IOWA MEDICAID - OCE EDIT - APC GROUPER 23.0 VERSION			
Edit Number and Description		Medicare Claim Disposition	Medicaid Claim Disposition
1	Invalid diagnosis code	Claim returned to provider	Claim denial
2	Diagnosis and age conflict	Claim returned to provider	Claim denial
3	Diagnosis and sex conflict	Claim returned to provider	Claim denial
5	E-code as reason for visit/principal diagnosis	Claim returned to provider	Claim denial
6	Invalid procedure code	Claim returned to provider	Claim denial
8	Procedure and sex conflict	Claim returned to provider	Claim denial
9	Non-covered service under Medicare	Line item denial	Line item denial
10	Service submitted for verification of denial (condition code 21)	Claim denial	Claim denial
11	Service submitted for FI review (condition code 20)	Claim suspension	No OCE edits posts
12	Questionable covered service	Claim suspension	No OCE edits posts
13	Separate payment for services not provided by Medicare (V1.0-V6.3)	Line item rejection	Line item denial
17	Inappropriate specification of bilateral procedure	Claim returned to provider	Claim denial
18	Inpatient procedure	Line item denial	Line item denial
20	Component of a comprehensive procedure that is not allowed by NCCI even if appropriate modifier is present	Line item rejection	Line item denial
21	Medical visit on same day as type T or S procedure without modifier 25	Line item rejection	Claim denial
22	Invalid modifier	Claim returned to provider	Claim denial
23	Invalid date	Claim returned to provider	Claim denial
24	Date out of OCE range	Claim suspension	No OCE edits posts
25	Invalid age	Claim returned to provider	Claim denial
26	Invalid sex	Claim returned to provider	Claim denial
27	Only incidental services reported	Claim rejected	Claim denial
28	Code not recognized by Medicare; alternate code for same service may be available	Line item rejection	Line item denial
29	Partial hospitalization service for non-mental health diagnosis	Claim returned to provider	Claim denial
30	Insufficient services on day of partial hospitalization	Claim suspension	No OCE edits posts
35	Only mental health education and training services provided	Claim returned to provider	Claim denial
37	Terminated bilateral procedure or terminated procedure with units greater than one	Claim returned to provider	Claim denial
38	Inconsistency between implanted device and implantation procedure	Claim returned to provider	Claim denial
40	Code 2 of a code pair that would be allowed b NCCI if appropriate modifier were present	Line item rejection	Line item denial
41	Invalid revenue code	Claim returned to provider	Claim denial
42	Multiple medical visits on same day with same revenue code without condition code G0	Claim returned to provider	Claim denial
43	Transfusion of blood product exchange without specification of blood product	Claim returned to provider	Claim denial
44	Observation revenue code on line item with non-observation HCPCS code	Claim returned to provider	Claim denial
45	Inpatient separate procedures not paid	Line item rejection	Line item denial
46	Partial hospitalization condition code 41 not approved for type of bill	Claim returned to provider	Claim denial
47	Service is not separately payable	Line item rejection	Line item denial
48	Revenue center requires HCPCS	Claim returned to provider	Claim denial
49	Service on same day as inpatient procedure	Line item denial	Line item denial
50	Non-covered based on statutory exclusion	Line item rejection	Claim denial
51	Observation code G0378 not allowed to be reported more than once per claim	Claim returned to provider	Claim denial
53	Observation codes G0378 and G0379 only allowed with bill type 13x or 85x	Line item rejection	Line item denial
55	Non-reportable for site of service	Claim returned to provider	Claim denial

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Edit Number and Description		Medicare Claim Disposition	Medicaid Claim Disposition
57	E/M or ancillary procedure conditions are not met and line item dates for obs code G0244 is 12/31 or 1/1	Claim suspension	Claim suspension
58	G0263 only allowed with payable G0244	Claim returned to provider	Claim denial
60	Use of modifier CA with more than one procedure not allowed	Claim returned to provider	Claim denial
61	Service can only be billed to DMERC	Claim returned to provider	Claim denial
62	Code not recognized by OPPS; alternative code for same service may be available	Claim returned to provider	Claim denial
65	Revenue code not recognized by Medicare	Line item rejection	Line item denial
66	Code requires manual pricing	Claim suspension	No OCE edits post
67	Service provided prior to FDA approval	Line item rejection	Line item denial
68	Service provided prior to date of National Coverage Determination (NDC) approval	Line item rejection	Line item denial
69	Service provided outside approval period	Line item rejection	Line item denial
70	CA modifier requires patient status code 20	Claim returned to provider	Claim denial
72	Service not billable to the Fiscal Intermediary	Claim returned to provider	Claim denial
73	Incorrect billing of blood and blood products	Claim returned to provider	Claim denial
74	Units greater than one for bilateral procedure billed with modifier 50	Claim returned to provider	Claim denial
76	Trauma response critical care code without revenue code 068x and CPT 99291	Line item rejection	Line item denial
79	Incorrect billing of revenue code with HCPCS code	Claim returned to provider	Claim denial
80	Mental health code not approved for partial hospitalization program	Claim returned to provider	Claim denial
81	Mental health service not payable outside the partial hospitalization program	Claim returned to provider	Claim denial
82	Charge exceeds token charge ($1.01)	Claim returned to provider	Claim denial
83	Service provided on or after effective date of NCD non-coverage	Line item denial	Line item denial
84	Claim lacks required primary code	Claim returned to provider	Claim denial
86	Manifestation code not allowed as principal diagnosis	Claim returned to provider	Claim denial
87	Skin substitute application procedure without appropriate skin substitute product code	Claim returned to provider	Claim denial
88	FQHC payment code not reported for FQHC claim	Claim returned to provider	Claim denial
89	FQHC claim lacks required qualifying visit code	Claim returned to provider	Claim denial
90	Incorrect revenue code reported for FQHC payment code	Claim returned to provider	Claim denial
91	Item or service not covered under FQHC PPS or for RHC	Line item rejection	Line item denial
92	Device-dependent procedure reported without device code	Claim returned to provider	Claim denial
93	Corneal tissue processing reported without cornea transplant procedure	Line item rejection	Line item denial
95	Weekly partial hospitalization services require a minimum of 20 hours of service as evidenced in PHP plan of care	Line item rejection	Line item denial
98	Claims with pass-through device, drug or biological lacks required procedure	Claim returned to provider	Claim denial
99	Claims with pass-through or non-pass-through drug or biological lacks OPPS payable procedures	Claim returned to provider	Claim denial
100	Claim for HSCT allogeneic transplantation lacks required revenue code line for donor acquisition services	Claim returned to provider	Claim denial
101	Item or service with modifier PN no allowed under PFS	Claim returned to provider	Claim denial
102	Modifiers PO/PN not allowed on the same line	Claim returned to provider	Claim denial
104	Service not eligible for all-inclusive rate	Line item rejection	Line item denial
105	Claim reported with pass-through device prior to FDA approval for the procedure	Line item denial	Line item denial
106	Add-on code reported without required primary procedure	Line item denial	Line item denial

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107	Add-on code reported without required contractor-defined primary procedure code	Line item denial	Line item denial
108	Add-on code reported without required primary procedure or required contractor-defined primary procedure code	Line item denial	Line item denial
109	Code first diagnosis present without mental health diagnosis as the first secondary diagnosis	Claim returned to provider	Claim denial
110	Service provided prior to initial marketing date	Line item rejection	Line item denial
111	Service cost is duplicative; included in cost of associated biological	Line item rejection	Line item denial
112	Information only service(s)	Line item rejection	Line item denial
113	Supplementary or additional code not allowed as principal diagnosis	Claim returned to provider	Claim denial
114	Item or service not allowed with modifier CS	Claim returned to provider	Claim denial
115	COVID-19 lab add-on code reported without required primary procedure	Line item rejection	Line item denial
116	Opioid treatment program service not payable outside the opioid treatment program	Claim returned to provider	Claim denial
117	Token charge less than $1.01 billed by provider	Line item rejection	Line item denial
118	Invalid bill type	Claim returned to provider	Claim denial
119	Invalid claims processing receipt date	Claim returned to provider	Claim denial