the operating 1 provider is invalid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	77
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1229 - NPI IS MISSING FOR BILLING PROVIDER**

This edit posts when the billing provider's NPI number is missing from the claim. Below are the form locators that apply:

ADA	49
1500	33A
UB-04	56
MC-6	N/A
MC-9	Only Applies to DDE
MC-12	Only Applies to DDE
MC-19	Only Applies to DDE
TAD	Only Applies to HIPAA

**EDIT 1230 - NPI IS INVALID FOR BILLING PROVIDER**

This edit will post a claim when the billing provider's NPI was submitted on the claim, but the NPI was not found to be valid on the Provider File.

ADA	FL49
1500	FL33A
UB-04	FL56
MC-6	N/A
MC-9	FL10
MC-12	FL9
MC-19	FL24
TAD	N/A

**EDIT 1231 - NPI IS MISSING FOR OTHER PROVIDER**

This edit posts when the NPI is missing for the other provider.

**EDIT 1232 - NPI IS INVALID FOR OTHER PROVIDER**

This edit posts when the NPI is invalid for the other provider.

**EDIT 1233 - NPI IS MISSING FOR PRESCRIBING PROVIDER**

This edit posts when the NPI is missing for prescribing provider.

**EDIT 1234 - NPI IS INVALID FOR PRESCRIBING PROVIDER**

This edit posts to a claim when the NPI reported on the claim for the prescribing provider is invalid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	Only Applies to DDE
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1235 - NPI NOT ON FILE FOR SERVICING/RENDERING PROVIDER**

This edit posts when the NPI is not on file for the servicing/rendering provider.

**EDIT 1236 - ZIP CODE IS MISSING OR INVALID**

This edit posts when the Zip code is missing or invalid.

**EDIT 1237 - PROVIDER NOT MAPPED - SERV/REND**

This edit posted to an electronic claim when an NPI was found, but there is no corresponding provider entry and a default provider was not found.

**EDIT 1238 - PROVIDER NOT MATCHED - SERV/REND**

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

**EDIT 1239 - MOTHER OF NEWBORN HAS SERVICE IN-PLAN**

This edit posts to newborn claims with dates of service after 1/1/16 when the mom has Managed Care at the time of service. The cost of the services is covered in the capitation paid to the MCO's for up to 60 days of service from the date of birth of the newborn, through period ending at the end of the month in which the 60th day falls. This does not apply to any specific form locator.

**EDIT 1240 - PROVIDER NOT MAPPED - BILLING**

This edit is posted to an electronic claim when an NPI was found, but there is no corresponding provider entry and a default provider was not found.

**EDIT 1241 - PROVIDER NOT MATCHED - BILLING**

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

**EDIT 1242 - PROVIDER ID AND NPI REQUIRED - BILLING**

This edit posts to a claim when the information reported on the claim is either missing the provider Medicaid number or the provider NPI number. Below are the form locators that apply:

ADA	49, 52A
1500	33A, 33B
UB-04	56 and 57
MC-6	N/A
MC-9	Only Applies to DDE
MC-12	Only Applies to DDE
MC-19	Only Applies to DDE
TAD	N/A

**EDIT 1243 - PROVIDER NOT MAPPED - ATTENDING**

This edit is posted to an electronic claim when an NPI was found, but there is no corresponding provider entry and a default provider was not found.

**EDIT 1244 - PROVIDER NOT MATCHED - ATTENDING**

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

**EDIT 1245 - PROVIDER ID AND NPI REQUIRED - SERVICING**

This edit posts to a claim when the information reported on the claim is either missing the provider Medicaid number or the provider NPI number. Below are the form locators that apply:

ADA	54, 58
1500	24J
UB-04	56 and 57
MC-6	N/A
MC-9	Only Applies to DDE
MC-12	Only Applies to DDE
MC-19	Only Applies to DDE
TAD	N/A

**EDIT 1246 - PROVIDER NOT MAPPED-REFERRING**

This edit is posted to an electronic claim when an NPI was found, but there is no corresponding entry and a default provider was not found.

**EDIT 1247 - PROVIDER NOT MATCHED - REFERRING**

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

**EDIT 1249 - MISSING PRIMARY PAYER ID**

This edit will post to an inpatient hospital claim when the primary payer ID is equal to zeroes or spaces. The system has determined that the Primary approved amount, paid amount, deductible/coinsurance amount is greater than zeroes.

**EDIT 1250 - MISSING SECONDARY PAYER ID**

This edit will post to an Inpatient hospital claim when the secondary payer ID is equal to zeroes or spaces. The system has determined that the Secondary approved amount, paid amount, deductible/coinsurance amount is greater than zeroes.

**EDIT 1251 - MISSING TERTIARY PAYER ID**

This edit will post to an inpatient hospital claim when the tertiary payer ID is equal to zeroes or spaces. The system has determined that the tertiary approved amount, paid amount, deductible/coinsurance amount is greater than zeroes.

**EDIT 1252 - MISSING DEDUCTIBLE, COINSURANCE OR CO-PAYMENT AMOUNT**

This edit will post to an Inpatient hospital claim with a carrier approved amount or paid amount on the claim that is greater than zero and the sum of the deductible, coinsurance or co-payment amount is zero.

**EDIT 1253 - SUM OF SUBMITTED DEDUCT, COINS OR CO-PAY EXCEEDS APPR AMT**

This edit will post to an inpatient hospital claim when the claim indicates a sum for deductible, coinsurance and/or co-payment amount that exceeds the Medicare approved amount. This edit applies to HIPAA claims only.

**EDIT 1254 - INVALID PRIMARY BENEFITS EXHAUST DATE**

This edit will post to an inpatient hospital claim when the Primary Benefits Exhaust Date is not prior to or equal to the service through date.

**EDIT 1255 - NO PRIMARY PAYOR LIABILITY AMOUNTS**

This edit will post to an Inpatient Medicare Supplementation claim when the exhausted charges indicated show no Patient Liability Amounts corresponding to the Primary Payor submitted on the claim.

**EDIT 1256 - NO SECONDARY PAYOR LIABILITY AMOUNTS**

This edit will post to an Inpatient Medicare Supplementation claim when the exhausted charges indicated show no Patient Liability Amounts corresponding to the Secondary Payor submitted on the claim.

**EDIT 1257 - NO TERTIARY PAYOR LIABILITY AMOUNTS**

This edit will post to an Inpatient Medicare Supplementation claim when the exhausted charges indicated show no Patient Liability Amounts corresponding to the Tertiary Payor submitted on the claim.

**EDIT 1258 - SERVICES PAID AT CHILDREN'S RATE**

This edit posts when the claim is for a beneficiary 21 years or younger and the procedure is being paid at the children's rate. This rate can be found at [www.njmmis.com](http://www.njmmis.com) under Forms and Documents". This edit does not apply to any specific form locator.

**EDIT 1260 - PROVIDER ID AND NPI REQUIRED - ATTENDING**

This edit posts to a claim when the attending provider information reported is either missing the NPI or the Medicaid ID number of the attending provider. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	76
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	7, 39

**EDIT 1261 - NPI NOT CROSSWALKED - OPERATING**

This edit posts to a claim when the NPI that was reported cannot be crosswalked. This edit does not apply to any specific form locator.

**EDIT 1262 - PROVIDER NOT MATCHED - OPERATING**

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

**EDIT 1263 - PROVIDER ID AND NPI REQUIRED - REFERRING**

This edit posts to a claim when the information reported for the referring physician is either missing the NPI or the Medicaid Provider Number. Below are the form locators that apply:

ADA	Only Applies to HIPAA
1500	17A, 17B
UB-04	78 or 79 with qualifier DN
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	Only Applies to DDE
TAD	N/A

**EDIT 1264 - PROVIDER NOT MAPPED - OTHER**

This edit is posted to an electronic claim when an NPI was found, but there is no corresponding provider entry and a default provider was not found.

**EDIT 1265 - PROVIDER NOT MATCHED - OTHER**

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

**EDIT 1266 - PROVIDER ID AND NPI REQUIRED - OPERATING 1**

This edit posts to a claim when the information reported for the operating 1 physician is either missing the NPI or the Medicaid ID number. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	77
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1267 - PROVIDER NOT MAPPED-PRESCRIBING**

This edit is posted to an electronic claim when it was determined that an NPI was found, but there is no corresponding provider entry and a default provider was not found.

**EDIT 1268 - PROVIDER NOT MATCHED - PRESCRIBING**

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

**EDIT 1269 - ATTENDING NPI SAME AS BILLING/SERVICING NPI**

This edit posts when the NPI being reported for the billing provider is the same as the NPI being reported for the attending provider. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	56, 76
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	7, 39

**EDIT 1270 - REFERRING NPI SAME AS BILLING/SERVICING NPI**

This edit will post to a claim if the referring NPI is the same as the billing and/or servicing NPI. Below are the form locators that apply:

ADA	Only Applies to HIPAA
1500	24J, 33A,17B
UB-04	56, 78 or 79 with qualifier DN
MC-6	N/A
MC-9	10,17, 27 (only for DDE)
MC-12	N/A
MC-19	11, 14J, and 24 (only for DDE)
TAD	N/A

**EDIT 1271 - OTHER NPI SAME AS BILLING/SERVICING NPI**

This edit will post to an electronic claim if the "Other" NPI is the same as the billing and/or servicing NPI.

**EDIT 1272 - PRESCRIBING NPI SAME AS BILLING/SERVICING NPI**

This edit will post to a vision claim if the prescribing NPI is the same as the billing and/or servicing NPI. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	10,17, 27 (only for DDE)
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1280 - NPI INVALID - OPERATING 2 PROVIDER**

This edit posts to a Hospital claim when the NPI reported for the Operating Physician is invalid or incorrect. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	78 or 79 with qualifier ZZ
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1281 - UB-04 OPERATING 1 NPI SAME AS BILLING/SERVICING NPI**

This edit posts to a Hospital claim when the Operating 1 NPI is the same as the billing/servicing NPI. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	56, 77
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1290 - UB04 PAT RSN VISIT REQD - UNSCHEDULED VISIT**

This edit will post to a claim when if the Type of Bill is 13X (outpatient) and the Admit type is 1, 2 or 5, and revenue code is 45X, 516, 526, or 762 and there is not at least one Patient Reason for Visit code.

ADA	N/A
1500	N/A
UB-04	70
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1291 - INVALID UB04 PATIENT REASON FOR VISIT**

This edit will post to a claim when the following occurrences have not been met:

1. The first digit of the IC9 patient reason for visit code contains a value other than "0"- "9", "V" or "E"
2. The second or third digit of the patient reason for visit code contains a value of other than "0-9"
3. Or ICD10 patient reason for visit code has first digit not alphabetic (except U) or the second digit is not numeric

ADA	N/A
1500	N/A
UB-04	70
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1292 - UB04 PATIENT REASON FOR VISIT NOT ON FILE**

This edit will post to a claim when the patient reason for visit diagnosis code is not on file.

ADA	N/A
1500	N/A
UB-04	70
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1293 - INVALID UB04 EXTERNAL INJURY CODE**

This edit will post to a claim when the External Injury Codes on the UB-04 claim occurrences have not been met:

1. The first digit of the ICD9 External Injury Code contains a value other than "E", "8" or "9"
2. The second or third digit of the External Injury Code contains a value of other than "0" - "9"
3. The first digit of the ICD10 External Injury Code contains a value other an S-Y

ADA	N/A
1500	N/A
UB-04	72 A, B, C
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1294 - UB04 EXTERNAL INJURY CODE NOT ON FILE**

This edit will post to a claim when the External Injury Diagnosis Code is not on file.

ADA	N/A
1500	N/A
UB-04	72 A, B, C
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1295 - UB-04 OPERATING 2 NPI SAME AS BILLING/SERVICING NPI**

This edit posts to a Hospital claim when the Operating 2 NPI is the same as the billing/servicing NPI. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	56, 78 or 79 with qualifier ZZ
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1296 - PROVIDER ID AND NPI REQUIRED - OPERATING 2**

This edit posts to a claim when the information reported for the operating 2 physician is either missing the NPI or the Medicaid ID number. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	78 or 79 with qualifier ZZ
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1303 - MENTAL HEALTH SERVICE UNDER 2 NOT COVERED**

Based on the diagnosis code on the claim and the beneficiaries age, this service is not covered by NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	3 & 21
UB-04	10 & 67 - 67A-Q
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	2 & 14F
TAD	N/A

**EDIT 1310 - MISSING/INVALID DENTAL CLINIC REV CODE**

This edit will post under the following circumstances for claims with a service date equal or greater than November 1, 2008:

- The claim is an Outpatient claim
- The procedure code is a dental procedure code
- The revenue code is not equal to 512

**EDIT 1311 - MISSING/INVALID DENTAL PROCEDURE CODE**

This edit will post under the following circumstances for claims with a service date equal or greater than November 1, 2008:

- The claim is an Outpatient claim
- The procedure code is Not a dental procedure code
- The revenue code is equal to 512

**EDIT 1312 - MISSING/INVALID PRESENT ON ADMISSION INDICATOR**

This edit will post when an Inpatient claim is submitted with a diagnosis code that has a missing or invalid Present On Admission (P.O.A.) Indicator.

Valid values for Present On Admission indicators are as follows:

- N = Not present at time of admission
- U = Undetermined if condition was present at time of admission
- W = Clinically undetermined
- Y = Yes, Present at time of admission
- 1 = Unreported/Not used

The only valid P.O.A. indicators that can be used on the primary diagnosis are the values of 'Y' and 'W'.

**EDIT - 1314 - HOSPICE PROCEDURE/ PLACE OF SERVICE RESTRICTION**

This edit will post to hospice claims when the following conditions occur:

Hospice claims with procedure codes T2044 or T2045: service date on or greater than 5/1/2009, valid submitted referring provider, place of service not equal to 3 or 5

Hospice claims with procedure codes T2042 or T2043: service date on or greater than 5/1/2009, place of service not equal to 2, 4 or 5

Hospice claims with procedure codes T2046 or Y6338: service date on or greater than 5/1/2012, place of service not equal to 5

Below are the form locators that apply:

ADA	N/A
1500	24A, 24B, 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1315 - AUTHORIZING PROVIDER/CLAIM PROVIDER MISMATCH**

This edit is posted when the servicing provider on the claim is not the same as the one authorized.

**EDIT 1320 - P.O.A. INDICATOR WITH NO CORRESPONDING DIAGNOSIS CODE**

This edit will post when an Inpatient or Inpatient Crossover claim is submitted with a Present On Admission (P.O.A.) Indicator that does not have a corresponding diagnosis code.

**EDIT 1321 - CLAIM UOM INVALID OR NOT = TO NDC UOM**

This edit will post to a claim when the valid unit of measure submitted on the claim must be one of the following listed below. If any other value is listed, the edit is posted.

- UN - UNITS
- ML - MILLILITER
- GR - GRAMS

ADA	N/A
1500	24A
UB-04	43
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1322 - SERVICE/PROCEDURE INCLUDED IN COMPOSITE RATE**

This edit will post to a claim when the revenue code is NOT one of the following: 821, 829, 831, 839, 841, 849, 851, 859, 881

ADA	N/A
1500	N/A
UB-04	42
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1326 - INVALID PROVIDER TYPE FOR ATTENDING PROVIDER**

This edit will post to a claim when the following instances have occurred:

Attending Provider ID number is for the Group Practice and not the individual doctor within the group who rendered the service.

OR

The Attending Providers specialty on file is considered to be an entity and is not appropriate to be an Attending Physician

OR

The listed Attending provider is an individual with the following specialty (Optometrist or Chiropractor) and would be inappropriate to be listed as an Attending Physician.

ADA	N/A
1500	N/A
UB-04	FL76
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1327 - HMO RESPONSIBLE FOR NON-ABP FACILITY COSTS**

This edit will post to a claim when a recipient is enrolled in the Alternative Benefit Plan (ABP) and are not eligible for LTC services. This does not apply to any specific form locator.

**EDIT 1328 - BILL OUTPATIENT DRUG CLAIMS USING REVENUE CODES 631 THRU 637**

This edit will post to a claim when it is for Outpatient medical injectable drug(s), the revenue code submitted on the claim must be 631 thru 637.

ADA	N/A
1500	N/A
UB-04	FL 44
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1329 - HEALTHCARE PRVDR FEDERALLY EXCLUDED FROM NJMM PARTICIPATION**

This edit will post to a claim when where any of the NPI entries are on the Federally excluded database.

ADA	FL49
1500	FL17B, 24J, 33B
UB-04	FL56, 76 thru 79
MC-6	N/A
MC-9	FL10 and 30
MC-12	FL9
MC-19	FL24
TAD	FL39

**EDIT 1330 - METRIC QUANTITY INCORRECTLY REPORTED FOR DRUG BILLED**

This edit will post to a claim when Medical Injectable Professional claims if two times the claim charge is less than the Medicaid Tentative Payment amount. Tell the provider to verify the metric quantity.

ADA	N/A
1500	24A shaded area
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1336 - INVALID REFERRING PROVIDER FOR PLACE OF SERVICE 2 OR 4**

This edit will post to an electronically (HIPAA) submitted claim when the following conditions have been met:

- Procedure codes T2042 or T2043 with a service date on or greater than 1/30/12. Or procedure code G0299 with a service date on or greater than 01/01/16
- A referring provider or referring NPI has been submitted
- the place of service is equal to 2 or 4

NOTE: if the claim is submitted paper and/or DDE the following form locators apply:

ADA	N/A
1500	17A, 17B, 24B, 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1340 - PROVIDER PREVENTABLE CONDITION - NOT COVERED**

This edit will post to a claim when the procedure code contains the following modifiers:

- A) PA - Surgery wrong body part
- B) PB - Surgery wrong patient
- C) PC - Wrong surgery on patient

ADA	FL29
1500	FL24D modifiers field
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1343 - ADV PRACTICE NURSE INELIGIBLE TO RECEIVE ACA ENHANCED PAYMNT**

This edit posts to an eligible claim submitted by a qualified physician group practice when the servicing provider is an Advanced Practice Nurse whose supervising physician in the group practice has not self-attested for the service date billed on the claim. Please refer to Newsletter Volume 23, No. 12 for further details.

This edit does not to any specific form locator.

**1344 - BIRTH WEIGHT ON CLAIM AND DRG CONFLICT**

This edit will post to a claim when the birth weight submitted on the claim for the original newborn DRG does not conform to the allowed birth weights.

ADA	N/A
1500	N/A
UB-04	39-41, 71
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1345- SUBMIT CLAIM WITH ELIGIBLE MEDICAID RECIPIENT ID**

This edit will post to DOC (Dept. Of Corrections) claims that were submitted with the SBI number and the recipient has valid Medicaid coverage for the claim service dates. The claim should be resubmitted using the recipient's eligible Medicaid ID number.

ADA	N/A
1500	1A
UB-04	60
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1347 - MLTSS WAIVER FFS CLAIM REPROCESS**

This edit posts to claims when the recipient was auto-enrolled in MLTSS effective July 2014 and the claims were reprocessed and paid based on their old waiver service.

This edit does not apply to any specific form locator.

**EDIT 1348 - HMS AUDIT- ADJUSTMENT/VOID REQUEST DENIED**

This edit will post to an Adjustment/Void Request when the adjustment reason code 2166 (DME audit recovery adjustment) if the adjustment does not contain an EOB edit in the range 1352-1361; if reason code 2177 (DME audit re-payment adjustment) is not an adjustment with the reason code 2166; an adjustment reason code 2166 is present but the submitted adjustment does not contain adjustment reason code 2177; posted to a void if the claim is an adjustment with either adjustment reason code 2166 or 2177.

For other claim types : this edit is posted when the provider initiated the adjustment.

This edit does not apply to any specific form locator.

**EDIT 1349 - VERIFY METRIC QUANTITY REPORTED**

This edit will post to a claim when the metric quantity on the claim is less than the package size of the NDC or exceeds the maximum units for the NDC.

ADA	N/A
1500	24A shaded area
UB-04	43
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1362 - LTC XOVER MISSING MCARE PAID &/OR MCARE COV DAYS &/OR COINS**

This edit will post to a claim when the Medicare EOMB is missing the coinsurance amount, the Medicare covered days and the Medicare payment. This does not apply to any specific form locator.

**Edit 1364 - CANNOT ADJUST A LINE LEVEL SURGERY**

This edit will post to a claim when a line level surgical procedure code is adjusted on an outpatient claim when the original claim had a valid surgical revenue code and a valid surgical procedure code and adjusting to a non-surgical revenue code and non-surgical procedure code. It will also post if the original revenue and procedure code is not a valid surgical procedure code, and the adjustment revenue and procedure code is a valid surgery.

ADA	N/A
1500	N/A
UB-04	42, 44 (Outpatient Claims only)
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1365 - HMS PERMEDION NJUR**

This edit will post to a claim when it is an Inpatient Claim and has been voided by HMS Permedion. This does not apply to any specific form locator.

**EDIT 1366 - HMS RECOVERY - PATIENT DECEASED DOS**

This edit will post to a claim when the claim is recovered by HMS and the claim was adjusted/voided by HMS because the beneficiary was deceased on the date of service.

This edit does not apply to any specific form locator.

**EDIT 1367 - HMS COMMERCIAL TPL RECOVERY-NO FURTHER PROVIDER ADJUSTMENTS**

This edit will post to a claim when the claim is recovered by HMS and the claim was adjusted/voided by HMS. No further action is needed by the provider to do the adjustment/void.

This edit does not apply to any specific form locator.

**EDIT 1368 - HMS COMMERCIAL TPL RECOVERY-PROVIDER ADJUSTMENT ALLOWED**

This edit will post to a claim when the claim is recovered by HMS and the claim was adjusted/voided by HMS. The provider is allowed to do the adjustment/void.

This edit does not apply to any specific form locator.

**EDIT 1369 - HMS CREDIT BALANCE RECOVERY - EXCESS PAY**

This edit will post to a claim when the claim is recovered by HMS and the claim was adjusted/voided by HMS.

This edit does not apply to any specific form locator.

**EDIT 1370 - HMS CREDIT BALANCE RECOVERY - READMISSION**

This edit will post to a claim when the claim is recovered by HMS and the claim was adjusted/voided by HMS.

This edit does not apply to any specific form locator.

**EDIT 1371 - HMS CREDIT BALANCE RECOVERY - TRANSFER**

This edit will post to a claim when the claim is recovered by HMS and the claim was adjusted/voided by HMS.

This edit does not apply to any specific form locator.

**EDIT 1372 - HMS CREDIT BALANCE RECOVERY - DUPLICATE PAYMENT**

This edit will post to a claim when the claim is recovered by HMS and the claim was adjusted/voided by HMS.

This edit does not apply to any specific form locator.

**EDIT 1373 - HMS MEDICARE RECOVERY-NO FURTHER PROVIDER ADJUSTMENTS**

This edit will post to a claim when the claim is recovered by HMS and the claim was adjusted/voided by HMS. No further provider adjustment action is needed.

This edit does not apply to any specific form locator.

**EDIT 1374 - HMS MEDICARE RECOVERY - PROVIDER ADJUSTMENTS ALLOWED**

This edit will post to a claim when the claim is recovered by HMS and the claim was adjusted/voided by HMS. The provider is able to do the allowed adjustment.

This edit does not apply to any specific form locator.

**EDIT 1375 - HMS CREDIT BALANCE RECOVERY - ON-SITE FINANCIAL REVIEW**

This edit will post to a claim when the claim is recovered by HMS and the claim was adjusted/voided by HMS. On-site review is needed.

This edit does not apply to any specific form locator.

**EDIT 1376 - HMS RAC RECOVERY - NO FURTHER PROVIDER ADJUSTMENTS**

This edit will post to a claim when the claim is recovered by HMS and the claim was adjusted/voided by HMS. No further provider adjustment action is needed.

This edit does not apply to any specific form locator.

**EDIT 1377 - HMS RAC RECOVERY PROVIDER ADJUSTMENTS ALLOWED**

This edit will post to a claim when the claim is recovered by HMS and the claim was adjusted/voided by HMS. The provider is able to do the allowed adjustment.

This edit does not apply to any specific form locator.

**EDIT 1378 - FQHC MENTAL HEALTH/MEDICAL PROC/DIAG MISMATCH**

This edit posts to FQHC claims if the procedure code on the claim is W9820 instead of T1015 HE and the primary diagnosis code is a psychiatric diagnosis.

ADA	N/A
1500	21 & 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1379 - PMT AMT ON THE APPROVED HMS ADJ GT THAN OR EQUAL TO ORIG PMT**

This edit will post to a claim when the claim is recovered by HMS. The claim was adjusted by HMS and the Payment Amount on the approved adjustment is greater or equal to the original payment.

This edit does not apply to any specific form locator.

**EDIT 1380 - GHI CROSSOVER - SERVICE IS IN-PLAN (MANAGED CARE)**

This edit is posted when a Medicare/GHI Crossover claim has been forwarded to the HMO automatically for processing. However, the provider may need to submit the claim directly to the recipient's HMO, depending on the HMO's crossover claim policy rules. Contact the recipient's HMO.

This edit does not apply to any specific form locator.

**EDIT 1382 - INVALID PROVIDER TYPE - PRESCRIBING PHYSICIAN**

This edit posts to a vision claim when the prescribing physician reported on the claim is not the correct Provider Type. For example a Pharmacy cannot be the prescribing physician. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	17 (only for DDE)
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1383 - INVALID PROVIDER TYPE - OPERATING 1**

This edit posts to a Hospital claim when the Operating 1 is an invalid provider type. For example the Operating provider information cannot be a Pharmacy. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	77
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1384 - INVALID PROVIDER TYPE - OPERATING 2 PHYSICIAN**

This edit posts to a Hospital claim when the Operating Physician information entered on the claim in the wrong provider type. For example a provider cannot report a Pharmacy in this field. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	78 or 79 with qualifier ZZ
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1385 - PROVIDER NOT APPROVED FOR SERVICE TO MEDICAID CLIENT - SERVICING**

This edit posts to a claim when the servicing provider reported on the claim is not an approved NJ Medicaid Provider. Below are the form locators that apply:

ADA	52A, 58
1500	24J, 33B
UB-04	56, 57, 76
MC-6	N/A
MC-9	10, 27
MC-12	9
MC-19	14J, 24
TAD	N/A

**EDIT 1386 - PROVIDER NOT APPROVED FOR SERVICE TO MEDICAID CLIENT - BILLING**

This edit posts to a claim when the billing provider reported on the claim is not an approved NJ Medicaid Provider. Below are the form locators that apply:

ADA	52A
1500	33B
UB-04	56 and 57
MC-6	11
MC-9	10
MC-12	9
MC-19	24
TAD	N/A

**EDIT 1387 - PROVIDER ID AND NPI REQUIRED - PRESCRIBING**

This edit posts to a vision claim when the prescribing provider and NPI number are missing from the claim. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	17 (Only Applies to DDE)
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1389 - ATTENDING PROVIDER INELIGIBLE ON DATES OF SERVICE**

This edit posts to a claim submitted on the UB-04 claim form when the attending provider reported on the claim is not eligible for the dates of service being billed. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	76
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1390 - PRESCRIBING PROVIDER INELIGIBLE ON DATES OF SERVICE**

This edit posts when the prescribing physician reported on the claim is ineligible for the dates of service being billed. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	17
MC-12	23
MC-19	N/A
TAD	N/A

**EDIT 1391 - REFERRING PROVIDER INELIGIBLE ON DATES OF SERVICE**

This edit posts to a claim when the referring provider number reported on the claim is ineligible on the date of service being billed. Below are the form locators that apply:

ADA	N/A
1500	17A
UB-04	78 or 79 with qualifier DN
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	11
TAD	N/A

**EDIT 1392 - OPERATING 1 PROVIDER INELIGIBLE ON DATES OF SERVICE**

This edit posts to a Hospital claim when the Operating 1 Provider reported on the claim is not eligible on the date of service. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	77
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1393 - OPERATING 2 PROVIDER INELIGIBLE ON DATES OF SERVICE**

This edit posts to a Hospital claim when the operating 2 provider reported on the claim is ineligible on the dates of service. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	78 or 79 with qualifier ZZ
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1394 - SUPERVISING PROVIDER INELIGIBLE ON DATES OF SERVICE**

This edit posts to a claim submitted electronically when the supervising provider reported is ineligible on the dates of service. This edit does not apply to any specific form locator.

**EDIT 1395 - ATTENDING PROVIDER NOT FOUND ON PROVIDER DATABASE**

This edit posts to a claim submitted on the UB-04 when the attending Provider reported is not on file with NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	76
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	7

**EDIT 1396 - PRESCRIBING PROVIDER NOT FOUND ON PROVIDER DATABASE**

This edit posts to a claim when the prescribing provider reported on the claim is not on file with NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	17
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1397 - REFERRING PROVIDER NOT FOUND ON THE PROVIDER DATABASE**

This edit posts to a claim when the referring provider reported is not on file with NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	17A
UB-04	78 or 79 with qualifier DN
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	11
TAD	N/A

**EDIT 1398 - OPERATING 1 PROVIDER NOT FOUND ON PROVIDER DATABASE**

This edit posts to a claim when the operating 1 provider reported on the claim is not on file with the NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	77
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1399 - OPERATING 2 PROVIDER NOT FOUND ON PROVIDER DATABASE**

This edit posts to a claim when the Operation 2 Provider reported on the claim is not on file with NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	78 or 79 with qualifier ZZ
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1400 - NO OCCURRENCE SPAN CODE 74 OR 77**

This edit will post to a non-DRG Inpatient or Inpatient crossover claim where there is a POA Indicator of 'N' or 'U' and there is no Occurrence Span Code with "74" or "77" or the Occurrence Span Dates are missing or invalid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	35-36, 67 shaded box, 67A-Q shaded box
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1401 - PAYMENT ADJUSTED FOR HOSPITAL ACQUIRED CONDITION**

This edit will post to a claim when it is an Inpatient or Inpatient crossover and the payment is cutback due to a Hospital Acquired Condition (HAC).

This edit does not apply to any specific form locator.

**EDIT 1402 - SUPERVISING PROVIDER NOT FOUND ON PROVIDER DATABASE**

This edit posts to an electronically submitted claim when the supervising provider reported is not on file with NJ Medicaid. This edit does not apply to any specific form locator.

**EDIT 1403 - NPI NOT CROSSWALKED - ATTENDING**

This edit posts to a claim submitted electronically when the NPI number being reported for the attending provider cannot be mapped to the provider number based on the submitted information. This edit does not apply to any specific form locator.

**EDIT 1404 - NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - BILLING**

This edit post to a claim when the NPI reported is not on file with NJ Medicaid. Below are the form locators that apply:

ADA	49
1500	33A
UB-04	56
MC-6	N/A
MC-9	10
MC-12	9
MC-19	24
TAD	N/A

**EDIT 1405 - NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - SERVICING**

This edit will post to a claim when the Servicing Provider(s) NPI reported is not on file with NJ Medicaid. Below are the form locators that apply:

ADA	49
1500	33A
UB-04	56
MC-6	N/A
MC-9	10
MC-12	9
MC-19	24
TAD	N/A

**EDIT 1406 - NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - ATTENDING**

This edit will post to a claim when the Attending Provider(s) NPI reported is not on file with NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	76, 78, & 79 when the qualifier is DN
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	39

**EDIT 1408 - HOSPICE CUTBACK DAY OF REVOCATION**

This edit will post to a claim when the hospice benefit has been revoked and the beneficiary has not died. The date of service that coincides with the revocation date is not paid and appears as a cutback day. This edit does not apply to any specific form locator.

**EDIT 1409 - HOSPICE DATE OF DEATH PAYMENT CUTBACK**

This edit posts when the claim is for hospice code T2046 and the recipient's date of death is the same as the through date on the claim. This day is not payable and the claim has been cutback. This edit does not apply to any specific form locator.

**EDIT 1410 - NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - REFERRING**

This edit will post to a claim when the Referring Provider(s) NPI reported is not on file with NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	17B
UB-04	76, 78, & 79 when the qualifier is DN
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1411 - NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - OPERATING 1**

This edit will post to a claim when the first Operating Provider NPI reported is not on file with NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	77
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1412 - NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - OPERATING 2**

This edit will post to a claim when the second Operating Provider NPI reported is not on file with NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	78 & 79 when the qualifier is ZZ
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1413 - NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - PRESCRIBING**

This edit will post to a claim when the Prescribing Provider NPI reported is not on file with NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	17
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1414 - NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - SUPERVISING**

This edit will post to a claim when the Supervising Provider NPI reported is not on file with NJ Medicaid. There are no form locators that apply.

**EDIT 1415 - NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - BILLING**

This edit will post to a claim when the Billing Provider ID and the Billing NPI reported does not match the NPI information on file with NJ Medicaid. Below are the form locators that apply:

ADA	49
1500	33 A & B
UB-04	56 &57
MC-6	N/A
MC-9	27
MC-12	9
MC-19	24
TAD	39

**EDIT 1416 - ICD VERSION MISMATCH**

This edit will post if the HIPAA claim contains both ICD9 and ICD10 qualifiers. This edit will also post to paper claims that do not have an ICD version indicated. This edit is also posted to an ICD9 claim with an ICD10 diagnosis code or an ICD10 surgical procedure code. Below are the form locators that apply:

ADA	N/A
1500	21, A-L
UB-04	66, 67, 67A-Q, 74, 74A-E
MC-6	N/A
MC-9	12, 25B
MC-12	N/A
MC-19	13A, 14D
TAD	N/A

**EDIT 1418 - NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - SERVICING**

This edit will post to a claim when the Servicing Provider ID and the Servicing NPI reported does not match the NPI information on file with NJ Medicaid. Below are the form locators that apply:

ADA	54
1500	24J
UB-04	56
MC-6	N/A
MC-9	10
MC-12	N/A
MC-19	14J
TAD	N/A

**EDIT 1419 - NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - ATTENDING**

This edit will post to a claim when the Attending Provider ID and the Attending NPI reported does not match the NPI information on file with NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	76, 79, & 79 when the qualifier is DN
MC-6	N/A
MC-9	17
MC-12	N/A
MC-19	N/A
TAD	7

**EDIT 1420 - NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - REFERRING**

This edit will post to a claim when the Referring Provider ID and the Referring NPI reported does not match the NPI information on file with NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	17 A & B
UB-04	76
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	11
TAD	N/A

**EDIT 1421 - NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - OPERATING 1**

This edit will post to a claim when the Operating 1 Provider ID and the Operating 1 NPI reported does not match the NPI information on file with NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	77 when the qualifier is 1D
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1422 - NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - OPERATING 2**

This edit will post to a claim when the Operating 2 Provider ID and the Operating 2 NPI reported does not match the NPI information on file with NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	78 & 79 when the qualifier is ZZ
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1423 - NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - PRESCRIBING**

This edit posts to a claim when the Prescribing NPI reported on the claim is not mapped to the Prescribing NJ Medicaid Provider Number reported on the claim. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	17
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1424 - NO ASSOCIATION FOUND FOR DDD-SP/CCW SVC LOCATION NPI**

This edit is posted to a DDDSW/CCW claim when there is no link between the servicing (rendering) provider NPI and the billing provider NPI. Below are the form locators that apply:

ADA	N/A
1500	24J, 33A
UB04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1425 - INVALID DIAGNOSIS FOR SERVICE**

This edit will appear on a claim when the diagnosis code(s) field on the procedure code file indicates that the procedure code is restricted to certain diagnosis code(s) and the claim does not meet the restriction. For doulas, the following restrictions apply: Perinatal visits (99600HDU7), 99600HD, 99600HD22, Postpartum visits (99199HD22, 99199HD), Labor & Delivery codes (59409HD, 59514HD) required diagnosis code Z322. Below are the claim forms and form locators that apply.

ADA	N/A
1500	21A-L, 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT CODE 1426 - EARLY ELECTIVE DELIVERY**

This edit will post to a claim for professional and hospital claims for obstetricians, midwives and hospitals for non-medically indicated early elective deliveries as of date of service through 01/01/2021. If the claim is for delivery AND 1. No diagnosis code is present to indicate the weeks of gestation - OR - 2. The diagnosis code indicates less than 39 weeks of gestation. Below are the claim forms and form locators that apply.

ADA	N/A
1500	21A-L, 24D
UB-04	42, 67, 67A-Q
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1427 - NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - SUPERVISING**

This edit will post to a claim when the Supervising Provider ID is not on file with NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	33A
UB-04	76
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1428 - UNSPECIFIED DIAGNOSIS CODE**

This edit will post to a claim when the first occurrence of the diagnosis code contains an Unspecified-Indicator on the diagnosis master file. A more specific diagnosis code exists that should be used instead. This applies to ICD-10 diagnosis codes only.

This edit does not apply to any specific form locator.

**EDIT 1429 - DDD-SP/CCW SVC LOCATION NPI IS INELIGIBLE FOR DOS**

This edit is posted to a DDDSW/CCW claim when the servicing (rendering) NPI and the billing NPI are not linked for all of the dates of service on the claim or if the servicing (rendering) NPI is not active. Below are the form locators that apply:

ADA	N/A
1500	24J, 33A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1430 - OUTPATIENT TRANSPORTATION SERVICE HAS NO RATE**

This edit will post to outpatient claims when revenue code OP540, OP542, OP543, OP545 or OP546 is present along with emergency transportation code A0427, A0429, A0431, A0434 or A0436 but the system doesn't have a max rate for the emergency transportation code.

This edit does not apply to any specific form locator.

**EDIT 1431 - OUTPATIENT SERVICE NOT PAYABLE TRANS/PERS**

This edit will post to outpatient claims when revenue code OP540, OP542, OP543, OP545 or OP546 is present without emergency transportation code A0427, A0429, A0431, A0433, A0434 or A0436 **OR** when emergency transportation procedure code A0427, A0429, A0431, A0433, A0434 **OR** A0436 is present without revenue code OP540, OP542, OP543, OP545 or OP546.

This edit will post to outpatient claims effective for service dates on or after 5/6/2014 for PERS when revenue code 900 is present without PERS procedure code T2034, or 90839. **OR** When revenue code 911 is present without PERS procedure code S9480, or S9484. **OR** When PERS procedure code T2034 or 90839 is present without revenue code 900. **OR** When PERS procedure code S9480 or S9484 is present without revenue code 911.

This edit does not apply to any specific form locator.

**EDIT 1438 - HOSPICE SERVICE INTENSITY ADD-ON PREVIOUSLY PAID**

This edit will post to a hospice claim for a service intensity add-on when one has previously been paid within 7 days of death.

**EDIT 1439 - ROUTINE HOME CARE HOSPICE WITH MOD 22 PRICED AT LOWER RATE**

This edit will post if a hospice claim was submitted after 1/1/16 with a "22" modifier and the system has determined that the recipient is not eligible for the higher rate and the system has paid it at the lower rate. This edit does not deny your claim.

**EDIT 1440 - PROCEDURE NEEDS A DATE OF DEATH TO BE PROCESSED**

This edit will post to pend claims for a Hospice service intensity add-on procedure (G0299 01 - G0299 09) that have a service date on or after 01/01/2016 when the recipient does not have a date of death has been billed. This edit does not apply to any specific form locator.

**EDIT 1443 - HOSPICE DOS OVERLAP THE FIRST 60 DAYS OF HOSPICE CARE**

This edit will post when a routine hospice home care claim overlaps with a hospice claim that has a "22" modifier.

**EDIT 1444 - SERVICE INTENSITY ADD-ON PROCEDURE BEYOND 7 DAYS**

This edit will deny a hospice claim with service intensity add-on if the date of death is more than 7 days from the service date.

**EDIT 1447 - RECIPIENT INELIGIBLE FOR CSOC RESPITE SERVICE**

This edit will post when the claim is a CSOC Respite claim and the recipient is not enrolled in the CSOC respite program for all or part of the service period on the claim. Below are the form locators that apply:

ADA	15, 24
1500	1A, 24A
UB-04	6, 60
MC-6	1, 2, 12
MC-9	3, 4, 25A
MC-12	3, 4, 17
MC-19	8, 14A
TAD	5, 10, 11

**EDIT 1455 - NOT A COVERED SERVICE UNDER NJ MEDICAID**

This edit will post to Long Term Acute Care Hospital Medicare providers to identify their claims for the sole purpose of denying their claims so that the provider can go back to CMS and claim bad debt. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1459 - PRA INVALID FOR PRENATAL SERVICE**

This edit will post to a claim when a prenatal claim does not have an active initial Prenatal Risk Assessment (PRA) for the provider and recipient on the claim. This edit does not apply to any specific form locator.

**EDIT CODE 1461 - INCORRECT SUBMITTER ID FOR EVV SERVICE**

This edit will post to a claim when the Submitter ID is NOT 3300099 - AND - The Place of Service is '2' (Patient's Home) - AND - Date of Service is greater than or equal to 1/1/2021 - AND - The Service on the claim is on one of the following:

(T1019, T1019HQ, T1020, T1019SE, T1019SEU1, S5125SEHQ, S5125SEU3, S5130, S5130HQ, T1005, H2016HI, H2016HI22, H2016HIU8, T1005HI, T1005HIU8, H2021HI, H2021HI22, H 2021HI52).

If the Submitter ID is NOT 3300099 - AND - Date of Service is greater than or equal to 10/1/2021 - AND - The Service on the Claim is equal to one of the following:

(H2015HM, H2015HAH0, H2016HAH0, H2015HAHN, H2016HAHN, T2021HAHN, T2021HAH0, S9125HA52, H0031HA, H0031HA22 ,H0031HAHP, 96158HA, 96159HA)

Below are the form locators that apply:

ADA	N/A
1500	24B, 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1462 - INCORRECT SUBMITTER ID FOR EVV SERVICE**

This edit will post to a claim when the Submitter ID is NOT 3300099 and Place of Service is '2' (Patient's Home) and not one of the service/procedure codes used for EVV services. Below are the form locators that apply:

ADA	N/A
1500	24B, 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT CODE 1464 - PRA INVALID - NO BILLING NPI NUMBER FOUND FOR PRENATAL SERVICE**

This edit will post to prenatal claims when: 1. The recipient from the claim and the PRA match - AND - 2. The billing NPI number from the claim and the PRA DO NOT Match.

Below are the form locators that apply:

ADA	N/A
1500	33A
UB-04	56
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT CODE 1465 - PRA INVALID - CLAIM DOS NOT WITHIN PRA DOS**

This edit will post to prenatal claims when: 1. The recipient from the claim and the PRA match - AND - 2. The billing NPI number from the claim and the PRA match - BUT -

3. Claim service dates are not within the effective dates of the PRA with the matching recipient and billing NPI number. Below are the form locators that apply:

ADA	N/A
1500	24A, 33A
UB-04	6, 56
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1600 - CLAIM EXCEEDS BEDS LICENSED TO PROVIDER FOR THE MONTH**

This edit posts to a Long Term Care claim when the Provider in is excess of the allowable monthly licensed beds. For example: a Provider with 20 licensed beds in January is entitled to be paid for a maximum of 620 days. This edit does not apply to any specific form locator.

**EDIT 1601 - PA REQUIRED NOT IN LTC FACILITY ON DOS**

This edit is for transportation and transportation crossover claims that indicate a skilled nursing facility is the beginning and/or ending transportation service, but there is no corresponding claim indicating that the recipient was in a skilled nursing facility on the date of service billed. A PA number must be supplied in the appropriate field if the beneficiary was not in a LTC on the date of service. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	Top right hand corner
MC-19	N/A
TAD	N/A

**EDIT 1602 - OP PSYCH SERVICE IN CONFLICT WITH Y99XX CLAIM**

This edit will post if the incoming claim matches the following on a previously paid claim with the same recipient number, with any overlap in dates of service, with service dates on or after July 1, 2008 for BA/IIC services; Partial Care; Partial Hospital or Hospital Outpatient services; or YCM claims. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	44
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1603 - ADJ/VOID CREATED FOR RECIPIENT CHANGE FROM GA TO OTHER ELIG**

This edit is posted by the system when a claim is reprocessed because a GA Beneficiary was granted retroactive eligibility to another program. Claims that were reprocessed had no financial impact on the provider. This edit does not apply to any specific form locator.

**EDIT 1604 - NO FQHC DELIVERY, OB/GYN OR ENCOUNTER MATCHING CLAIM**

This edit posts to an FQHC claim when the procedure code being billed is for OB/GYN and there is no matching claim for the encounter code, or vice versa. This edit does not apply to any specific form locator.

**EDIT 1605 - FQHC PAID HIGHEST DELIVERY, OB/GYN OR ENCOUNTER CLAIM**

This edit posts to an FQHC claim to inform the Provider that the highest tentative payment amount will be paid. This edit does not apply to any specific form locator.

**EDIT 1606 - RATE DECREASE WHEN PARTIAL HOSPITALIZATION EXCEEDS 24 MONTH**

This edit will post to an outpatient claim(s) when history of revenue code of 912 or 913 causes the incoming claim to exceed the 24 month payment limitation; therefore the payment rate is decreased.

ADA	N/A
1500	N/A
UB-04	FL42
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1607 - FQHC DUPLICATE CONFLICT**

This edit posts to an FQHC claim when it is a duplicate of another paid claim on the system. This edit does not apply to any specific form locator.

**EDIT 1608 - INITIAL DETERMINATION OF PURCHASE**

This edit posts to a DME claim for a rental item to indicate that the rental limits have been reached. This means that the item is now considered a purchase. This edit does not apply to any specific form locator.

**EDIT 1609 - LONG TERM PSYCHIATRIC CLAIM REDUCED BY PR1**

This edit posts to a long term psychiatric inpatient stay when the payment was reduced by the Beneficiary's PR1 amount for that month. This edit does not apply to any specific form locator.

**EDIT 1610 - NO MATCH FOUND IN HISTORY FOR HOSPITAL ADJUSTMENT**

This edit posts to a Hospital adjustment when the claim being adjusted was already adjusted by the State, or if the ICN being reported to adjust is not on file. This edit does not apply to any specific form locator.

**EDIT 1611 - PARTIAL PR-1 DEDUCTION APPLIED**

This edit posts to a LTC claim when the total deducted amount on the Remittance Advice is less than the PR-1 amount from the LTC file. The PR-1 deducted amount is reduced by the amount reported on a previously approved Hospice claim for the same billing month. This is an Explanation of Benefit (EOB) message only. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	35

**EDIT 1612 - PARTIAL PATIENT PAYMENT AMOUNT APPLIED**

This edit posts to a LTC claim when the total deducted amount on the Remittance Advice is less than the Patient Payment amount reported on the claim. The amount is reduced by the amount reported on an Approved Hospice claim for the same billing month. This is an Explanation of Benefit (EOB) message only. Make sure the Patient Payment amount reported on the claim represents the total income collected from the beneficiary for that billing month. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	35

**EDIT 1614 - OBSERVATION OFFICE VISIT CONFLICT WITH OTHER DENTAL SERVICE**

This edit posts for a dental claim when the code being billed is for observation (D9430) and there is another claim for the same provider, same beneficiary, same date of service has already been paid for one of the following procedure code ranges:

D0120 - D0119  
D0331 - D9999

Below are the form locators that apply:

ADA	24
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1615 - CUTBACK-OBSERVATION OFFICE VISIT ALREADY PAID**

This edit posts to a Dental claim when the procedure being billed is for one of the following codes D0120 - D0119 or D0331 - D9999 and the Provider already received payment for D9430. This edit informs the Provider that there claim is being cutback due to the previous payment. Below are the form locators that apply:

ADA	24
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1616 - FQHC HCPCS WITH NO ENCOUNTER FOUND**

This edit posts to an FQHC CHEC claim when there is no matching encounter billed for the same date of service, same Beneficiary. This edit does not apply to any specific form locator.

**EDIT 1617 - PA NUMBER CHANGED SYSTEMATICALLY**

This edit posts to a DME claim when the system automatically changed the PA that was reported on the claim to match the updated PA information in the system. This edit does not apply to any specific form locator.

**EDIT 1618 - MEDICARE PART A REQUIRED FOR MN HOSPICE SERVICES**

This edit posts to hospice claims with procedure code T2046 when the beneficiary is not Medicare Part A eligible on the date of service.

This edit does not apply to any specific form locator.

**EDIT 1621 - DENY REASON CODE OR DENY EXPLANATION MISSING ON EOB**

This edit posts when the other insurance denies the claim and there is no explanation why. This edit does not apply to any specific form locator.

**EDIT 1622 - CHARITY CARE AND MEDICAID DUPLICATE ERROR**

This edit will post if an incoming Medicaid fee for service claim was matched against a previously paid Charity Care claim. This edit does not apply to any specific form locator.

**EDIT 1624 - PAYMENT AMOUNT WAS REDUCED DUE TO PATIENT LIABILITY**

This edit post on an Inpatient claim when the final claim payment amount was reduced to be the sum of the Patient Liability amounts because the value is less than the Medicaid approved amount minus TPL. This edit does not apply to any specific form locator.

**EDIT 1625 - COMMERCIAL HMO CO-PAY/COINS/DEDUCT**

This edit posts to a claim when the final payment is calculated based on Co-pay, coinsurance, or Deductible amount submitted on the claim. Below are the form locators that apply:

ADA	35
1500	19
UB-04	39-41
MC-6	N/A
MC-9	19
MC-12	18
MC-19	27
TAD	N/A

**EDIT 1626 - MEDICARE COVERAGE IND OF 4 FOR MEDICARE HMO CLAIM LOGIC**

This edit posts to an institutional XOVER claim and the Beneficiary is Medicare HMO eligible on dates of service rendered. This edit does not apply to any specific form locator.

**EDIT 1627 - EXHAUSTED CHARGES A3 AMOUNT REPORTED ON THE CLAIM**

This edit posts to an inpatient claim when there is an exhausted charge amount reported for the Medicare or Private coverage payor ID. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	31-36
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1628 - REQUIRED DENTAL CLAIM NOT RECEIVED FOR SAME DOS**

This edit posts to a Dental claim for Behavioral Management (D9920) and there was no other procedure billed with it. The Provider cannot bill for just D9920. This edit does not apply to any specific form locator.

**EDIT 1629 - DENTAL ANESTHESIA CLAIM CUTBACK BY BEHAVIOR MANAGEMENT CLAIMS**

This edit will post for a Dental Anesthesia claim with a procedure code of D9220, D9221, D9241, or D9242, when a behavior management claims (D9920) had already paid for that date of service. This edit does not apply to any specific form locator.

**EDIT 1630 - MCARE LTC CLAIM WITH OVERLAPPING DOS**

This edit posts to a Long Term Care claim when the dates of service reported overlap with dates that were previously paid on a Long Term Care crossover claim. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	10 & 11

**EDIT 1631 - THERAPY CONFLICT WITH RESIDENTIAL, PARTIAL CARE, TRANSPORT**

This edit posts to a claim when the service being billed is for; residential, partial care, or transportation, and another claim for one of these services was already paid for the same date. This edit does not apply to any specific form locator.

**EDIT 1632 - PROVIDER ADULT MDC UNIT EXCEEDS 200 UNIT PER DAY**

This edit posts to any claim for an Adult Medical Daycare Center when they have already been paid for 200 paid claims for that date of service. This edit does not apply to any specific form locator.

**EDIT 1633 - PA REQUIRED FOR PARTIAL CARE**

This edit posts to any claim for Partial Care (Z0170) if the Beneficiary is 18 years or older, or if the claim is not for a new admission. (PA not required for first 30 days). Below are the form locators that apply:

ADA	N/A
1500	23
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1634 - NON-EMERGENCY TRANSPORTATION PROCEDURE**

This edit will post to a Transportation claim with a code of A4020, A0422, A0424, A0425, A042522, A0425ET, A0427ET, or A0433ET and there is no emergency transportation claim with a code of A0429 or A0434 for the same Beneficiary, date of service, and Provider. This edit does not apply to any specific form locator.

**EDIT 1636 - MEDICARE CROSSOVER CLAIM PAID AND DUPLICATE DME CLAIM VOIDED**

This edit posts to a VOIDED Durable Medical Equipment (DME) claim when a Medicare DME crossover claim is paid for the same Provider, same Beneficiary, and same or overlapping dates of service. This edit does not apply to any specific form locator.

**EDIT 1640 - HOSPICE TRANSFER DAY OF DISCHARGE PAYMENT CUTBACK**

This edit posts to a Hospice claim when the system has another claim paid for the same Beneficiary, Procedure Code, but for another Provider, and there is a single day of overlap between the paid claim and the current claim. The final day of the claim with the earlier dates of service is cut back. This edit will post to the claim that is cut back.

When the claim is for T2043 and overlaps with a single date of service for the same Beneficiary, Procedure Code, different Provider, and both claims exceed 24 units, the current claim will be cut back with any units over 24. Below are the Form Locators that apply to the edit:

ADA	N/A
1500	24A, and 24G
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1641 - HOSPICE TRANSFER WITH MORE THAN ONE OVERLAPPING SERVICE DAY**

This edit posts to a Hospice claim when the system has another claim paid for the same Beneficiary, Procedure Code, but for another Provider, and there is more than one day of overlap between the paid claim and the denied claim. Below are the Form Locators that apply:

ADA	N/A
1500	24A and 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1642 - HOSPICE XFER DAY OF DISCHARGE WITH > 1 OVERLAPPING SVC DAY**

This edit will post to a Hospice claim when the system has another paid claim for the same Beneficiary, Procedure Code, but a different Provider, and there is a single day of overlap between the paid claim and the current claim. The paid claim is earlier than this claim and will automatically adjust to cut back a unit for the date of discharge. This claim will pend for one week until the adjustment is completed for the paid claim. Below are the Form Locators that apply:

ADA	N/A
1500	24A
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1643 - CLAIM VOID PENDED - UNCONFIRMED RECIPIENT DEATH**

This edit posts to a system generated void of a claim, if the beginning date of service is later than the Beneficiary's date of death, but there is open eligibility with an expiration date later than the Beneficiary's date of death. This edit does not apply to any specific form locator.

**EDIT 1644 - CLAIM VOIDED - RECIPIENT DEATH**

This edit will post to a claim when the system generated void of a claim to indicate the void was done because the beginning date of service is later than the beneficiary's date of death. This edit does not apply to any specific form locator.

**EDIT 1645 - HMS MEDICARE COVERAGE IS NOT PRESENT ON TPL**

This edit will post when recovered by HMS that Medicare Coverage has been identified for this service.

This edit does not apply to any specific form locator.

**EDIT 1646 - HMS PRIVATE COVERAGE IS NOT PRESENT ON THE TPL**

This edit will post when recovered by HMS that Other Private Coverage has been identified for this service. This edit does not apply to any specific form locator.

**EDIT 1647 - INVALID REVENUE CODE FOR LONG TERM PSYCH CLAIMS**

This edit will post to a claim when it is for an Inpatient or Inpatient crossover claim from a Long Term Psychiatric facility and contains the following revenue code lines:  
190 thru 196; 183 and 185

**EDIT 1649 - OP TRANS PMT REDUCED BY PREVIOUS PAID OP TRANS CLM**

This edit will post when the claim payment was reduced by a previously paid outpatient transportation claim when there is an approved claim in history containing revenue code OP540, OP542, OP543, OP545 or OP546 and procedure code A0427, A0429, A0431, A033 or A0434.

This edit does not apply to any specific form locator.

**EDIT 1652 - MENTAL HEALTH CLAIM CUTBACK - BENEFIT LIMIT REACHED**

This edit posts to a claim when the mental health benefit has been reached for that Beneficiary. The system cut back the claim units to only pay out for the maximum allowed benefit. Below are the form locators that apply:

ADA	N/A
1500	24G
UB-04	46
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1653 - PAYMT BASED ON AFFORDABLE CARE ACT ENHANCED RATES CY 13 & 14**

This edit posts to eligible claims when a qualified billing provider meets the requirements to be paid based on the Healthcare Education Reconciliation Act, Section 1202. Please refer to Newsletter Volume 23, No. 04 for further details.

This edit does not apply to any specific form locator.

**EDIT 1654 - RECIPIENT INELIGIBLE FOR ACA TITLE 19**

This edit posts to claims ineligible for enhanced FFS payments under the Healthcare Education Reconciliation Act, Section 1202 because the recipient has not been determined eligible under Title 19 of the Social Security Act. Please refer to Newsletter Volume 23, No. 04 for further details.

This edit does not apply to any specific form locator.

**EDIT 1655 - SERVICE/VISIT CONFLICT**

This edit will post to a claim when it is used to prevent payment of a claim for a visit that occurred within the post-op days limit associated with a paid surgery claim. The primary diagnosis code for one claim is ICD9 and the other claim is ICD10, therefore it could not determine if they were the same diagnosis. Below are the form locators that apply:

ADA	N/A
1500	24A-L
UB-04	67, A-Q
MC-6	N/A
MC-9	12
MC-12	N/A
MC-19	14F
TAD	14-16

**EDIT 1656 - DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR NJ**

This edit will post to a claim when two exist which met the conditions for edit 0919, but the primary diagnosis code for one claim is ICD9 and the other claim is ICD10, therefore it could not systemically determine if they were the same diagnosis. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	67, A-Q
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1657 - DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR PA**

This edit will post to a claim when two claims exist which met the conditions for edit 0920, but the primary diagnosis code for one claim is ICD9 and the other claim is ICD10, therefore it could not systemically determine if they were the same diagnosis. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	67, A-Q
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1658 - DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR NY**

This edit will post to a claim when two claims exist which met the conditions for edit 0924, but the primary diagnosis code for one claim is ICD9 and the other claim is ICD10, therefore it could not systemically determine if they were the same diagnosis. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	67, A-Q
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1669 - NO RECORD OF AN EPISODE OF CARE ON FILE**

This edit will post to a claim when an on-site follow-up or an off-site follow-up did not have an on-site Episode of Care or an off-site Episode of Care in history within the past 14 days from the service date of the follow-up service.

This edit does not apply to any specific form locator.

**EDIT 1670 - NUMBER OF UNITS EXCEEDS 6 IN A 14 DAY PERIOD**

This edit posts when the total number of units for an off-site follow up exceeds 6 units within a 14 day period of time, following the date of service for an off-site episode of care. This edit does not apply to any specific form locator.

**EDIT 1671 - SERVICE DATE/HCPCS COMBINATION MATCH OCCURRENCE IN HISTORY**

This edit will post to a PERS claim when the date of service on the claim for a revenue/HCPCS procedure code combination matches a history occurrence with the same date of service. Below are the claim forms and form locators that apply:

ADA	N/A
1500	N/A
UB-04	6, 45
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1673 - DEPT OF CORRECTIONS/MEDICAID DUPLICATE ERROR**

This edit will post when there is a duplicate paid original or adjusted Inpatient or Inpatient Crossover claims when the following conditions are found: the same patient account number or medical record number, servicing provider, exact service dates and the Special Program Code is equal or not equal to 98.

This edit does not apply to any specific form locator.

**EDIT 1674 - REPROCESS PE CLAIMS NOW ELIGIBLE FOR NEW ADULT GROUP**

This edit will post to a claim when the claim is reprocessed because the recipient was originally granted Presumptive Eligibility and then retroactive eligibility to the New Adult Group (Program Status Code 380 or 762). The PE claim is voided and a new claim is created with the new eligibility. Claims that were reprocessed have no financial impact to the provider.

This edit does not apply to any specific form locator.

**EDIT 1686 - SUD MGMT CLAIM WITH NO MATCHING E&M CLAIM**

This edit will post to a claim billed for Navigator services when the appropriate E&M claim is not found for the same original recipient, any servicing provider and within the defined dates of service. This edit does not apply to any specific form locator.

**EDIT 1688 - CLM FOR REQUIRED BASE TIME CODE NOT RECEIVED FOR ADD ON CODE**

This edit will post to a claim when a claim was received for the additional 15 minutes of service time and there is no base 30 minute service time claim found for the same date of service. Below are the form locators that apply:

ADA	N/A
1500	24D
UB-04	44
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1702 - DOULA VISITS EXCEED LIMIT**

This edit will post to a claim when for doula visits if the number of visits exceed the maximum per pregnancy. This edit does not apply to any specific form locator.

**EDIT 1703 - POSTPARTUM VISIT EXCEEDS 6 MONTHS FROM L&D**

This edit will post to claim when for doula postpartum visits (99199HD, 99199HD22) if the visit is more than 6 months from the Labor & Delivery claim or no L&D claim exists. Below are the form locators that apply:

ADA	N/A
1500	24A, 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 1704 - DOULA INCENTIVE PAYMENT MISSING REQUIRED CLAIMS**

This edit will post to a claim for the doula incentive payment, 99199H DU8, when qualifying claims are not present. This edit does not apply to any specific form locator.

**EDIT 1705 - DOULA VISIT EXCEEDS AGE LIMIT**

This edit will post to a claim when the doula visits 99600HD22 and 99199HD22 are present when the mother's age at the first doula visit is 20 years old or older. These visit codes are for extra visits for mother's aged 19 and younger at the time of the first doula visit. Below are the form locators that apply:

ADA	N/A
1500	3, 24D
UB-04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT CODE 1709 - OORP WEEKLY SERVICE (X4) WITH NO PAID INITIAL SERVICE (X3)**

This edit will post to a claim when procedure code H0038HF X4(weekly service) is billed and there is no claim history for procedure code H0038HF X3(initial service) within an 8 week time period for the same recipient and same billing provider. Below are the form locators that apply:

ADA	N/A
1500	24D
UB04	N/A
MC-6	N/A
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT CODE 1752 - NO PRESUMPTIVE DRUG TEST WITHIN 7 DAYS**

This edit will post on a definitive drug test claim when a presumptive drug test claim was not paid within the prior 7 days.

This edit does not apply to any specific form locator.

**EDIT 1801 - CLAIM CHECK: CLM DIAG INVALID BASED ON ICD-9 EXPIRATION DT**

This edit will post if the ICD-9 diagnosis code has expired.

**EDIT 1802 - CLAIM CHECK: CLM DIAGNOSIS INVALID ICD-10**

This edit will post if the ICD-10 diagnosis code has expired.

**EDIT 1803 - CLAIM CHECK: INVALID OR MISSING GENDER**

This edit will post if the gender indicated is not M or F, or if the gender indicator is missing.

**EDIT 1804 - CLAIM CHECK: COSMETIC PROCEDURE**

This edit will post if the procedure code on the claim is classified as cosmetic.

**EDIT 1805 - CLAIM CHECK: CLAIM LINES EXCEED MAXIMUM**

This edit will post if the number of claim lines exceed the maximum allowed.

**EDIT 1806 - CLAIM CHECK: UNLISTED PROCEDURE CODE**

This edit is set by Claim Check if the procedure code is unlisted.

**EDIT 1807 - CLAIM CHECK: PROCEDURE CODE IS COSMETIC AND UNLISTED**

This edit will post if the procedure is classified as cosmetic and is unlisted.

**EDIT 1808 - CLAIM CHECK: INVALID PROCEDURE CODE**

This edit will post if the procedure code on the claim is invalid.

**EDIT 1809 - CLAIM CHECK: DOB CANNOT BE GREATER THAN DATE OF SERVICE**

This edit will post if the date of birth on the claim is greater than the date of service.

**EDIT 1810 - CLAIM CHECK: PROCEDURE CODE IS EXPERIMENTAL**

This edit will post if the procedure code is classified as experimental.

**EDIT 1811 - CLAIM CHECK: PROCEDURE CODE IS OBSOLETE**

This edit will post if the procedure code is classified as obsolete.

**EDIT 1812 - CLAIM CHECK: PROCEDURE CODE IS MISSING**

This edit will post if the procedure code is missing on the claim.

**EDIT 1813 - CLAIM CHECK: DATE OF SERVICE REQUIRED FOR PROCEDURE**

This edit will post if the required date of service for the procedure is missing.

**EDIT 1814 - CLAIM CHECK: MODIFIER 26 NOT ALLOWED FOR PROCEDURE CODE**

This edit is posted if the procedure code had a modifier 26, but does not have a professional component.

**EDIT 1815 - CLAIM CHECK: DUPLICATE PROCEDURE FOR SAME DATE OF SERVICE**

This edit will post if there is a duplicate procedure for the same date of service.

**EDIT 1818 - CLAIM CHECK: PROCEDURE NOT VALID DUE TO REBUNDLING**

This edit will post if the procedure code should not be used when billed with another, similar procedure code on the same date of service. Rebundling occurs when one procedure code can be used instead of two.

**EDIT 1819 - CLAIM CHECK: SERVICE DAYS EXCEED NUMBER OF UNITS**

This edit will post if the service days exceed the number of units billed.

**EDIT 1820 - CLAIM CHECK: DATE OF SERVICE IS A FUTURE DATE**

This edit will post if the date of service is a future date.

**EDIT 1821 - CLAIM CHECK: BIRTH DATE IS A FUTURE DATE**

This edit will post if the beneficiary date of birth is indicated as a future date.

**EDIT 1822 - CLAIM CHECK: MISSING PROCEDURE CODE**

This edit will post if the procedure code is missing on the claim.

**EDIT 1823 - CLAIM CHECK: NUMBER OF UNITS EXCEED NUMBER OF SERVICE DAYS**

This edit will post if the number of units on the claim exceeds the number of service days.

**EDIT 1824 - CLAIM CHECK: AGE CANNOT BE GREATER THAN 124 YEARS**

This edit will post if the beneficiary age is greater than 124 years.

**EDIT 1825 - CLAIM CHECK: PROCEDURE INDICATED FOR NEONATE PATIENT**

This edit will post if the beneficiary is not 0-30 days old.

**EDIT 1826 - CLAIM CHECK: PROCEDURE INDICATED FOR PEDIATRIC PATIENT**

This edit will post if the beneficiary is not 31 days-17 years old.

**EDIT 1827 - CLAIM CHECK: PROCEDURE INDICATED FOR MATERNITY PATIENT**

This edit will post if the beneficiary is not 12-55 years old.

**EDIT 1828 - CLAIM CHECK: PROCEDURE INDICATED FOR ADULT PATIENT**

This edit will post if the beneficiary is not over 14 years old.

**EDIT 1829 - CLAIM CHECK: PROCEDURE NOT INDICATED FOR A MALE**

This edit will post if the procedure code billed is indicated for a female.

**EDIT 1830 - CLAIM CHECK: NUMBER OF PROCEDURES IS GREATER THAN 100**

This edit will post if the number of procedure codes is greater than 100.

**EDIT 1831 - CLAIM CHECK: PROCEDURE NOT INDICATED FOR A FEMALE**

This edit will post if the procedure code billed is indicated for a male.

**EDIT 1832 - CLAIM CHECK: DIFFERENT PROVIDERS NOT VALID FOR CLAIMS**

This edit is set by Claim Check because the claim lines contain different providers.

**EDIT 1833 - CLAIM CHECK: MISSING PROVIDER**

This edit is set by Claim Check because a history claim sent to Claim Check did not have a provider.

**EDIT 1834 - CLAIM CHECK: INVALID MODIFIER**

This edit is set by Claim Check because the claim had an invalid modifier.

**EDIT 1835 - CLAIM CHECK: INVALID MODIFIER/PROCEDURE CODE COMBINATION**

This edit is set by Claim Check because the modifier and procedure code combination is not valid.

**EDIT 1837 - CLAIM CHECK: ASSISTANT SURGEON NOT ALLOWED FOR PROCEDURE**

This edit is set by Claim Check for procedures which sometimes allow an assistant surgeon, but not always.

**EDIT 1843 - CLAIM CHECK: INVALID DIAGNOSIS CODE**

This edit will post if the diagnosis code is invalid.

**EDIT 1847 - CLAIM CHECK: INVALID CLAIM DIAGNOSIS CODE**

This edit will post if the diagnosis code is invalid.

**EDIT 1849 - CLAIM CHECK: INVALID DATE OF BIRTH CENTURY VALUE**

This edit will post if the date of birth does not contain a valid century.

**EDIT 1850 - CLAIM CHECK: INVALID DATE OF BIRTH**

This edit will post if the beneficiary date of birth is invalid.

**EDIT 1851 - CLAIM CHECK: INVALID CLAIM DATE OF SERVICE**

This edit will post if the date of service is invalid.

**EDIT 1852 - CLAIM CHECK: INVALID DATE OF SERVICE**

This edit will post if the date of service is invalid.

**EDIT 1853 - CLAIM CHECK: INVALID CHARGE AMOUNT**

This edit will post if the charge amount is invalid.

**EDIT 1854 - CLAIM CHECK: INVALID NUMERIC FIELD**

This edit will post if the numeric field contains invalid data.

**EDIT 1857 - CLAIM CHECK: NUMERIC FIELD NOT POPULATED**

This edit is set by Claim Check because a numeric field contains spaces.

**EDIT 1858 - CLAIM CHECK: CLAIM LINES EXCEED THE MAXIMUM**

This edit will post if the claim exceeds the maximum of 100 lines.

**EDIT 1862 - CLAIM CHECK: MISSING PROVIDER ON CLAIM**

This edit will post if the provider ID is missing from the claim.

**EDIT 1867 - CLAIM CHECK: DIAGNOSIS INDICATES POSSIBLE TPL**

This edit is set by Claim Check because a diagnosis code indicates possible coverage of the service by a third party payor.

**EDIT 1868 - CLAIM CHECK: PROCEDURE CODE INDICATES POSSIBLE TPL**

This edit is set by Claim Check because the procedure code indicates possible coverage of the service by a third party payor.

**EDIT 1877 - CLAIM CHECK: PROCEDURE NOT EXPECTED FOR DIAGNOSIS**

This edit will post to a claim when the procedure code is not expected for the diagnosis code

ADA	N/A
1500	FL21 and 24D
UB-04	N/A
MC-6	N/A
MC-9	FL12 and 25B
MC-12	N/A
MC-19	FL14D&F
TAD	N/A

**EDIT 1878 - CLAIM CHECK: MEDICALLY UNLIKELY EDIT (EXCESSIVE UNITS)**

The MUE (medically unlikely edit) represents the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. If the units are exceeded, the edit will post. This edit references the number of units on a single claim line.

ADA	N/A
1500	FL24G
UB-04	N/A
MC-6	N/A
MC-9	FL25D
MC-12	N/A
MC-19	FL14G
TAD	N/A

**EDIT 1879 - CLAIM CHECK: DIAGNOSIS INVALID BASED ON ICD-9 EXPIRATION DT**

This edit will post if the ICD-9 diagnosis code has expired.

**EDIT 1880 - CLAIM CHECK: DIAGNOSIS INVALID ICD-10**

This edit is set by Claim Check if the diagnosis code on the claim is invalid based on the ICD-10 effective date.

**EDIT 1881 - CLAIM CHECK: PROCEDURE CODE AGE RESTRICTED**

This edit will post if there is a discrepancy in the beneficiary's age and the procedure code.

**EDIT 1882 - CLAIM CHECK: ASSISTANT SURGEON DENIED**

This edit will post if the assistant surgeon was denied for this claim.

**EDIT 1883 - CLAIM CHECK: ASSISTANT AT SURGERY DENIED**

This edit will post if the assistant surgeon was denied for this claim.

**EDIT 1884 - CLAIM CHECK: NEW PATIENT PROC NOT APPROPRIATE**

This edit is set if Claim Check determines that a new patient evaluation and management service was not warranted. An established patient procedure should have been used instead.

**EDIT 1885 - CLAIM CHECK: CCI INCIDENTAL PROCEDURE**

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

**EDIT 1886 - CLAIM CHECK: CCI MUTUALLY EXCLUSIVE PROCEDURE**

This edit indicates a National Correct Coding Initiative mutually exclusive edit. A mutually exclusive relationship involves procedures that would not reasonably be performed during the same session, or combinations of procedures that are medically improbable or impossible to be performed at the same time.

**EDIT 1887 - CLAIM CHECK: INCIDENTAL PROCEDURE**

Certain procedures are commonly performed in conjunction with other procedures as a component of the overall service provided. An incidental procedure is one that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.

**EDIT 1889 - CLAIM CHECK: MUTUALLY EXCLUSIVE PROCEDURE**

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

**EDIT 1890 - CLAIM CHECK: POST OPERATIVE PROCEDURE CODE**

This edit will post if the procedure is determined to be a post-operative procedure.

**EDIT 1891 - CLAIM CHECK: PRE OPERATIVE PROCEDURE CODE**

This edit will post if the procedure is determined to be a pre-operative procedure.

**EDIT 1892 - CLAIM CHECK: PROCEDURE NOT VALID DUE TO REBUNDLING**

This edit will post if the procedure code should not be used when billed with another, similar procedure code on the same date of service. Rebundling refers to when one procedure code can be used instead of two procedure codes.

**EDIT 1893 - CLAIM CHECK: PROCEDURE GENDER RESTRICTION**

This edit will post if there is a discrepancy with the beneficiary's gender and the procedure code.

**EDIT 1894 - CLAIM CHECK: INTENSITY OF SERVICE**

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

**EDIT 1895 - CLAIM CHECK: DUPLICATE PROCEDURE**

This edit is set by Claim Check if a duplicate procedure code exists

**EDIT 1896 - CLAIM CHECK: MEDICAL VISIT PROCEDURE**

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

**EDIT 1897 - CLAIM CHECK: DIAGNOSIS NOT EXPECTED FOR PROCEDURE**

This edit will post if the diagnosis code is not expected for the procedure code.

ADA	N/A
1500	FL21&24D
UB-04	N/A
MC-6	N/A
MC-9	FL12&25B
MC-12	N/A
MC-19	FL14D&F
TAD	N/A

**EDIT 2000 - SERVICE ADMINISTRATIVELY DENIED**

This edit posts when the claim has been reviewed by the State and Administratively denied.

**EDIT 2001 - COMPOUND CONTAINS DUPLICATE INGREDIENTS**

This edit posts when the claim is a compound drug and two or more ingredients are the same.

**EDIT 2002 - LTC COMPOUND MUST CONTAIN ACTUAL NDC**

This edit posts when the claim is a compound drug for a recipient in a LTC facility and one or more of the ingredients are in the drug class of "V". (Vial)

**EDIT 2003 - COMPOUND DRUG-INCORRECT INGREDIENT QUANTITY/COST**

This edit will post when the claim is a compound drug and one or more of the ingredients are charged higher than the usual and customary charge on file.

**EDIT 2004 - CLAIM PENDING RE-ENROLLMENT**

This edit post when the provider has either sent back incomplete/invalid information on their re-enrollment package, or the provider has not sent the package back to Gainwell Technologies at all.

**EDIT 2005 - INVALID PART D DEDUCTIBLE AMOUNT**

This edit posts when the Medicare Part D deductible amount is less than zero or greater than \$250.00.

**EDIT 2006 - PART D CO-PAY AMOUNT IS NEGATIVE**

This edit post when the Medicare Part D co-insurance/co-pay amount is less than zero.

**EDIT 2007 - PRIOR AUTHORIZATION (PA) REQUIRED**

This edit posts for some drugs that need to meet certain DURB-established criteria. Sometimes simple knowledge of the Beneficiary's diagnosis especially for first fill would help expedite the call.

**EDIT 2008 - PART D COB BYPASS EARLY REFILL**

This edit posts when the claim is bypassing early refill edits 0830-0832.

**EDIT 2010 - WRONG PCN (104-A4) VALUE MUST = SUPPNJ, ADDP, OR PAAD**

This edit post when the above mentioned values are incorrect.

**EDIT 2011 - CLAIM PAID BY DIFFERENT PDP**

This edit posts when the claim has a PDP New Jersey Insurer Code (Medicare D) that is different from what is on the Gainwell Technologies file. This edit does not deny the claim.

**EDIT 2012 - POSSIBLE PART D ELIGIBLE BENEFICIARY HAS PART A OR B COVERAGE**

This edit posts when the drug is a Medicare Part D covered drug and the beneficiary has Medicare Part A or B and has not yet enrolled but not declined for Part D coverage. This edit does not deny the claim.

**EDIT 2013 - POSSIBLE PART D ELIGIBLE > 64 YRS OLD**

This edit posts when the beneficiary is not enrolled in a Medicaid Special Program for Aliens, greater than 64 years old, not yet applied for Part D, but not yet declined. This edit does not deny the claim.

**EDIT 2014 - POSSIBLE PART D ELIGIBLE / BENEFICIARY DISABLED**

This edit posts when the beneficiary is PAAD Disabled, is eligible for Part D, has not yet enrolled or declined. This edit does not deny the claim.

**EDIT 2015 - PART D ELIGIBLE BUT NO PDP ON FILE**

This edit posts when the drug is a Part D covered drug, and the beneficiary has not yet enrolled or declined Part D. This edit does not deny the claim.

**EDIT 2016 - BENEFICIARY PART D ELIGIBLE: REQUEST INSURANCE CARD**

This edit will post when the drug is a Part D covered drug and the beneficiary has declined part D coverage.

Please send an E1 query to determine/verify Part D enrollment. If E1 query returns a "no match", submit the claim to Anthem at 800-662-0210. (See Newsletter Vol. 16 No. 20)

**EDIT 2017 - PART D COVERAGE KNOWN BILL PART D**

This edit posts when the drug is a Part D covered drug and the claim does not reflect that Part D was billed.

**EDIT 2018 - PART D PDP PAID BUT KNOW COVERAGE ON FILE**

This edit posts when the claim comes in showing PDP paid and Gainwell Technologies does not show coverage on the beneficiary file.

**EDIT 2019 - PART D CO-INSURANCE/CO-PAY + DEDUCTIBLE CANNOT BOTH BE ZERO**

This edit posts when the claim is submitted with the above fields all equal to zero.

**EDIT 2021 - PART D WRAPAROUND WITH PA**

This edit posts when the drug is on the POS wraparound (with prior authorization required table).

This edit does not deny the claim.

**EDIT 2022 - PART D CLAIM FOR BENE WITH MULTI ELIG -RESUBMIT WITH ALT ID#**

This edit posts when the claim is submitted for a beneficiary with ADDP eligibility and Medicaid or other eligibility open for the date of service on the claim. The pharmacy billed under the wrong Recipient ID number for that type of drug.

**EDIT 2023 - BENEFICIARY NOT ELIGIBLE FOR PART D**

This edit posts if the date of service is before 01/03/05 and the claim is for an ADDP, PAAD, or Senior Gold Beneficiary. This edit does not deny the claim.

**EDIT 2024 - PART D DRUG EMERGENCY SUPPLY-ONE TIME ONLY**

This edit posts for Part D drugs dispensed as an emergency supply. This edit does not deny the claim.

**EDIT 2025 - PART D WRAPAROUND**

This edit posts if the drug is on the Part D wraparound drug table. (with or without prior authorization). This edit does not deny the claim.

**EDIT 2026 - PART D EMERGENCY SUPPLY OF ANTIBIOTICS**

This edit posts if the drug is on the part D Emergency Supply Antibiotics Table. This edit does not deny the claim.

**EDIT 2027 - PART D DEDUCTIBLE/COPAY CLAIM**

This edit posts for Part D PDP approved Part D claims where the tent-pay is the sum of co-insurance and the deductible amounts. This edit does not deny the claim.

**EDIT 2028 - INCORRECT CLAIM COB AMOUNT**

This edit posts for a Medicare Part D covered drug and the payment to the pharmacy is greater than \$125,000.00.

**EDIT 2029 - PART D PAPER CLAIM NOT ALLOWED FOR PART D COB CLAIMS**

This edit will post when a pharmacy Part D claim is submit by paper.

**EDIT 2030 - Part D Co-payment exceeds \$3.00/\$3.10**

This edit posts if the drug has been approved by Medicare Part D and effective on the DOS, the low income subsidy info indicates the max allowed co-pay is \$3.00 for 2006 and \$3.10 for 2007 and the Medicare Part D co-pay/co-insurance is greater than \$3.00 for a date of service in 2006 and \$3.10 if date of service is in 2007.

**EDIT 2031 - PART D CO-PAYMENT EXCEEDS \$5.00/\$5.35**

This edit posts if the drug has been approved by Medicare Part D and effective on the DOS, the low income subsidy info indicates the max allowed co-pay is \$5.00 for 2006 and \$5.35 for 2007 and the Medicare Part D co-pay/co-insurance is greater than \$5.00/\$5.35.

**EDIT 2032 - DAILY DRUG QUANTITY EXCEEDS APPROVED AMOUNT**

This edit posts when the days supply/units exceeds the amount approved on the prior authorization file.

**EDIT 2034 - MEDICARE PART D - NOT COVERED AS WRAPAROUND BENEFIT**

This edit posts to a pharmacy claim being billed with a Part D denial and our records show that this is not a wraparound drug. This claim is the responsibility of the PDP.

**EDIT 2035 - INVALID PDP REJECT CODE FOR PART D WRAPAROUND BENEFIT**

This edit posts to a pharmacy claim that is for a Medicare Part D covered drug being billed to Medicaid without a NCPDP reject code of AC, 60, 61, 66, 70, or MR and the drug is on the Medicare Part D wraparound table.

**EDIT 2036 - MAIL ORDER NOT ELIGIBLE**

This edit posts for Pharmacies only when a beneficiary is not eligible for mail order drugs due to a special program.

**EDIT 2038 - FIRST FILL OF THIS DRUG (BY NDC/GCN/STC) REQUIRES PRIOR AUTHORIZATION**

This edit posts to a pharmacy claim if the drug ( NDC, GCN, or STC ) on the claim is deemed "First Fill". The Pharmacy must contact the MEP Unit at 1-877-888-2939.

**EDIT 2039 - EXEMPT LTC RECIPIENTS FROM MEDICARE PART D CO-PAYMENT**

This edit posts when the submitted Medicare Part D co-pay/co-insurance is greater than zeros. This recipient is exempt from any Medicare Part D co-pay liability since they reside in a nursing home.

**EDIT 2040 - MEDICARE PART D CO-PAYMENT EXCEEDS MAX ALLOWED**

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

- a. The claim is for Medicaid recipient and
- b. The claim has been approved by Medicare Part D and
- c. Effective on DOS, the Low Income Subsidy info (co-pay level 4), and
  - 1) The Medicare Part D co-pay/co-insurance is greater than \$10,000.00 and the STC is NOT equal to 'MOE' or 'MOF', OR
  - 2) The Medicare Part D co-pay/co-insurance is greater than \$125,000.00 and the STC IS equal to 'MOE' or MOF'.

**EDIT 2041 - INVALID DEDUCTIBLE FOR RECIPIENT**

This edit posts if the Medicare Part D deductible is greater than zeros.

**EDIT 2042 - COPAY EXCEEDS CHARGE FOR 3 MONTH SUPPLY**

This edit will post to a Part D pharmacy claim for a 90 day supply and the copay is greater than 3x's the allowed amount for the beneficiary's Low Income Subsidy (LIS) level.

**EDIT 2043 - RECIPIENT ELIGIBLE FOR MEDICARE PART D**

This edit post to a pharmacy claim when the drug shows to be a Part D payable drug and the beneficiary shows to be eligible for Part D.

**EDIT 2044 - PART D EMERGENCY SUPPLY MAY BE FILLED ONLY ONCE IN 90 DAYS**

This edit post to a pharmacy claim when the incoming claim is a Part D claim and the days supply is less than 90 days and there was a prescription for an emergency supply already paid within 90 days.

**EDIT 2046 - PRESCRIPTION NOT ALLOWED DUE TO CHANGE OF THERAPY**

This edit post to a pharmacy claim when the Medical Exception Process (MEP) Unit has determined that this beneficiary should not be filling this prescription at this time.

**EDIT 2047 - PA REQUIRED: DRUG / PRESCRIBER RESTRICTION**

This edit posts to pharmacy claims when there is a special entry that restricts either the Prescriber or the Beneficiary by drug for a specific date range. The Pharmacy must call the MEP Unit at 1-877-888-2939.

**EDIT 2048 - PHARMACY NOT APPROVED STATE PROVIDER**

This edit posts when a pharmacy is not approved to provide services to certain Medicaid Pharmacy Programs. The provider can refer the beneficiary to another participating pharmacy provider.

**EDIT 2050 - BAD PRESCRIBER LICENSE NUMBER**

This edit posts to pharmacy claims when the State License on the claim is not found, missing or invalid, or not from NJ, PA, DE, MD, NY, CT, or FL.

**EDIT 2051 - FIELD 411-DB PRESCRIBER ID MUST CONTAIN A STATE LICENSE NUMBER**

This edit posts to a pharmacy claim when the prescriber ID on the in-coming claim is not the State License Number.

**EDIT 2052 - PART D CLAIM EMERGENCY SUPPLY - NO PDP REJECT CODE**

This edit post when a Pharmacy Part D emergency supply claim has no PDP reject code.

**EDIT 2053 - CLAIM REJECTED BY PART D PDP**

This edit posts to a pharmacy claim with a PDP denial showing a coinsurance and or deductible. The provider needs to take out the coinsurance and or deductible and resubmit the claim.

**EDIT 2054 - CLAIM IS INCORRECTLY BILLED - NO MEDICARE ON FILE**

This edit posts to pharmacy claims when there is no Medicare information on file and the Provider indicates otherwise.

**EDIT 2055 - PART D PDP RESPONSIBLE FOR PAYMENTS/BILL PRIMARY PAYER**

This edit posts to a pharmacy claim when there is a discrepancy in the Part D COB/Other Payments Segment.

**EDIT 2056 - THE LENGTH OF THE SERVICE/BILLING NPI IS INVALID**

This edit posts when the length of the service/billing NPI is invalid.

**EDIT 2057 - SERVICE/BILLING PROVIDER NPI FAIL CHECK DIGIT 201-B1**

This edit posts when the service/billing provider failed checking digits 201-B1.

**EDIT 2058 - SERVICING/BILLING PROVIDER NPI OS REQUIRED AS OF 05/23/08**

This edit posts when the servicing/billing provider NPI is missing.

**EDIT 2059 - THE FIRST DIGIT OF THE SERVICING/BILLING NPI IS INVALID**

This edit posts when the first digit of the servicing/billing NPI is invalid.

**EDIT 2060 - THE MEDICAID ID IS NOT FOUND FOR SERVICING/BILLING NPI**

This edit posts when the Medicaid ID is not found for the servicing/billing NPI.

**EDIT 2061 - FOUND MULTIPLE MEDICAID IDS FOR THE SERVICING/BILLING NPI**

This edit posts when there are multiple Medicaid IDS for the servicing/billing NPI.

**EDIT 2062 - THE LENGTH THE PRESCRIBER NPI IS INVALID**

This edit posts when the length of the prescriber NPI is invalid.

**EDIT 2063 - CHECK DIGIT VALIDATION FAIL FOR THE PRESCRIBER NPI**

This edit posts when the validation failed to check the prescribing NPI.

**EDIT 2064 - PRESCRIBER NPI IS REQUIRED AS OF 05/23/08**

This edit posts when the claim is not submitted with the prescriber's NPI.

**EDIT 2065 - THE FIRST DIGIT OF THE PRESCRIBER NPI IS INVALID**

This edit posts when the first digit of the prescriber's NPI is invalid.

**EDIT 2066 - THE MEDICAID ID IS NOT FOUND FOR THE PRESCRIBER NPI**

This edit posts when the Medicaid number is not found for the prescriber NPI.

**EDIT 2067 - FOUND MULTIPLE MEDICAID IDS FOR THE PRSCRIBING NPI**

This edit posts when the system finds multiple Medicaid IDS for the prescribing provider.

**EDIT 2069 - METRIC QUANTITY MUST REFLECT WHOLE PACKAGE**

This edit posts to a pharmacy claim when a pharmacy tries to split up a package. Pharmacies must bill for the whole package size; this can not be broken up.

**EDIT 2070 - EXCEEDS MAXIMUM METRIC QUANTITY FOR PACKAGE SIZE/FULL PKGS**

This edit posts when the number of packages dispensed exceeds the maximum allowed.

**EDIT 2071 - PAAD RECIPIENT W/MEDICAID COVERAGE**

This edit posts when the system determines that the PAAD Beneficiary has Medicaid coverage.

**EDIT 2072 - DUPLICATE STATE LICENSE # FOUND ON PROVIDER FILE**

This edit post when there are more than one State License number found on the provider's file and the Medicaid number is populated with "44444444".

**EDIT 2073 - REQUESTOR IS NOT AUTHORIZED TO ADJUST/VOID THIS CLAIM**

This edit posts to pharmacy claims when the person requesting an adjustment/void is not authorized to do so.

**EDIT 2074 - CLAIM HAS BEEN PREVIOUSLY VOIDED BY THE STATE - CANNOT RESUBMIT**

This edit will post to pharmacy claims only that have been previously voided by the State. The system will not reprocess the same claim with the same GCN, Service Date and Provider ID. This edit does not apply to any specific form locator.

**EDIT 2076 - SENIOR GOLD RECIPIENT W/MEDICAID COVERAGE**

This edit posts to a pharmacy claim when the system determines that the Senior Gold Beneficiary has Medicaid coverage.

**EDIT 2077 - MEDICAID DUPLICATE ELIGIBILITY WITH PAAD OR SENIOR GOLD**

This edit posts to a pharmacy claim when the system shows that the beneficiary has Medicaid coverage and coverage with either PAAD or Senior Gold.

**EDIT 2078 - MEDICAID DUPLICATE ELIGIBILITY WITH PAAD OR SENIOR GOLD**

This edit posts to a pharmacy claim when the beneficiary has duplicate eligibility with PAAD and Senior Gold.

**EDIT 2083 - DAYS SUPPLY GREATER THAN 34 FOR NURSING HOME EARLY REFILL**

This edit posts to a pharmacy claim when a beneficiary has a change in nursing home status. The pharmacy must change the days supply to not more than 34.

**EDIT 2084 - PRESCRIPTION FILLED BY MAIL ORDER PHARMACY**

This edit posts to a claim for a PAAD, Senior Gold, or ADDP beneficiary who has Medicare Part D and the prescription is filled by a mail order pharmacy.

**EDIT 2085 - MAC OVERRIDE NOT ALLOWED - DISPENSE AS WRITTEN INDICATOR IS INCORRECT**

This edit posts to pharmacy claims when the (DAW) Dispense as Written Indicator is incorrect.

**EDIT 2086 - SUBMISSION OF 6666666 FOR NJ PRESCRIBER IS INVALID**

This edit posts to a pharmacy claim when the pharmacy uses 6666666 instead of the Medicaid ID number in the prescribing physician field. If the prescribing physician does not have a NJ Medicaid ID number, the pharmacy may use the State License number, or NPI.

**EDIT 2089 - DIABETIC SUPPLIES NOT COVERED - BILL MCARE PT B OR OTH TPL**

This edit applies to electronic pharmacy claims with dates of service on or after 7/1/2008 when all of the following are true:

1. The claim is for a PAAD Recipient (the first digit of the current Recipient ID is "6") or Senior Gold (the first digit of the current Recipient ID is "7") and the table has "P" in the program indicator column.
2. The table contains:
  - a. Blood glucose test strips: 062059, 006373, 062084, 061768
  - b. Lancing devices: 053036, 011567
  - c. Lancets: 011186
  - d. Glucose control solutions: 050327, 062133, 062136

These claims are no longer covered. Pharmacy should bill these claims to the beneficiary's alternate insurance, such as Medicare Part B or private/commercial insurance.

**EDIT 2090 - PRESCRIBER LIC#/QUALIFIER N/A WHEN NPI EXISTS**

This edit applies to electronic pharmacy claims only, from May 16, 2008 through November 3, 2009, when all of the following are true:

1. Input electronic claim has Prescriber Qualifier "08" License number
2. An NPI number exists in our system for the Prescriber's Medicaid ID

Action: Pharmacy should resubmit the claim with Prescriber NPI and correct qualifier in 466-EZ.

**EDIT 2091 - COPAY APPLIED FOR BRAND DRUG**

This edit applies to electronic pharmacy claims only, when all of the following are true:

1. The claim is for a PAAD Recipient (the first digit of the current Recipient ID is "6")
2. The drug is determined to be a brand name drug
3. The date of service is after 8/1/2008
4. Brand co-pay of \$7 is applied to the claim, as of 8/1/08.

**EDIT 2092 - COPAY APPLIED FOR GENERIC DRUG**

This edit applies to electronic pharmacy claims only, when all of the following are true:

1. The claim is for a PAAD Recipient (the first digit of the current Recipient ID is "6")
2. The drug is determined to be a generic
3. The date of service is after 8/1/2008
4. Generic co-pay of \$6 is applied to the claim (as of 8/1/08) or \$5 (as of 7/1/10)

**EDIT 2096 - PATIENT PAID AMOUNT UNKNOWN - 433-DX**

This edit applies to pharmacy claims only, when the Payment Amount on a claim with Third Party Liability is equal to zero. This can occur when field 433-DX Patient Paid Amount submitted is missing or invalid. Refer to Section 3 of the NCPDP HIPAA Companion Guide, which can be found on [www.njmmis.com](http://www.njmmis.com).

**EDIT 2098 - INVALID COMPOUND - CONTAINS ONE INGREDIENT PLUS WATER**

This edit applies to pharmacy claims only, when the claim is for a compound drug with no more than two ingredients and one of the ingredients has GCN = 02670 (water).

Action: Pharmacy should resubmit the claim without the compound segment. Compound Indicator should be corrected.

**EDIT 2099 - INCORRECT UNIT OF MEASURE REPORTED FOR DRUG**

This edit applies to electronic pharmacy claims only, when the NCPDP transaction for the claim contains a Unit of Measure (EA/ML/GM), in field 600-28, that does not match the drug form code for the drug on the drug file. The mapping of the Unit of Measure to the Drug Form code is:

EA = 1  
ML = 2  
GM = 3

This edit replaces edit 0607; refer to Newsletter Volume 19, Number 49, issued in September 2009 for additional information.

Action: Pharmacy should use correct Unit of Measure; verify Unit of Measure on the link titled, "Physician Administered Drugs (UOM) on [www.njmmis.com](http://www.njmmis.com).

**EDIT 2100 - FDB DAILY DOSAGE QUANTITY STANDARD EXCEEDED**

This edit applies to pharmacy claims only, when the daily drug quantity on the claim (claim service units divided by days' supply) is larger than the Max Dose Units Quantity on the First DataBank Adult or Geriatric Range table.

**EDIT 2102 - DUPLICATE PHARMACY/SERVICE DATE/PRESCRIPTION NUMBER**

This edit applies to pharmacy claims only, when another paid claim is found in the Claims History file with the same Provider ID, Date of Service, and Prescription Number.

Action: Pharmacy must verify their practice management system Rx sequence numbers and resubmit the claim with a different Rx number.

**EDIT 2107 - WRONG OTHER PAYER ID (340-7C) CORRECT CLIENT INFO & RESUBMIT**

This edit is posted to pharmacy claims only: when either one or two carrier code(s) are present on the claim; the input claim has a Part D PDP; no Part D is on file for the beneficiary; the claim has a Part D Payment, Deductible, or Co-insurance amount; the claim does not have any Part D Rejection Code(s). This edit does not apply to any specific form locator.

**EDIT 2108 - CARDHOLDER ID INVALID**

This edit posts to a pharmacy claim when the cardholder ID Number reported is invalid. This edit does not apply to any specific form locator.

**EDIT 2109 - DRUG NOT PAYABLE DUE TO CHANGE IN COVERAGE RULES**

This edit will post to pharmacy claims when the drug being billed is not reimbursable by NJ Medicaid. Below are the form locators that apply:

ADA	N/A
1500	N/A
UB-04	N/A
MC-6	15
MC-9	N/A
MC-12	N/A
MC-19	N/A
TAD	N/A

**EDIT 2110 - PATIENT PAID AMOUNT UNKNOWN**

This edit posts to a Pharmacy claim when the Patient Amount Paid on a claim is not valid. This edit does not apply to any specific form locator.

**EDIT 2111 - NOT COVERED FOR RELIEF OF COUGH AND COLD SYMPTOMS**

This edit posts to pharmacy claims if the claim is for prescription cough and cold medications and the beneficiary is 21 years of age or older and there wasn't a claim for antibiotics submitted for the same date of service. This edit does not apply to any specific form locator.

**EDIT 2112 - CONFLICTING GENDER CODE - CONFIRM GENDER AND BENE ID NUMBER**

This edit posts to pharmacy claims when the gender code on the claim (1=male, 2= female) does not match the gender code on the recipient file. Pharmacy should verify gender code and recipient ID. This edit does not apply to any specific form locator.

**EDIT 2113 - CONFLICTING DATE OF BIRTH - CONFIRM DOB AND BENE ID NUMBER**

This edit posts to pharmacy claims when the date of birth on the claim does not match the date of birth on the recipient file.

**EDIT 2115 - AWP WITH PRE-SETTLEMENT FORMULA LESS THAN AWP ON FILE**

This edit applies to pharmacy claims only, if the Service Date is 09/27/2009 through 06/30/2010. The AWP Price, on the drug file provided by FDB, for drug claims affected by the AWP/FDB Settlement with service dates on or after September 26, 2009 and prior to July 1, 2010 shall be calculated based on the new AWP pricing formula of Wholesale Acquisition Cost (WAC) or Direct Price for an NDC times 120%. NJMMIS will continue to use the pre-settlement value of the AWP in the pricing calculation. If the pre-settlement value is lower than the post-settlement value reported by First DataBank, the claim will be denied with edit 2115. It is anticipated that this edit will never be needed, because the pre-settlement value should always be higher due to the formula used for the pre- and post-settlement values. This edit does not apply to any specific form locator.

**EDIT 2117 - INCORRECT BILLING PROVIDER NUMBER FOR INSTITUTIONAL SERVICES**

This edit applies to pharmacy claims only, that are submitted by one of the Neighborcare provider IDs for State Institutional residents and the Facility Provider Number, as reported by the Neighborcare Provider in the NCPDP Field 336-8c, does not match the Neighborcare Provider Number. This edit does not apply to any specific form locator.

**EDIT 2118 - THERAPEUTIC DUPLICATE FOUND USING NATIONAL STANDARD**

This edit applies to pharmacy claims only, when all of the following are true to one or more paid claims in the history:

1. The claim has the same original Recipient ID as the current claim.
2. When service date of the older claim is extended by the Day's Supply to find the first and last date of the day's supply of the drug, the service date of the newer claim falls within the day's supply date range.
3. The Generic Sequence Number (GSN) of the current claim is found on the Therapeutic Class Duplication tables included in the First DataBank Standard Product.
4. The GSN of the history claim is connected to the GSN of the current claim in the Therapeutic Class Duplication tables.
5. The number of history claims found, that meet the above criteria, exceeds the Duplication Allowance number in the Therapeutic Class Duplication tables.

This edit does not apply to any specific form locator.

**EDIT 2119 - NON-COVERED NDC PER CMS/FDA RESTRICTION**

This edit is applicable to pharmacy claims only:

This edit is posted when the NDC on the claim is found on CMS's "non-matched NDC" file. This file lists NDCs that otherwise could be claimed for Medicaid payments but are not on the FDA Drug Registry. The FDA Drug Registry lists all drugs that are registered with the FDA. Pharmacy claims cannot be approved unless the drug is registered with the FDA. The non-matched list can be viewed on the NJMMIS Website or CMS's website: [www.cms.hhs.gov/prescriptiondrugcovcontra/03\\_RxContracting\\_FormularyGuidance.asp#TopOfPage](http://www.cms.hhs.gov/prescriptiondrugcovcontra/03_RxContracting_FormularyGuidance.asp#TopOfPage)

Resubmit claim using a valid NDC. This edit does not apply to any specific form locator.

**EDIT 2120 - LAST CHARACTER OF SIGNED FIELD IS NUMERIC & MUST BE SIGNED**

This edit is posted when a signed field on the NCPDP transaction is numeric. For signed fields, the last character should be A-1 (to correspond with I-9) or zero. POS will convert the numeric field to the corresponding character. This edit applies only to electronic pharmacy claims. This edit does not apply to any form locator.

**EDIT 2121 - OTC NOT ON MEDICAID PART D WRAPAROUND**

This edit is applicable to pharmacy claims only, for drugs that are not "V" class drugs. This edit is posted when a drug is Over the Counter and is claimed on a secondary claim where Part D is the primary coverage. In this case, this edit will be applied if the OTC drug is not found on the Part D Wraparound table. This edit does not apply to any specific form locator.

**EDIT 2122 - PART D DEDUCTIBLE INVALID FOR TITLE XIX BENEFICIARY**

Effective 06/08/2010, this edit is applicable to pharmacy claims only. This edit will post if a claim is submitted having a beneficiary that is Title XIX according to the Part D rules and the claim has a Part D deductible amount that is greater than zeroes. This edit does not apply to any specific form locator.

**EDIT 2124 - PA NUMBER FIELD CONTAINING AUDIT DATA REQUIRED FOR HMS AUDIT**

This edit is applicable to pharmacy claims only, where the claim was submitted by HMS to represent the results of their pharmacy claim auditing. This edit will post if a claim has submitter number 9900080 (=HMS Audit) and the Prior Authorization Number, NCPDP field 462-EV, is missing or does not contain valid data.

The data in the Prior Authorization Number (462-EV) for HMS audit claims must be formatted as follows:

POSITION	VALUE
1	'2' (=Acquisition Audit) or '7' (=Compliance Audit)
2-5	4-digit edit code to be applied to the claim that was audited
6-11	last 6 digits of ICN of claim that was audited

**EDIT 2125 - DRUG NOT COVERED FOR ADDP LIMITED COVERAGE PROGRAM**

As of September 1, 2010, higher income beneficiaries were removed from the ADDP program. They are now in a new program, Temporary AIDS Supplemental Rebate and Federal Assistance Program, and are only allowed coverage for HIV-specific drugs. These drugs are listed in the Senior Services Newsletter Volume 13, No. 3, available on [www.NJMMIS.com](http://www.NJMMIS.com). This edit does not apply to any specific form locator.

**EDIT 2127 - HMS AUDIT B1 REPLACEMENT CLAIM, ORIG CLM NOT AUDITED BY HMS**

This edit is applicable to pharmacy claims only, where the B1 claim was submitted by HMS to represent the results of their pharmacy claim auditing Fair Hearing. This edit will post if an original, claim has submitter number 9900080 (=HMS Audit) and the claim that is being replaced, does not have an HMS Audit Adjustment Reason Code. HMS Audit Adjustment Reason Codes are xx42 (Acquisition Audit) or xx47 (Compliance Audit). This edit does not apply to any specific form locator.

**EDIT 2128 - 6-DIGIT ICN ON HMS AUDIT CLAIM DOES NOT MATCH NJMMIS CLAIM**

This edit is applicable to pharmacy claims only, where the claim was submitted by HMS to represent the results of their pharmacy claim auditing. This edit will post if an original, void or adjustment claim has submitter number 9900080 (=HMS Audit) and the claim is not found on the POS History Database:

OR

1. A claim was found on the POS history database matching the Prescription Number, Provider NPI/Number, and Date of Service the HMS audit input claim. And
2. The last six digits of ICN on the POS history claim does not match the six digits that were sent by HMS in positions 6-1 of the Prior Authorization Number (462-EV).

The data in the Prior Authorization Number (462-EV) for HMS audit claims is formatted as follows:

POSITION	VALUE
1	'2' (=Acquisition Audit) or '7' (=Compliance Audit)
2-5	4-digit edit code to be applied to the claim that was audited

**EDIT 2129 - HMS AUDIT ADJUSTMENT REASON 42/47 ADDED TO POS HISTORY CLAIM**

This edit is applicable to pharmacy claims only, where the claim was submitted by HMS to represent the results of their pharmacy claim auditing. This edit will post if a void claim (B2) has submitter number 9900080 (=HMS Audit) and the claim HMS is trying to void is already voided by another entity, meaning the Adjustment Reason Code on that claim is not HMS audit reason xx42 or xx47. When this situation is found, the system will move the HMS Adjustment Reason Code xx42 or xx47 to the voided claim. This will prevent the provider from sending in a new original; only HMS will be able to replace the claim. This edit does not apply to any specific form locator.

**EDIT 2137 - PART D COPAY NOT COVERED AS OF FY2012**

This edit will post to PHARMACY claims only when the claim has Part D as the primary payer, and the remaining liability represents copay, coinsurance or deductible and the service date is after 7/1/2011.

This edit does not apply to any specific form locator.

**EDIT 2146 - COVERED BY ADDP HEALTH INSURANCE CONTINUATION (HIC) PROGRAM**

This edit posts to pharmacy claims when the beneficiary ID number begins with '59' and the beneficiary has other private insurance on the TPL file that covers this drug.

This edit does not apply to any specific form locator.

**EDIT 2212 - INVOICE IS ILLEGIBLE**

This edit is applicable to pharmacy claims only, where the claim was submitted by HMS to represent the results of their pharmacy claim auditing. It is applied to the claim that HMS audited and is an EOB message to identify the HMS audit finding and reason for the void, adjustment, or replacement claim. Provider inquiries should be referred to HMS Audit Staff at 1-800-310-0865.

This edit does not apply to any specific form locator.

**EDIT 2213 - INSUFFICIENT QTY-INVOICE DOC DOES NOT SUPPORT QTY BILLED**

This edit is applicable to pharmacy claims only, where the claim was submitted by HMS to represent the results of their pharmacy claim auditing. It is applied to the claim that HMS audited and is an EOB message to identify the HMS audit finding and reason for the void, adjustment, or replacement claim. Provider inquiries should be referred to HMS Audit Staff at 1-800-310-0865. This edit does not apply to any specific form locator.

**EDIT 2214 - CLAIMS WAS PREVIOUSLY RESERVED BY THE PHARMACY**

This edit is applicable to pharmacy claims only, where the claim was submitted by HMS to represent the results of their pharmacy claim auditing. It is applied to the claim that HMS audited and is an EOB message to identify the HMS audit finding and reason for the void, adjustment, or replacement claim. Provider inquiries should be referred to HMS Audit Staff at 1-800-310-0865. This edit does not apply to any specific form locator.

**EDIT 2215 - PHARMACY FAILED TO RESPOND WITHIN ALLOTTED TIMEFRAME**

This edit is applicable to pharmacy claims only, where the claim was submitted by HMS to represent the results of their pharmacy claim auditing. It is applied to the claim that HMS audited and is an EOB message to identify the HMS audit finding and reason for the void, adjustment, or replacement claim. Provider inquiries should be referred to HMS Audit Staff at 1-800-310-0865. This edit does not apply to any specific form locator.

**EDIT 2216 - CLAIM RESERVED AND MEDICATION WAS RETURNED TO STOCK**

This edit is applicable to pharmacy claims only, where the claim was submitted by HMS to represent the results of their pharmacy claim auditing. It is applied to the claim that HMS audited and is an EOB message to identify the HMS audit finding and reason for the void, adjustment, or replacement claim. Provider inquiries should be referred to HMS Audit Staff at 1-800-310-0865. This edit does not apply to any specific form locator.

**EDIT 2220 - INVALID FACILITY NAME FOR FACILITY ID**

This edit will post to pharmacy claims if the facility ID is present but the facility name is not populated.

**EDIT 2221 - INV/MISSING OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT**

This edit posts to pharmacy claims submitted in the NCPDP D.0 format. It is applied when the other payer - patient responsibility amount does not contain a numeric value or it is zero.

**EDIT 2222 - INV/MISSING OTHER PAYER-PATIENT RESPONSIBILITY AMT QUALIFIER**

This edit posts to pharmacy claims submitted in the NCPDP D.0 format. It is applied when the other payer - patient responsibility amount qualifier does not contain standard value (01-13) on each submitted segment or the same value is present more than once for the same payer.

**EDIT 2223 - INV/MISSING OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT**

This edit posts to pharmacy claims submitted in the NCPDP D.0 format. It is applied when the other payer - patient responsibility amount is less than zero (negative value).

**EDIT 2224 - INVALID OTHER PAYER AMOUNT PAID QUALIFIER FOR D.0 CLAIM**

This edit posts to pharmacy claims submitted in the NCPDP D.0 format. It is applied when the other payer amount paid qualifier (342-HC) has an invalid value or the same value is presented more than once for the same other payer ID.

**EDIT 2225 - INVALID OTHER COVERAGE CODE FOR NCPDP D.0 CLAIM**

This edit posts to pharmacy claims submitted in the NCPDP D.0 format. It is applied when the other coverage code is not a valid code for NCPDP D.0 claims.

**EDIT 2226 - INVALID CLAIM FORMAT-NCPDP D.0 IS IN MANDATORY PERIOD**

This edit posts to pharmacy claims submitted after April 30, 2012 when the electronic claim is not submitted in the NCPDP D.0 format.

**EDIT 2227 - DIAGNOSIS CODE QUALIFIER VALUES ARE NOT EQUAL**

This edit will be applied if the claim has more than one diagnosis code, and all diagnosis qualifiers (field 492-WE) do not match. Note: After October 1, 2015, all diagnosis codes must be ICD-10 format, and the qualifier input in NCPDP will be '02'. No other qualifier should be present. Before that date, there will be a transition period where the diagnosis code can still be ICD-9. This edit prevents a mix of ICD-9 and ICD-10 codes on the same record.

**EDIT 2228 - PAYER-PAT DATA FOR HEALTH PLAN FUNDED ASSISTANCE (129-UD) > 0**

This edit is applicable to pharmacy claims only, submitted in NCPDP D.0 format. This edit is applied when all of the following are true:

- Other Payer-Patient Responsibility Amount Qualifier is 09, which represents the payer-patient data for health plan funded assistance (129-UD field on the NCPDP response to the provider from the previous payer)
- The Other Payer-Patient Responsibility Amount is greater than or equal to zero.
- Field 129-UD must always be a negative number.

**EDIT 2229 - MISSING QUALIFIER FOR OTHER PAYER AMOUNT PAID**

This edit is applicable to pharmacy claims only, submitted in NCPDP D.0 format. This edit is applied when the Other Payer Amount Paid Qualifier (field 342-HC) is missing and Other Payer Amount Paid is present on NCPDP D.0 claims, for the same Other Payer. The Other Payer Amount Paid represents amounts paid by a previous payer and are used in the calculations for NJMMIS payment, for claims that have coordination of benefits.

**EDIT 2230 - PATIENT RESIDENCE IS NOT NUMERIC**

This edit is applicable to pharmacy claims only, submitted in NCPDP D.0 format. This edit is applied when the Patient Residence (field 384-4X) is not numeric.

**EDIT 2231 - BENEFIT STAGE AMOUNT IS NOT NUMERIC**

This edit is applied when a Benefit Stage Amount (field 394-MW) is not numeric. The Benefit Stage Amounts are: Deductible, Initial Stage, Donut Hole, Catastrophic.

**EDIT 2232 - BENEFIT STAGE AMOUNT SUBMITTED FOR DEDUCTIBLE STAGE**

This edit is applicable to pharmacy claims only, submitted in NCPDP D.0 format when the input Benefit Stage Qualifier (field 394-MW) has '01' which signifies that the Benefit Stage Amount field represents the Part D deductible amount. This edit does not deny the claim.

**EDIT 2233 - BENEFIT STAGE AMOUNT SUBMITTED FOR INITIAL STAGE**

This edit is applicable to pharmacy claims only, submitted in NCPDP D.0 format when the input Benefit Stage Qualifier (field 394-MW) has '02' which signifies that the Benefit Stage Amount field represents the Part D initial amount. This is usually the Part D Co-pay amount. This edit does not deny the claim.

**EDIT 2234 - BENEFIT STAGE AMOUNT SUBMITTED FOR DONUT HOLE STAGE**

This edit is applicable to pharmacy claims only, submitted in NCPDP D.0 format where the input Benefit Stage Qualifier (field 394-MW) has '03' which signifies that the Benefit Stage Amount field represents the Part D donut hole amount. This is also referred to as the Coverage Gap. This edit does not deny the claim.

**EDIT 2235 - BENEFIT STAGE AMOUNT SUBMITTED FOR CATASTROPHIC STAGE**

This edit is applicable to pharmacy claims only, submitted in NCPDP D.0 format when the input Benefit Stage Qualifier (field 394-MW) has '04' which signifies that the Benefit Stage Amount field represents the Part D catastrophic amount. This edit does not deny the claim.

**EDIT 2236 - PART D PDP ON CLAIM AND NO BENEFIT STAGES SUBMITTED**

This edit is applicable to pharmacy claims only, submitted in NCPDP D.0 format when there are no Benefit Stage Amount (field 394-MW) on the submitted claim, but the claim has a Part D PDP in field 340-7C. The Benefit Stage Amount field represents the Part D benefit stage that the beneficiary is in at the time the claim was paid by the Part D PDP (deductible, initial, donut hole (coverage gap), or catastrophic). The presence of this EOB edit can be used to make sure Part D is billing these claims correctly. Claims that receive this edit should be for a Part D supplemental drug. This edit does not deny the claim.

**EDIT 2237 - OTHER PAYER-PATIENT RESP AMT COUNT NOT EQUAL # REPETITIONS**

This edit is applicable to pharmacy claims only, submitted in NCPDP D.0 format when Other Payer-Patient Responsibility Amount Count (field 353-NR) does not equal the number of repetitions of the Other Payer-Patient Responsibility Amount Data for one Other Payer ID when the COB segment is submitted. These amounts are the patient's remaining liability after the third-party payment and are used as a basis for NJMMIS payment.

**EDIT 2238 - OTHER PAYER-PATIENT RESP AMT DOES NOT HAVE A CORRESP QUAL**

This edit is applicable to pharmacy claims only, submitted in NCPDP D.0 format when all of the following are true:

- Other Payer-Patient Responsibility Amount (field 352-NQ) is not equal to zero
- Corresponding Other Payer-Patient Responsibility Amount Qualifier (field 351-NP) is blank (supplied by other insurer/payer)
- The Coordination Of Benefits segment is submitted on the claim
- These amounts are the patient's remaining liability after the third-party payment and are used as a basis for NJMMIS payment.

**EDIT 2239 - BENEFIT STAGE AMOUNT DOES NOT HAVE A CORRESPONDING QUALIFIER**

This edit is applicable to pharmacy claims only, submitted in NCPDP D.0 format when the benefit stage amount is not equal to zero and the corresponding Benefit Stage Amount Qualifier (field-393-MV) is blank.

**EDIT 2240 - OTHER PAYER ID FIELD IS MISSING OR INVALID**

This edit is applicable to pharmacy claims only, submitted in NCPDP D.0 format when the number of COB segments does not match EOB/Other Payments Count (field 337-4C) -or- Other Payer Coverage Type (field 338-5C) is present on a COB segment and the corresponding Other Payer ID (field 340-7C) for the same segment is blank.

**EDIT 2241 - INVALID BENEFIT STAGE AMOUNT, NO PART D PAYER SUBMITTED**

This edit is applicable to pharmacy claims only, submitted in NCPDP D.0 format when one or more Benefit Stage Amount (field 394-MW) is present and the claim does not contain an Other Payer ID (field 340-7C) that represents a Part D payer.

**EDIT 2249 - GERIATRIC PRECAUTION FOUND-DRUG IS ON THE BEERS/HEDIS/STOPP LIST**

This edit applies to pharmacy claims when the beneficiary is over 64 years of age on the date of service and any of the following are true:

- The Generic Sequence Number for the NDC for the claim is found on the Beer's List, signifying that there is a geriatric precaution.
- The Generic Sequence Number for the NDC for the claim is found on the HEDIS List, signifying that there is a geriatric precaution.
- The Generic Sequence Number for the NDC for the claim is found on the STOPP List, signifying that there is a geriatric precaution.

This edit does not apply to any specific form locator.

**EDIT 2250 - TPL PAYER ID REQUIRED WHEN BILLING FOR TPL COPAY/COINSURANCE**

This edit posts to pharmacy claims when all of the following are true:

1. The claim has a blank other payer ID.
2. The claim has edit 2097 posted to it.

**EDIT 2266 - INELIGIBLE PRESCRIBER, 15-DAY GRACE PERIOD BEGINS FOR RECIP**

This edit posts to pharmacy claims if the provider is ineligible to prescribe for Medicaid claims. This starts the 15 day grace period during which new claims from the prescriber and beneficiary on the claim with edit 2266 can be accepted if the days supply is less than or equal to 30 or the drug is an exception to this rule. See edits 2267, 2268 and 2269 for more details.

**EDIT 2267 - GRACE PERIOD LIMITED TO 30 DAYS SUPPLY FOR NORMAL SOLID DOSE**

This edit posts to pharmacy claims if the provider is ineligible to prescribe for Medicaid claims and the pharmacy has already had a claim denied with edit 2266 to start the 15 day grace period. During the grace period, claims from the same prescriber and beneficiary can be accepted if the days supply is less than or equal to 30 or the drug is an exception to this rule. See edits 2266, 2268, and 2269 for more details.

**EDIT 2268 - INELIGIBLE PRESCRIBER, PRESCRIPTION IN 15-DAY GRACE PERIOD**

This edit posts to pharmacy claims if the provider is ineligible to prescribe for Medicaid claims but this claim was accepted because the prescription was dispensed during the 15 day grace period. See edits 2266, 2267, and 2269 for more details.

**EDIT 2269 - INELIGIBLE PRESCRIBER-OUTSIDE GRACE PERIOD, NO FILLS ALLOWED**

This edit posts to pharmacy claims if the provider is ineligible to prescribe for Medicaid claims and the pharmacy has already had a claim denied with edit 2266 to start the 15 day grace period but this claim is outside the 15 day grace period. See edits 2266, 2267, and 2268 for more details.

**EDIT 2270 - PROVIDER ONLY AUTHORIZED TO PRESCRIBE- NOT A BILLING PROV**

This edit posts to pharmacy claims if the provider ID on the claim has cancel reason 02 signifying that this provider enrolled using the abbreviated enrollment form (FD20-B) and is enrolled as a non-billing provider.

**EDIT 2271 - PROVIDER NOT AUTHORIZED TO PRESCRIBE AS PER ACA REQUIREMENT**

This edit posts to pharmacy claims if any of the following are true for the Medicaid prescriber ID on the claim:

1. The prescriber has a cancel code 41 (death) and no other cancel reason on file.
2. The prescriber has a cancel code 41 (death) and the claim has a prescription written date during the period of eligibility where the cancel code was 41.
3. The prescriber has a cancel code of 30, 32, 35 or 37 and the claim has a date of service during the period of eligibility where the cancel code was one of these codes.
4. The prescriber has a provider type that is not 20, 27, 28, 32, 60, 70, or 90.

Providers with the above conditions will not be eligible for the 15 day grace period. For more information on the grace period see edit 2266.

**EDIT 2272 - PRESCRIBER NPI MAPS TP GROUP NUMBER-PRESCRIBER MUST BE INDIV**

This edit applies to Pharmacy claims only. It will post to claims when the Medicaid Prescriber ID on the claim is a group provider number. Claims must be submitted with a NPI that cross-references to an individual prescriber ID.

**EDIT 2274 - BNFT STG 61-NOT PARTD CLM-PD BY COADMIN PLAN BNFT-PARTD DRUG**

This edit posts to pharmacy claims submitted in the NCPDP D.0 format only. This edit posts if the claim has benefit stage amount with benefit stage qualifier equal to 61. Qualifier 61 indicates claims are not paid under Part D. They are for part D drugs but the claim was paid using a co-administered insured benefit. Rebate could be collected on these claims but this edit will deny for certain benefit programs because these programs do not allow payment for benefit stage 61. Either that provider can fill the prescription with an NDC that is covered by Part D or the beneficiary or provider must absorb the cost of the remaining patient liability for the co-administered benefit.

**EDIT 2275 - BNFT STG 62-NOT PARTD CLM-PD BY COADMIN PLAN-NOT PARTD DRUG**

This edit posts to pharmacy claims submitted as NCPDP D.0 only. This edit posts if the claim has a benefit stage amount with benefit stage qualifier equal to 62. 62 represents claims that are not paid under Part D. They are also not Part D drugs. The claim was paid using a co-administered insured benefit. Rebate can be collected on these claims.

**EDIT 2276 - BNFT STG 90-NOT PARTD CLM-OTC/ENH-NO TROOP BUT PTD COVERED**

This edit posts to pharmacy claims submitted as NCPDP D.0 only. This edit posts when the claim has benefit stage amount and benefit stage qualifier equal to 90. 90 represents claims that are paid under Part D but are not applicable to the Part D drug spend (TrOOP). They are not for Part D drugs but the claim was paid under a Part D plan. Rebate can be collected for these claims.

**EDIT 2277 - VOID RECEIVED AFTER HOURS-HELD UNTIL POS SYSTEM AVAILABLE**

This edit posts to pharmacy claims submitted as NCPDP D.0 only. This edit posts if all of the following are true:

1. The claim is a void transaction. These transactions have transaction type '2' and are entered with NCPDP 'B2' transaction codes identifying an NCPDP reversal.
2. The claim was submitted to POS when the POS system was not running. Normally, POS does not run between midnight and 6am. It can also be down at other times, however it can be down at other times. For example, if there are problems with the production server or the system needs to be switched to the backup machines due to an emergency situation in NJ.
3. The claim was processed through POS in batch mode after the system became next available, usually at 6am the following day.

**EDIT 2285 - COMPOUND INGREDIENT DRUG COST IS NON-NUMERIC OR NEGATIVE**

This edit will post to pharmacy claims if there is a compound ingredient submitted and the drug cost for the compound ingredient is submitted as non-numeric or as a negative number. This edit does not apply to any specific form locator.

**EDIT 2290 - PHARMACY CLAIM NOT PAYABLE FOR SPC 98 OR 99**

This edit posts to pharmacy claims because the beneficiary file is showing a special program code of 98 or 99 which indicates that beneficiary has restricted benefits. This edit does not apply to any specific form locator.

**EDIT 2295 - FACILITY PROVIDER IS NOT ACTIVE ON THE DATE OF SERVICE**

This edit will post to PHARMACY claims only when the servicing provider is on the NEIGHBORCARE LINKAGE table OR the service date is not between the effective date and the expiration date of the record found on the NEIGHBORCARE LINKAGE table.

This edit does not apply to any specific form locator.

**EDIT 2302 - 344-HF QUANTITY INTENDED TO BE DISPENSED IS NOT NUMERIC**

This edit posts to an electronically submitted Pharmacy claim when the quantity reported is not numeric. This edit does not apply to any specific form locator.

**EDIT 2303 - 345-HG DAYS SUPPLY INTENDED TO BE DISPENSED IS NOT NUMERIC**

This edit posts to an electronically submitted Pharmacy claim when the days supply reported is not numeric. This edit does not apply to any specific form locator.

**EDIT 2304 - 600-28 UNIT OF MEASURE NOT VALID VALUE (EA/GM/ML)**

This edit posts to an electronically submitted Pharmacy claim when the Unit of Measure reported is not a valid value of EA, GM, or ML. This edit does not apply to any specific form locator.

**EDIT 2305 - 343-HD DISPENSING STATUS IS NOT BLANK, PARTIAL FILLS NOT SUP**

This edit posts to an electronically submitted Pharmacy claim when the Dispensing Status is not blank. THE DISPENSING STATUS MUST BE BLANK. This edit does not apply to any specific form locator.

**EDIT 2306 - 442-E7 QUANTITY DISPENSED NOT NUMERIC OR IS NEGATIVE**

This edit posts to an electronically submitted Pharmacy claim when quantity dispensed is not numeric, or is negative. This edit does not apply to any specific form locator.

**EDIT 2307 - 414-DE PRESCRIPTION DATE IS NOT NUMERIC**

This edit posts to an electronically submitted Pharmacy claim when the prescription date is not numeric. There are no form locators that apply.

**EDIT 2308 - 335-2C PREGNANCY INDICATOR IS NOT 1, 2 OR BLANK**

This edit posts to an electronically submitted Pharmacy claim when the Pregnancy Indicator is not 1, 2, or blank. This edit does not apply to any specific form locator.

**EDIT 2309 - 409 D-9 INGREDIENT COST IS NOT NUMERIC**

This edit posts to an electronically submitted Pharmacy claim when the Ingredient cost reported is not numeric. This edit does not apply to any specific form locator.

**EDIT 2310 - 412-DC DISPENSING FEE SUBMITTED IS NOT NUMERIC**

This edit posts to an electronically submitted Pharmacy claim when the Dispensing Fee reported is not numeric. This edit does not apply to any specific form locator.

**EDIT 2311 - 466-EZ PRESCRIBE QUALIFIER ID IS NOT VALID VALUE 01, 05 OR 08**

This edit posts to an electronically submitted Pharmacy claim when the Prescriber ID Qualifier reported is not 01, 05, or 08. This edit does not apply to any specific form locator.

**EDIT 2312 - 411-DB PRESCRIBER ID IS BLANK OR NOT SUBMITTED**

This edit posts to an electronically submitted Pharmacy claim when the Prescriber ID is blank or not submitted. This edit does not apply to any specific form locator.

**EDIT 2313 - 406-D6 COMPOUND CODE IS NOT 0, 1, OR 2**

This edit posts to an electronically submitted Pharmacy claim when the Compound Code reported is not 0, 1, or 2. This edit does not apply to any specific form locator.

**EDIT 2314 - 407-D7 INVALID COMBINATION OF NDC, CMPND NDC OR CMPND CODE**

This edit posts to an electronically submitted Pharmacy claim when there is an invalid combination of NDC, Compound NDC, or Compound Code. This edit does not apply to any specific form locator.

**EDIT 2315 - 488-RE COMPOUND PRODUCT ID QUALIFIER IS NOT 03**

This edit posts to an electronically submitted Pharmacy claim when The Compound Product ID reported is not 03. This edit does not apply to any specific form locator.

**EDIT 2317 - 415-DF NUMBER OF REFILLS AUTHORIZED IS NOT NUMERIC**

This edit posts to an electronically submitted Pharmacy claim when the number of refills authorized is not numeric. This edit does not apply to any specific form locator.

**EDIT 2319 - 202-B2 SERVICE PROVIDER ID QUALIFIER NOT 01**

This edit posts to an electronically submitted Pharmacy claim when the Service Provider Qualifier is not 01. This edit does not apply to any specific form locator.

**EDIT 2320 - 455-EM PRESCRIPTION/SERVICE REFERENCE NUM QUALIFIER IS NOT 1**

This edit posts to an electronically submitted Pharmacy claim when the Prescription/Service Reference Number Qualifier is not 1. This edit does not apply to any specific form locator.

**EDIT 2321 - 436-E1 PROD/SERV ID QUAL NOT 03 FOR SINGLE OR 00 FOR CMPND**

This edit posts to an electronically submitted Pharmacy claim when the Prod/Serv ID Qualifier is not 03 for single or 00 for compound. This edit does not apply to any specific form locator.

**EDIT 2322 - 492-WE DIAGNOSIS CODE QUALIFIER IS NOT 01, 02, 00 OR BLANK**

This edit posts to an electronically submitted Pharmacy claim when the Diagnosis Code Qualifier reported is not 01, 02, 00, or blank. This edit does not apply to any specific form locator.

**EDIT 2326 - 301-C1 GROUP ID IS NOT BLANK**

This edit posts to an electronically submitted Pharmacy claim when the Group ID reported is not blank. This edit does not apply to any specific form locator.

**EDIT CODE 2347 - COVID VACCINE ADMINISTRATION CONFLICT**

This edit will post to an electronic pharmacy claim. If a pharmacy claim for a two dose vaccine is submitted with a Submission Clarifier Code (SCC) = '02'(first dose of vaccine) - OR - '06' (second dose of vaccine) when another claim is found in history for a conflicting vaccine. This edit will initially apply to the covid-19 VACCINE NDCs on the POS TABLE COVID-19 Vaccine Table.

This does not apply to any specific form locator.

**EDIT CODE 2348 - VACCINE ADMINISTRATION EXCEEDED FOR MEMBER**

This edit will post to an electronic pharmacy claim. This edit will limit vaccine administration claims for certain vaccines on the POS COVID Vaccine Table based on the maximum number of days having to have passed between the current claim and any history claim on file for the same type of vaccine.

This edit does not apply to any specific form locator.

**EDIT CODE 2349 - MINIMUM DAYS REQUIRED BETWEEN VACCINE DOSES**

This edit will post an electronic pharmacy claim. This edit will deny pharmacy claims for vaccines, when the second (or additional/booster) dose of the vaccine is trying to be administered without the minimum number of days having passed as defined by the MIN DAYS REQUIRED value on the POS COVID Vaccine Table.

This edit does not apply to any specific form locator.

**EDIT CODE 2351 - OTC COVID TEST EXCEEDED- LIMIT 4 KITS PER MONTH**

This edit is applicable to pharmacy claims only. Total limit exceeds 4 test kits per month, per member for the NDC in Specific Therapeutic Class (STC) X6C.

This edit does not apply to any specific form locator.