IOWA MEDICAID - OCE EDIT - APC GROUPER 26 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
5	External cause of morbidity code cannot be used as principal diagnosis	Claim returned to provider	Claim denial
6	Invalid procedure code	Claim returned to provider	Claim denial
7	Procedure and age conflict	Line item rejection	Line item denial
9	Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion	Line item denial	Line item denial
11	Service submitted for MAC review	Claim suspension	No OCE edits posts
12	Questionable covered service	Claim suspension	No OCE edits posts
13	Separate payment for services is not provided by Medicare	Line item rejection	Line item denial
17	Inappropriate specification of bilateral procedure	Line item rejection	Line item denial
18	Inpatient procedure	Line item denial	Line item denial
20	Code2 of a code pair 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	Claim returned to provider	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 for outpatient claims; alternate code for same service may be available	Line item rejection	Line item denial
29	PHP/IOP for non-applicable diagnosis	Claim returned to provider	Claim denial
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 or administered substance and implantation or associated procedure	Claim returned to provider	Claim denial
40	Code2 of a code pair that would be allowed by 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 under any Medicare outpatient benefit, based on statutory exclusion	Claim returned to provider	Claim denial
51	Observation code G0378 not allowed to be reported more than once per claim	Claim returned to provider	Claim denial
53	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
57	E/M condition not met for observation and line item date for code G0378 is 1/1	Claim suspension	Claim suspension
58	G0379 only allowed with G0378	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 the DMERC	Claim returned to provider	Claim denial
62	Code not recognized by OPPS; alternate	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 denial	Line item denial
68	Service provided prior to date of National Coverage Determination (NDC) approval	Line item denial	Line item denial
69	Service provided outside approval period	Line item denial	Line item denial
70	CA modifier requires patient discharge status indicating expired or transferred	Claim returned to provider	Claim denial
72	Service not billable to the Medicare Administrative Contractor	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	Claim returned to provider	Claim denial

IOWA MEDICAID - OCE EDIT - APC GROUPER 26 VERSION			
Edit Number and Description		Medicare Claim Disposition	Medicaid Claim Disposition
81	Mental health service not payable outside the partial hospitalization program	Claim returned to provider	Claim denial
82	Charge exceeds token charge ($1.00)	Claim returned to provider	Claim denial
83	Service provided on or after effective date of NCD	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-intensive 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	7-day spanning 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 or device with payment limitation 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	Modifier pairing 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 code	Line item denial	Line item denial
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
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
120	Incorrect reporting of modifier PT	Claim returned to provider	Claim denial
121	Non-covered service reported with inpatient only procedure where patient expired or transferred	Line item denial	Line item denial
122	340B-acquired drug modifier(s) reported inappropriately	Claim returned to provider	Claim denial
123	Modifier used after CMS termination date	Claim returned to provider	Claim denial
124	HCPCS reported after CMS termination date	Claim returned to provider	Claim denial
125	Incorrect billing of IMRT planning and delivery	Claim returned to provider	Claim denial
126	Incorrect reporting of telehealth modifier	Claim returned to provider	Claim denial
127	Service not allowed for Part B Inpatient claim	Line item rejection	Line item denial
128	Insufficient services on day of IOP	Line item rejection	Line item denial
129	7-day spanning IOP services require a minimum of 9 hours of service	Line item rejection	Line item denial
130	Incorrect reporting of modifier on RHC IOP claim	Claim returned to provider	Claim denial
131	Insufficient services on day of PHP	Line item rejection	Line item denial
132	Mental health code not approved for Intensive Outpatient program	Claim returned to provider	Claim denial
133	Mental health service not payable outside the Intensive Outpatient program	Claim returned to provider	Claim denial
134	Service provided outside designated approval period	Line item rejection	Line item denial
135	Claim Day lacks required device code	Claim returned to provider	Claim denial
136	Service provided prior to ACIP approval date	Line item rejection	Line item denial
137	More than 2 non-opioid pain relief devices reported	Line item rejection	Line item denial
138	More than 3 non-opioid surgical pain drugs reported	Line item rejection	Line item denial
190	IOP Primary service not reported for IOP day	Claim returned to provider	Claim denial
191	PHP Primary service not reported for PHP day	Claim returned to provider	Claim denial