IOWA MEDICAID -OCE EDIT - APC GROUPER 24.2 VERSION			
Edit Number and description	**Medicare edit disposition**	**Medicaid edit disposition**	**Active/ Inactive**
1. Invalid diagnosis code	Claim returned to provider	Claim denial	Active
2. Diagnosis and age conflict	Claim returned to provider	Claim denial	Active
3. Diagnosis and sex conflict	Claim returned to provider	Claim denial	Active
4. Medicare secondary payer alert (v1.0 and v1.1 only)	Claim suspension	Claim denial	Inactive
5. External cause of morbidity code can not be used as principal diagnosis	Claim returned to provider	Claim denial	Active
6. Invalid procedure code	Claim returned to provider	Claim denial	Active
7. Procedure and age conflict	Line item rejection (Informational Only, no impact to payment)	Not activated	Active
8. Procedure and sex conflict	Claim returned to provider	Claim denial	Active
9. Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion	Line item denial	Line item denial	Active
10. Service submitted for denial (condition code 21)	Claim denial	Claim denial	Active
11. Service submitted for FI/MAC review (condition code 20)	Claim suspension	No OCE edit posts	Active
12. Questionable covered service	Claim suspension	No OCE edit posts	Active
13. Separate payment for services is not provided by Medicare (v1.0–v6.3 and for v.18.0- for codes with SI = E2)	Line item rejection	Line item denial	Active
14. Code indicates a site of service not included in OPPS (v1.0–v6.3 only)	Claim returned to provider	Claim denial	Inactive
15. Service unit out of range for procedure(v1.0–9.1 only)	Claim returned to provider	Claim denial	Inactive
16. Multiple bilateral procedures without modifier 50 (v1.0–v6.2 only)	Claim returned to provider	Claim denial	Inactive
17. Inappropriate specification of bilateral procedure	Line item rejection	Claim denial	Active
18. Inpatient procedure	Line item denial	Line item denial	Active
19. Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present (deleted, combined with edit 20 retroYes to earliest included version)	Line item rejection	Line item denial	Inactive
20. Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is presen	Line item rejection	Line item denial	Active

21. Medical visit on same day as a type T or S procedure without modifier 25	Claim returned to provider	Claim denial	Active
22. Invalid modifier	Claim returned to provider	Claim denial	Active
23. Invalid date	Claim returned to provider	Claim denial	Active
24. Date out of OCE range	Claim returned to provider	No OCE edit posts	Active
25. Invalid age	Claim returned to provider	Claim denial	Active
26. Invalid sex	Claim returned to provider	Claim denial	Active
27. Only incidental services reported	Claim rejection	Claim denial	Active
28. Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	Line item rejection	Line item denial	Active
29. Partial hospitalization service for non-mental health diagnosis	Claim returned to provider	Claim denial	Active
30. Insufficient services on day of partial hospitalization	Line item denial	No OCE edit posts	Active
31. Partial hospitalization on same day as ECT or type T procedure (v1.0–v6.3 only)	Claim suspension	No OCE edit posts	Inactive
32. Partial hospitalization claim spans 3 or less days with insufficient services on at least one of the days (v1.0–v9.3 only)	Claim suspension	No OCE edit posts	Inactive
33. Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services (v1.0–v9.3 only)a	Claim suspension	No OCE edit posts	Inactive
34. Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria (v1.0 - v9.3 only	Claim suspension	No OCE edit posts	Inactive
35. Only Mental Health education and training services provided	Claim returned to provider	Claim denial	Active
36. Extensive mental health services provided on day of ECT or type T procedure (v1.0–v6.3 only)	Claim suspension	No OCE edit posts	Inactive
37. Terminated bilateral procedure or terminated procedure with units greater than one	Claim returned to provider	Claim denial	Active
38. Inconsistency between implanted device or administered substance and implantation or associated procedure	Claim returned to provider	Claim denial	Active

39. Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present (deleted, combined with edit 40 retroYes to earliest included version)	Line item rejection	Line item denial	Inactive
40. Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present	Line item rejection	Line item denial	Active
41. Invalid revenue code	Claim returned to provider	Claim denial	Active
42. Multiple medical visits on same day with same revenue code without condition code G0	Claim returned to provider	Claim denial	Active
43. Transfusion or blood product exchange without specification of blood product	Claim returned to provider	Claim denial	Active
44. Observation revenue code on line item with non-observation HCPCS code	Claim returned to provider	Claim denial	Active
45. Inpatient separate procedures not paid	Line item rejection	Line item denial	Active
46. Partial hospitalization condition code 41 not approved for type of bill	Claim returned to provider	Claim denial	Active
47. Service is not separately payable	Line item rejection	Line item denial	Active
48. Revenue center requires HCPCS	Claim returned to provider	Claim denial	Active
49. Service on same day as inpatient procedure	Line item denial	Line item denial	Active
50. Non-covered under any Medicare outpatient benefit, based on statutory exclusion	Claim returned to provider	Claim denial	Active
51. Observation code G0378 not allowed to be reported more than once per claim	Claim returned to provider	Claim denial	Active
52. Observation does not meet minimum hours, qualifying diagnoses, and/or 'T' procedure conditions (v3.0–v6.3 only)	Claim returned to provider	Claim denial	Inactive
53. Codes G0378 and G0379 only allowed with bill type 13x or 85x	Line item rejection	Line item denial	Active
54. Multiple codes for the same service (No)	Claim returned to provider	Claim denial	Inactive
55. Non-reportable for site of service	Claim returned to provider	Claim denial	Active

56. E/M condition not met and line item date for obs code G0244 is not 12/31 or 1/1 (v4.0–v6.3 only)	Claim returned to provider	Claim denial	Inactive
57. E/M condition not met for observation and line item date for code G0378 is 1/1	Claim suspension	Claim suspension	Active
58. G0379 only allowed with G0378	Claim returned to provider	Claim denial	Active
59. Clinical trial requires diagnosis code V707 as other than primary diagnosis (deleted, retroYes to the earliest included version)	Claim returned to provider	Claim denial	Inactive
60. Use of modifier CA with more than one procedure not allowed	Claim returned to provider	Claim denial	Active
61. Service can only be billed to the DMERC	Claim returned to provider	Claim denial	Active
62. Code not recognized by OPPS; alternate code for same service may be available	Claim returned to provider	Claim denial	Active
63. This OT code only billed on partial hospitalization claims (v1.0–v13.3)	Claim returned to provider	Claim denial	Inactive
64. AT service not payable outside the partial hospitalization program (v1.0–v13.3)	Line item rejection	Line item denial	Inactive
65. Revenue code not recognized by Medicare	Line item rejection	Line item denial	Active
66. Code requires manual pricing	Claim suspension	No OCE edit posts	Active
67. Service provided prior to FDA approval	Line item denial	Line item denial	Active
68. Service provided prior to date of National Coverage Determination (NCD) or Demonstration approval	Line item denial	Line item denial	Active
69. Service provided outside approval period	Line item denial	Line item denial	Active
70. CA modifier requires patient discharge status indicating expired or transferred	Claim returned to provider	Claim denial	Active
71. Claim lacks required device code (v6.1–v15.3 only)	Claim returned to provider	Claim denial	Inactive
72. Service not billable to the Medicare Administrative Contractor	Claim returned to provider	Claim denial	Active
73. Incorrect billing of blood and blood products	Claim returned to provider	Claim denial	Active

74. Units greater than one for bilateral procedure billed with modifier 50	Claim returned to provider	Claim denial	Active
75. Incorrect billing of modifier FB or FC (v.8.0–v15.3 only)	Claim returned to provider	Claim denial	Inactive
76. Trauma response critical care code without revenue code 068x and CPT 99291	Line item rejection	Line item denial	Active
77. Claim lacks allowed procedure code (v6.1–v15.3 only)	Claim returned to provider	Claim denial	Inactive
78. Claim lacks required radiolabeled product (v9.0–v14.3)	Claim returned to provider	Claim denial	Inactive
79. Incorrect billing of revenue code with HCPCS code	Claim returned to provider	Claim denial	Active
80. Mental health code not approved for partial hospitalization program	Claim returned to provider	Claim denial	Active
81. Mental health service not payable outside the partial hospitalization program	Claim returned to provider	Claim denial	Active
82. Charge exceeds token charge ($1.00)	Claim returned to provider	Claim denial	Active
83. Service provided on or after effective date of NCD non-coverage	Line item denial	Line item denial	Active
84. Claim lacks required primary code	Claim returned to provider	Claim denial	Active
85. Claim lacks required device code or required procedure code (v.13.0–v.14.3)	Claim returned to provider	Claim denial	Inactive
86. Manifestation code not allowed as principal diagnosis	Claim returned to provider	Claim denial	Active
87. Skin substitute application procedure without appropriate skin substitute product code	Claim returned to provider	Claim denial	Active
88. FQHC payment code not reported for FQHC claim	Claim returned to provider	Claim denial	Active
89. FQHC claim lacks required qualifying visit code	Claim returned to provider	Claim denial	Active
90. Incorrect revenue code reported for FQHC payment code	Claim returned to provider	Claim denial	Active
91. Item or service not covered under FQHC PPS or for RHC	Line item rejection	Line item denial	Active
92. Device-intensive procedure reported without device code	Claim returned to provider	Claim denial	Active
93. Corneal tissue processing reported without cornea transplant procedure	Line item rejection	Line item denial	Active

94. Biosimilar HCPCS reported without biosimilar modifier (v17.0–v19.0 only)	Claim returned to provider	Claim denial	Inactive
95. Weekly partial hospitalization services require a minimum of 20 hours of service as evidenced in PHP plan of care (v17.2 only-RTP, v18.3-present, LIR)	Line item rejection (Informational Only, no impact to payment)	Line item denial	Active
96. Partial hospitalization interim claim From and Through dates must span more than 4 days (v17.2 only)	Claim returned to provider	Claim denial	Inactive
97. Partial hospitalization services are required to be billed weekly (v17.2 only)	Claim returned to provider	Claim denial	Inactive
98. Claim with pass-through device lacks required procedure.	Claim returned to provider	Claim denial	Active
99. Claim with pass-through or non-pass-through drug or biological lacks OPPS payable procedure	Claim returned to provider	Claim denial	Active
100. Claim for HSCT allogeneic transplantation lacks required revenue code line for donor acquisition services	Claim returned to provider	Claim denial	Active
101. Item or service with modifier PN not allowed under PFS	Claim returned to provider	Claim denial	Active
102. Modifier pairing not allowed on the same line	Claim returned to provider	Claim denial	Active
103. Modifier reported prior to FDA approval date (v19.0 only)	Line item denial	Line item denial	Inactive
104. Service not eligible for all-inclusive rate	Line item rejection	Line item denial	Active
105. Claim reported with pass-through device prior to FDA approval for procedure	Line item denial	Line item denial	Active
106. Add-on code reported without required primary procedure code	Line item denial	Line item denial	Active
108. Add-on code reported without required primary procedure or without required contractor-defined primary procedure code	Line item denial	Line item denial	Active
109. Code first diagnosis present without mental health diagnosis as the first secondary diagnosis	Claim returned to provider	Claim denial	Active

110. Service provided prior to initial marketing date	Line item rejection	Line item denial	Active
111. Service cost is duplicative; included in cost of associated biological	Line item rejection	Line item denial	Active
112. Information only service(s)	Line item rejection	Line item denial	Active
113. Supplementary or additional code not allowed as principal diagnosis	Claim returned to provider	Claim denial	Active
114. Item or service not allowed with modifier CS	Claim returned to provider	Claim denial	Active
115. COVID-19 lab add-on code reported without required primary procedure	Line item denial	Line item denial	Active
116. Opioid treatment program service not payable outside the opioid treatment program	Claim returned to provider	Claim denial	Active
117. Token charge less than $1.01 billed by provider	Line item rejection	Line item denial	Active
118. Invalid bill type	Claim returned to provider	Claim denial	Active
119. Invalid claim processing receipt date	Claim returned to provider	Claim denial	Active
120. Incorrect reporting of modifier PT	Claim returned to provider	Claim denial	Active
121. Non-covered service reported with inpatient only procedure where patient expired or transferred	Line item denial	Line item denial	Active
122. 340B-acquired drug modifier(s) reported inappropriately	Line item rejection (Information only edit)	Line item denial	Active
123. Modifier used after CMS termination date	Claim returned to provider	Claim denial	Active
124. HCPCS reported after CMS termination date	Claim returned to provider	Claim denial	Active
125. Incorrect billing of IMRT planning and delivery	Claim returned to provider	Claim denial	Active
126. Incorrect reporting of telehealth modifier	Claim returned to provider	Claim denial	Active
127. Service not allowed for Part B Inpatient claim	Line item rejection	Line item denial	Active